North East London
Clinical Commissioning Group

NEL Clinical Commissioning Group Governing Body

26 January 2022

12.30pm – 2.30pm, MS Teams

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	**12.30**	**Chair**		
1.1	Declaration of conflicts of interest			**Attached**	**Note**
1.2	Minutes of the meeting held on 27 October 2021			**Attached**	**Approve**
1.3	Matters arising			**Attached**	**Note**
2.0	**Chair and accountable officer reports**				
2.1	Chair's report	**12.35**	**Chair**	**Attached**	**Note**
2.2	Accountable Officer's report	**12.40**	**HB**	**Attached**	**Note**
3.0	**People and patient engagement**				
3.1	Questions from the public	**12.45**	**Chair**	**Verbal**	**Discussion**
3.2	Patient and public involvement update	**1.00**	**KA**	**Attached**	**Note**
3.3	People and OD update	**1.05**	**RP**	**Attached**	**Note**
4.0	**Governing body assurance**				
4.1	Governing body assurance framework	**1.15**	**KP/MP**	**Attached**	**Note**
5.0	**Corporate strategy and planning**				
5.1	National Evidence Based Interventions Wave 2	**1.20**	**VT/SH**	**Attached**	**Approve**
5.2	2022/23 planning guidance	**1.30**	**AM**	**Attached**	**Note**
6.0	**Quality, finance and performance**				
6.1	Performance report	**1.40**	**NC/AM**	**Attached**	**Note**
6.2	Finance report	**1.50**	**SC**	**Attached**	**Note**
6.3	Quality report	**2.00**	**FS/DJ**	**Attached**	**Approve**
6.4	Annual safeguarding reports 2020/21	**2.10**	**DJ**	**Attached**	**Approve**
7.0	**Governance**				
7.1	EPRR update	**2.15**	**AM**	**Attached**	**Note**
7.2	Committee chair reports and minutes of relevant fora:	**2.20**	**Chair**	**Attached**	**Note**

	• Audit and Risk Committee Chair's report and minutes • Primary Care Commissioning Committee Chair's report and minutes • Finance and Performance Committee Chair's report and minutes • Quality, safety & improvement committee Chair's report and minutes • BHR ICP Committee Chair's report and minutes • C&H ICP Committee Chair's report and minutes • TNW ICP Committee Chair's report and minutes				
8.0	**Any other business and close**	**2.25**	**Chair**	**Verbal**	**Discuss**
Date of next meeting – 23 March 2022					

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Glossary of terms and abbreviations

Term	Explanation
A&G	Advice and Guidance
A&E	Accident and Emergency
AF	Atrial Fibrillation
AO	Accountable Officer
ADL	Activities of Daily Living
APC	Area Prescribing Committee
APMS	Alternative Provider Medical Services
AQP	Any qualified provider
BH	Barts Health NHS Trust
BCF	Better Care Fund
BP	Borough Partnership
BCP	Business Continuity Plan
BHR	Barking and Dagenham, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
BMA	British Medical Association
C&H	City and Hackney
CAMHS	Children and Young People Mental Health Services
CCG	Clinical Commissioning Group
CCS	Complex Care Service
CCU	Critical Care Unit
CD	Clinical Director
CDOP	Child Death Overview Panel
CEG	Clinical Effectiveness Group
CEO	Chief Executive Officer
CEPN	Community Education Provider Network
CFO	Chief Finance Officer

CHC	Continuing Healthcare
CHS	Community Health Services
CHSCS	Community Health and Social Care Services
CIL	Community Infrastructure Levies
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
CTT	Community Treatment Team
CVS	Council of Voluntary Services
CYPP	Children and Young Person Plan
DES	Direct Enhanced Service
DoH	Department of Health
DToC	Delayed Transfer of Care
EBI	Evidence Based Interventions
ECG	Electrocardiogram
ED	Emergency Department
ELFT	East London NHS Foundation Trust
EOL/ EOLC	End of Life/ End of Life Care
EPR	Electronic Patient Record
FOI	Freedom of Information
FYE	Full Year Effect
GBAF	Governing Body Assurance Framework
GLA	Greater London Authority
GMC	General Medical Council
GMS	General Medical Services
HCAIs	Healthcare Associated Infections
HEE	Health Education England
HLP	Healthy London Partnership
HSC	Health Scrutiny Committee
HUH	Homerton University Hospital NHS Foundation Trust

HWBB	Health & Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICPB	Integrated Care Partnership Board
ICS	Integrated Care System
ICM	Integrated Case Management
ICSG	Integrated Care Joint Health and Social Care Steering Group
IG	Information Governance
IFR	Individual Funding Request
IRS	Intensive Rehabilitation Service
IST	Intensive Support Team
ITU	Intensive Therapy Unit
JHWS	Joint Health & Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
KPIs	Key Performance Indicators
LAC	Looked After Children
LAS	London Ambulance Service
LAs	Local Authorities
LCFS	Local Counter Fraud Specialist
LD	Learning Disability
LES	Local Enhanced Service
LETB	Local Education and Training Boards
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LSCB	Local Safeguarding Children's Board
LTC	Long Term Conditions
MD	Managing Director
MOU	Memorandum of Understanding
MPIG	Minimum Practice Income Guarantee
MSK	Musculoskeletal

MSRB	Maternity Systems Readiness Board
NEL	North East London
NELCA	North East London Commissioning Alliance
NELFT	North East London Foundation Trust
NELHCP	North East London Health and Care Partnership
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
OD	Organisation Development
ONEL	Outer North East London
OOH	Out of hours
OPD	Outpatient department
PALS	Patient Advice and Liaison Service
PCCC	Primary Care Commissioning Committee
PEF	Patient Engagement Forum
PELC	Partnership of East London Cooperatives
PHE	Public Health England
PBP	Place Based Partnership
PMCF	Prime Minister's Challenge Fund
PMO	Project Management Office
PMS	Personal Medical Services
POD	Point of Delivery
PPGs	Patient Participation Groups
PPI	Patient and Public Involvement
PSED	Public Sector Equality Duty
PTL	Patient Tracking List
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality Outcome Framework
RAG	Red, Amber, Green
RTT	Referral to Treatment
SAB	Safeguarding Adults Board
SCB	Safeguarding Children's Board

SCN	Strategic Clinical Network
SDPB	System Delivery Programme Board
SEND	Special Educational Needs and Disability
SLAM	Service Level Agreement Monitoring
SMT	Senior Management Team
SPA	Single Point of Access
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plan
TDA	Trust Development Agency
TNW	Tower Hamlets, Newham and Waltham Forest
ToR	Terms of Reference
UCC	Urgent Care Centre
UCL	University College London
UCLP	University College London Partners
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
VFM	Value for Money
WICs	Walk in Centres
WTE	Whole Time Equivalent
WX	Whipps Cross Hospital
YTD	Year to Date

NHS
North East London
Clinical Commissioning Group

Name	Position/Relationship with CCG	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Anil Mehta	Redbridge Clinical Chair	BHR ICP Health and Care Cabinet BHR ICP Primary Care Management Group BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC)	Financial Interest	Fullwell Cross Medical Centre	GP Partner	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Metropolitan Police	Forensic Medical Examiner	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	NHSE	GP Appraiser	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Healthbridge Direct	Shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Fouress Enterprise Ltd	Director	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Prescon	Ad-hoc screening work	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	The Cleaning Company	Sister-in-law is owner	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Healthwise Ltd (non-trading)	Director	2009-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GMC	Associate	2019-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NEL CCG	Registered as a patient at a GP practice in NEL.	2000-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Redbridge Health and Wellbeing Board	Vice Chair	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Anglia Ruskin University Medical School	Lecturer	2019-01-01		Declarations to be made at the beginning of meetings

			Non-Financial Professional Interest	QMUL	GP Tutor	2021-01-01		Declarations to be made at the beginning of meetings
Archna Mathur	Director of Performance and Assurance	NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Quality Committee	Indirect Interest	NHSX	Husband employed as Director of Platforms at NHSX	2020-04-01	2021-04-01	Declarations to be made at the beginning of meetings
			Financial Interest	Maylands Healthcare	GP Partner	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Maylands Healthcare Ltd	Director and shareholder in on-site pharmacy	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Essex Medicare LLP	Part-owner (which owns Westland Clinic, Hornchurch. Space rented out to: · Inhealth (Diagnostics) · Nuffield Health (Brentwood) · Communitas Clinics (Dermatology and gynaecology)	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Havering Health Ltd	Shareholder. GP partner at Maylands Surgery (Dr joti) is a Director	2014-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Parkview Dental Practice	Sister is NHS Dentist within Havering she is an associate and does not own the business	1996-01-01		Declarations to be made at the beginning of meetings
Atul Aggarwal	Havering Clinical Chair	BHR ICP Finance Sub-committee BHR ICP Health and Care Cabinet BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body	Indirect Interest	Westlands Clinic (Langton Dental) who has an outsourced contract with BHRUT for oral surgery)	Spouse is dentist	2018-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking, Dagenham and Havering LMC	Co-opted member	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Havering and Wellbeing Board	Member	2013-01-01		Declarations to be made at the beginning of meetings

			Non-Financial Professional Interest	Anglia Ruskin University Medical School	Lecturer	2019-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	NEL CCG	Registered as a patient at a GP practice in NEL.	1990-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica LTD	Prather at Surgery who is director or company - I am a shareholder	2021-10-31		Declarations to be made at the beginning of meetings
Charlotte Harrison	Independent Secondary Care Specialist	NEL CCG Audit & Risk Committee NEL CCG Governing Body NEL CCG Quality Committee NEL CCG Primary Care Commissioning Committee (PCCC)	Non-Financial Professional Interest	South West London and St Georges Mental Health NHS Trust	Deputy Medical Director and Consultant Psychiatrist	2021-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	CYP Covid-19 Recovery Steering Group	Co-Chair	2020-01-01		Declarations to be made at the beginning of meetings
Christopher Cotton	Director of Strategy and System Transformation	NEL CCG Governing Body	Non-Financial Personal Interest	Hillsborough Court Limited	Director	2018-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	PA Consulting, PwC LLP	Previous employee	2011-01-01	2021-01-01	Declarations to be made at the beginning of meetings
Diane Jones	Chief Nurse	NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Quality Committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01		Declarations to be made at the beginning of meetings
Fiona Smith	Independent Board Registered Nurse	TNW Finance & Performance Sub-committee TNW ICP Area Committee/ Delivery Group TNW Quality, Safety and Improvement Sub-committee	Financial Interest	Honesta Partners Ltd (a healthcare management consultancy)	Director and co-owner	2015-01-01		Declarations to be made at the beginning of meetings

		NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Quality Committee						
			Indirect Interest	Honesta Partners Ltd	Spouse is a shareholder	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	First Community Health and Care, Surrey	Non-Executive Director	2019-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	First Community Health and Care CIC	I am a Non-Executive director at FCHC. FCHC is a community services social enterprise provider, in Surrey and West Sussex.	2019-11-01		Declarations to be made at the beginning of meetings
Henry Black	Acting Accountable Officer	NEL CCG Governing Body BHR Integrated Care Partnership Board (ICPB)/ Area Committee BHR Integrated Care Executive Group (ICEG) TNW ICP Area Committee/ Delivery Group	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Tower Hamlets GP Care Group	Daughter is Social Prescriber	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Clinical Commissioners	Board Member	2018-01-01	2021-07-31	Declarations to be made at the beginning of meetings
Jagan John	NEL CCG Chair	BHR ICP Health and Care Cabinet BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	Parkstone Holdings Ltd	Director	2020-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	2020-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	2020-05-01		Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and Shareholder	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifieth Ltd)	Director and Shareholder	2020-10-01		Declarations to be made at the beginning of meetings

		NEL CCG Governing Body NEL CCG Quality Committee NEL CCG Remuneration Committee						
			Indirect Interest	Aurora Medcare (previously known as King Edward Medical Group)	Other GPs are family members	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	2020-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Personalised Care – Healthy London Partnerships and NHS England London Region	Clinical Lead	2017-05-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust– Barking and Dagenham Community Cardiology Service	GPWSI in Cardiology	2011-08-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking and Dagenham Health and Wellbeing Board	Deputy Chair	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is share holder	2021-10-31		
Kash Pandya	Lay Member Governance and Audit Chair	BHR ICP Finance Sub-committee BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Audit & Risk Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC)	Financial Interest	Southend-on-Sea Borough Council	Independent Audit Committee Member	2016-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Essex Police, Fire and Crime Commissioner's Audit Committee	Independent Audit Committee Member	2021-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	University of Essex	Independent Audit Committee Member	2014-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Brentwood Citizen's Advice Bureau	General Advisor	2009-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Metro Bank	Son is Procurement Manager	2019-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Accenture	Son is a Legal Director	2017-01-01		Declarations to be made at the beginning of meetings

Ken Aswani	Waltham Forest Clinical Chair	TNW Finance & Performance Sub-committee TNW ICP Area Committee/ Delivery Group NEL CCG Finance & Performance Committee NEL CCG Governing Body	Financial Interest	Allum Medical Centre	GP Partner	1990-01-01	2021-04-29	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NEL RCGP Faculty	Member	1995-01-01	2021-04-29	Declarations to be made at the beginning of meetings
			Financial Interest	Fednet	Member Practice	2014-01-01	2021-04-29	Declarations to be made at the beginning of meetings
			Financial Interest	CQC	GP Inspector (Not in NE London)	2014-01-01	2021-04-29	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Clinical Panel	Advisory Role (Not in NE London)	2015-01-01	2021-04-29	Declarations to be made at the beginning of meetings
Khalil Ali	Lay Member for PPI	NEL CCG Audit & Risk Committee NEL CCG Governing Body NEL CCG Remuneration Committee NEL CCG Quality Committee NEL CCG Primary Care Commissioning Committee (PCCC)	Financial Interest	NEL CCG	Registered as a patient at a GP practice in NEL.	2019-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	St Francis Hospice, Havering	Spouse is a regular donor	2017-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Cancer Research UK	Spouse is a regular donor	2017-01-01		Declarations to be made at the beginning of meetings
Marie Price	Director of Corporate Affairs	NEL CCG Audit & Risk Committee NEL CCG Governing Body NEL CCG Remuneration Committee	Indirect Interest	Greater London Authority	Partner works as NE London Region Lead	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Lower Clapton GP Practice, Hackney	Registered as a patient at a GP practice in NEL.	2008-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Cadence Partners	Close friends with managing partner and head of operations. Cadence Partners is an executive search firm.	2018-12-03		Declarations to be made at the beginning of meetings
			Indirect Interest	Hackney Council	Close friend with Strategic Director Engagement,	2020-01-01		Declarations to be made at the beginning of meetings

					Culture and OD (also responsible for communications)			
Mark Rickets	City and Hackney Clinical Chair	NEL CCG Governing Body NEL CCG Finance & Performance Committee NEL CCG Primary Care Commissioning Committee (PCCC)	Financial Interest	GP Confederation	Nightingale Practice is a Member			Declarations to be made at the beginning of meetings
			Financial Interest	HENCEL	GP appraiser in City and Hackney and Tower Hamlets for HENCEL			Declarations to be made at the beginning of meetings
			Financial Interest	Nightingale Practice (CCG Member Practice)	Salaried GP			Declarations to be made at the beginning of meetings
			Indirect Interest	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow			Declarations to be made at the beginning of meetings
Muhammad Naqvi	Newham Clinical Chair	NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) TNW ICP Area Committee/ Delivery Group	Financial Interest	Woodgrange Medical practice	GP partner	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	NHC - Newham GP Federation, Woodrange practice is a shareholder	GP partner	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Frenford clubs for young people (registered charity/ voluntary organisation)	Trustee	2012-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Newham Health and Wellbeing Board	Co-Chair	2018-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Al-Sabr Foundation (registered charity/ voluntary organisation)	Trustee	2021-01-01		Declarations to be made at the beginning of meetings
Noah Curthoys	Lay Member (Performance) NEL CCG	TNW Finance & Performance Sub-committee NEL CCG Audit & Risk Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Remuneration Committee	Non-Financial Professional Interest	Democratic Society	Council Member - unremunerated non-exec role, previously a paid Senior Partner from 2016 to 2019. Demsoc has contracted with NHS England in the past.	2019-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Coastal West Sussex CCG	Chief of Corporate Affairs	2013-01-01	2015-01-01	Declarations to be made at the beginning of meetings

			Non-Financial Professional Interest	Wallands Community Primary School	Governor - Co-opted governor, unremunerated, ended in July 2021	2014-01-01	2021-06-01	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Priory School	Vice Chair and Local Authority Governor - unremunerated, voting member	2021-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Bridgenor Group Ltd	Director and owner of this market research consultancy, no contracts with the NHS	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Northshott Counsulting Ltd	Director and owner of this strategy consultancy, no contracts with the NHS	2011-01-01		Declarations to be made at the beginning of meetings
Sam Everington	Deputy Clinical CCG Chair and Clinical Chair Tower Hamlets	NEL CCG Governing Body	Financial Interest	Bromley By Bow Partnership - based at the Bromley by Bow Centre Charity 1999	Partner	1989-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	NEL CCG Board (Tower Hamlets)	Committee member	2021-04-01		Declarations to be made at the beginning of meetings
			Financial Interest	Health & Wellbeing Board - (London Borough Tower Hamlets & Tower Hamlets ICP)	Deputy Chair	2016-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	NHS Resolution	Associate non-executive	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	East London Foundation Trust	Non-executive Director	2020-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Bromley-by-Bow Ltd - Joint venture with Greenlight venture	Director	1st Jan 2020	-	Declarations to be made at the beginning of meetings

			Non-Financial Professional Interest	British Medical Association	Council member	1st Jan 1989	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	MDDUS (Insurance for GP Partnership)	Member	1st Jan 2010	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Queen Mary University London	Honorary Professor	1st Jan 2015	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Queens Nursing Institute	Vice President	1st Jan 2016	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	College of Medicine	Vice President and Council member	1st Jan 2010	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NESTA Advisory Board	Board Member	1st Jan 2018	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of GPs	Member	1st Jan 1989	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Health Education England	Medical Apprenticeship Committee - Chair	1st Jan 2021	-	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Health Education England	GP Pilot Committee - Member	1st Jan 2018	-	Declarations to be made at the beginning of meetings
			Indirect Interest	Bromley-by-Bow Partnership	Partner is a partner and a director of nursing (runs - XX Place, St Andrews and Bromley-by-Bow Health Centres.)	1st Jan 1999	-	Declarations to be made at the beginning of meetings

			Indirect Interest	Bromley-by-Bow Partnership	Son is employed as receptionist	2020-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	British Medical Association	Vice President	2015		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Strategic Infrastructure Board	Board Member	2020		Declarations to be made at the beginning of meetings
Simon Hall	Director of Transformation	NEL CCG Governing Body NEL CCG Quality Committee	Non-Financial Professional Interest	University Schools Trust (Charitable Academy Trust responsible for running schools in the London Borough of Tower Hamlets and the Royal Borough of Greenwich)	Trustee	2018-05-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Metro Charity Ltd (diversity and equalities charity based in Woolwich running HIV, youth, mental health and disability services in the south of London and south east of England; organisation also has lead charitable role in both Greenwich and Lewisham boroughs).	Unpaid role. Metro does have some pan-London contracts for HIV and sexual health work.	2018-05-15		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	The Keep Residents' Association Ltd. (residents' association in Blackheath, unpaid elected role)	Director	2015-11-10		Declarations to be made at the beginning of meetings
			Indirect Interest	Homerton University NHS Trust	Relative works in the governance team	2017-01-01		Declarations to be made at the beginning of meetings
Siobhan Harper	Director of Transition TNW ICP, NEL CCG	TNW Finance & Performance Sub-committee TNW ICP Area Committee/ Delivery Group TNW Quality, Safety and Improvement Sub-committee TNW Transformation and Innovation Committee NEL CCG Governing Body	Indirect Interest	Health and Justice at NHSE	Sister is Head of HJ	2021-01-01		Declarations to be made at the beginning of meetings

		NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Quality Committee						
Steve Collins	Acting Chief Finance Officer	TNW Finance & Performance Sub-committee TNW ICP Area Committee/ Delivery Group C&H Finance and Performance Subcommittee C&H Integrated Care Partnership Board (ICPB) BHR ICP Finance Sub-committee BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Audit & Risk Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Remuneration Committee	Non-Financial Professional Interest	Trisett Limited (business support service)	Director	2003-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Sevenoaks Primary School	Chair of Governors	2002-01-01	2021-01-01	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Hope Church Sevenoaks	Chair of Trustees	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Fegans (charity)	Wife is Chair of Trustees	2017-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	PwC	Daughter is Senior Associate	2019-01-01		Declarations to be made at the beginning of meetings
Sue Evans	Lay Member Primary Care	C&H Finance and Performance Subcommittee C&H Integrated Care Partnership Board (ICPB) NEL CCG Audit & Risk Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Remuneration Committee	Non-Financial Professional Interest	Worshipful Company of Glass Sellers' of London (City Livery Company) Charity Fund	Company Secretary / Clerk to the Trustees'	2014-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	North East London NHS	Self and family users of healthcare services in NEL	2017-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	St Aubyn's School Charitable Trust	Trustee and Director of	2013-01-01		Declarations to be made at the beginning of meetings

					Company Ltd by Guarantee			

- Nil Interests Declared as of 17/01/2022

Name	Position/Relationship with CCG	Committees	Declared Interest
Ceri Jacob	Managing Director; BHR ICP	BHR ICP Finance Sub-committee BHR ICP Primary Care Management Group BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Quality Committee	Indicated No Conflicts To Declare.

North East London
Clinical Commissioning Group

Governing Body meeting

12.30-3pm, Wednesday 27 October 2021, Microsoft Teams

Minutes

Present	
Khalil Ali	Lay Member for Patient and Public Involvement
Dr Ken Aswani	Clinical Chair, Waltham Forest
Henry Black	Acting Accountable Officer
Steve Collins	Acting Chief Finance Officer
Noah Curthoys	Lay Member for Performance
Sue Evans	Lay Member for Primary Care and Deputy CCG Chair
Professor Sir Sam Everington	Clinical Chair, Tower Hamlets and Deputy CCG Clinical Chair
Charlotte Harrison	Secondary Care Consultant
Dr Jagan John (Chair)	Chair, and Clinical Chair Barking and Dagenham
Dr Anil Mehta	Clinical Chair, Redbridge
Dr Muhammad Naqvi	Clinical Chair, Newham
Kash Pandya	Lay Member for Governance
Dr Mark Rickets	Clinical Chair, City & Hackney
Fiona Smith	Registered Nurse
In attendance	
Laura Anstey	Chief of Staff, NEL ICS
Dianne Barham	HealthWatch, Tower Hamlets
Chris Cotton	NEL ICS Transition Director
Mark Eaton (item 3.1)	Interim Director of System Recovery
Bob Edwards (item 2.1)	Integrated Care Director (Redbridge)
Keith Flaxman (item 3.2)	Project Director
Siobhan Harper	Transition Director, TNW
Ceri Jacob	Managing Director, BHR
Diane Jones	Chief Nurse
Anne-Marie Keliris	Head of Governance
Archna Mathur	Director of Performance and Assurance
Kate McFadden-Lewis (minutes)	Board Secretary
Rachel Patterson	Director of People and OD
Marie Price	Director of Corporate Affairs
Apologies	
Dr Atul Aggarwal	Clinical Chair, Havering

No.	Item
1	**Welcome, introductions, apologies** Dr Jagan John welcomed the group and introductions were made. Apologies were noted as above. The following members of the public were in attendance: • Sophia Jaques • Ross Lydall, Health Editor + City Hall Editor, Evening Standard-part • Gayle Thompson, Regional Market Access Manager, Aspire Pharma Limited. There were no declarations of interest.
1.2	**Minutes of the last meeting and matters arising** The minutes of the meeting held 25 August 2021 were agreed as an accurate record
1.3	**Chair's report** Jagan John presented the Chair's report, updating the group on the key areas of work over the previous months. The Governing Body noted the report.
1.4	**Accountable Officer's report** Henry Black presented the Accountable Officer's report, updating the group on the key areas of work over the previous months. The Governing Body noted the report.
2.1	**Questions from the public** Mark Dumbrill, Family Therapist, Redbridge CAMHS, asked in advance of the meeting: 1. Are the CCG aware that young people in Redbridge aged sixteen and seventeen are unlikely to receive any specialist CAMHS treatment due to the long waiting times for both assessment and any subsequent recommended treatment? 2. Are the CCG aware that adult mental health services in Redbridge are refusing to accept referrals for these young people until they turn 18, meaning they then must join new waiting lists for assessment and any subsequent treatment? Response: The CCG is aware that there are pressures on service within CAMHS – EWMHS currently, due to high numbers of children and young people being referred to the service. NELFT are increasing the service capacity above the usual establishment level by contracting with additional staff, who will be onstream shortly. Review clinics have been introduced that are run by psychologists and assistant psychologists to identify CYP who would benefit from group intervention. 350 CYP have been reviewed through this process so far. Adult mental health services are not refusing to accept referrals for young people until they turn 18. If the young person is open to CAMHS, a discussion can take place in the NELFT transitions meeting for a referral to adult mental health services after they reach the age of 171/2. If the young person is suitable for a referral, they will get their first appointment before their 18th birthday to ensure a smooth transition between services. Not all CYP are suitable for transfer to adult mental health services and adult mental health services are not able to accept referrals for young people who are not already under CAMHS prior to their 18th birthday. There is a workstream under the Mental Health Transformation programme that is reviewing the transitional processes and how they can be improved over the course of this year. The CCG have a set of actions in place with NELFT to address this issue and we will be tracking this through our quality committees. Liz Perloff, Newham resident, asked in advance of the meeting:

	1. A) Since January 2020, when it was minuted by the CCG that medical imaging at Newham General Hospital required improvement. What measures has the CCG put into place to monitor the accuracy of medical imaging reporting within Bart's Health and the Homerton Hospital? B) What improvements does the CCG intend to make with regards to acting on the public's concerns as members of the public told the CCG that medical imaging reporting was below par in 2017, 2018 and 2019 2.A) since minuting in the February 2020 board minutes that Newham General Hospital was discharging Newham residents without treatment in what was called an " Appointment Slippage Issue" what monitoring and improvement measures has the CCG put into place to ensure this does not happen again? B) What improvements does the NEL CCG and the next reincarnation of this organisation, intend to make to its complaints process to ensure that members of the public who raised this concerns about unfair discharge in 2017, 2018, 2019 concerns are taken seriously to prevent further harm to Newham residents? Response: Thank you for these, we have covered some of these topics in previous meetings where we have advised the processes by which we, our local NHS trusts and the Care Quality Commission review the quality of the services provided to the public. Where issues are raised by staff or members of the public we will investigate these and learn lessons. We work closely with our community trusts and local authority colleagues to ensure that patients are appropriately discharged. In relation to your specific queries regarding imaging accuracy - all discrepancies in imaging reports are reviewed in a regular (at least monthly) discrepancy meeting, to ensure that learning is captured and quality issues are recognised and escalated. In term of any issue regarding patients being discharged without treatment, we are not aware of such issues over the past 18 months and Trust colleagues have gone through a process of contacting patients on waiting lists for treatment who may have experienced delays as a result of the pandemic. We are in the process of reviewing our complaints policy and process as part of our preparations to become a new organisation in 2022, subject to legislation passing. We are looking at best practice and learning from the past, and will incorporate this into our final version. A full response to these questions will be provided in writing, and the updated questions log published on the CCG website.
2.2	**Patient engagement report** Khalil Ali updated the group on the patient engagement work since the last meeting and highlighted the following key points: i. the engagement with our patient groups and voluntary and community sector on the ICS ii. the work around the three overarching priority themes, commitment, culture and community iii. the aim to more ambitious in north east London than the ICS guidance on engaging people and communities iv. the successful bid to the voluntary community social enterprise Leadership Programme v. the continued support to maternity services. Discussion points included: i. the many patient engagement initiatives and programmes of work being nominated for awards, and the excellent engagement work happening across north east London ii. the important community insights work with Healthwatch, as well as the engagement around the ICS development

	iii. the importance of this work to support the health inequalities strategy for north east London.
2,3	**People and OD update, including WRES report and action plan** Rachel Patterson updated the group on the people and OD work to bring together the seven CCGs policies, practices and processes, the transition to the ICS and the creation of the NEL Integrated Care Board. Rachel then updated that the Workforce Race Equality Standard (WRES) outline action plan is in place, with BME staff at senior level, reducing bullying and harassment and improving the declaration of protected characteristics data quality as the key focus areas. In discussion the Governing Body noted: i. the importance of building meaningful and collaborative relationships between and across our ICS partners at all levels, as well as with our patients and local community, and ensuring staff have training and guidance on this ii. the important role of the staff networks in supporting this work iii. the need to ensure this work is future proofed and in line with the ICS guidance, and the NEL People Board as a basis for the ICS iv. the importance of ensuring that the WRES is met in our trusts and primary care providers.
3.1	**BHR Integrated Sustainability Plan** Ceri Jacob presented the BHR Integrated Sustainability Plan (ISP), which has been put in place to support the Covid-19 recovery and transformation across the BHR system. The plan has been developed in collaboration with providers and commissioners and focusses on ensuring the right care, in the right place for patients. Discussion points included: i. the learning from this plan which could extend across north east London ii. the importance of prevention and early intervention to the success of this plan, as well as a focus on child health and developing healthy ongoing lifestyle behaviours iii. the need for a workforce development plan, as well as an estates plan, aligned to the ISP iv. that patient and public involvement is key, and will be further developed. The Governing Body approved the ISP for implementation.
3.2	**St George's Health and Well Being Hub** Keith Flaxman joined the meeting to update on the progress of the Outline Business Case (OBC) for the St George's development. Key discussion points included: i. the development is an opportunity to improve access to a wide range of services for the local community ii. the tight timescale, with delivery required by 31 March 2024, with the current estimated delivery date of October 2023, however robust plans are in place to ensure this is met iii. the importance of this scheme to the overall estates plan for north east London, including creating space at Queens Hospital for the maternity expansion, as well as the role this hub will play in supporting the wider system strategy. The Governing Body noted the update and extended their support to NELFT for this important programme of work.
3.3	**NEL ICS Winter Plan** Archna Mathur presented on the winter plan for NEL ICS, which has been co-produced with our providers and local authorities. Areas of focus include Ambulance handover delays, discharge and hospital flow and ensuring the resilience of the NHS 111 service. Key discussion points included: i. the need to ensure that the governance in place allows an agile response and quick decisions to me made

	ii. NHS 111 as the first point of access for urgent care, and the direct dental line in place, accessed through NHS 111 iii. the importance of a robust communications strategy to support the winter plan, for patients and the public, as well as healthcare professionals, to ensure people are informed and aware of the available services, and are able to go to the right place for the right treatment iv. the programme of work in place to increase the level of direct booking into primary care from NHS 111, and the need to ensure urgent treatment centres are utilised out of hours and direct booking into primary care is used in hours.
3.4	**Improving access for patients and supporting general practice** Ceri Jacob presented on the submission to NHS England and Improvement for winter access funding to support increasing same day access to primary care from November 2021 to March 2022. The deadline is 28 October, and there has been a very tight turnaround time. Each ICS been asked to focus on unwarranted variation and identify a list of up to 20% of practices that had the lowest level of access, in particular face to face. The General Practitioners Committee and Local Medical Committees have advised GPs and primary care networks to disengage with this process until it was more supportive and less punitive, however the CCG is still required to submit a plan to ensure the funding is secured to support primary care winter plans. The plan will focus on supporting programmes of work which are already in place, and it has been agreed to anonymise the 20% of practices needing the most support. Given the very tight timescale for the submission, the Governing Body is asked to delegate authority to approve the submission to a group to consist of Dr Jagan John, Sue Evans, Kash Pandya and Henry Black/Steve Collins. Discussion points included: i. the recommendation to include Dr Mark Rickets, as primary care GP lead in the delegated group ii. that the primary care team will remain open to practices re-engaging with the process should they wish to, and will continue to support practices iii. the funding will make a significant difference to patients and will support digital and data improvements and increased access to patients iv. the need to ensure that the plan is flexible so that the funding shaped and used to best support practices through winter. The Governing Body approved the recommendation to delegate authority to approve the submission, subject to the addition of Dr Mark Rickets to the group.
4.1	**Performance update** Archna Mathur updated the Governing Body on performance across north east London, highlighting the following key points: i. the challenges around 104 week waits, in particular for paediatric dentistry and ENT at Barts Health. With a new paediatric dentistry service commencing in October and additional ENT consultants starting in November, improvements are expected soon ii. overall the NEL ICS delvers the highest volume of Advice and Guidance in London, with the majority delivered through Barts Health iii. NEL ICS is the lowest in London on delivery of the new target of 75% of cancer treatment within 28 days iv. areas of concern for mental health include dementia, SMI physical health checks, CAMHS and eating disorders in children and young people v. some concerns around the diagnostic back log, with the Mile End early diagnostic centre helping to improve this.

	Discussion points included: i. the need for assurances that patients are not coming to significant harm due to the long waits for treatment. It was agreed to report on this at the next meeting. (**ACTION: AM/ DJ**) ii. the importance of clinical validation of the elective and diagnostic waiting list for prioritisation, with every patient on the list given a rating which is regularly reassessed iii. the important initiatives across north east London to support elective recovery, including Advice and Guidance and project scalpel at BHRUT, and the need to spread good practice and initiatives across the system.
4.2	**Finance report** Steve Collins updated the Governing Body on the financial position for month six, reporting a breakeven position for Half-Year 1 (H1), with some risks to this position. Steve updated that H2 planning is underway, as well as preparation of capital transformation fund bid submission. In discussion the Governing Body noted: i. the increased private sector spending to support the elective backlog recovery. It was agreed to include the impact this is making on the waiting list in a future report (**ACTION: SC**) ii. with an average of 90% of people in ITU with Covid-19 being unvaccinated, the importance of increasing vaccination rates so that these beds can be used to treat the non-Covid patients and support the elective recovery iii. the need to carry out a full reconciliation on the assisted development funding for H1 to ensure any underspend is fully committed.
4.3	**Quality report** Diane Jones presented on the recent work of the quality groups and committees across NEL CCG since the last meeting, and updated the Governing Body on the unplanned CQC inspection of the maternity unit at BHRUT in June. Key points from the report, published 1 October 2021, include: i. the overall rating has decreased from Good to Requires Improvement due to the reduction in the Well Led domain, from Good to Requires Improvement ii. the need for the MDTs to work effectively together to respond to the needs of women was highlighted as a concern, as well as some disjointed working among senior staff iii. that an improvement plan has been devised and submitted to the CQC iv. key concerns around monitoring, and acting quickly when women are deteriorating, the holistic needs of women and listening to them when they feel something is not right and the need for a robust risk register v. there is a steering group in place to monitor adherence to the action plan and advise where the CCG can support. The Governing Body noted the update.
5.1	**Governing Body Assurance Framework** Marie Price presented the Governing Body Assurance Framework (GBAF), giving an overview of the current key risks for the CCG. These risks will continue to be monitored and reviewed, with regular updates to the Governing Body. The Governing Body noted the report.
5.2	**Major Incident Plan and Business Continuity Plan** Archna Mathur presented the Major Incident and Business Continuity Plan for 2021-22, highlighting that as the level of response for the organisation will likely change in the move to the ICS, these plans will be updated from April 2022. The Governing Body approved the plans.
6	**AOB** Sam Everington raised two items to consider for discussion in future: • Barts Life Sciences project • The patient waiting list - Project Scalpel and Project Advice and Guidance.

North East London
Clinical Commissioning Group

Highlighted items represent a recommendation to remove from register

NEL CCG action log December 2021

Reference	Meeting date	Minute reference	Action	Owner	Target completion date	Comment
GB - 5	25/08/2021	5.1	**Quality Report:** City and Hackney ICP quality dashboard to be replicated for TNW and BHR in future reports, as well as an update on the CCG's clinical audit arrangement with the provider trusts at a future meeting.	Diane Jones	Jan-22	On the agenda
GB - 7	27/10/2021	4.1	Update on the harm review of patients on the waiting list for treatment.	Archna Mathur/ Diane Jones	Jan-22	Clinical prioritisation exercise across all Trusts and specialities is in place to ensure that patients at risk of harm are seen in priority order. This process itself allows for a clinical review to take place. A similar process is in place for the non-admitted waiting list by way of the exercise required to ensure that patients on the waiting list still require treatment or have not deteriorated. The planned care programme has other initiatives also in place "waiting well". Clinical harm reviews for cancer are in place and have continued throughout the Covid-19 pandemic.
GB - 8	27/10/2021	4.2	**Finance Report:** include the impact that private sector spending is making on the waiting list in a future report.	Steve Collins	Jan-22	Verbal update

North East London
Clinical Commissioning Group

Governing Body meeting
26 January 2022

Title of report	Chair's Report
Item number	1.3
Author	Keeley Chaplin, Business Manager
Presented by	Dr Jagan John, Chair, NEL CCG
Contact for further information	Keeley.chaplin@nhs.net
Executive summary	This report provides highlights of the work of the Chair of North East London CCG since the last meeting.
Action required	Members are asked to note this update report.
Where else has this paper been discussed?	Not applicable.
Next steps/ onward reporting	Not applicable.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The report contains details of projects underway locally on our Covid-19 response, vaccination programme and tackling health inequalities.
Conflicts of interest	None.
Strategic fit	The report relates to work underway to support achievement of our corporate objectives.
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage.
Risks	There are no risks associated to this report.
Equality impact	Not applicable.

1. Introduction

My colleagues and I are continuing to manage the challenges faced at present with ongoing business as usual, winter pressures, Covid-19 response and vaccine delivery along with the change and preparation to transition to the NEL Integrated Care Board (ICB). It has now been over one year since the first Covid vaccine was given in England and this winter it is especially important to remember the basic ways to keep ourselves and others safe and get fully vaccinated and get a flu jab.

In December we received the news that transition to an ICB has been delayed from 1 April 2022 to a new target date of 1 July 2022 and during this time the CCG will remain in place as a statutory organisation. The delay is to allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and applies to all CCGs across the country. More detail is included in the accountable officer's report.

2. Meetings

Since the last meeting held in October, I have attended a number of meetings and forums, some of which are highlighted below.

2.1 NEL ICS development

I attend regular meetings of NEL senior leaders to review progress on ICS development.

2.2 Clinical leadership

I have continued with our twice weekly early morning meetings with my NEL Chair colleagues to review the system clinical leadership architecture to identify gaps and ensure that the structure supports the NEL integrated care system (ICS). My chair colleagues and I continue to support the NEL Clinical Advisory Group which meets fortnightly.

Along with Ken Aswani, I sat on the interview panel for GP clinical lead roles in Long Term Conditions which were held in December.

2.3 Personalised Care

I champion personalised care in London and for NEL and since the last governing body meeting I attended the London social prescribing partnership group which received updates from programmes including Digital, regional facilitators and clinical leads. I also attended the monthly meeting of the NHSE personalised care and the clinical leadership group. I was a guest speaker at a social prescribing webinar on best practice held on 8 December.

2.4 NEL BCYP programme

I am supporting the Babies, Children and Young People programme for NEL and we are now at a crucial stage to set up the work for the next 12-18 months with a particular focus on enabling out of hospital and integrated care and how to position the work in the emerging integrated care system.

2.5 NEL UEC Same Day Emergency Care (SDEC)

I lead on urgent and emergency care for NEL and chair the NEL UEC SDEC sub-group. We meet fortnightly and receive updates from related regional task and finish groups and progress updates from SDEC symptom pathway implementation groups.

2.6 NEL UEC restoration steering group

The steering group meet monthly and in December the group's main focus was on winter planning.

2.7 Community Diagnostic Hubs for Cardiology

We are looking at the design and development of community diagnostic centres for cardiology and preparation of the system business case which will outline the future model across NEL and ensure they are meeting the needs of patients and the health system.

2.8 London Regional meetings

2.8.1 CCG Chairs' meeting

I meet weekly with the London CCG Chairs to discuss areas of shared interest such as ICS clinical leadership structures, functions and engagement.

2.8.2 Post Covid Programme Board and Proactive Case Finding

I have participated in these meetings which review data on health inequalities in access to post Covid-19 pathways to create proactive case finding recommendations, best practice case studies and standards for post Covid services in London.

2.8.3 UEC transformation clinical leads network

This was held to gain an understanding of each ICS and each workstream achievements and priorities.

2.8.4 London Clinical Advisory Group

I join weekly meetings chaired by the regional medical director and regional chief nurse. Recently we have received updates on issues such as Covid therapy, infection prevention and control and delivery of pulmonary rehabilitation.

3. Royal College (RC) of GPs Award

I was truly honoured to receive the Provost Award from the RCGP NEL Faculty which was held at their AGM on the 6 December 2021.

4. Webinars and vaccination clinics

4.1 Celebrating black women's births

On 2 November I joined the panel of a webinar celebrating births within Black African and Black Caribbean communities which explored the role of the Covid-19 vaccinations in ensuring safety in pregnancy and fertility.

4.2 Vaccination clinics

We've now administered more than 3.3 million Covid-19 vaccine doses to our NEL population and I was invited to support our medicines management team with vaccinating at the West Ham United stadium and training ground during November.

4.3 NEL Covid-19 vaccination webinar

On 25 November I was part of a team of health experts delivering a question and answer session for people living in NEL.

14 January 2022

North East London
Clinical Commissioning Group

NEL CCG Governing Body

26 January 2021

Title of report	Accountable Officer update
Item number	2.2
Author	Henry Black, Acting Accountable Officer
Presented by	Henry Black, Acting Accountable Officer
Contact for further information	Laura Anstey l.anstey@nhs.net
Executive summary	This paper provides an update and overview of recent activity for the governing body members from the Accountable Officer for the NEL CCG
Action required	Note
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	N/A
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The report contains details of projects underway locally on our Covid-19 response, vaccination programme and tackling health inequalities.
Conflicts of interest	None
Strategic fit	The report relates to work underway to support achievement of our corporate objectives.
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage.
Risks	There are no risks associated to this report.
Equality impact	N/A

1.0 Introduction

It has been a busy period since we last met as a Governing Body. I have been working with colleagues across the system to respond to the latest Covid-19 wave caused by the Omicron variant and the subsequent acceleration of the vaccine booster rollout. This meant that we needed to step down non-essential activity through December and early January.

There are a number of updates since the Governing Body last met:

- Response to Covid and vaccine rollout
- Delay to the ICB launch and NEL CCG response to the revised timelines
    - ICB senior tier consultation
    - ICS purpose statement and priorities
- Leavers and new appointments

2.0 Response to Covid-19 and vaccination rollout

The spread of the Omicron variant put additional pressure on services in the run up to Christmas and we stepped up our gold command and system level response to support partners with managing this. Working closely with system partners we have been managing pressures on UEC, discharge, care homes, and critical care and through effective coordination have kept services running through the Christmas and New Year period.

Our vaccination teams responded admirably to the national directive to ensure all adults aged 18 and over received the offer of a booster by 31 December and continue to work at pace to deliver first, second and booster vaccines to eligible cohorts.

I would like to place on record my thanks to everyone involved for their hard work and commitment and for managing a particularly challenging period in December after another difficult year responding to the ongoing pandemic.

3.0 Vaccination as a condition of deployment in the NHS

The legislation mandating vaccination as a condition of deployment (VCOD) for health and care staff providing care regulated by the CQC was passed in December. We are working through the details of this as a system as the expectation is for staff whose roles are in scope of the legislation to be fully vaccinated by 1 April 2022. This includes identifying and supporting staff not yet vaccinated and encouraging them to have the two doses by 1 April 2022. It is a complex and sensitive piece of work and Directors of People and other workforce representatives are working closely with clinical leads to manage the process as smoothly as possible while minimising the risk to service delivery and providing appropriate advice and support to those staff who remain unvaccinated beyond that point.

4.0 Delay to the establishment of the Integrated Care Board

On 24 December NHSE confirmed that there will be a delay to the establishment of Integrated Care Boards across England. The update from NHSE outlined that in order to allow sufficient time for the remaining parliamentary stages of the Health and Care Bill, a revised target date of 1 July 2022 has been agreed for the new arrangements to take effect and ICBs to be legally and operationally established.

During the ‘extended preparatory period’ to the end of June:

- NEL CCG will remain in place as a statutory organisation, retaining all existing duties and functions and conducting its business through its governing body;

- the CCG's leaders will continue to work with the designate chair and chief executive of the ICB on key decisions that affect future working;
- NHSEI will retain all direct commissioning responsibilities not already delegated to the CCG.
- The employment commitment for CCG staff has been extended to reflect the new target date.
- NHSEI's updated requirements for the Readiness to Operate and System Development Plan submissions will be received later in January 2022, along with guidance on the specific implications for financial, people, and legal arrangements during the extended preparatory period.

We in North East London want to ensure we maintain the momentum already generated behind the design and launch of our integrated care system.

We therefore want still to complete as much work by the end of March as our collective capacity allows, recognising the constraints created by omicron and winter pressures throughout the system. This would allow us make positive use of the additional time now available by entering a 'test and learn' phase over April to June, where we mobilise elements of the ICS in shadow form, as well as picking up work more sensibly done closer to CCG closedown.

The focus over January has been on confirming the revised NEL approach with relevant groups, supporting work theme leads to update programme plans as necessary, revising the risks and interdependencies and planning ahead for the test and learn phase.

5.0 Recruitment to senior roles and developing the operating plan for the Integrated Care Board

Following the appointment of Zina Etheridge as the substantive Chief Executive for the Integrated Care Board in November 2021, the next phase is to recruit to the direct reports to the Chief Executive. Zina is due to take up her now role towards the end of February 2022. In the meantime work is underway to confirm the senior structure and job descriptions for the senior roles. Recruitment to these roles will continue in line with the original timelines and in line with the Integrated Care Systems across London and will not be impacted by the delay to the establishment of the ICB. Impacted individuals have been consulted with and are being supported through the process.

6.0 ICS Design and Development

Following an initial workshop in October, Marie Gabriel CBE, our ICS Chair designate, brought over 70 partners from across north east London (NEL) together again in November to discuss and agree a collective purpose statement and the key priorities of the NEL Integrated Care System (ICS) – the North East London Health and Care Partnership.

Partners from the NHS, local authorities, voluntary and community sector, and Healthwatch agreed the following purpose statement: "we will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity"

Four key priorities were identified as areas of focus that all partners will commit to delivering together in partnership, in addition to the many areas of work already underway:

- Employment and workforce – to work together to create meaningful work opportunities for people in North East London
- Children and Young People – to make North East London the best place to grow up

- Long Term Conditions – to support everyone living with a long term condition in North East London to live a longer, healthier life
- Mental Health – to improve the mental health and wellbeing of the people of North East London

The next step is to identify how best to deliver on the priorities in a meaningful and effective way, working in partnership across NEL and ensuring they are embedded throughout our work.

7.0 New appointments and leavers

Zina Etheridge
Welcome to Zina Etheridge who joins us in February as the ICB CEO designate. Zina is joining us from the London Borough of Haringey where she has been the Chief Executive for the last four years. Zina has a wealth of experience across national and local government and we are looking forward to Zina joining us and leading us through the remainder of the transition to the Integrated Care Board.

Raliat Onatade, Chief Pharmacist for NEL ICS
I am pleased to update the Board that following a recruitment process, Raliat Onatade has been appointed as the Chief Pharmacist for NEL ICS. This is a key leadership appointment working with system partners to develop a system-wide vision for medicines optimisation and pharmacy. Raliat joins us from Barts Health NHS Trust where she has been the Group Chief Pharmacist and Clinical Director for Medicines Optimisation. We look forward to working with Raliat when she joins us in March.

Tracey Fletcher
Many thanks and best wishes to Tracey Fletcher, CEO of the Homerton NHS Foundation Trust, who has announced that she is leaving the Homerton to take up a new role closer to home in Kent in 2022. Tracey has been a key leader in City and Hackney for many years and will be very much missed by the system. Recruitment to a new CEO will start in due course and Tracey is with us for a bit longer so we will say a proper goodbye nearer to her leaving date. In the meantime thank you for everything you have done for the residents of City and Hackney and the wider NEL system.

Henry Black
26 January 2022

North East London
Clinical Commissioning Group

NEL CCG Governing Body

26 January 2022

Title of report	Patient and Public Involvement update
Item number	3.2
Author	Amy Burgess, Senior Engagement Manager
Presented by	Khalil Ali, Lay Member PPI
Contact for further information	amy.burgess7@nhs.net
Executive summary	This report provides a summary of patient and public involvement activity/planning at a north east London (NEL) and ICP/borough level. The report focusses on engagement work underway with communities in response to Covid-19 and more specifically our efforts to vaccinate the population. The report also outlines the work underway to improve and embed patient and public voice in our new system arrangements, in anticipation of the new ICS in July 2022.
Action required	To note the progress on developing patient and communities engagement.
Where else has this paper been discussed?	NEL CCG PPI Engagement Leads meeting.
Next steps/ onward reporting	Any feedback from the NEL CCG Governing Body to be actioned by CCG engagement leads
What does this mean for local people? **How does this drive change and reduce health inequalities?**	This paper sets out PPI activity across NEL and outlines progress for planning on how we engage with our local communities. All PPI activity has tackling inequalities at the forefront.
Conflicts of interest	N/A
Strategic fit	This paper provides information to the governing body in line with the running theme throughout our corporate objectives of patient and public voice being central to all that we do.
Impact on finance, performance and quality	N/A
Risks	Potential risks related to engagement structures or methods which do not meet the needs of our communities or enable us to reach all, but this can be mitigated through thorough planning and consultation with partners.
Equality impact	Equality impact assessments will be carried out as appropriate on specific pieces of work set out in this paper.

1. Purpose of the report

This paper sets out to assure the Governing Body that patient and public involvement (PPI) is of the highest priority as we move towards becoming a statutory Integrated Care Board (ICB) and Integrated Care System (ICS), and updates the Governing Body on patient and public involvement activity and strategic planning, both at NEL and current Integrated Care Partnership (ICP) levels.

The Governing Body are a/sked to confirm that this level of information is appropriate in providing assurance and whether or not there are any suggestions ahead of the next paper submission.

2. Key messages

This paper provides information about the following:

- Plans to engage our communities about the ICS
- Embedding engagement across NEL
- Working with the voluntary and community sector and Healthwatch
- Engagement activity on cancer services, mental health services and Long Covid
- Engaging with pregnant women, their families and carers
- ICP level PPI activity highlights.

3. NEL level update

3.1 Embedding engagement across NEL

Significant work is underway to develop the NEL ICS Strategy, and at its heart is the development of a collective NEL ICS approach, which is being developed in partnership with colleagues from ICS health and care organisations across the system. The aim is to furnish the ICS with a set of complimentary tools which, when used together, will deliver a sustainable strategy.

Colleagues leading on engagement from across NEL have been coming together as a working group to make recommendations on how best to embed engagement across the system. The group is co-chaired by the NEL Senior Engagement Manager and C&H ICP's Engagement and Co-Production Manager, a role hosted by Healthwatch Hackney on behalf of the C&H ICP. Together the working group have identified three overarching priority themes - Commitment, Culture and Community *(The Three Cs)*. Under each theme they have agreed on three projects which they see as realistic, tangible building blocks on which to construct a shared and supportive foundation for the delivery of engagement, which have been progressed through the establishment of three sub-working groups:

1. **Development of a shared NEL *commitment* to engagement** through creation of NEL-wide ICS pledges between the NEL organisations – a period of wider engagement on this work is taking place over the coming months
2. **Building a *culture* of PPI across NEL** through the development of an introductory training module for staff across the ICS footprint which sets the context of the ICS and places engagement at its centre

3. **Developing a NEL *community* of practice** for NEL engagement staff to share challenges and best practice, and problem solve within a supportive group of peers

A paper outlining progress to date was presented to the ICS Exec meeting on 2 December and activity was endorsed.

3.2 VCSE Leadership Programme

In the last update to the governing body we informed members that NEL CCG had successfully received funding as part of the NHSEI Voluntary, Community Sector and Social Enterprise (VCSE) sector Leadership Programme, with a view to developing alliances to enable the VCSE to play an active role in NEL ICS.

This funding has been used to appoint an independent consultant, hosted within Redbridge CVS, to develop this work and hold an extensive number of meetings with VCSE partners from across NEL to discuss what they see to be priorities for increasing the impact of VCSE engagement with health, care and wellbeing structures and delivery. Feedback from these meetings will inform a report of recommendations, due this month, will feed directly into the NEL ICS Engagement Strategy. This will provide the basis for developing more meaningful partnerships with the VCSE in north east London as part of our broader ICS structures.

3.3 Healthwatch

Healthwatch England recently published some Promising Practice case studies on their website to showcase the benefits of Healthwatch and ICS's working together, and we were delighted that NEL was chosen to be one of the six case studies. The NEL case study, which includes the development of the NEL Community Insight System, can be found here.

3.4 Cancer

We are working with the British Islamic Medical Association and local mosques to help improve the uptake of bowel screening amongst our Muslim communities. We held a series of focus groups in December to provide feedback on our planned activities, which are due to take place from January onwards.

Work is also taking place with Leyton Orient Football Club to promote awareness of lung, bowel and prostate cancer in older men from deprived areas. This will be extended to advertising and promotion in key locations across north east London and also via social media. We are looking to work with other sports clubs and across different locations this year.

Engagement for a cancer case finding project is due to start in the new year, looking at getting the number of referrals back to pre-pandemic levels. We will be working with local communities to encourage patients to come forward if they have any signs or symptoms of cancer.

3.5 Long Covid

Communications has gone out to GPs to launch a new referral form for long COVID, along with a new tool called OneContact, designed to help make the referral process easier for both patients and GPs. A training schedule for health and care professionals and an online resource hub was launched in the week of 13 December.

We are working on a long COVID patient video, with filming due to start in the next couple of weeks. This is to help our residents understand the common symptoms and to provide information on where to get help. We have developed a patient leaflet and are working on an easy-read version and homeless version.

We are working with local community groups to understand their needs with a view to providing translated versions of the video and leaflets as appropriate. Local information on both medical and non-medical services (things like housing, finance and employment support) is being added to relevant public web pages too.

3.6 Mental Health

We are promoting the NEL Suicide Prevention Services across north east London. More information is on our web pages.

3.7 Maternity

3.7.1 East London Women's Experience Forum

This monthly forum continues to provide an opportunity for pregnant / expectant families or people planning pregnancy to ask questions and seek information and advice from senior midwives. The forum is advertised by Maternity Voice Partnerships (MVPs), social media and maternity contacts. The November forum meeting saw 18 attendees, including MVPs and *Maternity Mates* seeking updates and information from each of the trusts to pass onto the women and families they engage with.

3.7.2 Maternity Voices Partnerships

We continue to communicate with MVPs to ensure that feedback from pregnant people across NEL informs our workstreams. We are currently working with MVPs and commissioners to establish a centralised model for MVPs across NEL, while maintaining a localised focus. This centralised model hopes to bring equity to MVP members across the region and support them to understand what the core offer of support looks like - both the support we give them, and they give us.

3.7.3 Engaging with Black African and Black Caribbean pregnant women about the Covid-19 vaccination

A webinar took place on 2 November led by ethnic minority clinicians, to celebrate Back Births following Black History Month and discuss the Covid-19 vaccination in ensuring safety in pregnancy and fertility. 40 people joined and the session was recorded and shared with NHS Futures.

3.7.4 Providing spaces for pregnant women and their families to

access information easily

The East London Pregnancy Whatsapp group and NEL Local Maternity System (LMS) Facebook community group continue to provide a space for women and their families to receive information and ask questions. We will also be exploring ways to engage with seldom heard voices, utilising alternative social media platforms with a more information sharing view. The maternity section on the East London Health and Care Partnership website will be restructured and content refreshed to allow for more accessible, helpful information for staff, partners and communities.

3.7.5 Baby Buddy App

The *Baby Buddy* app will be launched across NEL in the new year. The personalisation element will provide localised information and updates from each of the maternity units across NEL, meaning for example, a person booked to give birth at Homerton will receive specific updates regarding services and updates from Homerton. The app is free and will be promoted heavily through comms and engagement and by all sites, to encourage pregnant people to utilise this great resource.

3.7.6 Equity and Equality needs assessment and action plan

An Equity and Equality needs assessment has been conducted in response to the 2021/22 priorities and operational planning guidance. The process is in two steps:

1. an equity and equality needs assessment covering health outcomes, community assets and staff experience
2. co-producing equity and equality action plans setting out how the NHS will work in partnership to ensure equity for women and babies and race equality for staff

The needs assessment has been completed with the support of community partners, to map and understand what support services are available for pregnant people and families across NEL. In order to inform the second step, a series of workshops with maternity stakeholders, including community members, will take place in January to help determine what our action plan will look like to ensure we achieve equity for pregnant people from ethnic minorities and those living in the most deprived areas, and equality for ethnic minority staff. NEL LMS hosted an engagement event with all maternity stakeholders to present the needs assessment on 14 December.

3.8 Developments in Personalised Care and Strategic Co-Production

Developing personalised care is a key strategic goal of the NHS. Co-production is recognised alongside strong system leadership and workforce development as a key enabler to embed the necessary culture to deliver the full benefits of personalised care.

There is an opportunity for ICSs to use strategic co-production approaches, which have been developed over many years via the Personalised Care Group in NHS England. One example of this is the *Peer Leadership Development Programme* (PLDP), a successor to the successful Peer Leadership Academy, which allows access for more people from diverse backgrounds to become Peer Leaders.

A regional collaborative working group is being established in early 2022 to take forward this agenda across London, with two key objectives:

1. Embedding strategic co-production and establishing strategic coproduction groups across London that are connected into the wider health and care system
2. Embedding PLDP as an offer of investment to people with lived experience

The NEL personalised care and engagement leads will be participating in this newly formed regional working group, and will ensure that developments are fed into the NEL Personalised Care Board and emerging ICS structures.

4. ICP level updates

4.1 Barking and Dagenham, Havering and Redbridge

4.1.1 Obesity

Through engagement work with the Bangladeshi community in Redbridge, members of this community have expressed a need for support to improve their eating habits and lose weight, particularly following Covid-19 lockdowns over the past 18 months.

The traditional Bangladeshi diet is high in oil and sugar. British Bangladeshi people are 5-6 times more likely to have Type 2 diabetes than the general population. Type 2 diabetes is a largely preventable chronic metabolic condition, for which obesity is the main risk factor.

We are supporting Redbridge Council in their efforts to inform and educate people on healthy eating, and we are involved in planning an event in January 2022 to support the Bangladeshi community. Based on the success of this project, we hope to roll it out to different communities across BHR.

4.1.2 Mental health

We are currently planning a series of mental health events to support local communities across BHR, using our Health and Faith Network meeting to co-plan this work.

We hope to run events in early 2022 that will target specific communities across BHR and we are liaising with different faith communities to ensure the events will target those who will benefit most. This work will run alongside a NEL-wide project aimed at supporting young people's mental health.

We continue to promote mental health services in BHR on social media and through our weekly stakeholder updates, sharing toolkits and information externally, but also internally in our engagement meetings to ensure that, where appropriate, these services are promoted NEL-wide.

4.1.3 St George's redevelopment

The public and stakeholder engagement piece around the proposed new health and wellbeing hub on the site of the former St George's Hospital in Hornchurch began on 22 November and runs until 13 Feb 2022.

A series of public listening events, online 'drop-ins' and online community outreach events have already begun and we are looking at ways to encourage more people to attend and feedback their views on our proposals.

The public facing engagement document, which explains the proposals in more detail, and our online questionnaire are available now on the NEL CCG website here.

4.1.4 BHR Phlebotomy service pilot

The rollout of the phlebotomy pilot across BHR continues to be successful. Local CCG leads were invited to take part in a virtual healthcare conference in November entitled *'Transforming patient experience in phlebotomy clinics'*. They talked about both the challenges and best practice of the rollout so far and highlighted the fact that the single biggest enabler to delivering success has been treating community phlebotomy as a system challenge.

We continue to engage with our stakeholders around the pilot via our monthly phlebotomy update, our weekly stakeholder update, our dedicated phlebotomy feedback inbox, our network and partner colleagues and a patient survey that is texted to all patients following their appointment.

Work is currently underway to provide Learning Disability specific phlebotomy clinics.

4.2 City and Hackney

4.2.1 Covid-19 vaccine

The engagement team continues to support the groups that were successful in round two of the City and Hackney Covid-19 community outreach grant scheme. This included a 2 hour induction session for all grantees which took place in early November.

We are working closely with the Children, Young People, Maternity and Family workstream to develop communications and engagement plans for 16–17 year olds and 12–15 year olds. This includes identifying local influencers and developing an online Q&A session.

4.2.2 Trowbridge GP Practice provider procurement and pharmacy site visits

Five public reps are taking part in the Trowbridge GP Practice provider procurement as evaluators to bring the patient perspective to the procurement process. The initial evaluation of seven questions to eight bidder responses are now complete and public reps have been supported to participate in moderation sessions.

In collaboration with Healthwatch Hackney, public reps are conducting site visits to confirm the accessibility of pharmacies and treatment rooms.

Following on from this work there will be a review of how patients are involved in the procurement process.

4.2.3 Review of engagement structures in City and Hackney

Working closely with Public Health, we are undertaking a review of the engagement structures in City and Hackney. The aim of the review is to better align and coordinate community and resident engagement, avoid duplication and ensure sustainability. On 1 December, we were excited to welcome 35 representatives from across C&H to discuss and begin to align a shared model for resident involvement. It was fantastic to see representatives from NHS, CCG, the councils, the voluntary sector and residents coming together to begin to agree a universal approach.

4.2.4 Inequalities Resource Pack

With system partners, we are developing an inequalities resource pack to support and equip all staff, including individuals, teams and senior leaders across City and Hackney, to routinely consider health inequalities in their day-to-day planning and decision-making. This will also help them to determine where, when, and to what extent there is need for patient and public involvement to support fair and proportionate plans. The plan is to pilot the tool and resources with teams across the partnership, including the Voluntary and Community sector (VCS) organisations from early February 2022.

4.2.5 NHS Community Voices (Community Involvement Forum)

NHS Community Voice have come together three times in recent weeks to discuss topics at the forefront of resident's minds. The group has been expanded and now includes a diverse age range. It has been agreed that the group will focus on key topics and host engagement events in the New Year. The first engagement event will focus on the experience of young people when accessing GP services. In particular, our young representatives have reported they do not feel listened to. The group will seek buy in from GP Confed ahead of the event to ensure possible outcomes from the co-produced recommendations

The Forum has produced their first report, highlighting engagement from various sources including patient involvement/special interest groups and the Community Insight Forum. The report went to People and Place for information and to allow the group to comment. The report was well received, and it was agreed future reports (quarterly) will include greater detail and more figures around how many people fed in/demographics of engagement.

4.2.6 Co-production charter review

The next stage includes sign-up to the Charter of all partner organisations and a launch event for the new revised Charter in early 2022.

4.2.7 People and Place Group meeting

The City and Hackney People and Place Group held its third official meeting on Wednesday 3rd November. On the agenda were a set of draft questions to be used

for presenters to help them think through and provide authentic responses to how they are tackling inequality in their work. A review of the feedback will be reflected in a new version of questions. The group received a presentation that highlighted the Quality and Outcomes Group approach to working with residents and co-production. In addition, the first of quarterly insight reports highlight the key themes from resident voices across the system. A version of the report will be sent to ICB.

4.3 Tower Hamlets, Newham and Waltham Forest

4.3.1 NHS App project

The NHS App project continues to make the NHS App available to people who do not speak or read English. Three animations describing the benefits of the NHS App are on YouTube and people are being encouraged to leave feedback in the 'comments' section.

4.3.2 Experience of people with disabilities

Based on the insight we gained about disabled residents struggling to access health and care services and information during the pandemic, a working group has been formed in Tower Hamlets (TH) to look at what improvements can be made – members of the working group include LBTH, REAL, CCG, Healthwatch, Apasen and Deafplus. Together we are looking at disability-awareness training for all Tower Hamlets Together staff. We are also identifying a local PCN to work with on piloting some small changes to improve the experience for disabled patients on their list.

4.3.3 End of life care

A new steering group to improve end of life care in the community has been established, linked to the end of life plans for the Whipps Cross redevelopments including the hospital footprint across Redbridge, Barking & Dagenham and Newham.

We will need to develop sensitive forms of engagement that can both gather insight and be supportive to those on an end-of-life journey, including loved ones. The engagement plan aims to gather insight from individuals and carers from diverse backgrounds, and an update was presented to the new health overview scrutiny committee (HOSC) set up for the Whipps Cross redevelopment on 6 December.

4.3.4 Waltham Forest Integrated Partnership Strategic Reset

On 8 December engagement plans for the Integrated Partnership Strategic Reset were presented to the Waltham Forest HOSC. The strategic reset has hugely broadened the scope of the integrated community development's three major programmes, bringing all the work and services happening in primary care, community services, mental health, learning disability, children and young people, into a coherent strategy for community health and care in Waltham Forest. It also links to the work happening in planned and unplanned care and the Whipps Cross redevelopment.

A narrative has been developed to support the engagement, and a small budget agreed which allows us now to start creating some materials to support the engagement, including an animation. We are currently collecting people stories for the main components of the programme, to make the very complex and extensive developments

more accessible to understand and get involved in - these include people with learning disabilities, autism and mental health problems.

5. Risks and mitigations

Potential risks related to engagement structures or methods which do not meet the needs or enable us to reach all of our communities, but this can be mitigated through thorough planning and consultation with partners.

6. Conclusion

This paper is intended to inform NEL CCG Governing Body members about patient and public involvement activity at both a NEL and ICP level.

Amy Burgess
NEL Senior Engagement Manager

North East London
Clinical Commissioning Group

NEL CCG Governing Body

26 January 2022

Title of report	People and OD update
Item number	3.3
Author	Rachel Patterson, Director of People and OD
Presented by	Rachel Patterson, Director of People and OD
Contact for further information	Rachel.patterson3@nhs.net
Executive summary	The People and OD update provides an indication of progress against our agreed People and OD priorities for 2021/22. It focusses on achievements and progress by quarter 3.
Action required	Discussion and for noting.
Where else has this paper been discussed?	People and Culture Group for a number of the items referenced.
Next steps/ onward reporting	Reporting and assurance relating to delivery of NEL CCG People and OD priorities will routinely be done through the People and Culture Group.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	As a local employer and leader of workforce transformation more broadly in north east London the impact of improvements in opportunities for employment and progression within our health and care organisations have an ability to impact and improve health inequalities.
Conflicts of interest	N/A
Strategic fit	Relates to these corporate objectives: • Support our people to thrive • Develop our NEL integrated care system
Impact on finance, performance and quality	While work is being undertaken to quantify this there are expected to be costs related to developing our learning and development offer for the CCG workforce and increasing our capacity and capabilities to support through the transition into the ICB. There are costs associated with the consultancy and headhunters referenced in relation to the ICB/ICS development.
Risks	The key risks relating to our People and OD priorities and transition to the new ICB are: - Retention of staff - Poor engagement in development of a new ICB operating model and impact on measures of staff satisfaction

	through things such as the staff survey, WRES action plan and other feedback routes - Stability of the workforce due to higher reliance on temporary staff.
Equality impact	Where necessary on specific pieces of work there will be Equality Impact Assessments undertaken.

North East London
Clinical Commissioning Group

NEL CCG Governing Body People and OD update

- **Freedom To Speak Up service development** – there is a clear plan in place to establish a service that meets our requirements as set out in national FTSU guidance. This will involve inviting people to put themselves forward for roles as our Freedom To Speak Up Guardian, Freedom To Speak Up Ambassadors, Lay Member and Executive leads. All those in the new roles will be provided with appropriate training and support. Clear reporting lines will be established through the People and Culture Group to the Remuneration Committee to ensure appropriate oversight of themes, issues and actions arising from what is being raised by concerned staff.

- **Pre-consultation** discussions have commenced with Trade Union representatives to prepare for formal consultation with them and engagement with staff on the TUPE transfer in January 2022. There is work being progressed with CSU and London Region colleagues to ensure the CSU in-housing related transfer is aligned as far as possible to the NEL CCG transfer activities.

- The next tranche of **policies for harmonisation** are being developed and include Organisational Change, Pay Protection, Maternity Leave and Covid Vaccination Policies.

- **WRES workshop** took place on 16 December 2021 to develop a more detailed action plan and reflect on achievements over the last three years. Key areas all are keen to focus on is improving our recruitment and selection practices by introducing the role of Inclusion Ambassadors into selection processes and using the regional debiasing recruitment toolkit.

- Procured **consultancy services to support the design of the ICB** and development of an ICS People Function in accordance with requirements set out in the relevant ICS Guidance. The intention is that the company will commence this work early January, working closely primarily with CCG senior leaders and their teams to help design the operating model and structure for the ICB as one of their earliest priorities.

- **Skill Up** – a range of online training and development offers in place for staff at all levels to access. Specific focus for a range of modules on change and supporting teams through change.

- **Civility and Respect** – as part of the anti-bullying week messaging, materials and approaches have been launched to support our culture and leadership programme work. These focus on behaviours and approaches to encourage a civil and respectful workplace rather than focussing on the more negative and punitive approaches associated with bullying and harassment, recognising there is still a need for people to have a route to raise issues of this nature.

- **Clinical and care professional leadership model** – supporting work to design the new model and advising on the impact of changes for existing clinical leads and office holders. Preparing for high volume recruitment expected as a result of the termination of those on current arrangements and recruiting to new/changed roles in the ICB.

- **Consultation has been concluded with senior leaders** impacted by the implementation of the new ICB executive structure. **Recruitment expected to start mid January 2022** supported by headhunters.

People Priorities 2021-22 – Quarterly Milestones (summary)

Aim	Priority	Q1	Q2	Q3	Q4
To develop and provide tools for managers to support and develop staff To develop lean processes and have plans in place for the organisation transition to the ICS on 1 April 2022	Policy harmonisation and development	First three policies drafted and agreed with Joint Partnership Forum	Communication changes, FAQs and guidance publicised	Change Management Policy to be reviewed	Outstanding Policy prioritisation and timetable for 2022-23
	Recruitment and Selection	Review Recruitment and induction documentation Including job evaluation, WAP, JD formats and induction	Develop guidance on competency-based questions and selection for hiring managers	Review and deliver recruitment training to focus on sufficient emphasis on the diversity, culture and inclusion	
	Change management and restructures	Identify NEL central and local functions requiring restructure and timetable	Review and develop change guidance and templates	Staff Consultations, review and implement new structures	
	Integration of CSU staff and Services	CSU engagement with staff to separate London- SE and regional services		CSU services and staff lists for agreement	Prepare receiving teams and compete admin, payroll and induct staff via TUPE/COSOP TBC
	TUPE/COSOP		Prepare detailed TUPE – COSOP plan – with Coms plan	Prepare TUPE-COSP[formal docs and engage TUs	Implement TUPE COSOP process w

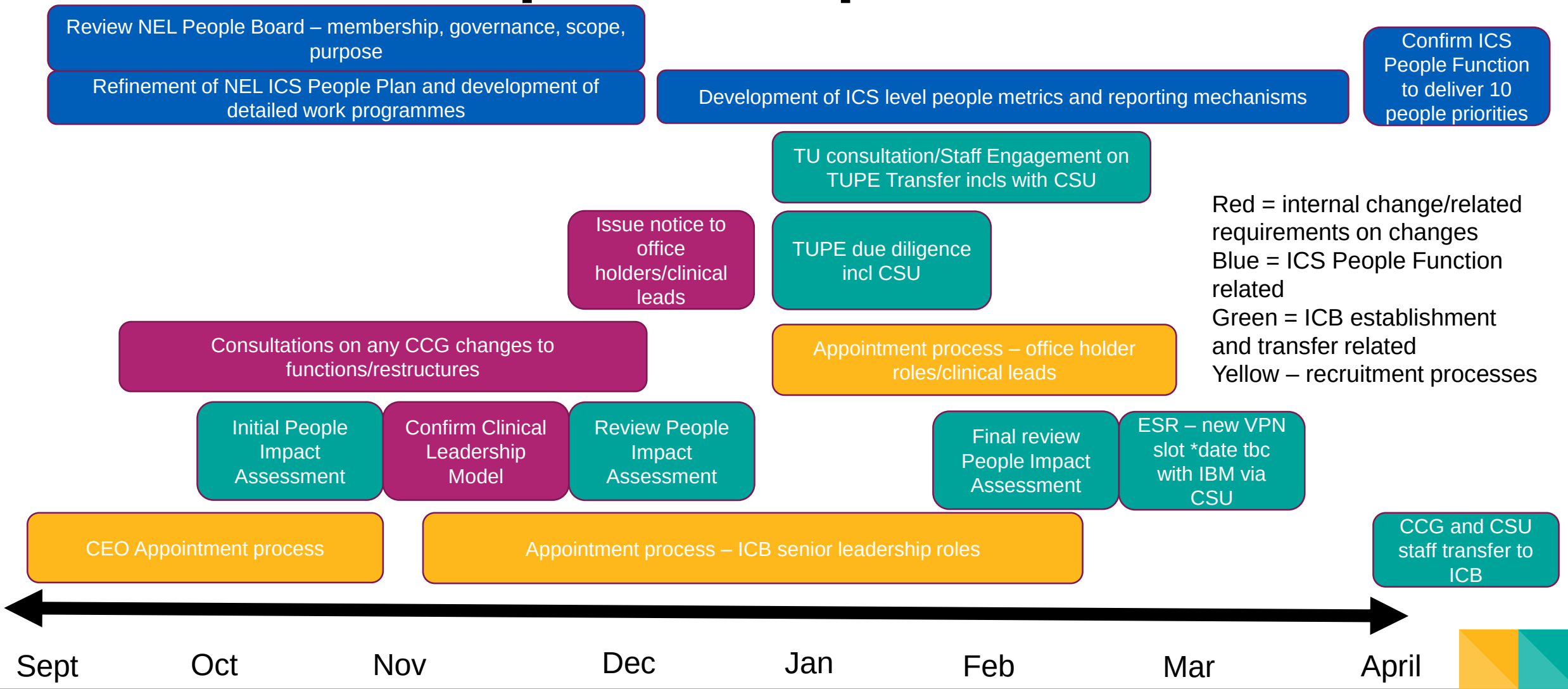
Moving our people to the ICS

OD Priorities 2021-22 – Quarterly Milestones (summary)

Aim	Priority	Q1	Q2	Q3	Q4
Enable, empower and equip our staff to be the best they can be, so that we can provide an exceptional service to our providers and the population of North East London. We will do this by; developing a more collaborative and compassionate culture, engaging our staff in decisions that affect them, providing relevant learning and development opportunities, prioritising wellbeing, appreciation and recognition and putting systems in place that support great management	Collaborative and compassionate culture	Discovery phase	Design phase	Respect and civility training	Delivery phase Psychological safety Bullying & Harassment
	Leadership Development	Induction, PMC developed, launched, training sessions		Leadership strategy	Leadership development programmes at all levels Leadership curriculum including line management basics Coaching, 360 appraisal and psychometrics
	Learning and Development	Leading Together completed, evaluated Explore use of apprenticeships levy	LNA Standardised Stat/Man TNA	Analysis, commissioning & business case	Launch of new programme Apprenticeship offers available Culture of career conversations

Aim	Priority	Q1	Q2	Q3	Q4
Enable, empower and equip our staff to be the best they can be, so that we can provide an exceptional service to our providers and the population of North East London. We will do this by; developing a more collaborative and compassionate culture, engaging our staff in decisions that affect them, providing relevant learning and development opportunities, prioritising wellbeing, appreciation and recognition and putting systems in place that support great management.	Wellbeing	Harmonised, clear WB resources, campaigns		Build expertise for line managers to hold wellbeing conversations	Toolkit for assessing and managing stress in the workplace
	Staff Engagement and Recognition		Rationalise existing staff engagement groups	Undertake national staff survey Explore pulse surveys	Staff awards /celebration
	Bespoke OD Offer	Bespoke OD support, particularly focussed on team/directorate development and ICS		Test out new tooklits and approaches to develop OD skills and capacity in the organisation	

ICS Transition Timeline – People Sept 2021– April 2022



**Needs Staff Communications and Engagement Plan detail overlaying

North East London
Clinical Commissioning Group

NEL CCG Governing Body

26 January 2022

Title of report	Governing Body Assurance Framework - update
Item number	4.1
Author	Marie Price, Director of Corporate Affairs
Presented by	Marie Price, Director of Corporate Affairs Kash Pandya, Lay Member for Governance
Contact for further information	marie.price9@nhs.net
Executive summary	Since the last meeting the overall risk register and Governing Body Assurance Framework (GBAF) updated in December and January by the senior management team (SMT). Further work continues to refine the overall register and GBAF to ensure ICP/borough risks are managed appropriately locally, but that key risks of significant score or applicable across NEL are escalated to the Governing Body. The current key risks relate to: • Underperformance against H2 metrics, specifically elective recovery • Continuing healthcare • Use of resources and finance balance. • Health inequalities • Vaccine delivery – workforce challenges A further risk has been added in relation to the **vaccination of all health and social care front line NHS staff.**
Action required	Discuss and note.
Where else has this paper been discussed?	SMT
Next steps/ onward reporting	Audit and Risk Committee for 'deep dives' as agreed by the committee. SMT refresh and review of the corporate risk register and GBAF in February.
What does this mean for local people?	Through effective management of risks to delivery of the CCG's objectives which focus on improving patient experience, quality

How does this drive change and reduce health inequalities?	of care, recovery post pandemic, preparations for potential further waves and our transition to an ICS.
Conflicts of interest	None identified.
Strategic fit	Implementing the risk strategy and policy for NEL CCG should support achievement of the CCG's corporate objectives through managing risks to delivery.
Impact on finance, performance and quality	Relates to achievement of our corporate objectives on these matters.
Risks	This report relates specifically to risk. The key risk in relation to this process is ensuring that we retain high levels of delegation but ensure a joined-up approach to ensure proper management and oversight of risk both locally and NEL wide.
Equality impact	N/A

North East London Clinical Commissioning Group
Governing Body Assurance Framework report

1. Purpose of the report

The purpose of the Governing Body Assurance Framework (GBAF) is to set out the key risks to the NEL CCG in achieving its objectives and priorities. It sets out the actions in place to manage those risks.

2. Background

NEL CCG has a responsibility to maintain sound risk management processes and ensure that internal control systems are appropriate and effective and where necessary to take remedial action. It is a key part of good governance.

The risk review uses the standard NHS methodology that considers the likelihood of the risk alongside its severity. Both measures are scored out of 5 (with 5 being the most likely and worst impact). The risk score takes account of the mitigating action proposed. This then gives a risk score and categorisation of:

Risk rating	Risk Score
Low	**1 – 3**
Medium	**4 – 6**
High	**8 – 12**
Severe	**15 - 25**

The GBAF is organised around the NEL CCG corporate objectives, and the GBAF will be updated monthly to reflect the progress being made, as well as identifying any new risks from the consideration of its business.

3. Risk appetite

The chart below shows the appetite grading for risks based on their potential impact

Appetite description	Appetite level
The CCG is not willing to accept these risks under any circumstances	1
The CCG is not willing to accept these risks (except in very exceptional circumstances)	2
The CCG is willing to accept some risk in this area	3
The CCG is willing to accept moderate risk in this area	4
The CCG is willing to accept high risk in this area	5

4. Process for escalation

Risks managed through the committees of the NEL CCG Governing Body, including the ICP area committees and programmes of work (e.g. ICS and vaccine delivery),

as well as in directorates that are rated 12 or above should be considered for escalation to the Governing Body. The escalated risk will still be maintained in the committee's / PMO register.

5. Progress to date

The Audit and Risk Committee continues to hold 'deep dives' into directorate/ICP registers, most recently reviewing the risk management process and cycle and the governing body assurance framework. During December 2021 and January 2022, SMT reviewed the overall joint risk register including those with a score of 12+ and the draft governing body assurance framework.

Further work on triangulation of risks between ICPs and a north east London level is ongoing to understand the overall impact for the CCG, and specifically the governing body in achieving the CCG's objectives.

6. Risks for escalation

The current risks escalated to the governing body are as follows, with the detail included in the appendix.

- **Underperformance against the H2 Operating Plan metrics, specifically in relation to elective recovery**
  The inability to deliver elective activity to pre-pandemic levels, increases the likelihood of lengthening waiting times for patients, affecting their quality of life and experience.

- **Use of resources and financial balance**
  There is a risk that the CCG does not ensure financial resources are deployed effectively, resulting in poor value for money, and inability to deliver effective services and recovery, or failure to delivery statutory financial duties.

- **Continuing healthcare**
  Risks relate to the backlog of cases and delays for patients/families/carers, delay in procurement of one management system, workforce shortages in health and social care, deprivation of liberty concerns and rising costs.

- **Vaccine delivery (workforce)**
  The risk relates specifically to workforce challenges with constrained ability to provide the necessary staff.

- **Health inequalities**
  Health inequalities have been exposed and exacerbated as a result of the pandemic. There is a risk of widening health inequalities in the absence of focused and systematic action across the ICS.

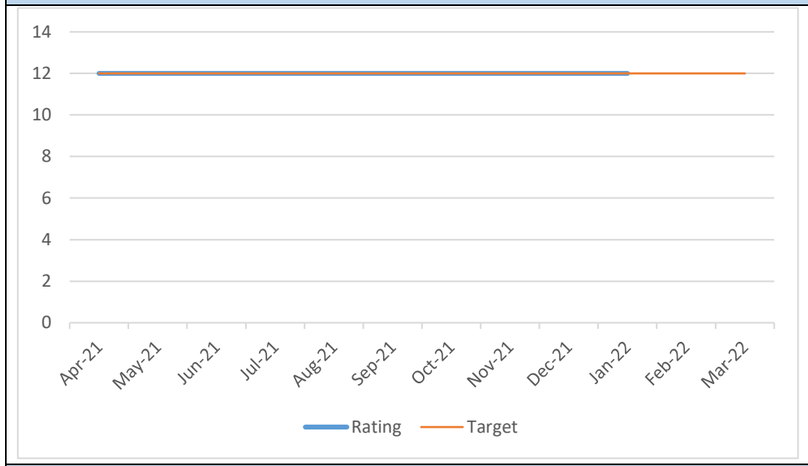
- **Vaccination of all front-line health and social care staff – new**
  From 1 April 2022, anyone working or volunteering in a CQC registered health and social care setting and having face to face contact with service users/ patients will need to be fully vaccinated against coronavirus (Covid-19), unless exempt. If significant numbers of staff exit the market instead of complying with the vaccination mandate, this could impact on system wide health and care service delivery.

7. Next steps

The Head of Governance will meet with risk owners to review risks and current mitigations. SMT will continue to discuss the NEL wide risks to ensure further development and refinement of the GBAF, including agreement on risk appetite levels.

GBAF – January 2022

Corporate objective	All six corporate objectives			**Risk reference**	
Risk description	Underperformance against the H2 Operating Plan metrics, specifically in relation to elective recovery. The inability to deliver elective activity to pre-pandemic levels, increases the likelihood of lengthening waiting times for patients, affecting their quality of life and experience. There is particular risk around the clearance of 104ww			**Risk owner**	**Archna Mathur Director of Performance and Assurance**
ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	4
	✓	✓	✓		

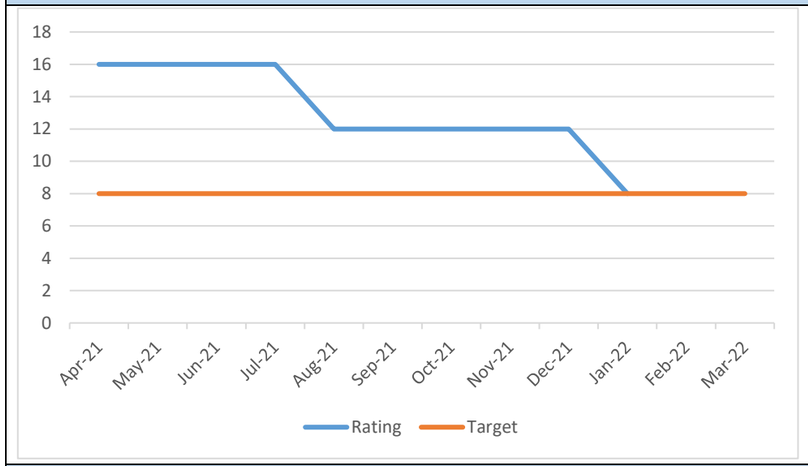
Score history and targets (NB rating and target fully aligned to date)	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**12**	October 2021	As per risk description
	Target rating (LxS)	**Target date**	**Rationale**
	12	March 22	While mitigations in place, uncertainty regarding the impact of winter and staffing challenges means the target risk rating is unlikely to reduce.
	Current rating (LxS)	**Latest review date**	**Rationale**
	12	January 2022	As per risk description

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
NEL ICS Acute Collaborative Alliance is leading across the system via the planned care recovery work stream solely on Elective Recovery. Assurance is undertaken from within the ICS performance function and external with the NHSEI London Regional team specifically for HVLC work, outpatients and diagnostics.	I and E	Papers for monthly elective performance challenge sessions	Monthly
The NHSE regional team hold a monthly elective recovery board, outpatient board and the ICS focus calls to assure ICS plans for elective recovery.	I and E	Papers for monthly regional ICS Focus Calls	Monthly

Mitigations/ actions to address the risk	**Target date**
The Elective programme aims, objectives, underpinning workstreams and governance have been refreshed by the acute alliance planned care programme director. The programme is focussed on waiting list management, outpatients, mutual aid, independent sector provision, productivity and efficiency, workforce, diagnostics and new capacity/investment. Performance is reported weekly via the H2 dashboard and monthly to confirm the month end position and ensure corrective action. Monthly speciality specific performance challenge sessions are held across NEL to challenge and share best practice, in addition to targeted work with Barts Health on 104ww, speciality deep dives and diagnostics.	Ongoing in accordance with Operating Plan trajectories
Clinical oversight across NEL ICS in place	In place

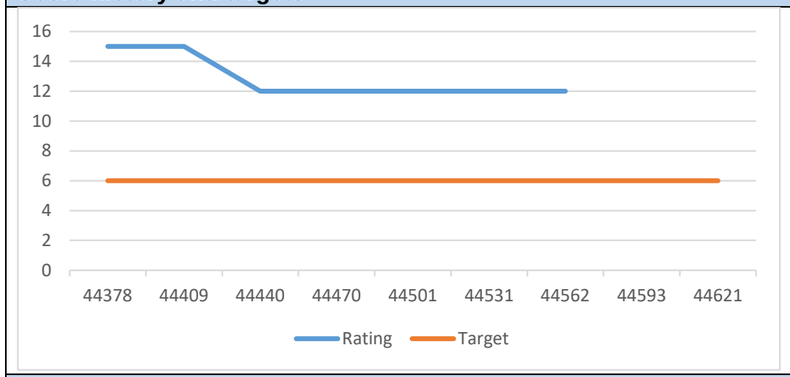
Governance - how, where and when this risk is being managed
NEL ICS - Planned Care Board chaired by Alwen Williams, CE Barts Health
Operational Elective Cell
Planning and transformation cell
Speciality clinical networks
Diagnostics working group and sub groups
Outpatient steering group
Data Group

Corporate objective	Ensure the best use of resources • to make sure we achieve maximum value from all available resources • to target our resources to address health inequalities			**Risk reference**	
Risk description	There is a risk that the CCG does not ensure financial resources are deployed effectively, resulting in poor value for money, and inability to deliver effective services and recovery, or failure to deliver its statutory financial duties			**Risk owner**	**Steve Collins Acting CFO**
ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	3
	✓	✓	✓		

Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**16**	April 21	Significant impact if resources are not deployed effectively, resulting in breach of statutory duties and impact on patient services
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 22	Controls, mitigations and system working effective to manage probability of risk, although impact/severity score remains significant, especially with a number of provider trusts operating with a financial deficit.
	Current rating (LxS)	**Latest review date**	**Rationale**
	8	January 22	The H2 plan has been agreed and the CCG will present a breakeven position but with an underlying deficit position. This will be mitigated by non-recurrent balance sheet provisions for this financial year but will increase the financial risk for NEL next year if allocations remain the same.

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
Defined monthly financial close process	I	Monthly Finance report and regular planning submissions	Monthly
Regular system level report and ongoing review of specific financial risks and opportunities	I	Risks reviewed through Finance and Performance Committee	Bi -monthly
Financial performance reported and reviewed by regional/national teams	E	ISFE/non-ISFE returns and ad hoc analyses	Monthly
Agreed Internal Audit and Counter Fraud Programmes with RSM	E	Updates provided to audit committee at each meeting	On-going
Annual External Audit with KPMG	E	Unqualified financial opinion provided at last audit	June-21
Mitigations/ actions to address the risk			**Target date**
For each planning round, CCG and system partners agree a contingency to allow for additional risks			31/10/21
Systematic review of current Covid related funding streams, such as Elective Recovery Fund and Hospital Discharge Fund			30/11/21
Review of risks and opportunities and balance sheet provisions			On-going
Business cases and transformation proposals reviewed for VfM, quality improvement and return on investment through ICP delivery boards or Finance and Performance in line with agreed delegated limits			On-going
Governance - how, where and when this risk is being managed			
Risk is managed through the Finance & Performance Committee and Audit & Risk Committee, reported through the full Governing Body			
Operational review takes place in ICP delivery/area committees, with financial controls managed through a defined monthly financial close process			

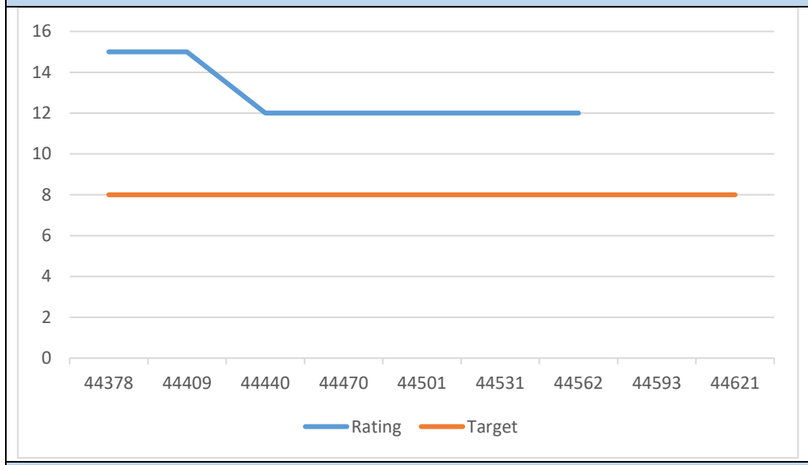
Corporate objective	High quality services for patients Put patient experience at the centre of our delivery Ensure the best use of resources			**Risk reference**	**CHC1**
Risk description	The current fragmented CHC system across NEL creates a number of organisational risks including: - Inequity across services - Patient care risks due to new referral and care review backlogs - Further scrutiny from NHSE & I due to not meeting national performance targets - Inability to manage service performance accurately due to not having a single IT solution and delays in procuring a new solution - Varied Local arrangements creating resource gaps, in particular social worker allocation to assessment process.			**Risk owner**	**Diane Jones** **Chief Nurse**
ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	2
	✓	✓	✓		

Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**15**	29 July 2021	Fragmented systems and ways of working across ICP and lack of social workers availability within the required timeframe
	Target rating (LxS)	**Target date**	**Rationale**
	6	October 2022	Mitigating actions will have impact on reducing risk
	Current rating (LxS)	**Latest review date**	**Rationale**
	12	January 2022	Governance arrangements agreed to enable continuation of the improvement plan. LA are working to address social worker allocation issues. Next steps for system procurement agreed. Assurance plan in place with NHSE & I for areas under-performing against KPIs Variation assurance plan under development for NHSE & I which will help identify/answer service equity questions. Policy harmonisation working group has been set up to align policies and procedures across services.

Controls	**Assurances** **I= internal, E= external**	**Evidence for assurance**	**Date received**
The CHC transformation board is in place. However, the workstreams need to be reviewed and priority actions taken forward	I	Minutes of the meeting	18.08.21
ICP leads undertaking local reviews of staffing and operating models within CHC to feed into CCG restructure		Staffing model across NEL	07.09.21
There is a regular review of activity and monitoring number of assessments completed and delays	I	Minutes of the monthly Board meeting	18.08.21
Improvement trajectory in place	I	Signed off assurance plan from NHSE & I	18.08.21
Quarterly reporting to NHSE/I	E	Quarterly submission data	14.07.21
High level milestones for procurement of one management system outlined to meet October 2022 deadline	I	Milestones	Not received to date

Mitigations/ actions to address the risk	**Target date**
Case management reviews by assessors	Weekly
Monthly meeting with CHC leads and LA	Monthly
Monthly assurance meeting with NHSE/I	Monthly
Policy Harmonisation workgroup has been established to develop aligned policies and procedures across NEL	Fortnightly
Monthly meeting with Directors of Adults Social Care	Monthly
Existing management system contracts extended	October 2022
Establish project workstream with identified (employed) leads to progress the re-procurement	September 2021
Develop detailed procurement workstream plan that meets the deadline of October 2022	October 2021
Ensure all Learning Disabilities patients in Waltham Forest are assessed for CHC eligibility and their needs are being met	June 2022
Undertake a variation assurance process with NHSE/I for area's reporting significant variation in referral and eligibility rates for CHC	Dec 2022
Hold CHC training events across NEL	Nov 2022
Put in place monthly meetings of CHC Senior Management Team to discuss system issues/blockages and develop solutions to resolve	Monthly
Update CHC Maturity Matrix	Dec 2021
Implement improvement opportunities/alignment opportunities identified through CHC Maturity Matrix workshop	Oct 2022
Hold Organisational Development workshop with LSS and CHC colleagues	Jan 2022
Implement improvement opportunities identified through Organisational Development workshop	Oct 2022
Governance - how, where and when this risk is being managed	
CHC Transformation board reporting into the quality and safety committee and audit committee.	

Corporate objective	Ensure the best use of resources			**Risk reference**	**CHC2**
Risk description	NHSE & I funding the Discharge to Assess pathway during and following the pandemic is resulting in increased number of requests for complex care packages. This may impact budgets planned efficiencies going forwards.			**Risk owner**	**Diane Jones Chief Nurse**
ICPs impacted	C&H ✓	TNW ✓	BHR ✓	**Risk appetite level (1-5)**	3

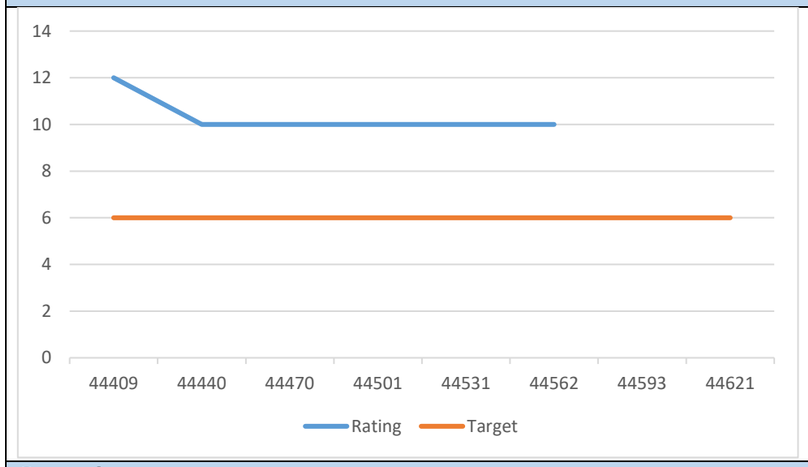
Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**15**	July 2021	As per risk description.
	Target rating (LxS)	**Target date**	**Rationale**
	6	October 2022	Risk mitigations to be put in place and progressed thereby reducing the risk score to the CCG.
	Current rating (LxS)	**Latest review date**	**Rationale**
	12	January 2022	Policies and templates are under development to help guide and manage care requests. Care request issues are being discussed and troubleshooted at bi-monthly commissioning lead meetings.

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
The CHC transformation board is in place. Workstreams have been reviewed and prioritised	I	Minutes of the meeting	18.08.21
CHC Strategic Finance Group in place, meets regularly	I	Minutes of the meeting	10.09.21
A workstream is underway investigating complex packages of care	I	Findings and recommendations from workstream	31.03.21
The Policy Harmonisation workstream has developed 1:1 care request principles and a request template	I	Signed off 1:1 care request principles and request template	June 2022

Mitigations/ actions to address the risk	**Target date**
Case management reviews by assessors	Weekly
Fortnightly meeting with CHC leads	Monthly
Implement policies that minimise excessive package costs (1:1 care, patient choice, etc.)	September 2021
CHC Checklist training with staff to ensure appropriate referrals are received through the pathway.	Ongoing

Governance - how, where and when this risk is being managed
CHC Transformation board reporting into the Finance and performance committee

Corporate objective	High quality services for patients Put patient experience at the centre of our delivery			**Risk reference**	**CHC3**
Risk description	There are a number of patients in the community who are currently being deprived of their liberty through the care being provided and living situation. There is a change to the legislation expected in 2022 (date TBC) calling the need to implement the Liberty Protection Safeguards (LPS). These will increase the volume and scope of work required to ensure patients deprived of their liberty are being cared for appropriately.			**Risk owner**	**Diane Jones Chief Nurse**
ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	2
	✓	✓	✓		

Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**12**	August 2021	As per risk description.
	Target rating (LxS)	**Target date**	**Rationale**
	6	March 2022	Mitigating actions will have impact on reducing risk
	Current rating (LxS)	**Latest review date**	**Rationale**
	10	January 2022	The LPS working group has been set up, focussing on developing a NEL-wide approach to meeting the requirements of implementing the LPS.

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
Workstream reporting	I	Minutes and action log of the meeting	10.09.21
Monthly reporting to the CHC Transformation Board	I	Minutes of the meeting	15.09.21
Quarterly reporting to CCG Senior Management Team	I	Minutes of the meeting	To be confirmed

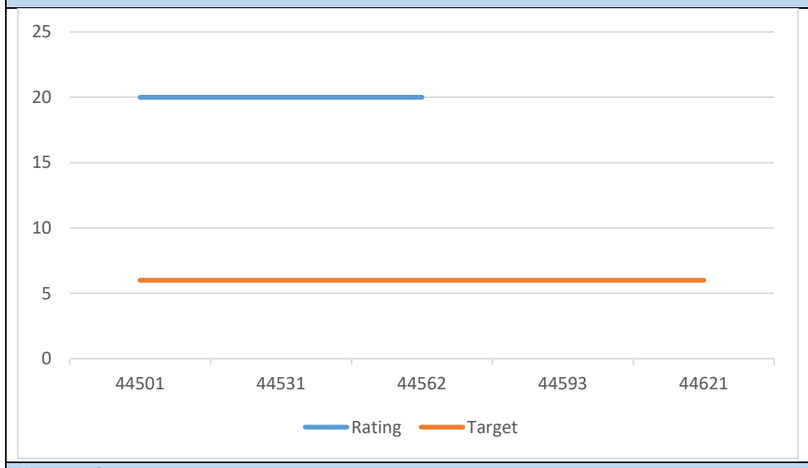
Mitigations/ actions to address the risk	**Target date**
Establish workstream to focus on the development of a Business Case for a team to undertake the work required in order to meet the requirements of this legislation	Fortnightly
Develop Business Case	December 2022
Establish Team	Feb 2022

Governance - how, where and when this risk is being managed
CHC Transformation board reporting

Corporate objective	High quality services for patients Put patient experience at the centre of our delivery Ensure the best use of resources	**Risk reference**	**CHC4**
Risk description	There is a workstream underway within the CHC Transformation Programme focussed on the procurement of a single CHC Digital System across North East London, this workstream currently has a number of risks associated with it including: - The current contracts with system providers expire in Oct-22, this is not a realistic timeframe to procure and implement a new digital system - The current workstream is resourced using a combination of Programme Team resource and BAU staff. System mobilisation will require additional resource in order to achieve a successful implementation - There is a lack of technical IT expertise in the current workstream team - There is currently no funding envelope identified for a new system, the expectation is that any system procured will require investment above the contract values with existing system providers.	**Risk owner**	**Diane Jones Chief Nurse**

ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	2
	✓	✓	✓		

Score history and targets



Initial rating (LxS)	**Initial date**	**Rationale**
20	November 2021	As per risk description.
Target rating (LxS)	**Target date**	**Rationale**
6	October 2022	Mitigating actions will have impact on reducing risk
Current rating (LxS)	**Latest review date**	**Rationale**
20	January 2022	

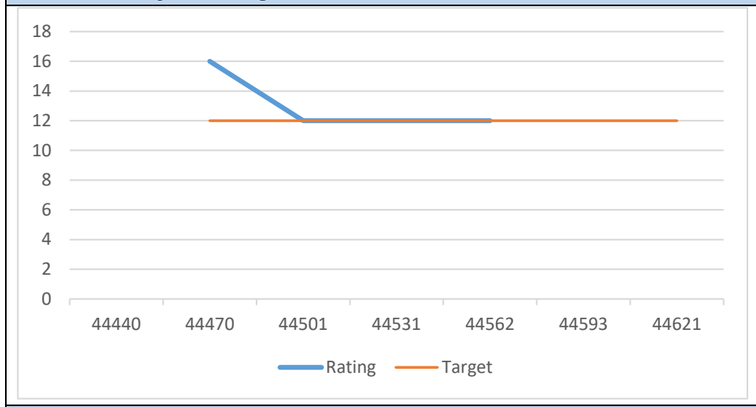
Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
Workstream reporting	I	Minutes and action log of the meeting	10.09.21
Monthly reporting to the CHC Transformation Board	I	Minutes of the meeting	15.09.21
Quarterly reporting to CCG Senior Management Team	I	Minutes of the meeting	To be confirmed

Mitigations/ actions to address the risk	**Target date**
Appoint a Senior IT Project Manager to lead on this workstream	November 2021
Extend contract with existing system providers to October 2023	March 2022
Develop a resource plan for workstream	December 2021
Develop a funding envelope for the new system including mobilisation costs	December 2021

Governance - how, where and when this risk is being managed

CHC Transformation board reporting

Corporate objective	Recover from the pandemic and be prepared for future waves			**Risk reference**	
Risk description	The vaccination programme has to rely on limited amount of workforce to manage multiple demands from NHSE, often at short notice. There will also be times when as an ICS we have to significantly expand the capacity of the vaccination programme to support national initiatives linked to increasing COVID-19 vaccination levels amongst our local population.			**Risk owner**	Simon Hall, Director of Transformation and SRO for the COVID-19 vaccination programme
ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	5
	✓	✓	✓		

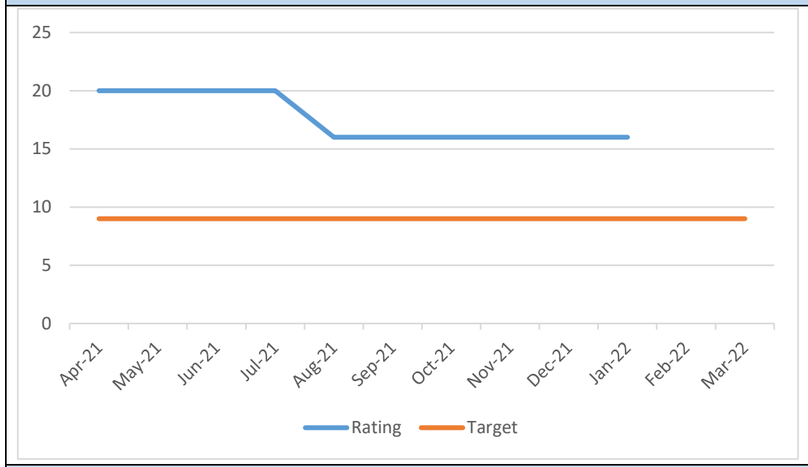
Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**16**	October 2021	As per risk description.
	Target rating (LxS)	**Target date**	**Rationale**
	12	March 22	Mitigating actions will have impact on reducing risk
	Current rating (LxS)	**Latest review date**	**Rationale**
	12	January 2022	As per risk description

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
The NEL COVID-19 Vaccination Programme Inbox operates 7 days a week to cascade the latest clinical and operational guidance from NHSE&I to SROs in each vaccination site, ICP leads and the NEL vaccination programme team. Where there is a change in national policy, or introduction of a new national requirement, this is followed up by a national assurance process and sitreps that are collated by the London region and sent to national.	Internal and external	National documents are cascaded to relevant sites. NEL Vaccination Programme PMO team oversee the collation of daily and weekly sitreps for NHSE&I.	Daily and weekly sitrep returns and cascades.
The NEL response to any current/new national mandate linked to the national COVID-19 vaccination programme is discussed and co-designed through the NEL COVID-19 Vaccination Programme Operational Group. This includes a regular review of the workforce demand and capacity issues linked to the vaccination programme as a whole and additional workforce asks to establish hyper-local pop-up clinics to reduce health inequalities.	Internal and external	Action log and papers sent to the weekly Operational Group meetings.	Weekly
The NEL Vaccination Programme Workforce Recruitment Task and Finish Group brings together workforce leads across the system to plan and respond to any new workforce supply issues linked to the vaccination programme.	Internal and external	Papers linked to weekly meetings, NHSE&I London workforce meetings and workforce sitreps.	Weekly

Mitigations/ actions to address the risk	**Target date**
1. Identify alternative ways to fill shifts 2. Use paid staff where volunteers can't be used (due to lack of availability or last minute cancellations) 3. Use vaccinator staff to fill admin shifts and build a more flexible workforce 4. Expand the volunteer network further (e.g. Barts Volunteers, Red Cross) 5. Understand capacity gaps to current capacity as well as to max capacity. Establish what workforce is available once VCs would run at max capacity and communicate when workforce requests for surge pop ups are made 6. NHS England and Improvement has issued an operational letter enabling PCNs to stand down some of their QOF activity to increase workforce and capacity to support the current surge in the national vaccination programme. 7. Increase in the number of Community Pharmacy LVS sites able to support the COVID-19 vaccination programme and increase existing sites workforce capacity through the Lead Employer. 8. Seek support from the Army, NHSE&I and Local Authorities to redeploy staff for specific tasks/roles within a vaccination site to support significant increases in vaccination capacity across NE London. 9. NHS system response to support the additional staffing requirements needed to support significant increases in vaccination capacity across NE London.	

Governance - how, where and when this risk is being managed
The risks are managed through the NEL Vaccination Programme Workforce Recruitment Task and Finish Group and the NEL Vaccination Programme Operational Group. The risks are also managed through national sitreps.

Corporate objective	Recover from the pandemic and be prepared for future waves			**Risk reference**	
Risk description	Health inequalities have been exposed and exacerbated as a result of the pandemic. There is a risk of widening health inequalities in the absence of focused and systematic action across the ICS.			**Risk owner**	**Hilary Ross, Director of Strategic Programmes**
ICPs impacted	C&H	TNW	BHR	**Risk appetite level (1-5)**	2
	✓	✓	✓		

Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
	**20**	1 April 21	Many controls (e.g. wider determinants) are outside the direct remit of the NHS and we have already seen how the pandemic has disproportionately affected groups that are more highly represented within the NEL population e.g. people from black and minority ethnic backgrounds, low income families, rough sleepers
	Target rating (LxS)	**Target date**	**Rationale**
	9	1 April 22	Systematic action embedded across the ICS in terms of service delivery, but also prevention priorities and tackling the wider determinants of health through our role as anchor institutions, has the potential to reduce health inequalities
	Current rating (LxS)	**Latest review date**	**Rationale**
	16	January 22	In addition to our local programmes of work, there is a much greater central focus on tackling health inequalities and we have made significant progress towards developing a plan to address health inequalities across a number of domains. It will, however, take more time to fully embed these approaches systematically across the ICS and for some longer term work eg on wider determinants to make an impact

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
Covid risk stratification in primary care		Increased availability of data on ethnicity and other covid risk factors in primary care	31 March 21
Range of interventions to reduce inequalities in Covid-19 vaccinations, co-produced with communities and implemented across NEL	E	Vaccination uptake rates particularly in vulnerable and underserved population groups	Ongoing
Digital inclusion activity across NEL including local champions and analysis of GP appointments		TBC	TBC

Mitigations/ actions to address the risk	**Target date**
In addition to local plans, development of a NEL Health Inequalities Plan and programme with established workstreams addressing heath equity, prevention, population health management and wider determinants of health through our role as anchor institutions.	1.11.21
Health inequalities impact assessment in elective recovery and other key areas e.g. maternity	30.11.21
Analysis of equity in waiting lists and prioritisation of LD patients for surgery (Barts Health NHS Trust)	TBC
Implementation of a consistent step down pathway for homeless people	31.3.22
Implementation of tobacco dependence treatment services across NHS trusts and development of a NEL tobacco strategy	TBC
Producing updates against the health inequalities priorities of the NHS Operating Framework (24 Dec 2021) including the Core20PLUS5 framework	31.3.22
Recruitment of a Programme Manager to lead on tobacco across NEL	01.02.22

Governance - how, where and when this risk is being managed

ICS Health Inequalities Steering Group co-chaired by Paul Calaminus (CEO ELFT) and Jason Strelitz (DPH Newham) meets monthly to oversee development and delivery of the programme plan which is supported by a dedicated NEL PH Consultant.

Corporate objective	High quality services for patients Support our people to thrive Recover from the pandemic and be prepared for future waves				**Risk reference**	
Risk description	From 1 April 2022, anyone working or volunteering in a CQC registered health and social care setting and having face to face contact with service users/ patients will need to be fully vaccinated against coronavirus (COVID-19), unless exempt in accordance with legislation that was passed in December 2021. If significant numbers of staff choose to remain unvaccinated there is a potential risk to service delivery.				**Risk owner**	**Rachel Patterson, Director of People and OD**
ICPs impacted	C&H	TNW	BHR		**Risk appetite level (1-5)**	4
	✓	✓	✓			

Score history and targets	**Initial rating (LxS)**	**Initial date**	**Rationale**
[As this is a new risk, a graph cannot be produced]	**15**	January 22	As per risk description. If significant numbers of staff have their employment terminated by their employer there will be an impact on workforce capacity and the ability to deliver in some services.
	Target rating (LxS)	**Target date**	**Rationale**
	12	1 April 22	The legislation is due to come into effect from 1 April 2022 and the mitigations identified will impact on reducing the current risk rating.
	Current rating (LxS)	**Latest review date**	**Rationale**
	15	January 22	As per risk description. Early areas of concerns are domiciliary care, patient transport, IAPT and midwifery workforces.

Controls	**Assurances I= internal, E= external**	**Evidence for assurance**	**Date received**
Risk and mitigations discussed at the monthly ICS HR Directors meeting	I/E	Minutes and actions of the meeting	January 2022
Risk and mitigations discussed at the fortnightly London HR Regional Directors Steering Group	I/E	Minutes and actions of the meeting	January 2022

Mitigations/ actions to address the risk	**Target date**
Weekly Directors of People and system wide task and finish groups in place to develop consistent approaches and share learning/ resources.	Ongoing
Building on lessons learnt from delivering the Care Home Vaccination as a Condition of Deployment (VCOD) Mandate.	Ongoing
Working with NEL HR Directors group to ensure senior sponsorship at Trust level.	Ongoing
Liaising with Regional and National NHS teams to understand the scope of the mandate and feed in risks and issues and seek support to resolution.	Ongoing
Linking in with established forums and networks to spread awareness/ knowledge and sharing of good practice.	Ongoing

Governance - how, where and when this risk is being managed
This risk is being managed by the ICS HR Directors and HR Regional Directors steering groups.

SUPPORTING INFORMATION

Risk Category	Severe	
	High	
	Medium	
	Low	

Appetite description	Appetite level
The CCG is not willing to accept these risks under any circumstances	1
The CCG is not willing to accept these risks (except in very exceptional circumstances)	2
The CCG is willing to accept some risk in this area	3
The CCG is willing to accept moderate risk in this area	4
The CCG is willing to accept high risk in this area	5

Corporate Objectives

- High quality services for patients
- Put patient experience at the centre of our delivery
- Ensure the best use of resources
- Support our people to thrive
- Develop our NEL integrated care system
- Recover from the pandemic and be prepared for future waves

Risk grading matrix

												Likelihood				
												Rating	**1**	**2**	**3**	**4**	**5**
												Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
												Probability	**<10%**	**10% - 24%**	**25% to 45%**	**50% - 74%**	**>75%**
Severity	**Rating**	Description	A Objectives/ projects	B Harm/injury to patients, staff visitors & others	C Actual/potential complaints & claims	D Service disruption	E Staffing & competence	F Financial	G Inspection/ Audit	H Adverse media							
	1	**Insignificant**	Insignificant cost increase/time slippage. Barely noticeable reduction in scope or quality	Incident was prevented or incident occurred and there was no harm	Locally resolved complaint	Loss/ interruption more than 1 hour	Short term low staffing leading to reduction in quality (less than 1 day)	Small loss <£1000	Minor recommendations	Rumours		1	**1**	**2**	**3**	**4**	**5**
	2	**Minor**	Less than 5% cost or time increase. Minor reduction in quality or scope	Individual(s) required first aid. Staff needed <3 days off work or normal duties	Justified complaint peripheral to clinical care	Loss of one whole working day	On-going low staffing levels reducing service quality	Loss of 0.1% budget.	Recommendations given. Non-compliance with standards	Local media column		2	**2**	**4**	**6**	**8**	**10**
	3	**Moderate**	5-10% cost or time increase. Moderate reduction in scope or quality	Individual(s) require moderate increase in care. Staff needed >3 days off work or normal duties	Below excess claim. Justified complaint involving inappropriate care	Loss of more than one working day	Late delivery of key objectives/service due to lack of staff. On-going unsafe staff levels. Small error owing to insufficient training	Loss of more than 0.25% of budget.	Reduced rating. Challenging recommendations. Non-compliance with standards	Local media front page story		3	**3**	**6**	**9**	**12**	**15**
	4	**Major**	10-25% cost or time increase. Failure to meet secondary objectives	Individual(s) appear to have suffered permanent harm. Staff have sustained a "major injury" as defined by the HSE	Claim above excess level. Multiple justified complaints	Loss of more than one working week	Uncertain delivery of services due to lack of staff. Large error owing to insufficient training	Loss of more than 0.5% of budget.	Enforcement action. Low rating. Critical report. Major non-compliance with core standards	Local media short term		4	**4**	**8**	**12**	**16**	**20**

	5	**Severe**	>25% cost or time increase. Failure to meet primary objective	Individual(s) died as a result of the incident	Multiple claims or single major claims	Permanent loss of premises or facility	No delivery of service. Critical error owing to insufficient training	Loss of more than 1% of budget.	Prosecution. Zero rating. Severely critical report.	National media more than 3 days. MP concern	5	**5**	**10**	**15**	**20**	**25**

North East London
Clinical Commissioning Group

NEL CCG Governing Body
26 January 2022

Title of report	National Evidence Based Interventions (EBI) Wave 2
Item number	5.1
Author	Alison Glynn, Head of Commissioning and Contract Management
Presented by	Victoria Tzortziou, GP, Clinical Lead/Siobhan Harper, Director of Transition, SRO
Contact for further information	Alison Glynn
Executive summary	• Adoption of national Evidence Based Intervention recommendations into the NEL CCG Evidence Based Intervention Policy • Some further amendments made to the policy based on feedback from providers and clinicians. • **Governing Body is asked to approve the policy for implementation by NEL CCG**
Action required	Approve
Where else has this paper been discussed?	NEL CCG Quality, Safety and Improvement Committee, NEL SMT, NEL CAG, NEL Planned Care Recovery Group
Next steps/ onward reporting	1. Once approved, notice will be given to providers on the amended policy 2. Communications to GPs via GP intranet and newsletters. 3. Implementation plans for monitoring arrangements will be developed and where appropriate agreements incorporated into 2022/23 Contracts
What does this mean for local people? **How does this drive change and reduce health inequalities?**	A single policy across north east London that incorporates the latest clinical evidence enables equitable access to treatments across north east London. It contributes to improved outcomes and means we can free up valuable resources so they can be put to better use for clinically effective interventions. This is more important than ever as the NHS recovers from the impact of Covid-19 and restores services.
Conflicts of interest	None identified
Strategic fit	• High quality services for patients • Put patient experience at the centre of our delivery

	• Ensure the best use of resources • Recover from the pandemic and be prepared for future waves
Impact on finance, performance and quality	Supports elective recovery and improves outcomes. No financial impact.
Risks	None raised
Equality impact	Equality Impact Assessment was approved at the Quality, Safety and Improvement Committee on 10 November 21.

Board and committee paper guidance

Introduction/ Context/ Background/ Purpose of the report

Be clear on why you are writing a Board or Committee paper. If your purpose is to inform, you may start off with some background information about the issue. If your purpose is to provide assurance, while your starting point may still be the same, the critical difference will be the need to assure the Board or its Committees about how services, for example, currently configured are either serving the needs of the population, or where they are not, how the proposals you intend putting in place will provide that assurance.

Clearly state what you are asking the Board or Committee to do:

- For Decision
- For Approval
- For Discussion
- For Information

Reports to either the Board or Committees on specific tasks or activities should set out clearly, not only what has been done, but also what is expected in terms of decisions and actions.

Set out how the paper relates to the organisational corporate objectives and strategy. If a proposal is outside the organisation's strategy or policies, this needs to be highlighted.

Key messages

A short summary of the main high-level issues within the paper.

Body of report

Tell a succinct story – beginning, middle and end. Get the balance right between presentation and substance. Condense lengthy reports into concise summaries, charts and dashboards, visually highlighting trends and key findings and more importantly, drawing out the key issues for consideration by Board and Committee members.

- Ensure any metrics or performance indicators are outcome based
- Include as much patient experience data as you can, keeping the patient/service user at the heart of the report
- Write with your audience firmly in mind
- Try to avoid acronyms and write in plain English
- Ensure the 'so what' question is answered

Risks and mitigations

Highlight any risks that need to be brought to the Board or Committees attention and the mitigations that are in place.

Conclusion / Recommendations

The recommendation should relate back to the purpose of the paper. If the recommendation is to make a decision, then the recommendation field should explicitly state the decision the Board or its Committees is being asked to make. If the recommendation is to inform, then the recommendation field should be that members are informed.

End

The report should end with the name of the author and the date the report was drafted.

North East London
Clinical Commissioning Group

National Evidence Based Interventions (EBI) Wave 2

Submitted to: NEL CCG Governing Body
Date: 26 January 2021
Author: Alison Glynn, Head of Commissioning and Contract Management, London Shared Service
Clinical Lead: Victoria Tzortziou-Brown, GP Tower Hamlets
SRO: Siobhan Harper, Director of Transition, TNW ICP

1.0 Introduction and background

The national Evidence-based Interventions programme is an initiative led by the Academy of Medical Royal Colleges (AOMRC) to improve the quality of care.

It is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence tells us are inappropriate for some patients in some circumstances. We also know that sometimes these interventions can do more harm than good.

As well as improving outcomes, it also means we can free up valuable resources so they can be used for clinically effective interventions. This is more important than ever as the NHS recovers from the impact of Covid-19 and restores services.

The AOMRC undertook a national consultation in the summer of 2020 that included specialists and patient groups. The guidelines were published at the end of 2020[1] with a recommendation that these are implemented by CCGs and incorporated into contracts with providers.

In response NEL CCG launched a project to incorporate these guidelines into our existing Evidence Based Interventions policy which was original published in November 2019 with some minor revisions in April 2021. This policy already includes the national Wave 1 interventions.

In order to achieve this, a clinical review group (CRG) was established to review the 31 new policies and form a clinical consensus on the final policy.

The clinical review group consisted of GPs from each Integrated Care Partnership; TNW (Tower Hamlets, Newham and Waltham Forest) BHR (Barking and Dagenham, Havering and Redbridge) and City and Hackney. The group also sought the advice of local consultants for a number of procedures. This thorough review included an Equality and Quality Impact

[1] https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/EBI_list2_guidance_0321.pdf

Assessment on each of the interventions which has resulted in some changes to the national recommendations.

In addition to the new intervention guidelines, the group considered feedback that the CCG had received from providers and clinicians on the existing policy.

The following paper and Appendix summarises the changes to the policy that were made and where the group agreed to deviate from the national guidance. The full policy is also attached with the papers.

NEL CCG Governing Body is asked to:

- **Approve the policy for implementation by NEL CCG**
- **Note the next steps for implementation.**

2.0 Outcome of the Clinical Review Group (CRG) review of the policy

Appendix A summarises the changes and additions to the policy recommended by the Clinical Review Group. This group was made up of Primary Care clinicians, however advice and feedback was sought from secondary care clinicians as part of that review.

The first table covers the additions made to the policy to reflect the national EBI wave 2 guidance. The second table covers the changes to the policies in the current policy based on feedback from clinicians since the publication of the policy in November 2019.

Following a review of these recommendation including consideration of any Equality and Quality impacts, the Clinical Review Group accepted the overwhelming majority of the national recommendations, however there were 3 policies which the Clinical Review Group were not able to accept at this time. The first two relate to access to diagnostic tests by primary care for muscular skeletal conditions (Knee MRI for meniscal tears and scans for shoulder pain). The group felt that in the context of the current backlogs in secondary care that this would be detrimental to both access and waiting times. The group agreed that work should continue on these pathways to ensure that the use of these modalities is managed appropriately.

The third policy that has been put on hold relates to Adenoidectomy in Glue Ear. Local ENT consultants felt that this policy did not reflect the latest clinical evidence and this has been taken up with the national team for more discussion.

These exclusions and the overall Equality and Quality Impact Assessments were approved at the Quality, Safety and Improvement Committee on 10 November.

3. Next Steps

1. Once approved, notice will be given to providers on the amended policy.
2. Communications to GPs via GP intranet and newsletters.
3. Implementation plans for monitoring arrangements will be developed and where appropriate agreements incorporated into 2022/23 Contracts.

Appendix A

Summary of changes made to the North East London CCG Evidence Based Interventions Policy version 2.0 published April 2021

1.0 Additions to reflect the National Evidence Based Interventions Wave 2 guidance

Ref:	Test/ Treatment or Procedure	Category	Policy Page number
2A	Invasive angiogram to investigate stable chest pain	Cardiology	8
2B	Surgery for inguinal hernia	General Surgery	29
2C	Surgery for sinusitis (replacing previous policy)	ENT	20
2E	Surgery to treat knee problems	Orthopaedics	46
2F	Specialised blood tests (troponin) for investigation of chest pai	Blood test	10
2G	Removal of stones from the kidneys	Urology	32
2H	Camera test of the bladder in men	Urology	33
2I	Surgery for enlarged prostate	Urology	33
2J	Spinal surgery for a slipped disc	Orthopaedics	42
2K	A procedure to numb nerves for low back pain	Orthopaedics	44
2L	Treadmill test for heart disease	Cardiology	13
2M	Endoscopy to investigate gut problems	Gastroenterology	22
2N	Colonoscopy of the lower intestine	Gastroenterology	24
2O	Follow up colonoscopy of the lower intestine	Gastroenterology	26
2P	Test of the gallbladder	General Surgery	29
2Q	Removal of an inflamed gallbladder	General Surgery	29
2R	Tests to confirm appendicitis	General Surgery	29
2S	Tests to investigate low back pain	Orthopaedics	44
2T	Tests to investigate knee pain	Orthopaedics	46
2V	Procedures to build up brittle spine bones	Orthopaedics	44
2X	MRI scan of the hip for arthritis	Orthopaedics	47
2Y	Surgery to fuse the bones in the back for back pain	Orthopaedics	43
2Z	Helmets to reshape flat heads in babies Individual Funding Request	Paediatrics	50
2AA	Chest X-ray before an operation	Anaesthetics	8
2BB	Heart tracing (ECG) before an operation	Anaesthetics	8
2CC	Prostatespecific antigen (PSA) testing	Blood test	34
2DD	Regular blood tests when taking cholesterol lowering tablets	Blood test	11
2EE	Blood transfusions	Blood test	35

2.0 Changes to the policy based on feedback from providers

Test/ Treatment or Procedure	Amendments made based on guidance from the Clinical Review Meetings	Category	Policy Page number
Age Threshold	Policy will apply to adults 18 or over. Clarity sought by providers Wave 1 and Wave 2 guidance did not always agree.	All	4
Circumcision	Add wording of 'physical distress' to criteria no. 2. Based on feedback from clinicians	Gynaecology/Urology	31
Hair loss - Category 1 Procedures: Individual funding request (IFR)	Remove from IFR based on feedback from providers 'Treatment for hair loss (alopecia)'	Dermatology & Skin	14
Pinnaplasty/otoplasty (correction of prominent)	Remove reference to 'bat ears'.	ENT	18
Removal / revision of breast augmentation	Based on advice from Barts Health breast surgeon Remove narrative on 'revision' and replace with 'replacement' - Replacement with a new prosthesis will only be considered where original implants were funded by the NHS for reconstruction i.e.: non-cosmetic purposes. Additional cosmetic surgery (e.g. mastopexy or bigger implants) should not be done at the same time as the reimplantation and will not be funded.	Breast	13
Tonsillectomy	Add children to the policy as this was an omission in the original policy - The guidance applies to adults and children .	ENT	19

North East London
Clinical Commissioning Group

North East London

Evidence Based Interventions Policy

Procedures not routinely funded (Individual Funding Requests (IFR)) or funded only when specific criteria are met.

Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest Clinical Commissioning Group Boroughs (North East London CCG (NEL)

Date of publication: December 2021

Document details

Document reference	NEL Evidence Based Interventions Policy Version 2.1
Document category	Clinical Policy
Original Publication	October 2019
Approved By	North East London Clinical Commissioning Groups
Date Last Reviewed	December 2021
Next Review Date	November 2023

Version Control

Date	Page no.	Policy	Ratified by	Reason for change
April 2021	36	Cataract surgery	North East London CCG Quality and Safety Committee	Purposes of clarity
April 2021	42	Interventional treatments for back pain	As above	Purposes of clarity
April 2021	19	Tonsillectomy	As above	Purposes of clarity
April 2021	12	Breast reduction and correction of breast asymmetry	As above	Purposes of clarity
April 2021	38	Injections for non-specific low back pain	As above	Purposes of clarity
April 2021	19	Rhinoplasty/Septoplasty/Rhinoseptoplasty (surgery to reshape the nose)	As above	Purposes of clarity
April 2021	13	Removal / revision of breast augmentation	As above	Purposes of clarity
November 2021	4	Age Threshold	NEL CCG Quality, Safety and Improvement Committee	Purposes of clarity

November 2021	31	Circumcision	As above	Based on clinical feedback
November 2021	18	Pinnaplasty/otoplasty (correction of significantly prominent ears)	As above	Removal of reference to 'bat ears'
November 2021	13	Removal / revision of breast augmentation	As above	Based on clinical feedback
November 2021	19	Tonsillectomy	As above	Wording changed to include children
November 2021		Hair Loss – Category 1 Procedures: IFR	As above	Removal based on provider feedback
November 2021		Replacement of existing policies on Chronic Sinusitis, Discectomy and Spinal Fusion with national EBI Wave 2 guidance	As above	To reflect latest national guidance
November 2021		National EBI Wave 2 except for 2D, 2U, 2W(i) & 2W(ii) (see below for reason for exclusions)	As above	To reflect latest national guidance

Background

The NEL Evidence Based Interventions Policy (NEL EBI) is a list of treatments/interventions that are only funded by the NHS when a patient meets certain clinical threshold criteria. This policy applies to adult patients aged 18 and over only, unless specified otherwise in the body of text within each policy.

Policy development is an on-going process resulting from the publication of new evidence regarding clinical effectiveness. Policy reviews will be undertaken in response to NICE Guidance/Guidelines, health technology assessments etc.

This policy was first published in October 2019 after a rigorous clinically led programme which reviewed and incorporated where appropriate the latest national Evidence Based Interventions Programme[1] and the London Choosing Wisely Programme[2]. The policy replaced the two existing Procedures of Limited Clinical Evidence Policies (POLCE) policies (Barking and Dagenham, Havering and Redbridge CCGs POLCE policy and the Waltham Forest, Tower Hamlets, Newham and Waltham Forest (WELC) POLCE policy).

Revisions to the single policy were made in April 2021 to take account of provider feedback.

In 2020 the Academy of Medical Royal Colleges consulted on a new wave of evidence based interventions https://www.aomrc.org.uk/ebi/resources/list-2-documents-resources/

After a review by local clinicians, the majority of those interventions have now been incorporated into this policy. There are however 3 interventions that clinicians decided not to adopt at this time. The first two as it was felt that in the context current waiting, applying this would have a detrimental impact on equality of access and waiting times.

1. Knee MRI should not be routinely used to initially investigate suspected meniscal tears in primary care (policy ref: 2U; table 2B)

2. Imaging for shoulder pain should be offered under the guidance of shoulder specialists where possible. (Policy Ref: 2W(i)(ii); Table: 2B)

[1] https://www.aomrc.org.uk/ebi/

[2] https://www.healthylondon.org/our-work/london-choosing-wisely/

3. The third policy that has been put on hold relates to Adenoidectomy in Glue Ear (policy ref: 2D; table 2A) Local ENT consultants felt that this policy did not reflect the latest clinical evidence and this has been taken up with the national team for more discussion.

Purpose of the Policy

We know that some procedures are currently carried out on patients, where the evidence for intervention is not strong and more conservative approaches to the management of conditions would be more appropriate and present less risks than surgical intervention. We need to ensure that in making decisions on how we fund treatments, that our patients realise the best clinical and quality outcomes. Having a policy to govern these procedures that is adhered to will ensure that patients do not undergo unnecessary surgical interventions or procedures where clinical evidence is not strong or where in some cases carries significantly greater risk and cost, than alternative treatment options. Adherence to an effective policy will also ensure that surgical capacity is available for those patients that really need a procedure to be carried out that is supported by clinical evidence.
We need to continue to prioritise those services that deliver the greatest health gain for local people. By ceasing to make some services routinely available and putting in place criteria for accessing other services, we believe that will be able to protect the most important services so that they can be available when people need them whilst at the same time continuing to live within our financial means.

To achieve this aim, we will ensure the current NEL EBI Policy is:

1. Consistently applied across North East London Clinical Commissioning Group boroughs (Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets, and Waltham Forest) to avoid any postcode related inequity or inequality.

2. Presented using unambiguous language, which is easy for clinicians and patients to interpret.

3. Regularly reviewed, updated and reissued using the most up to date and validated evidence base.

4. Effectively and consistently communicated to health care professionals within the footprint.

5. An open and transparent process, adhering to local governance policies.

Where possible, references to the evidence/ guidelines underpinning individual clinical policies have been added to the relevant sections. However, it should be noted that an assumption is made that if National guidelines are updated that would impact upon this policy they will be taken into account when assessing eligibility for a particular treatment.

Securing NHS Funding

Category 1 - IFR (Not routinely funded) - The statement “NEL CCG will not routinely fund” means it is primarily a commissioning decision not to routinely fund. In these circumstances a clinician may still request funding for that treatment but this will only be approved if an Individual Funding Request (IFR) proves exceptional clinical need and is approved by the IFR panel (Please refer to IFR Policy).

A copy of the relevant IFR policy can be obtained from the IFR team by emailing at the following address:

For North East London CCG

Email: Nelcsu.ifr@nhs.net

Exceptional cases must have exceptional clinical circumstances supported by robust clinical evidence. We have defined exceptionality as an unusual clinical factor (or factor affecting the clinical condition) about the patient that suggests that they are

1. Significantly *different* to the general population of patients with the condition in question.

AND

2. Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

The fact that a treatment is likely to be effective for a patient is not, in itself, a basis for exceptionality. For further information on clinical exceptionality please refer to the IFR policy or contact the IFR team in advance of completing an IFR application to discuss the appropriateness of pursuing funding?

Any procedures carried outside of the funding governance arrangements outlined above will be subject to challenge and carries a significant risk of non-payment to the provider.

Category 2 – interventions which should only be routinely commissioned or performed when specific criteria are met

These interventions are only routinely commissioned or performed when specific criteria is met. Clinicians will need to demonstrate that the patient meets the criteria set out in this policy. If the patient does not meet the relevant clinical criteria, but the clinician feels the patient has exceptional clinical circumstances, the request for funding should be taken through the IFR process.

Commissioners will use national and local datasets to determine which of these interventions may require closer monitoring through either a Prior Approval Process (Blueteq) or trust electronic solutions such as TCI forms with embedded criteria. The remaining interventions will be subject to light touch monitoring using benchmarking data or occasional audit.

The national EBI guidance is given contractual effect through provisions included at SC29.28- 31. There is a requirement for the co-ordinating commissioner and the provider to agree clinically-appropriate goals for the annual number of procedures in each category to be undertaken. Material over-performance against the activity goals in-year should prompt review and action to ensure that EBI policy is being fully implemented. No individual patient should be prevented from accessing clinically appropriate treatment, in accordance with EBI guidance criteria, simply because the overall activity goal has been exceeded.

Any procedures carried outside of the funding governance arrangements previously outlined will be subject to challenge and carries a risk of non- payment to the provider.

Occasional retrospective audits - The frequency, scope and depth for any audits will be agreed with providers who will be given appropriate notice pending any such audits and or reviews. All providers will be asked to clarify any activity or procedure codes that fail to comply with those set out within the policy. These will be subject to challenge as is relevant and where appropriate challenged for non-payment.

Coding: CCGs and Providers will work collectively to agree, maintain and review coding as required to support policy implementation.

Equality statement

NEL CCG has a duty to have due regard for the need to reduce health inequalities in access to health services and health outcomes achieved as detailed in the Health and Social Care Act 2012. NEL CCG has committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, NEL CCG will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

NEL CCG completed an Equality Quality Impact Assessment (EQIA) and Full Quality Impact Assessment (fQIA) for the first version of this policy in November 19 and a further EQIA for the policy update published

in December 2021. The Academy of Medical Royal Colleges undertook an Equalities Impact Assessments on Wave 1 and 2 guidance. These assessment can be found at this link. https://www.aomrc.org.uk/ebi/resources/list-2-documents-resources/

Exclusions to this policy

The policy does not apply to the following:

- Patients diagnosed with cancer or suspected of having cancer: diagnoses should be dealt with via a two-week wait referral and NOT via an Individual Funding Request (IFR) or Prior Approval (PA) application.
- Policies will not apply to those patients where the treatment is in relation to and outlined in their cancer pathway e.g. breast reconstruction following breast cancer.
- If Mental Health affects functionality (ability to undertake activities of daily living such that there is a sustained impact on health and/or patient safety) then it should be considered for funding. Although in such cases there should be a recommendation by a clinical psychologist and confirmation that mental health interventions have been exhausted or are compromised significantly.
- Children (aged under 18) unless otherwise stated within individual treatment/intervention policy.
- Emergency or urgent care.
- Where NHS England commission the service as part of specialist commissioning arrangements.
- If a clinician considers the need for referral/treatment on clinical grounds outside of the Prior Approval (PA) criteria, please refer to the CCG Individual Funding Request policy for further information.

In relation to the above exclusions, the provider should be able to demonstrate the clinical need either through the coding or as part of the patient record.

Implementation time scales

This policy will be used to assess all patients being referred for assessment or treatment from the date of implementation (one month after publication). The NEL EBI will be reviewed biennially (every 2 years). If required, formal Clinical Review Group (CRG) will be reinstated, and Nationally mandated policies will be adopted without further consultation.

Age Threshold

These policies apply to all adults aged 18 or over unless otherwise stated.

Category 1 Procedures: Individual funding request (IFR)

This list includes procedures that are not routinely commissioned by NEL CCG, and therefore funding is only available through an IFR panel. Only IFR applications that demonstrate clear clinical exceptionality will be processed. Please refer to the local IFR policy for further guidance before completing an application form.

Liposuction	**Bariatric surgery**	**9**
Surgery to correct divarification (or diastasis) of the abdominal rectus muscle	**Bariatric surgery**	**9**
Breast augmentation	**Breast**	**11**
Breast lift (mastopexy)	**Breast**	**11**
Male breast reduction (gynaecomastia)	**Breast**	**11**
2L Exercise ECG for screening for coronary heart disease (Treadmill test for heart disease)	**Cardiology**	**13**
Face lifts and brow lifts (rhytidectomy)	**Dermatology & Skin**	**14**
Hair transplantation	**Dermatology & Skin**	**14**
Repair of split ear lobes	**Dermatology & Skin**	**14**
Tattoo removal	**Dermatology & Skin**	**14**
Treatment for scarring and skin hyper- or hypo-pigmentation	**Dermatology & Skin**	**14**
Surgical interventions for snoring in the absence of obstructive sleep apnoea	**ENT**	**17**
Double balloon enteroscopy for diagnostic purpose	**Gastroenterology**	**22**
All treatments for vascular lesions	**General Surgery**	**27**
Cosmetic genital procedures (labiaplasty – excluding Female Genital Mutilation (FGM) (refer to circumcision category 2 prior approval policy)	**Gynaecology/Urology**	**30**
Dilation & curettage (D&C) for heavy menstrual bleeding in women	**Gynaecology/Urology**	**30**
MRI guided ultrasound (MRgFUS) for uterine fibroids	**Gynaecology/Urology**	**30**
Non-medical circumcision	**Gynaecology/Urology**	**30**
Reversal of female sterilisation and reversal of vasectomy	**Gynaecology/Urology**	**30**
Sacral nerve stimulation for faecal and urinary incontinence	**Gynaecology/Urology**	**30**
Varicocele	**Gynaecology/Urology**	**30**
White cell apheresis	**Haematology**	**35**
Ketogenic diet for epilepsy	**Medicine**	**36**
Laser surgery for short sightedness	**Ophthalmology**	**36**
Autologous chondrocyte (cartilage) implantation	**Orthopaedics**	**38**
Injections for non-specific low back pain	**Orthopaedics**	**38**
Knee arthroscopy for patients with osteoarthritis	**Orthopaedics**	**38**
Interventional treatments for back pain	**Orthopaedics**	**38**
— Lumbar disc replacement	**Orthopaedics**	**38**
— Ozone discectomy	**Orthopaedics**	**38**
2Z Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children (Helmets to reshape flat heads in babies) Individual Funding Request	**Paediatrics**	**50**
Manual therapies (osteopathy – outside of an MSK integrated service)	**Physiotherapy**	**51**

Category 2 Procedures: interventions which should only be routinely commissioned or performed when specific criteria are met

The following interventions are only routinely commissioned or performed when specific criteria are met. Clinicians will need to demonstrate that the patient meets the criteria set out in this policy. If the patient does not meet the relevant clinical criteria, but the clinician feels the patient has exceptional clinical circumstances, the request for funding should be taken through the IFR process.

Commissioners will use national and local datasets to determine which of the following interventions may require closer monitoring through either a Prior Approval Process (Blueteq) or trust electronic solutions such as TCI forms with embedded criteria. The remaining interventions will be subject to light touch monitoring using benchmarking data or occasional audit. These arrangements will be detailed in contracts with providers.

Procedures	Speciality	Page No.
2AA Pre-operative chest x-ray (Chest X-ray before an operation)	**Anaesthetics**	**8**
2BB Pre-operative ECG (Heart tracing (ECG) before an operation)	**Anaesthetics**	**8**
Bariatric Surgery	**Bariatric surgery**	**9**
2F Troponin test (Specialised blood tests (troponin) for investigation of chest pain)	**Blood Test**	**10**
2DD Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy) (Regular blood tests when taking cholesterol lowering tablets)	**Blood Test**	**11**
Breast reduction and correction of breast asymmetry	**Breast**	**12**
Nipple inversion	**Breast**	**12**
Removal / revision of breast augmentation	**Breast**	**13**
2A Diagnostic coronary angiography for low risk, stable chest pain (Invasive angiogram to investigate stable chest pain)	**Cardiology**	**14**
Excision of skin and subcutaneous lesions	**Dermatology & Skin**	**14**
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Detailed Procedure Criteria Guidance

Alternative therapies

Category 1 Procedures: Individual funding request (IFR)

Acupuncture
Herbal medicines
Homeopathy

Anaesthetics

Category 2 Procedures

2AA Pre-operative chest x-ray (Chest X-ray before an operation)
Criteria
Pre-operative chest radiographs should not be routinely performed in adult elective surgical patients. However, they may be appropriate in specific cohorts of patients, including when the following criteria apply: • Patients undergoing cardiac or thoracic surgery • Patients undergoing organ transplantation or live organ donation • At the request of the anaesthetist in: — Those with suspected or established cardio-respiratory disease, who have not had a chest radiograph in the previous 12 months, and who are likely to go to critical care after surgery — Those with a recent history of chest trauma — Patients with a significant smoking history who have not had a chest radiograph in the previous 12 months, or those with malignancy and possible lung metastases — Those undergoing a major abdominal operation, who are at high risk of respiratory complications

2BB Pre-operative ECG (Heart tracing (ECG) before an operation)
Criteria
Pre-operative electrocardiograms should not be routinely performed in low risk, non-cardiac, adult elective surgical patients. However, they may be appropriately performed when the following criteria apply: — Patients with an American Society of Anaesthesiologists (ASA) physical classification status of 3 or greater and no ECG results available for review in the last 12 months — Patients with a history of cardiovascular or renal disease, or diabetes

— Patients with any history of potential cardiac symptoms (e.g. cardiac chest pain, palpitations, unexplained syncope or breathlessness) or a new murmur, that has not previously been investigated 71 Academy of Medical Royal Colleges EBI - List 2 Guidance

— Patients over the age of 65 attending for major surgery. Where pre-operative tests are completed outside the centre in which surgery will be completed, avoid unnecessarily repeating these tests on admission and ensure appropriate transfer of images takes place.

Bariatric Surgery

Category 1 Procedures: Individual funding request (IFR)

Excess skin excision from buttocks, thighs and arms
Liposuction
Surgery to correct divarification (or diastasis) of the abdominal rectus muscle

Category 2 Procedures

Bariatric Surgery
Criteria
NEL CCG will fund bariatric surgery when all of the following criteria are met: • They have a BMI of 40 kg/m2 or more, **OR** between 35 kg/m2 and 40 kg/m2 and other significant diseases (type 2 diabetes or high blood pressure) that could be improved if they lost weight **AND** • All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss **AND** • The person has been receiving or will receive intensive management in a tier 3 service **AND** • The person is generally fit for anaesthesia and surgery **AND** • The person commits to the need for long term follow up For further details see NICE clinical guidance CG189: https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations

Blood Test

Category 2 Procedures

2F Troponin test (Specialised blood tests (troponin) for investigation of chest pain)
Criteria
In order to rule out suspected acute coronary syndrome (moderate or high risk of myocardial infarction) in people presenting with acute chest pain, NICE recommends early rule out using high-sensitivity troponin tests. High-sensitivity troponin assays were developed to detect troponin in the blood at lower levels than non-high-sensitivity troponin assays. Using the high-sensitivity assays as part of an early rule-out protocol can reduce time to discharge. Guidance on early rule out of NSTEMI using high-sensitivity troponin assays recommends a 2-test strategy, typically on admission and at 3 hours. However, the committee concluded that there was insufficient evidence to recommend a specific test strategy and agreed that early rule-out protocols should be chosen according to local preference. High-sensitivity troponin measurements should not be considered in isolation but interpreted alongside the clinical presentation, the time from onset of symptoms, the 12-lead resting ECG, pre-test probability of NSTEMI, The possibility of chronically elevated troponin levels in some people and that 99th percentile thresholds for troponin I and T may differ between sexes. If ACS is not suspected, high-sensitivity troponin test should not be used. For people at low risk of myocardial infarction only perform a second high sensitivity troponin test if the first troponin test at presentation is positive. Diagnosis of myocardial infarction is the detection of a rise and/or fall of cardiac troponin with at least one value above the 99th percentile of the upper reference limit and at least one of the following: — symptoms suggesting myocardial ischaemia — new / presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB) — development of pathological Q waves on the ECG — imaging evidence of new loss of viable myocardium or new regional wall motion abnormality — Identification of an intracoronary thrombus by angiography. The appropriate use of high-sensitivity troponin testing should reduce the need for further investigation, result in shorter stays in hospital and overall result in cost-savings (if used in an early rule out clinical protocol). According to this recommendation, if acute coronary syndrome is suspected in a primary care setting, a referral should be made for prompt investigation and treatment. **This guidance applies to adults and children.**

2DD Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy) (Regular blood tests when taking cholesterol lowering tablets)
Criteria
Creatine Kinase Testing — Creatine kinase should not be routinely monitored in asymptomatic people who are taking lipid modification therapy — Creatine kinase measurement is indicated: — Prior to lipid modification therapy initiation in patients who have experienced generalised, unexplained muscle pains or weakness (whether or not associated with previous lipid-monitoring therapy) — If a patient develops muscle pains or weakness whilst on lipid modification therapy. **Liver Function Testing** — Baseline liver function should be measured before starting lipid modification therapy — Liver function should be measured within 3 months of starting treatment and at 12 months, but not again unless clinically indicated — Routine monitoring of liver function tests in asymptomatic people is not indicated after 12 months of initiating lipid lowering therapy — ALT can be used as a measure of liver function. **Lipid Testing** — Measure full lipid profile by taking at least one lipid sample before starting lipid modification therapy. This should include measurement of total cholesterol, HDL cholesterol, non-HDL cholesterol and triglyceride concentrations. A fasting sample is not needed. — Total cholesterol, HDL cholesterol and non-HDL cholesterol should be measured in all people who have been started on high-intensity statin treatment (both primary and secondary prevention, including atorvastatin 20 mg for primary prevention) at 3 months of treatment and aim for a greater than 40% reduction in non-HDL cholesterol. — Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews. Further details on creatine kinase, liver function and lipid testing during lipid lowering treatment are outlined in NICE guidance and ECS guidance for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk.

Breast

Category 1 Procedures: Individual funding request (IFR)

Breast augmentation
Breast lift (Mastopexy)
Male breast reduction (gynaecomastia)

Category 2 Procedures

Breast reduction and correction of breast asymmetry

Criteria

Section 1: Bilateral breast reduction
NEL CCG will fund bilateral breast reduction when all of the following criteria are met:

1. The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain

AND

2. In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided

AND

3. Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps)

AND

4. Breast reduction planned to be 500gms or more per breast or at least four cup sizes

AND

5. Body mass index (BMI) is <27 and stable for at least 12 months

AND

6. Women must be provided with written information to allow them to balance the risks and benefits of breast surgery

AND

7. Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking

AND

8. Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation

Section 2: Unilateral breast reduction
This treatment is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. **NEL CCG will fund unilateral breast reduction when all of the following criteria are met:**

1. A difference of 150 - 200gms size as measured by a specialist

AND

2. Body mass index (BMI) is <27 and stable for at least 12 months

Additional information
Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.

This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.

Gynaecomastia: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.

Nipple inversion

Criteria

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.

NEL CCG will fund surgical correction of nipple inversion when the following criteria is met:

1. The inversion has not been corrected by correct use of a non-invasive suction device after three months of use.

Additional information

Idiopathic nipple inversion may be corrected by the application of sustained suction. Commercially available devices are available from major chemists or online without prescription. Best results are seen where this is used correctly for up to three months.

Removal / revision of breast augmentation

Criteria

Removal

NEL CCG will fund removal of breast implants when one of the following criteria are met for patients who have undergone cosmetic augmentation mammoplasty:

1. Breast disease

OR

2. Implants complicated by recurrent infections

OR

3. Implants with capsule formation that is associated with severe pain

OR

4. Implants with capsule formation that interferes with mammography

OR

5. Intra or extra capsular rupture of silicon gel-filled implants

Replacement

Replacement with a new prosthesis will only be considered where original implants were funded by the NHS for reconstruction i.e.: non-cosmetic purposes. Additional cosmetic surgery (e.g. mastopexy or bigger implants) should not be done at the same time as the reimplantation and will not be funded.

Cardiology

Category 1 Procedures: Individual funding request (IFR)

2L Exercise ECG for screening for coronary heart disease (Treadmill test for heart disease)

2L Exercise ECG for screening for coronary heart disease (Treadmill test for heart disease)

Criteria

Exercise ECG has no role in the screening of asymptomatic and low risk patients for coronary heart disease because it has a very low pre-test probability of identifying pathology. Risk calculators, such as Systematic Coronary Risk Evaluation (SCORE), are instead recommended to identify patients who are at greater risk of CHD.

Under the guidance of cardiologists, the test has a limited role for diagnosis in selected patients with symptoms suggestive of CHD, and/or where CHD has been diagnosed to confirm functional capacity or severity**.**

Category 2 Procedures

2A Diagnostic coronary angiography for low risk, stable chest pain (Invasive angiogram to investigate stable chest pain)
Criteria
When results of non-invasive functional imaging are inconclusive and patients are assessed as having low risk, stable cardiac pain, invasive coronary angiography (cardiac catheterisation) should be offered only as third-line investigation. Patients who have chest pain that is not an Acute Coronary Syndrome (ACS), but there is concern that it is due to an ischemic cause (stable angina) should, in the first instance, be offered a CT Coronary angiography (64 slice or above). This is based on: • Clinical assessment indicating typical or atypical angina; or • Clinical assessment indicates non-anginal chest pain but the 12-lead resting ECG shows ST-T changes or Q waves. Significant coronary artery disease (CAD) found during CT coronary angiography is ≥ 70% diameter stenosis of at least one major epicardial artery segment or ≥ 50% diameter stenosis in the left main coronary artery. If the CT coronary angiography is inconclusive, non-invasive functional imaging for myocardial ischemia should be considered in the following forms: Stress echocardiography; or First-pass contrast-enhanced magnetic resonance (MR) stress perfusion; or — MR imaging for stress-induced wall motion abnormalities; or — Fractional flow reserve CT (FFR-CT); or — Myocardial perfusion scintigraphy with single photon emission computed tomography (MPS with SPECT). Invasive coronary angiography should only be offered as third-line investigation when the results of non-invasive functional imaging are inconclusive.

Dermatology & Skin

Category 1 Procedures: Individual funding request (IFR)

Face lifts and brow lifts (rhytidectomy)
Hair transplantation
Repair of split ear lobes
Tattoo removal
Treatment for scarring and skin hyper- or hypo- pigmentation

Category 2 Procedures

Excision of skin and subcutaneous lesions
Criteria
This policy refers to the following benign lesions when there is diagnostic certainty and they do meet the criteria listed below:

• benign moles (excluding large congenital naevi)
• solar comedones
• corn/callous
• dermatofibroma
• lipomas
• milia
• molluscum contagiosum (non-genital)
• epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
• seborrhoeic keratoses (basal cell papillomata)
• skin tags (fibroepithelial polyps) including anal tags
• spider naevi (telangiectasia)
• non-genital viral warts in immunocompetent patients
• xanthelasmata
• neurofibromata

NEL CCG will fund benign skin lesions which are listed above when one of the following criteria are met:

1. The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires two or more courses of antibiotics (oral or intravenous) per year

OR

2. The lesion causes regular pain

OR

3. The lesion is obstructing an orifice or impairing field vision

OR

4. The lesion significantly impacts on function e.g. restricts joint movement

OR

5. The lesion causes pressure symptoms e.g. on nerve or tissue

OR

6. If left untreated, more invasive intervention would be required for removal

OR

7. Facial viral warts

OR

8. Facial spider naevi in children causing significant psychological impact

Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.

The following are outside the scope of this policy recommendation:

• Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
• Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care.
• Removal of lesions other than those listed above.

Referral to dermatology or plastic surgery:
• The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria.
• This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services.

Hair epilation

Criteria

NEL CCG will fund hair epilation when either criteria 1(a) or criteria 1(b) AND 2 are met:

1(a). Have undergone reconstructive surgery leading to abnormally located hair-bearing skin to the face, neck, upper chest or hands (areas not covered by normal clothing)
OR
1(b). Are undergoing treatment for pilonidal sinuses to reduce recurrence for patients who do not meet these criteria
AND
2. Confirmation that the patient has not had more than six NHS/private treatments in the past

In the event that NHS funding is agreed up to a maximum of six treatments.

Additional information
An IFR application will ONLY be considered (for facial, neck or upper chest areas not covered by normal clothing) on completion of the relevant section explaining for the benefit of the IFR panel why the patient differs from the cohort of similarly hirsute patients such that they are likely to gain more health benefit from depilation which is not available to other similar patients.

Because NEL CCG do not fund maintenance treatment for hirsutism, it is not considered appropriate to commission an intervention whose effects are likely to be transitory and psychological distress would be likely to recur. Severe hirsutism due to an endocrine disorder may be referred to an endocrinology department but this is not an indication for NHS funding of epilation. NEL CCG will fund radiosurgery for the treatment of symptomatic trichiasis.

Keloid and other scar revision

Criteria

NEL CCG will not fund surgical procedures to re-fashion keloid scars for cosmetic purposes.

NEL CCG will fund symptomatic keloid scars when one of the following criteria are met:

1. Interferes with physical function
OR
2. Causes pain or itchiness for six months and is unrelieved by standard medication

Additional information
Corticosteroid injections and Haelan tape should be considered the first line treatment for keloid scars. The aim of injections and tape is to improve the appearance of the scar. Patients should be informed of the need to wear the tape for 12 hours daily for at least three months.

Patients should be informed that having surgery on a scar will in itself leave a new scar that will take up to two years to improve in appearance. If surgery is used to treat a hypertrophic scar, there is a risk that the scarring may be worse after the surgery.

Low-dose, superficial radiotherapy may reduce the recurrence rate of hypertrophic and keloid scars after surgery. Because of the possibility of long-term side effects, it is only reserved for the most serious cases. IFR applications should be submitted for this intervention describing the clinical exceptionality in any case.

Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary)

Criteria

NEL CCG will fund sympathectomy when criteria 1(a) and 2 are met or 1(b) and 2 are met:

1(a). Significant focal hyperhidrosis and a one to two month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition
OR
1(b). Significant focal hyperhidrosis and intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone
AND
2.All of the following conservative therapies have been tried and found to be unsuitable or unsuccessful:

- treatment of underlying anxiety if it is an exacerbating factor
- referral to a dermatologist for modified topical therapy
- prescription of oral anticholinergics (which block the effect of the nerves that stimulate the sweat glands)
- iontophoresis (for palmar or plantar hyperhidrosis) or botulinum toxin injections (for axillary hyperhidrosis)

Sympathectomy is an established intervention for this condition BUT should be considered only after all other non-invasive non-surgical treatment options have been tried and failed.

Additional Information
Compensatory sweating following sympathectomy is common and can be worse than the original problem. Patients should be made aware of this risk.

Ears, Nose & Throat (ENT)

Category 1 Procedures: Individual funding request (IFR)

Surgical interventions for snoring in the absence of obstructive sleep apnoea
Criteria

Surgical interventions for snoring in the absence of obstructive sleep apnoea

Criteria

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.
Alternative Treatments

There are a number of alternatives to surgery that can improve the symptom of snoring. These include:
- Weight loss
- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (to move jaw forward when sleeping)

In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (> 2years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to

58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.

Category 2 Procedures

Grommets for glue ear in children

Criteria

The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met.

NEL CCG will fund grommets for glue ear when criteria 1, 2 and 3 are met. Or exclusively when either 4(a) or 4(b) are met:

1. All children must have had specialist audiology and ENT assessment

AND

2. Persistent bilateral otitis media with effusion for at least three consecutive months

AND

3. Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2 & 4kHz

OR exclusively in one of the following circumstances

4(a). Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant

OR

4(b). Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant

Additional information

This guidance does not apply to children with Down's Syndrome or Cleft Palate, who may be offered grommets after a specialist Multi-Disciplinary Team (MDT) assessment in line with NICE guidance.

It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

For further information, please see: https://www.nice.org.uk/Guidance/CG60.

The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age).

Pinnaplasty/otoplasty (correction of significantly prominent ears)

Criteria

NEL CCG will fund pinnaplasty/otoplasty when all of the following criteria are met:

1. The patient is under the age of 18 at the time of referral for significantly prominent ears

AND

2. Where the prominence measures >30mm (using the measuring guide below)

Measuring guide

One of the most consistent methods for measuring the degree of prominence is the helical-mastoid (H-M) distance. Typically, the H-M distance is 18-20 mm. As the H-M distance increases, the ear is perceived to be increasingly prominent.

Measure from the posterior aspect of the Helix.

Prominence = H-M distance > 20mm

Pinnaplasty/otoplasty will only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids. In which case an IFR application would be required clearing setting out the patient's clinical exceptionality.

Rhinoplasty/Septoplasty/Rhinoseptoplasty (surgery to reshape the nose)

Criteria

NEL CCG will fund Rhinoplasty/Septoplasty/Rhinoseptoplasty (surgery to reshape the nose) when all of the following criteria are met:

Rhinoplasty, commonly known as a 'nose job', is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty.

a) Rhinoplasty, Septoplasty and Septorhinoplasty are not routinely commissioned for cosmetic reasons.

b) Rhinoplasty, Septoplasty and Septorhinoplasty are restricted for non- cosmetic/other reasons.

The CCG will fund this treatment if the patient meets the following criteria:

- Documented medical problems caused by obstruction of the nasal airway **AND** all conservative treatments have been exhausted.
  OR
- Correction of complex congenital conditions e.g. Cleft lip and palate

The above criteria apply in cases resulting from trauma. For the purposes of this eligibility criteria, a medical problem is defined as a medical problem that continually impairs sleep and/or breathing.

This means (for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Tonsillectomy

Criteria

The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the Scottish Intercollegiate Guidelines Network (SIGN) guidance and supported by ENT UK commissioning guidance.

NEL CCG will fund tonsillitis when criteria 1 and 2 and one of criteria 3(a) or 3(b) or 3(c) are met:

Section 1
1. Sore throats are due to acute tonsillitis

AND
2. The episodes are disabling and prevent normal functioning
AND
3(a). Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year
OR
3(b). Five or more such episodes in each of the preceding two years
OR
3(c). Three or more such episodes in each of the preceding three years

Section 2

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or where tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment. In these instances with prior approval, **NEL CCG will fund surgery when one of the following criteria are met:**

1. Acute and chronic renal disease resulting from acute bacterial tonsillitis
OR
2. As part of the treatment of severe guttate psoriasis
OR
3. Metabolic disorders where periods of reduced oral intake could be dangerous to health
OR
4. PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)
OR
5. Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Additional information
Further information on the SIGN guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf

Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include:

• Obstructive Sleep Apnoea / Sleep disordered breathing in Children
• Suspected Cancer (e.g. asymmetry of tonsils)
• Recurrent Quinsy (abscess next to tonsil)
• Emergency Presentations (e.g. treatment of parapharyngeal abscess)

It is important to note that a national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults which may warrant review of this guidance in the near future.

The guidance applies to adults and children.

2C Surgical intervention for chronic rhinosinusitis (Surgery for sinusitis)

Criteria

Patients are eligible to be referred for specialist secondary care assessment in any of the following circumstances:

— A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate / severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation.

AND

— In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)

OR

— Patient has nasal symptoms with an unclear diagnosis in primary care

OR

— Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait depending on local pathways.

No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (e.g. X-ray, CT scan). There is no role for prolonged courses of antibiotics in primary care.

Patients can be considered for endoscopic sinus surgery when the following criteria are met: — A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan

AND

— Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance 'Recommended secondary care pathway'.

AND

— Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient's pathway.

AND

— Patient and clinician have undertaken appropriate shared decision making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention.

OR

— In patients with recurrent acute sinusitis, nasal examination is likely to be relatively normal. Ideally, the diagnosis should be confirmed during an acute attack if possible, by nasal endoscopy and/or a CT sinus scan.

There are a number of medical conditions whereby endoscopic sinus surgery may be required outside the above criteria and in these cases they should not be subjected to the above criteria and continue to be routinely funded:

— Any suspected or confirmed neoplasia
— Emergency presentations with complications of sinusitis (e.g. orbital abscess, subdural or intracranial abscess)
— Patients with immunodeficiency
— Fungal Sinusitis
— Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter's Triad Aspirin Sensitivity, Asthma, CRS)
— Treatment with topical and / or oral steroids contra-indicated.
— As part of surgical access or dissection to treat non-sinus disease (e.g. pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery)

There is a strong evidence base and expert consensus opinion to support the medical management of chronic rhinosinusitis with intranasal steroids and nasal saline irrigation as a first-line treatment. They are low cost and low risk, with newer generations of nasal steroids safe for long-term use owing to minimal systemic absorption.

There is also evidence to support the trial of oral steroids, but only when nasal polyposis is present. The benefits of oral steroids should be balanced against the risks when considering repeated courses. A Cochrane review has demonstrated the benefits of oral steroids can last up to three months; however the risks and side effects must be balanced against benefit for the patient with repeated courses.

There is evidence to support that when endoscopic sinus surgery is performed in appropriately selected patients (as outlined in the recommendation), it will lead to a significant and durable improvement in symptoms. There is also evidence that patients who undergo surgery early in their disease course will have a longer and more beneficial impact from the surgery. All national and international guidelines support consideration of endoscopic sinus surgery once appropriate medical therapy has failed.

It is important to note that there is currently a UK multidisciplinary randomised controlled trial (RCT) comparing medical therapy with surgery in the management of chronic rhinosinusitis (MACRO Trial: https://www. themacroprogramme.org.uk). he outcome of this trial may lead to modification of guidance for sinus surgery in due course.

Endoscopic sinus surgery is generally safe and low risk. Risks include bleeding, infection, scar tissue formation, and very rarely, orbital injury or cerebrospinal fluid leak (with associated risk of meningitis). Patients should be counselled that there is a risk of recurrent symptoms and that ongoing medical treatment is normally required to maintain symptom improvement after endoscopic sinus surgery.

This guidance applies to adults and children.

Gastroenterology

Category 1 Procedures: Individual funding request (IFR)

Double balloon enteroscopy for diagnostic purpose

Category 2 Procedures

2M Upper GI endoscopy (Endoscopy to investigate gut problems)
Criteria
Upper GI Endoscopy should only be performed if the patient meets the following criteria: **Urgent: (Within two weeks)** — Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of dysphagia please refer to the Edinburgh Dysphagia Score OR — Aged 55 and over with weight loss and any of the following: — Upper abdominal pain — Reflux — Dyspepsia (4 weeks of upper abdominal pain or discomfort — Heartburn — Nausea or vomiting — Those aged 55 or over who have one or more of the following: — Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) OR — Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain OR

- Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.

For the assessment of Upper GI bleeding:

— For patients with haematemesis, calculate Glasgow Blatchford Score at presentation and any high-risk patients should be referred
— Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation
— Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.

For the investigation of symptoms:
— Clinicians should consider endoscopy:
- Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
- With suspected GORD who are thinking about surgery
- With H pylori that has not responded to second- line eradication
- Eradication can be confirmed with a urea breath test.

For management of specific cases
H pylori and associated peptic ulcer:

— Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer.

Barrett's oesphagus:

— Where available the non-endoscopic test called Cytosponge can be used to identify those who have developed Barrett's oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk
— Consider endoscopy to diagnose Barrett's Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy - negative reflux disease)
— Consider endoscopy surveillance if person is diagnosed with Barrett's Oesophagus.

Coeliac disease:

— Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy.

Surveillance endoscopy:

— Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance.
— Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years
— Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent H pylori infection, should undergo endoscopy every three years.

Screening endoscopy can be considered in:

— European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first before embarking on long term screening. Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines.
— Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).

Post excision of adenoma:

— Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.

2N Appropriate colonoscopy in the management of hereditary colorectal Cancer (Colonoscopy of the lower intestine)

Criteria

Follow the British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer: https:// www.bsg.org.uk/resource/guidelines-for-the-management-of-hereditarycolorectal-cancer.html.

Family history of CRC

For individuals with moderate familial CRC risk:
— Offer one-off colonoscopy at age 55 years
— Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines.

For individuals with high familial CRC risk (a cluster of 3x FDRs with CRC across >1 generation):

— Offer colonoscopy every 5 years from age 40 years to age 75 years.

Lynch Syndrome (LS) and Lynch-like Syndrome

For individuals with LS that are MLH1 and MSH2 mutation carriers:

— Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.

For individuals with LS that are MSH6 and PMS2 mutation carriers:

— Offer colonoscopic surveillance every 2 years from age 35 years to age 75 years.

For individuals with Lynch-like Syndrome with deficient MMR tumours without hypermethylation/BRAF pathogenic variant and no pathogenic constitutional pathogenic variant in MMR genes (and their unaffected FDRs), and no evidence of biallelic somatic MMR gene inactivation:

— Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.

Early Onset CRC (EOCRC)

For individuals diagnosed with CRC under age 50 years, where hereditary CRC symptoms have been excluded:

— Offer standard post-CRC colonoscopy surveillance after 3 years
— Then continue colonoscopic surveillance every 5 years until eligible for national screening.

Serrated Polyposis Syndrome (SPS)

For individuals with SPS:

— Offer colonoscopic surveillance every year from diagnosis once the colon has been cleared of all lesions >5mm in size
— If no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, the interval can be extended to every 2 years.

For first degree relatives of patients with SPS:

— Offer an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case
— Offer a surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines.

Multiple Colorectal Adenoma (MCRA)

For individuals with MCRA (defined as having 10 or more metachronous adenomas):

— Offer annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size
— If no polyps 10mm or greater in size are identified at subsequent surveillance examinations, the interval can be extended to 2 yearly.

Familial Adenomatous Polyposis (FAP)

For individuals confirmed to have FAP on predictive genetic testing:

— Offer colonoscopic surveillance from 12-14 years
— Then offer surveillance colonoscopy every 1-3 years, personalised according to colonic phenotype.

For individuals who have a first degree relative with a clinical diagnosis of FAP (i.e. “at risk”) and in whom a APC mutation has not been identified:

— Offer colorectal surveillance from 12-14 years
— Then offer every 5 years until either a clinical diagnosis is made and they are managed as FAP or the national screening age is reached.

MUTYH-associated Polyposis (MAP)

For individuals with MAP:

— Offer colorectal surveillance from 18-20 years, and if surgery is not undertaken, repeat annually.
For monoallelic MUTYH pathogenic variant carriers:
— The risk of colorectal cancer is not sufficiently different to population risk to meet thresholds for screening and routine colonoscopy is not recommended.

Peutz-Jeghers Syndrome (PJS)

For asymptomatic individuals with PSJ:

— Offer colorectal surveillance from 8 years
— If baseline colonoscopy is normal, deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years.

For symptomatic patients, investigate earlier.

Juvenile Polyposis Syndrome (JPS)

For asymptomatic individuals with JPS:

— Offer colorectal surveillance from 15 years
— Then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype.

For symptomatic patients, investigate earlier.

For some patients with multiple risk factors for CRC, for example those with Lynch Syndrome and inflammatory bowel disease/multiple polyps, more frequent colonoscopy may be indicated. This needs to be guided by clinicians but with a clear scientific rationale linked to risk management.

2O Repeat Colonoscopy (Follow up colonoscopy of the lower intestine)

Criteria

Proposal Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection: https://www.bsg. org.uk/resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectalcancer-resection-surveillance-guidelines.html.

Risk Surveillance Criteria for Colonoscopy

Either of the following put individuals at high-risk for future colorectal cancer following polypectomy:

— 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia); OR
— 5 or more premalignant polyps.

Surveillance colonoscopy after polypectomy

For individuals at **high-risk** and under the age of 75 **and** whose life expectancy is greater than 10 years:

— Offer one-off surveillance colonoscopy at 3 years.

For individuals with no high-risk findings:

— No colonoscopic surveillance should be undertaken
— Individuals should be strongly encouraged to participate in their national bowl screening programme when invited.

For individuals not at high-risk who are more than 10 years younger than the national bowel screening programme lower age-limit, consider for surveillance colonoscopy after 5 or 10 years, individual to age and other risk factors.

Surveillance colonoscopy after potentially curative CRC resection:

— Offer a clearance colonoscopy within a year after initial surgical resection
— Then offer a surveillance colonoscopy after a further 3 years
— Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria. 8. The number of interventions (415,262) represents colonoscopies for all indications, including those with symptoms and/or risk factors.

Surveillance after pathologically en bloc R0 EMR or ESD of LNPCPs or early polyp cancers:

— No site-checks are required
— Offer surveillance colonoscopy after 3 years
— Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance after piecemeal EMR or ESD of LNPCPs (large nonpedunculated colorectal polyps of at least 20mm in size):

— Site-checks at 2-6 months and 18 months from the original resection Once no recurrence is confirmed, patients should undergo post polypectomy surveillance after 3 years
— Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance where histological completeness of excision cannot be determined in patients with: (i) a non-pedunculated polyps of 10-19mm in size, or (ii) an adenoma containing high-grade dysplasia, or (iii) a serrated polyp containing any dysplasia:

— Site-check should be considered within 2-6 months
— Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria

Ongoing colonoscopic surveillance:

— To be determined by the findings at each surveillance procedure, using the high-risk criteria to stratify risk — Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited.

General Surgery

Category 1 Procedures: Individual funding request (IFR)

All treatments for vascular lesions

Category 2 Procedures

Abdominoplasty
Criteria
NEL CCG will fund abdominoplasty following significant weight loss after bariatric surgery when criteria 1 is met or when criteria 2(a) and 2(b) are met: **Section 1: Following weight loss** 1. Following non bariatric surgery weight loss have a stable BMI of less than 27 Kg/m2 for at least 24 months **OR** 2(a). Following post bariatric surgery weight loss have a stable BMI of less than 27 Kg/m2 for at least 24 months **AND** 2(b).Had their surgery at least two years previously **NEL CCG will fund abdominoplasty following significant weight loss after natural weight loss when one of criteria 3(a), 3(b) or 3(c) are met:**

Section 2 have severe functional problems from excessive abdominal skin folds as defined as:
3(a). Severe difficulties with daily living (i.e. walking, dressing, toileting) which have been formally assessed, and for which abdominoplasty will provide a clear resolution
OR
3(b). Documented evidence of clinical pathology due to excess overlying skin e.g. recurrent infections or intertrigo which has led to ulceration requiring four or more courses of antibiotics in the 24 month period of stable weight
OR
3(c). Where overhanging skin makes it impossible to maintain care of stoma bags

Haemorrhoidectomy

Criteria

Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection.

NEL CCG will fund haemorrhoidectomy when one of the following criteria are met:

1. Do not respond to the non-operative measures outlined above

OR if the haemorrhoids are more severe

2. Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding

OR

3. Irreducible and large external haemorrhoids

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

Varicose veins

Criteria

Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.

NEL CCG will fund varicose veins when one of the following criteria are met:

1. Symptomatic * primary or recurrent varicose veins

OR

2. Lower limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency

OR

3. Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence

OR

4. A venous leg ulcer (a break in the skin below the knee that has not healed within two weeks)

OR

5. A healed venous leg ulcer.

*Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).” [NICE CG 168]

For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment.

Refer people with bleeding varicose veins to a vascular service immediately.

Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

2B Repair of minimally symptomatic inguinal hernia (Surgery for inguinal hernia)

Criteria

Minimally symptomatic inguinal hernia can be managed safely with watchful waiting after assessment. Conservative management should therefore be considered in appropriately selected patients.

In women, all suspected groin hernias should be urgent referrals.
https://www.aomrc.org.uk/ebi/clinicians/repair-of-minimally-symptomatic-inguinal-hernia/

2P ERCP in acute gallstone pancreatitis without cholangitis (Test of the gallbladder)

Criteria

Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or obstructive jaundice with imaging evidence of a stone in the common bile duct. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours.

2Q Cholecystectomy (Removal of an inflamed gallbladder)

Criteria

For patients who are admitted to hospital with acute cholecystitis or mild gallstone pancreatitis, index laparoscopic cholecystectomy should be performed within that admission. These patients should have their gallbladders removed, ideally before discharge, to avoid further delay and prevent further potentially fatal attacks. If the patient is fit enough for surgery and same admission cholecystectomy will be delayed for more than 24 hours, it may be reasonable to make use of a virtual ward, where the patient can return home under close monitoring prior to undergoing surgery as soon as possible.

Otherwise patients diagnosed with acute cholecystitis should have their laparoscopic cholecystectomy on the same admission within 72 hours (NICE guidelines published in October 2014 state one week, but 72 hours is preferable). This guidance may not be applicable in patients with severe acute pancreatitis.

Surgery for these patients may be challenging and can be associated with a higher incidence of complications (particularly beyond 96 hours) and a higher conversion rate from laparoscopic surgery to open surgery. These patients should be operated on by surgeons with experience of operating on patients with acute cholecystitis, or if not available locally, transfer to a specialist unit should be considered. Timely intervention is preferable to a delayed procedure, and, if the operation cannot be performed during the index admission it should be performed within two weeks of discharge.

2R Appendicectomy without confirmation of appendicitis (Tests to confirm appendicitis)

Criteria

Consider imaging of patients with the suspicion of acute appendicitis in a defined clinical pathway.

Where patients present with a high clinical suspicion of appendicitis, then imaging may not be necessary, but imaging can help identify which patients can be managed conservatively. If there is clinical doubt then imaging can reduce the negative appendicectomy rate. Most patients should have

an ultrasound as the first-line investigation. If the diagnosis remains equivocal, a contrast-enhanced CT (CECT, preferably low dose) can be performed to give a definitive diagnosis prior to the patient returning to the surgical unit for a decision on management.

A pathway like this is dependent on the availability of an adequately skilled Radiologist (Consultant or Registrar) or Sonographer to perform the ultrasound assessment in a timely fashion. If this is not possible discretion should be used to proceed directly to limited dose CECT of the abdomen and pelvis.

This guidance applies to adults and children.

Gynaecology/Urology

Category 1 Procedures: Individual funding request (IFR)

Cosmetic genital procedures (Labiaplasty – excluding Female Genital Mutilation (refer to circumcision category 2 prior approval policy)
Dilation & curettage (D&C) for heavy menstrual bleeding in women (see below)
MRI guided ultrasound (MRgFUS) for uterine fibroids
Non-medical circumcision
Reversal of female sterilisation and reversal of vasectomy
Sacral nerve stimulation for faecal and urinary incontinence
Varicocele

Dilation & curettage (D&C) for heavy menstrual bleeding in women
Criteria
D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) should be used to investigate heavy periods. Medication and intrauterine systems (IUS) should be used to treat heavy periods. NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. Complications following D&C are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix.

Category 2 Procedures

Bartholin's cysts
Criteria
NEL CCG will fund the surgical treatment of Bartholin's cysts which cause one of the following: 1. Significant pain **OR** 2. Have become infected requiring anti-biotic treatment on at least two separate occasions

Circumcision

Criteria

NEL CCG will fund circumcision when one of the following criteria are met:

1. Phimosis seriously interfering with urine flow and/or associated with recurrent infection

OR

2. Patients with discomfort and physical distress

OR

3. Paraphimosis

OR

4. Suspected cancer or balanitis obliterans

OR

5. Congenital urological abnormalities when skin is required for grafting and interference with sexual activity in adult males

OR

6. Recurrent, significantly troublesome episodes of infection beneath the foreskin

OR

7. To restore functional anatomy after female circumcision to facilitate childbirth where mutilation renders this hazardous

Female circumcision (Female Genital Mutilation) is prohibited under the Prohibition of Female Circumcision Act 1995.

Hysterectomy for menorrhagia (heavy menstrual bleeding)

Criteria

Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

NEL CCG will fund hysterectomy when criteria 1 and 3(a), 3(b) and 3(c) are met or 2 and 3(a), 3(b) and 3(c) are met:

Hysterectomy should be considered only when:

1. Where other treatment options have failed

OR

2. Where other treatment options are contradicted

OR

3a. there is a wish for amenorrhoea (no periods)

AND

3b. the woman (who has been fully informed) requests it

AND

3c. the woman no longer wishes to retain her uterus and fertility

NICE guideline NG88 1.5 Management of HMB: When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.

NEL CCG will fund treatment for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis when one of the following criteria are met:

1. Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.

OR

2. If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.

Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.

OR

3. If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried, surgical options: second-generation endometrial ablation, hysterectomy.

OR

4. For women with submucosal fibroids, consider hysteroscopic removal

Treatments for women with fibroids of 3 cm or more in diameter

Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.

If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

For women with fibroids of 3cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.

Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3cm in diameter.

Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]

Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3cm or more in diameter who meet the criteria specified in the manufacturers' instructions.

If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation.

Pre-treatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

2G Surgical removal of kidney stones (Removal of stones from the kidneys)
Criteria
Please refer to NICE NG118 (recommendation 1.5) for full details on the assessment and management of renal and ureteric stones: https://www. nice.org.uk/guidance/ng118/chapter/Recommendations.

Adult renal stones

<5mm: If asymptomatic consider watchful waiting

5-10mm: If not suitable for watchful waiting offer SWL as first-line treatment (unless contra-indicated or not targetable)

10-20mm: Consider SWL as first-line treatment if treatment can be given in a timely fashion. URS can also be considered if SWL is contraindicated or ineffective

Over 20mm (including staghorn): Offer percutaneous nephrolithotomy (PCNL) as first-line treatment

Adult ureteric stones

<5mm: If asymptomatic consider watchful waiting with medical therapy e.g. Alpha blocker for use with distal ureteric stones

5-10mm: Offer SWL as first-line treatment where it can be given in a timely fashion (unless contra-indicated or not targetable)

10-20mm: Offer URS but consider SWL if local facilities allow stone clearance within 4 weeks.

2H Cystoscopy for men with uncomplicated lower urinary tract symptoms (Camera test of the bladder in men)

Criteria

Assessment of men with LUTS should focus initially on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and International Prostate Symptom Score where appropriate. This assessment may be initiated in primary care settings.

Specialist assessment should also incorporate a measurement of flow rate and post void residual volume.

Cystoscopy should be offered to men with LUTS only when clinically indicated, for example, in the presence of the following features from their history:

— Recurrent infection
— Sterile pyuria
— Haematuria
— Profound symptoms
— Pain.

Additional contextual information may also inform clinical decision-making around the use of cystoscopy in men with LUTS. Such factors might include, but not be limited to:

— Smoking history
— Travel or occupational history suggesting a high risk of malignancy
— Previous surgery.

2I Surgical intervention for benign prostatic hyperplasia (Surgery for enlarged prostate)

Criteria

Only men with severe voiding symptoms, or in whom conservative management options and drug treatment have been unsuccessful, should be offered surgical intervention. Surgery is indicated (in

healthy men) in complicated BPH i.e. chronic retention with renal impairment as evidenced by hydronephrosis and impaired GFR, and in most cases of acute retention secondary to BPH.

As such, a staged approach to managing voiding LUTS is recommended:

1. Conservative, or lifestyle interventions should be discussed.
2. Drug therapy should then be considered, in the context of more bothersome LUTS, or LUTS not responding to simple lifestyle interventions.
3. Where bothersome LUTS persist alongside high, or unchanged International Prostate Symptom Scores, or in the context of urinary tract infections, bladder stones or urinary retention, surgical intervention should be considered using a shared decision-making approach.

Men considering surgical intervention should be counselled thoroughly regarding alternatives to and outcomes from surgery. The quality of this counselling is deemed to be of major importance with respect to men's future experience and outcomes.

2CC Prostate-specific antigen (PSA) testing

Criteria

Where PSA testing is clinically indicated (see below), or requested by the man aged 50 and over, he should have a careful discussion about the potential risks and benefits of PSA testing which allows for shared decision making before a PSA test. Various tools are available to assist with shared decision making (see below).

PSA testing should be considered in asymptomatic men over age 40 who are at higher risk of prostate cancer if they are Black and/or have a family history of prostate cancer.

PSA testing should be considered when clinically indicated (ideally after counselling on the potential risks and benefits of testing) in men when there is clinical suspicion of prostate cancer, which may include the following symptoms:

— Lower urinary tract symptoms (LUTS), such nocturia, urinary frequency, hesitancy, reduced flow, urgency or retention.

— Erectile dysfunction.

— Visible haematuria.

— Unexplained symptoms that could be due to advanced prostate cancer (for example lower back pain, bone pain, weight loss).

PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history) is not recommended. This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results.

Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend.

Note: PSA testing for prostate cancer should be avoided if the man has:

— An active or recent urinary infection (PSA may remain raised for many months). — Had a prostate biopsy in the previous 6 weeks both of which are likely to raise PSA and give a false positive result.

Haematology

Category 1 Procedures: Individual funding request (IFR)

White cell apheresis

Category 2 Procedures

2EE Blood transfusion
Criteria
This guidance focuses on RBC transfusions for adults (or equivalent based on body weight for children or adults with low body weight) only. Do not give RBC transfusions to patients with B12, folate or iron deficiency anaemia unless there is haemodynamic instability. If haemodynamic instability is present, treat this with transfusion of appropriate blood components (do not delay emergency transfusions). Where, however, severe acute anaemia (Hb <70g/litre) exists that is symptomatic and prevents rehabilitation or mobilisation, those patients may benefit from a single unit of blood. For adult patients (or equivalent based on body weight for children or adults with low body weight) needing RBC transfusion, suggest restrictive thresholds and giving a single unit at a time except in case of exceptions below. Restrictive RBC transfusion thresholds are for patients who need RBC transfusions and who do not: — Have major haemorrhage or — Have acute coronary syndrome or — Need regular blood transfusions for chronic anaemia. While transfusions are given to replace deficient red blood cells, they will not correct the underlying cause of the anaemia. RBC transfusions will only provide temporary improvement. It is important to investigate why patients are anaemic and treat the cause as well as the symptoms. Note: Consider whether a dramatic fall in haemoglobin could be due to a severe haemolytic episode and not associated with any of the 3 exceptions. This would also be a possible indication to transfuse more than one unit at a time. When using a restrictive RBC transfusion threshold, consider a threshold of 70 g/litre and a haemoglobin concentration target of 70–90 g/litre after transfusion. For patients with acute coronary syndrome, a RBC transfusion threshold of 80 g/litre should be considered and a haemoglobin concentration target of 80–100 g/litre after transfusion. For patients requiring regular transfusion for chronic anaemia, NICE advise defining thresholds and haemoglobin concentration targets for each individual. **This guidance applies to adults (or equivalent based on body weight for children or adults with low body weight) only.**

Medicine

Category 1 Procedures: Individual funding request (IFR)

Ketogenic diet for epilepsy

Ophthalmology

Category 1 Procedures: Individual funding request (IFR)

Laser surgery for short sightedness

Category 2 Procedures

Cataract surgery
Criteria
This policy relates to cataract surgery only, as described in detail below. The policy does not apply to: • Patients with confirmed or suspected malignancy • Patients with acute trauma or suspected infection • Children under the age of 18 **NEL CCG will fund cataract surgery when both of the following criteria are met:** 1. Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye **AND** 2. Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls **OR** **NEL CCG will fund cataract surgery when the patient has any of the following ocular comorbidities:** • Glaucoma • Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening • Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction • Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) • Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis) • Severe anisometropia in patients who wear glasses • Posterior subcapsular cataracts **AND** • The consultant treating the patient agrees that cataract surgery is in the best interests of the patient

Additional information
All patients should be given the opportunity to engage with shared decision making at each point in the pathway to cataract surgery (e.g. optometrists, GPs, secondary care), to ensure they are well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

- Surgery is also indicated for management of cataract with coexisting ocular comorbidities. A full list of these ocular comorbidities can be found below.*

- Where patients have a best corrected visual acuity better than 6/9, surgery should still be considered where there is a clear clinical indication or symptoms affecting lifestyle. For NHS treatment to be provided, there needs to be mutual agreement between the provider and the responsible (i.e. Paying) commissioner about the rationale for cataract surgery prior to undertaking the procedure).

Chalazia removal

Criteria

NEL CCG will fund incision and curettage (or triamcinolone injection for suitable candidates) of chalazia when one of the following criteria have been met:

1. Has been present for more than six months and has been managed conservatively with warm compresses, lid cleaning and massage for four weeks

OR

2. Interferes significantly with vision

OR

3. Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy

OR

4. Is a source of infection that has required medical attention twice or more within a six month time frame

OR

5. Is a source of infection causing an abscess which requires drainage

OR

6. If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

Surgery on the upper or lower eyelid (blepharoplasty)

Criteria

NEL CCG will fund surgery on the upper or lower eyelid when one of the following criteria are met:

1. Impairment of visual field(s) in the relaxed, non-compensated state where visual field test results show that eyelids impinge on visual fields reducing them to 1200 laterally and 400 vertically

OR

2. Patients who have severe headache as a result of frontalis muscle overaction when trying to overcome brow ptosis, upper eyelid ptosis or excess dermatochalasis should be allowed corrective surgery

Additional information
These procedures should only be carried out in the ophthalmology department under the care of an oculoplastic surgeon.

NEL CCG will not fund ptosis repair, upper eyelid blepharoplasty and brow lift for cosmetic reasons. This will include corrective surgery for patients who are dissatisfied with the cosmetic appearance post-surgery of any of the procedure mentioned above.

Orthopaedics

Category 1 Procedures: Individual funding request (IFR)

Autologous chondrocyte (cartilage) implantation
Injections for non-specific low back pain (see below for further guidance)
Knee arthroscopy for patients with osteoarthritis
Lumbar disc replacement (see back pain interventions below)
Ozone discectomy (see back pain interventions below).

Injections for non-specific low back pain

Criteria

Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.

For people with non-specific low back pain the following injections should not be offered:

- Facet joint injections
- Therapeutic medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.

Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.

Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic.

Note definition of non-specific low back pain according to NICE guidance: Low back pain that is not associated with serious or potentially serious causes has been described in the literature as 'non-specific', 'mechanical', 'musculoskeletal' or 'simple' low back pain. Alternative options are suggested in line with the National Back Pain Pathway. For further information, please see: https://www.nice.org.uk/guidance/ng59

Knee arthroscopy for patients with osteoarthritis

Criteria

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.

More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non operative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.

Category 2 Procedures:

Bunion surgery (Hallux Valgus)

Criteria

NEL CCG will fund bunion surgery where one of the following criteria are met:

1. Significant pain on walking not relieved by chronic standard analgesia

OR

2. Deformity such that fitting adequate footwear is difficult

OR

3. Overlapping or underlapping of adjacent toe(s)

OR

4. Hammer toes

OR

5. Recurrent or chronic ulceration

OR

6. Bursitis or tendinitis of the first metatarsal head

Functional electrical stimulation (FES) for foot drop

Criteria

NEL CCG will fund initiation or continuation of treatment when one of the following criteria are met:

The patient will have objectively demonstrated that the use of FES is still clinically appropriate by:

Initiation

1. Foot drop which impedes gait and evidence that this is not satisfactorily controlled using ankle-foot orthosis

OR

Continuation

2. Gait improvement from its use

Dupuytren's contracture release

Criteria

Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.

NEL CCG will fund intervention/treatment in the form of (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) when one of the following criteria are met:

1. Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint

OR

2. Severe thumb contractures which interfere with function

NEL CCG will fund, in line with NICE Guidance, collagenase when 1 or 2(a) and 2(b) of the following criteria are met:

1. Participants in the ongoing clinical trial (HTA-15/102/04)

OR

2. Adult patients with a palpable cord if:

(a) there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints

AND

(b). needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

Ganglion excision

Criteria

Section 1: Wrist ganglia

NEL CCG will fund wrist ganglia excision when 1 and 3 or 2 and 3 of the following criteria are met:

1. No treatment unless causing pain or tingling/numbness or concern (worried it is a cancer)

OR

2. Aspiration if causing pain, tingling/numbness or concern

AND

3. Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function

Section 2: Seed ganglia that are painful

NEL CCG will fund seed ganglia that are painful when one of the following criteria are met:

1. Puncture/aspirate the ganglion using a hypodermic needle

OR

2. Surgical excision only considered if ganglion persists or recurs after puncture/aspiration

Section 3: Mucous cysts

NEL CCG will fund mucous cysts when one of the following criteria are met:

1. No surgery should be considered unless recurrent spontaneous discharge of fluid

OR

2. Significant nail deformity

Surgical treatment of carpal tunnel syndrome

Criteria

Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.

Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:

- Corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)

OR

- Night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

NEL CCG will fund surgical treatment for carpal tunnel syndrome when one of the following criteria are met:

1. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of eight weeks

OR

2. A permanent (ever-present) reduction in sensation in the median nerve distribution

OR

3. Muscle wasting or weakness of thenar abduction (moving the thumb away from the hand)

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

Trigger finger

Criteria

Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

Cases interfering with activities or causing pain should first be treated with:

- one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics

OR

- splinting of the affected finger for 3-12 weeks (weak evidence)

NEL CCG will fund trigger finger surgery when one of the following criteria are met:

1. The triggering persists or recurs after one of the above measures (particularly steroid injections)

OR

2. The finger is permanently locked in the palm

OR

3. The patient has previously had two other trigger digits unsuccessfully treated with appropriate nonoperative methods

OR

4. Diabetics

Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

Treatment with steroid injections usually resolve troublesome trigger fingers within one week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at one year and usually provides a permanent cure. Recovery after surgery takes two to four weeks. Problems sometimes occur after surgery, but these are rare (<3%).

Interventional treatments for back pain

Criteria

This policy relates to interventional treatments for back pain only as described in detail below and relates to people aged 18 and over.

Contained within this section are interventions that fall into both category 1 and 2.

For many patients, consideration of such treatments only arises after conservative management in primary care or specialist musculoskeletal services.

The following exclusions apply:

- Children (aged under 18)
- Patients thought to have/have cancer (including metastatic spinal cord compression)
- Patients with neurological deficit (spinal cord compression or cauda equina symptoms), fracture or infection

In ordinary circumstances, funding for interventional treatments for back pain is available for patients who meet the following criteria.

<u>Section 1: Epidurals</u> (Transforaminal epidurals and Interlaminar epidurals only) for radicular pain

NEL CCG will fund interventions for epidurals when criteria 1 and 2 and one of 3(a) or 3(b) are met:

1. The patient has radicular pain consistent with the level of spinal involvement

AND

2. The patient has moderate-severe symptoms that have persisted for 12 weeks or more

AND either one of the following:

3(a). The patient has severe pain and advice, reassurance, analgesia and manual therapy ideally part of community Musculoskeletal (MSK) service has been undertaken. (Evidence that disc prolapses get better on their own)

AND/OR

3(b). The MRI scan (unless contraindicated) shows pathology concordant with the clinical diagnosis.

A maximum of three epidural injections, within a 12 month period with objective with functional benefit demonstrable with each injection, will be funded

For patients with persisting symptoms after three injections, re-approval of treatment with epidural injections will be needed through the IFR panel. This may be older/frailer patients who derive medium term benefit but are unsuitable for or unwilling to have surgery.

<u>Section 2: Spinal decompression</u>

NEL CCG will fund interventions for spinal decompression when all of the following criteria are met:

1. The patient has radicular/claudicant leg pain consistent with the level of spinal involvement

AND

2. The MRI scan (unless contraindicated) shows one or more areas of spinal stenosis whereby the pathology is concordant with the clinical diagnosis

AND

3. The patient has shown no sign of improvement despite conventional therapy for one year

<u>Section 3: 2J Lumbar Discectomy (Spinal surgery for a slipped disc)</u>

Patients presenting with radiculopathy who show objective evidence of clinical improvement within six weeks (e.g. VAS pain scores, ODI), are more likely than not to continue improving with non-operative treatment as the natural history of most intervertebral disc herniations is favourable.

Primary care management typically includes reassurance, advice on continuation of activity with modification, weight-loss, analgesia, manual therapy and screening patients who are high risk of developing chronic pain (i.e. STaRT Back).

Persistent symptoms may warrant onward referral to spinal services for consideration of interventional pain management injections (e.g. nerve root blocks / caudal epidural injections) or surgery.

In the presence of concordant MRI changes, Discectomy may be offered to patients with compressive nerve root signs and symptoms lasting three months (except in severe cases) despite best efforts with non-operative management.

Please note: This guideline is not intended to cover patients who demonstrate a deterioration in neurological function (e.g. objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent referral to an acute spinal centre for further evaluation and imaging, as non-operative treatment may lead to irreversible harm.

Section 4: Epidurolysis (See also NICE IPG 333)

NEL CCG will fund interventions for epidurolysis when all of the following criteria are met:

1. The patient has late onset radiculopathy post spinal surgery

AND

2. MRI Gadolinium-enhanced or dynamic epidurogram (unless contraindicated) findings are concordant to show adhesive radiculopathy

AND

3. Conservative management and epidural injections have failed

The specialist applying for funding must confirm that they are trained in the technique.

Subsequent epidurolysis treatments will require an IFR approval, including information about the nature and duration of benefit from initial treatment.

2Y Fusion surgery for mechanical axial low back pain (Surgery to fuse the bones in the back for back pain)

Spinal fusion is not indicated for the treatment of non-specific, mechanical back pain. The NICE exclusion criteria are:

— Conditions of a non-mechanical nature, including:
— inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
— serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
— scoliosis
— Pregnancy-related back pain
— Sacroiliac joint dysfunction
— Adjacent-segment disease
— Failed back surgery syndrome
— Spondylolisthesis.

Instead, spinal fusion is usually reserved for,

— Patients with a symptomatic spinal deformity (e.g. scoliosis)
— Instability (e.g. spondylolisthesis; trauma)
— An adjunct during spinal decompression surgery, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable.

Primary care management typically includes reassurance, advice on continuation of activity with modification, weight-loss, analgesia, manual therapy and screening patients who are high risk of developing chronic pain (i.e. STaRT Back). Use combined physical and psychological programme for management of sub-acute and chronic low back pain e.g. Back Skills Training (BeST).

Lumbar Disc Replacement (Category 1)
Lumbar disc replacement surgery is not routinely funded

Acupuncture (Category 1)
Acupuncture for back pain is not routinely funded but can continue to be provided as part of existing physiotherapy packages of care.

Ozone Discectomy – (Category 1)
Ozone discectomy is not routinely funded

Medial Branch Blocks
Diagnostic Medial branch blocks, are only funded if performed in a Pain Service with a multidisciplinary team approach, only to be performed by doctors trained in Biopsychosocial Assessment.

2K Lumbar radiofrequency facet joint denervation (A procedure to numb nerves for low back pain)

Lumbar radiofrequency facet joint denervation (RFD) should only be offered in accordance with NICE Guideline NG59 which recommends it as an adjunct in the management of chronic low back pain only when non-operative treatment has failed, and the main source of pain is thought to arise from one or more degenerate facet joints.

2V Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures (Procedures to build up brittle spine bones)

Criteria

Vertebroplasty (VP) or kyphoplasty (KP) should be offered as a treatment for painful osteoporotic vertebral fractures on a case-by-case basis.

As per advice in the NICE Technology Appraisal Guidance 279 (TAG 279), VP or KP may be considered:

— In cases where patients have ‘severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management’ and in particular hospitalised older people
— Where the acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination
— The decision to treat should be taken after multidisciplinary team discussion
— The procedure should take place at a facility with access to spinal surgery services
— Processes for audit and clinical governance should be in place
— VP/KP must be performed in conjunction with additional measures to improve bone health.

NICE TAG 279 (https://www.nice.org.uk/guidance/ta279) delegates the eligible timeframe for intervention to the clinician. However, evidence from a 2016 randomised controlled trial (RCT) offers evidence that older patients (>60 years old) with fractures at most 6 weeks old and severe pain despite optimal pain management that benefit most from the procedure.

2S Low back pain imaging (Tests to investigate low back pain)

Criteria

Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags, or suspected serious underlying pathology following medical history and examination.

Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease.

Further information can be accessed at the relevant NICE guideline for these conditions. Patients presenting with low back pain and sciatica should be reviewed in accordance with the low back pain and sciatica guidance (https://www. nice.org.uk/guidance/ng59).

Patients presenting with low back pain without sciatica should be reviewed and if none of the above serious underlying pathology are suspected, primary care management typically includes reassurance, advice on continuation of activity with modification, weight loss, analgesia, manual therapy and reviewing patients who are high risk of 51 Academy of Medical Royal Colleges EBI - List 2 Guidance developing chronic pain (i.e. STaRT Back).

NICE guidelines recommend using a risk assessment and stratification tool, (e.g. STaRT Back), and following a pathway such as the National Back and Radicular Pain Pathway, to inform shared decision making and create a management plan.

Consider a combined physical and psychological programme for management of sub-acute and chronic low back pain (greater than 3 to 6 months duration) e.g. Back Skills Training (BeST).

Consider referral to a specialist centre for further assessment and management if required. Imaging within specialist centres is indicated only if the result will change management.

For further information please see the following NICE guidance:

— Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59
— Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging https:// www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referralsfor-imaging
— National Pathway of Care for Low Back and Radicular Pain https://www. nice.org.uk/guidance/ng59/resources/endorsed-resource-nationalpathway-of-care-for-low-back-and-radicular-pain-4486348909.

Shoulder decompression

Criteria

NEL CCG will fund arthroscopic subacromial decompression when:

1. The Arthroscopic subacromial decompression is for pure subacromial shoulder impingement

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, ‘pure subacromial shoulder impingement’ means subacromial pain not caused by
associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of

subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

2E Arthroscopic surgery for meniscal tears (Surgery to treat knee problems)

Criteria

The use of arthroscopic surgery to treat degenerate meniscal tears should follow published BASK guidelines https://online.boneandjoint.org.uk/doi/ pdf/10.1302/0301-620X.101B6.BJJ-2019-0126.R1.

This guidance applies to adults and children.

2T Knee MRI when symptoms are suggestive of osteoarthritis (Tests to investigate knee pain)

Criteria

In primary care, where clinical assessment is suggestive of knee OA, imaging is not usually necessary. If imaging is required than weight bearing radiographs are the first-line of investigation.

Patients with persistent symptoms should, after three to four months, be referred to secondary care and should have imaging of the knee to investigate for OA and/or other pathology.

Where imaging is necessary, in secondary care the first-line investigation of potential knee OA is weight bearing plain radiography. If the patient has a pattern of disease that allows surgical treatment to be adequately planned with plain radiographs, then MRI is not required.

However, there are a number of situations where MRI of the osteoarthritic knee can be useful:

— Patients who have severe symptoms but relatively mild OA on standard X-rays. In this situation the MRI offers more detail and can show much more advanced OA or Osteonecrosis within the knee
— In working up a patient for possible HTO or partial knee replacement an MRI can be a very useful investigation focusing on the state of the anterior cruciate ligament and state of the retained compartments.

In summary an MRI scan can be a useful investigation in the contemporary surgical management of osteoarthritis, giving critical information on the pattern of disease and state of the soft tissues. However, requesting an MRI scan when it is not indicated potentially prolongs further waiting times for patients, can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for appropriate patients.

The diagnosis of knee OA can be effectively made in primary care based upon the patient's history and physical examination. In particular, NICE recommends diagnosing osteoarthritis clinically, and without investigations, in patients who:

— Are 45 or over AND
— Have activity-related joint pain AND
— Has either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

It is important to exclude other diagnoses in some cases where there may be atypical features which may indicate alternative or additional diagnoses such as:

— A history of trauma
— History of cancer or corresponding risk factors
— Prolonged morning joint-related stiffness
— Rapid worsening of symptoms

— The presence of a hot swollen joint. Important differential diagnoses include gout, other inflammatory arthritides (for example, rheumatoid arthritis), septic arthritis and malignancy (bone pain).

In secondary care when surgical intervention for OA is being considered an MRI scan can offer valuable information about the pattern of disease within the knee. This includes planning for osteotomy around the knee for OA and for partial knee replacement, where in both cases information about the state of the preserved compartments and the anterior cruciate ligament are critical to the surgical plan.

A meta-analysis published in 2017 assessing the role of MRI in OA assessed 16 studies, which included 1220 patients. It found that MRI can detect OA with an overall high specificity and moderate sensitivity so better used to exclude OA than to confirm it. The study recommended that standard clinical algorithm for OA diagnosis, aided by radiographs is the most effective method for diagnosing OA.

The European League Against Rheumatism (EULAR) conducted a systematic review including 390 studies leading to seven recommendations concerning the use of imaging in peripheral joint OA as below:

— Imaging is not required to make the diagnosis in patients with typical presentation of OA. Level of evidence: III–IV. LOA (95% CI) 8.7 (7.9 to 9.4)
— In atypical presentations, imaging is recommended to help confirm the diagnosis of OA and/or make alternative or additional diagnoses. Level of evidence: IV. LOA (95% CI) 9.6 (9.1 to 10)
— Routine imaging in OA follow-up is not recommended. However, imaging is recommended if there is unexpected rapid progression of symptoms or change in clinical characteristics to determine if this relates to OA severity or an additional diagnosis. Level of evidence: III–IV. LOA (mean, 95% CI) 8.8 (7.9 to 9.7)
— If imaging is needed, conventional (plain) radiography should be used before other modalities. To make additional diagnoses, soft tissues are best imaged by US or MRI and bone by CT or MRI. Level of evidence: III–IV. LOA (95% CI) 8.7 (7.9 to 9.6). — Consideration of radiographic views is important for optimising detection of OA features; in particular for the knee, weightbearing and patellofemoral views are recommended. Level of evidence: III. LOA (95% CI) 9.4 (8.7 to 9.9)
— According to current evidence, imaging features do not predict nonsurgical treatment response and imaging cannot be recommended for this purpose. Level of evidence: II–III. LOA (95% CI) 8.7 (7.5 to 9.7)
— The accuracy of intra-articular injection depends on the joint and on the skills of the practitioner and imaging may improve accuracy. Imaging is particularly recommended for joints that are difficult to access due to factors including site (e.g., hip), degree of deformity and obesity. Level of evidence: III–IV. LOA (95% CI) 9.4 (8.9 to 9.9).

2X MRI scan of the hip for arthritis

Criteria

Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment.

Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip.

The diagnosis of hip OA can be effectively made based upon the patient's history and physical examination. NICE recommends diagnosing osteoarthritis clinically without investigations in patients who:

— Are 45 or over AND — Have activity-related joint pain AND
— Have either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

It is important to exclude other diagnoses, especially when red flags are present. If imaging is necessary, the first-line investigation should be plain x-ray.

An MRI or urgent onward referral may be warranted in some circumstances. These include:

— Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis
— Trauma
— History or family history of an inflammatory arthropathy
— Mechanical, impingement type symptoms
— Prolonged and morning stiffness
— History of cancer or corresponding risk factors
— Suspected Osteonecrosis / Avascular necrosis of the hip
— Suspected transient osteoporosis — Suspected periarticular soft tissue pathology e.g. abductor tendinopathy

Important differential diagnoses include inflammatory arthritis (for example, rheumatoid arthritis), femoro-acetabular impingement, septic arthritis and malignancy (bone pain).

A meta-analysis published in 2017 assessing the role of MRI in OA, assessed 16 studies which included 1220 patients. It concluded that MRI is more useful in excluding OA rather than diagnosing it. The study recommended that standard clinical algorithm for OA diagnosis, aided by radiographs is the most effective method for diagnosing OA.

The European League Against Rheumatism (EULAR) conducted a systematic review including 390 studies leading to seven recommendations concerning the use of imaging in peripheral joint OA as below:

— Imaging is not required to make the diagnosis in patients with typical presentation of OA. Level of evidence: III–IV. LOA (95% CI) 8.7 (7.9 to 9.4)
— In atypical presentations, imaging is recommended to help confirm the diagnosis of OA and/or make alternative or additional diagnoses. Level of evidence: IV. LOA (95% CI) 9.6 (9.1 to 10)
— Routine imaging in OA follow-up is not recommended. However, imaging is recommended if there is unexpected rapid progression of symptoms or change in clinical characteristics to determine if this relates to OA severity or an additional diagnosis. Level of evidence: III–IV. LOA (mean, 95% CI) 8.8 (7.9 to 9.7)
— If imaging is needed, conventional (plain) radiography should be used before other modalities. To make additional diagnoses, soft tissues are best imaged by US or MRI and bone by CT or MRI. Level of evidence: III–IV. LOA (95% CI) 8.7 (7.9 to 9.6)
— Consideration of radiographic views is important for optimising detection of OA features; in particular for the knee, weightbearing and patellofemoral views are recommended. Level of evidence: III. LOA (95% CI) 9.4 (8.7 to 9.9)
— According to current evidence, imaging features do not predict nonsurgical treatment response and imaging cannot be recommended for this purpose. Level of evidence: II–III. LOA (95% CI) 8.7 (7.5 to 9.7)
— The accuracy of intra-articular injection depends on the joint and on the skills of the practitioner and imaging may improve accuracy. Imaging is particularly recommended for joints that are difficult to access due to factors including site (e.g., hip), degree of deformity and obesity. Level of evidence: III–IV. LOA (95% CI) 9.4 (8.9 to 9.9)

Other

Category 2 Procedures

Botulinum toxin (not cosmetic)

Criteria

NEL CCG will not fund the use of Botulinum Toxin for cosmetic treatments.

Botulinum Toxin applications in oculoplastics

NEL CCG will fund the use Botulinum A by an oculoplastics specialist when one of the following criteria are met:

Section 1: Entropion

Botox will be commissioned by NEL CCG for patients with INVOLUTIONAL entropion who meet one of the following criteria:

1. Have a corneal ulcer/keratopathy secondary to entropion

OR

2. Where surgery is contraindicated due to medical co-morbidities not warranting cessation of anticoagulation

OR

3. Patient with advanced dementia, who is not fir for surgery under local, with or without sedation or general anaesthesia

Section 2: Corneal Ulcer/lagophthalmos

NEL CCG will fund corneal ulcer/lagophthalmos by an oculoplastics specialist when one of the following criteria are met:

Botox will be commissioned by NEL CCG for patients with corneal ulcer/ lagophthalmos who:

1. Have a corneal ulcer due to facial palsy and lagophthalmos to induce a protective ptosis

OR

2. Have a corneal ulcer due to lagophthalmos secondary to eyelid retraction, trauma or proptosis to induce a protective ptosis

Botox treatment may need to be repeated after three to six months.

Prior approval is not required for the following treatments:

Blepharospasm

Botulinum A toxin is routinely funded and does not require prior approval for the treatment of blepharospasm.

For palmar or plantar hyperhidrosis, other procedures such as iontophoresis appear to be more effective and have fewer side effects and should be considered as initial treatment.

Botulinum A toxin is routinely funded and does not require prior approval for:

1. spasticity, hand and wrist disability associated with stroke, hemofacial spasm, spasmodic torticollis
2. severe hyperhidrosis, overactive bladder syndrome

Botulinum B toxin is routinely funded and does not require prior approval for:

1. spasmodic torticollis
2. as alternative to Botulinum toxin A in presence of antibodies to Botulinum A.

Botulinum A will also be approved for treatment of migraine for patients who meet the criteria described in NICE TA 260 (https://www.nice.org.uk/guidance/ta260/chapter/1-Guidance) :

1.1 Botulinum toxin type A is recommended as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine):

- that has not responded to at least three prior pharmacological prophylaxis therapies and
- whose condition is appropriately managed for medication overuse.

1.2 Treatment with botulinum toxin type A that is recommended according to 1.1 should be stopped in people whose condition:

- is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) or
- has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months.

Open MRI
Criteria
Claustrophobic patients Most patients with claustrophobia can be successfully scanned using a conventional MRI scanner. **NEL CCG will fund open MRI when 1(a) and 2 or 1(b) and 2 of the following criteria are met:** 1(a). The patient has failed to tolerate a conventional scan using feet first **OR** 1(b). Oral sedation approaches as appropriate **AND** 2. Confirm that no other diagnostic tests are suitable. If more serious health problems preclude sedation, this will need to be detailed **Obese patients** Patients who are too large to fit within a conventional MRI scanner should be referred by a secondary care clinician to a bariatric MRI service.

Paediatrics

Category 1 Procedures: Individual funding request (IFR)

2Z Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children (Helmets to reshape flat heads in babies)
Individual Funding Request

2Z Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children (Helmets to reshape flat heads in babies) **Individual Funding Request**
Criteria
As clinically evidenced by the four major designated supra-regional craniofacial services in the UK (prior to the availability of Helmet therapy), the flattened area of the head usually self-corrects naturally, as a baby grows, develops and becomes more mobile with increased muscle strength, and spends less time lying in one position.

There is clear evidence and expert consensus that a helmet does not affect the natural course of skull growth and should not be used.

Helmets may be associated with significant risks such as pain, pressure sores and may adversely affect the bond between baby and parents. They are also expensive.

To reduce pressure on the flattened part of the head and encourage remoulding, the following simple interventions are suggested:

— 'Tummy time' - Allow baby to spend time lying on their front while awake, supervised and playing.
— Change the position of toys / mobiles / cot in the room to encourage baby to move their head away from the flattened side
— Use a sling or a front carrier to reduce the amount of time baby spends lying on a firm flat surface
— Modify Parental lap "nursing" position to promote contact with less flattened side to parental chest.

All babies including those with non-synostotic/positional plagiocephaly or brachycephaly must be laid to sleep on their back. Sleeping in positions other than this is associated with an increased risk of Sudden Infant Death Syndrome or SIDS (formerly known as Cot Death). For the same reason, no pillows or props should be used to change a baby's sleeping position.

This guidance applies to children aged 2 years and under.

Physiotherapy

Category 1 Procedures: Individual funding request (IFR)

Manual therapies (osteopathy – outside of an MSK integrated service)

North East London
Clinical Commissioning Group

NEL CCG Governing Body
26 January 2022

Title of report	2022/23 Planning Guidance
Item number	5.2
Author	Saem Ahmed, Head of Planning and Performance
Presented by	Archna Mathur, Director of Performance and Assurance
Contact for further information	archnamathur@nhs.net
Executive summary	The paper provides an initial view of planning guidance requirements from a technical perspective and reflects NEL wide conversations with respect to work that can be undertaken in advance of the publication of technical guidance with regards to principles and NEL wide planning assumptions, reflecting on improvements that are required following previous planning rounds. The planning guidance is divided into core sections, and a broad outline of what is required is as follows: **Investment in workforce** • Improving staff experience, supporting health, wellbeing and return to work • Addressing inequalities in recruitment and promotion • Embedding new ways of working, delivering increased virtual care and optimising capacity • Expanding training and recruitment efforts to grow the workforce **Responding to Covid 19** • Supporting patients with post covid syndrome • Considering new treatment options for high risk patients • Delivering the covid 19 vaccination booster programme **Delivering more elective care, reducing long waits and improving cancer performance**

	• Delivering 10% more elective activity than pre pandemic levels • Reducing long waits and accelerating personalised follow up • Continuing to restore cancer services, improving waiting times and achieving faster diagnosis • Increasing diagnostic activity to 120% of pre pandemic levels • Delivering safe and equitable maternity care in line with Ockenden recommendations **Improving UEC** • Create 5000 additional beds including through the virtual ward model • Eliminate 12h waits in Emergency Departments and minimise handover delays • Increase 111 capacity and UTC (Urgent Treatment Centre) provision • Continue work on 2h urgent community response • Develop plans for anticipatory care and sustain improvement in delayed discharges **Mental Health** • Improve crisis provision • Ensure admissions are intervention focussed, therapeutic and supported by an MDT • Reduce reliance on inpatient care and develop community services for people with LD/autism • Continue to expand specialist care and treatment for infants, children and young people **Primary Care** • Deliver 50 million more GP appointments by 2024 • Every patient offered digital first primary care by 20223/24 • Expand number of GPs and PCN roles, implementing shared employment models • Secure universal participation in the community pharmacy consultation service offer • Support PCNs to work with local communities to address health inequalities • Continue to develop population health management, prevent ill health and address health inequalities • Reduce anti-biotic use in primary and secondary care **Digital**

	• Achieve core level of digitalisation by March 2025 to facilitate shared care records **Resources** • Deliver significant efficiencies to address excess costs driven by pandemic response, returning to signed contracts and local ownership **ICB Development** • Prepare plans for ICBs to be legally and operationally established by 1 July 2022 • ICBs to undertake preparatory work through 2022/23, to develop their five-year system plan from 2023/24
Action required	Note.
Where else has this paper been discussed?	Finance & Performance Committee.
Next steps/ onward reporting	Pre-planning on NEL wide planning principles and planning assumptions.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The Planning guidance provides certainty and clarity by setting out the priorities and financial arrangements for the whole of 2022/23, recognising that they will have to be kept under review. The objectives set out in this document are based on a scenario where Covid19 returns to a low level and we are able to make significant progress in the first part of next year as we continue to restore services and reduce the Covid backlogs. Planning guidance outlines how we can significantly increase the number of people we can diagnose, treat and care for in a timely way. This will depend on us doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available to us across health and social care, and ensure reducing inequalities in access is embedded in our approach.
Conflicts of interest	Nil
Strategic fit	• High quality services for patients • Put patient experience at the centre of our delivery • Ensure the best use of resources

	• Support our people to thrive • Develop our NEL integrated care system • Recover from the pandemic and be prepared for future waves
Impact on finance, performance and quality	Directly related as per paper.
Risks	There are many risks that will need to be described in more detail as the planning process is undertaken.
Equality impact	N/A

NHS
North East London
Clinical Commissioning Group

A guide to 2022/23 priorities and operational planning guidance

Date: 26 January 2022

Governing Body

Introduction

- The operational planning guidance for 2022/23 was published 24 December 2021.
- This paper aims to highlight key targets and requirements systems are expected to deliver through 2022/23.
- This is not aimed to be an exhaustive list of requirements, as further requirements may follow as the templates are published.
- So far, only the strategic operational guidance has been published, however we expect further supporting guidance over the coming weeks which will provide clarity around the expected delivery requirements for 2022/23.
- To start planning now, we have drawn on previous supported guidance and templates from 2021/22 to indicate what we may be required to provide and submit.
- Further technical guidance, submission guidance and activity, performance and workforce technical definitions will be published in January 2022.

Key principles agreed across the system

- **Governance**

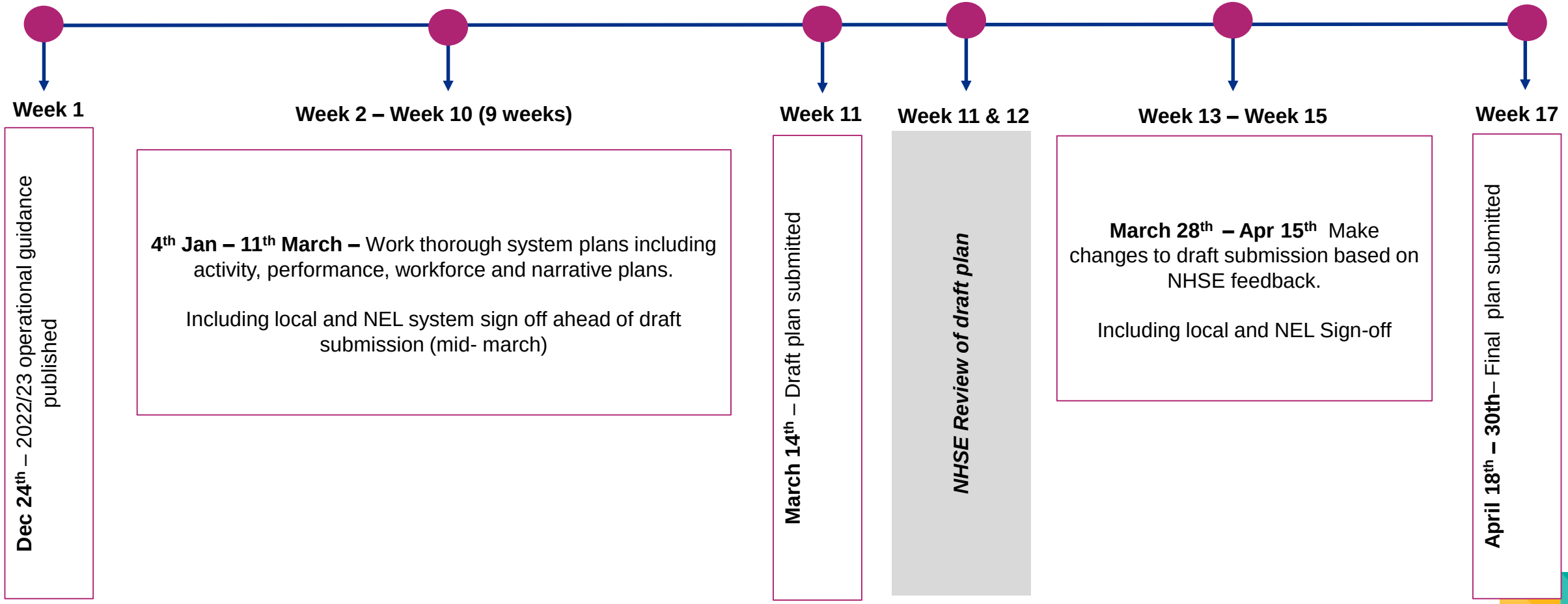
- **Compliance vs deliverability**

- **Start building trajectories based on accurate exit position forecast and operating plan ask**

- **Development of consistent planning assumptions across NEL**
- > Elective – activity to clear backlogs and consistent assumptions on referral growth, productivity and diagnostics
- > Non elective
- > Workforce to consider impacts of mandatory vaccination

Estimated planning timeline (indicative)

While we await further guidance



A: Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

Anticipated 2022/23 requirement (based on workforce template based 2021/22 H1 or H2)	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
Acute, Community and Ambulance • Workforce (WTE) • Total Provider Workforce (WTE) • Substantive by staff group • Total non-medical - Clinical staff substantive • Total medical and Dental Staff substantive • Total non-medical - non-clinical staff substantive **Primary Care** • Total by staff group • Total Provider Workforce (WTE) **Urgent Community Response** • WTE Clinical staff • WTE Non-clinical staff	Set out the specific actions that, as a system, you will prioritise over the next 6 to months to address the objectives below: 1. Looking after our people and helping them to recover 2. Belonging in the NHS and addressing inequalities 3. Embed new ways of working and delivering care 4. Grow for the future Summarise the key assumptions that underpin the numerical workforce plan submissions listed below, highlighting any key risks and issues and set out any system actions that are critical to the delivery of the planned workforce levels where these are not set out above, including recruitment and retention, use of bank and agency, redesign of teams and roles, deployment across sectors and/or organisations and sickness absence in: 1. Primary Care 2. Acute, Community and Ambulance 3. Mental Health

B: Respond to COVID-19 ever more effectively – delivering the NHS COVID vaccination programme and meeting the needs of patients with COVID-19

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (COVID) – However NEL did not provide this in our H1 or H2 submission as prediction of this is extremely difficult.	Set out the specific actions that, as a system, you will prioritise over the next 12 months to prepare for any future potential surge requirements for Covid patients

C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance

Elective

1. Deliver 110% of pre pandemic activity, ERF set at 104% to tackle the elective backlog and reduce long waits (ultimate aim to deliver around 30% more activity by 2024/25)
2. Eliminate >104ww as a priority and maintain this position through 2022/23 (with the exception of patient choice)
3. Reduce >78ww and conduct three-monthly reviews
4. Extend three-monthly reviews to >52ww from 1 July 2022
5. Reduce >52ww

Outpatients

1. Reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023
2. Expand PIFU to all major outpatient specialties (H2 ask is for 5 major specialties)
3. Move or discharge 5% of outpatient attendances to PIFU by March 2023 (H2 ask is 1.5% in Dec-21 and 2% in Mar-22 - NEL is significantly below this at circa 0.3-0.4%)
4. 16% specialist advice/A&G (16 requests per 100 outpatient first attendances) by March 2023 (H2 ask is 12% and NEL is exceeding this)

Activity trajectories

1. Total outpatient attendances (all TFC; consultant and non consultant led), face to face and telephone/virtual
2. Total Advice and Guidance requests processed/answered
3. Number of patients moved or discharged to a PIFU pathway for the first time
4. Consultant-led first outpatient attendances (Spec acute) and Consultant-led first outpatient attendances with procedures (Spec acute)
5. Consultant-led follow-up outpatient attendances (Spec acute) and Consultant-led follow-up outpatient attendances with procedures (Spec acute)
6. Total number of Specific Acute elective spells in the period
7. Total number of Specific Acute elective day case spells in the period
8. Total number of Specific Acute elective ordinary spells in the period
9. Total number of Specific Acute elective day case spells in the period of which children under 18 years of age
10. Average number of occupied G&A bed and Average number of available G&A beds

Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
1. Please summarise the key assumptions that underpin the activity plan submission for elective spells, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels. 2. Please summarise the key assumptions that underpin the activity plan submission for outpatients, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels. 3. To qualify for ERF funding, systems are required to demonstrate their elective recovery plan supports the requirements in sections C1 and C2 of the planning guidance and the five objectives listed in the accompanying implementation guidance. Please set out the specific actions that, as a system, you will take to meet the 'gateway criteria': - Addressing health inequalities - Transforming outpatient services - System led recovery - Clinical validation, waiting list data quality and reducing long waits

C2: Complete recovery and improve performance against cancer waiting times standards

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance

1. Improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
2. Return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020) - same as per H1/H2
3. Meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments - same as per H1/H2
4. FDS - extend coverage of non-specific symptom pathways with at least 75% population coverage by March 2023
5. FDS - ensure at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones
6. Ensure sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on lower GI, prostate and skin
7. Cancer Stratified FUP in place for breast, prostate, colorectal (NEL already meets this) and one other cancer by the end of the first quarter of 2022/23; and for two further cancers (one of which should be endometrial cancer) by March 2023

Activity and performance template

1. CCG level **-** Total number of patients receiving first definitive treatment for cancer within 31-days for all cancers (ICD-10 C00 to C97 and D05)
2. CCG level - Numbers of patients seen in a first outpatient appointment following urgent referrals
3. Provider level - The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non site specific symptoms
4. Provider level - Total number of patients receiving first definitive treatment for cancer within 31-days for all cancers (ICD-10 C00 to C97 and D05)
5. Provider level - Numbers of patients seen in a first outpatient appointment following urgent referrals

Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
Summarise the key assumptions that underpin the activity plan submission, highlighting any key risks and issues. Set out any system actions that are critical to the delivery of the planned activity levels. (Note: this submission is not designed to replace the single comprehensive delivery plan for cancer that Cancer Alliances have been asked to develop on behalf of their respective ICSs. Systems will want to engage with their Cancer Alliance to inform this submission) around: ○ Urgent cancer referrals ○ Cancer treatment volumes ○ Patients waiting 63 or more days

C3: Diagnostics activity

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
• Increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 - there has been no specified % ask previously, only monitoring against 19/20 BAU **Activity and performance template** 1. Diagnostic Tests - Magnetic Resonance Imaging 2. Diagnostic Tests - Computed Tomography 3. Diagnostic Tests - Non-Obstetric Ultrasound 4. Diagnostic Tests - Colonoscopy 5. Diagnostic Tests - Flexi Sigmoidoscopy 6. Diagnostic Tests - Gastroscopy 7. Diagnostic Tests - Cardiology - Echocardiography	C1 to cover diagnostics assumptions, actions, risks and issues that impact on elective recovery.

C4: Deliver improvements in maternity care

Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
Update on the specific actions that, as a system, you will prioritise over the next 6 to 12 months to address the objectives below: 1. Pandemic recovery - recovering the full maternity care pathway 2. Confirmation that Local Maternity Systems have a plan in place, agreed with their ICS to deliver the maternity transformation priorities for 2021/22 in line with the timings set out in section 5 of the implementation guidance 3. How Local Maternity Systems will improve their governance and how ICSs will strengthen their oversight

D: Improve the responsiveness of urgent and emergency care and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance

1. Reduce 12-hour waits in ED towards zero and no more than 2% - H2 ask was to eliminate 12-hour waits
2. Improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards
3. Eliminate 60 min handover delays
4. 95% of handovers within 30 minutes
5. 65% of handovers within 15 minutes
6. >15% of 111 calls received having clinical input

Activity and performance template

1. Total number of attendances at all A&E departments, excluding planned follow-up attendances (Types 1&2 + Types 3&4)
2. Total number of attendances at all Type 1 and Type 2 A&E departments, excluding planned follow-up attendances
3. Total number of attendances at all Type 3 and Type 4 A&E departments, excluding planned follow-up attendances
4. Number of Specific Acute non-elective spells in the period
5. Number of Specific Acute non-elective spells in the period with a length of stay of zero days
6. Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days
7. Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (COVID) - did not provide in 2021/22 as NEL agreed to leave blank
8. Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (Non-COVID)
9. Number of calls where the caller was referred into an SDEC service
10. Count of 2 hour crisis response first care contacts delivered within reporting quarter

Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
1. Please summarise the key assumptions that underpin the activity plan submission for non-elective spells, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels. 2. Key Line of Enquiry 1: ECDS - Assurance a plan exists and associated timescales for completion by end September, in expectation that we may be asked to implement the three additional standards from November. May be required for a progress update? 3. Key Line of Enquiry 2: 111 CAS Pathways to SDEC - Direct referrals for NHS111 and paramedics on scene into SDEC for the 9 symptom-based pathways that are currently in development by the end of September. Working this through the Same Day Emergency Care Sub Group to meet the September timeline. May be required for progress update? 4. Key Line of Enquiry 3: NEL 111 IUC Resilience - Assurance that a plan exists to consistently meet the Service Level/ Abandonment Rate/ ED Validation requirements for 111. NEL hold a weekly UEC System Resilience group to take forward the following key areas. May be required for a progress update?

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
1. Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3. 2. Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contact 3. Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth. 4. Delivery against delayed discharge trajectories through the Better Care Fund.	1. ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC. 2. Develop a trajectory for reducing their community service waiting lists and significantly reduce the number of patients waiting for community services.

E: Improve timely access to primary care – expanding capacity and increasing the number of appointments available

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
1. Planned number of General Practice appointments	1. Getting practice appointment levels to appropriate pre-pandemic levels 2. Maximising clinically appropriate dental activity 3. Workforce in Part A.

F: Grow and improve mental health services and services for people with a learning disability and/or autistic people

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
1. Update on the LTP ambitions tool on perinatal, CYP, Adult SMI, Adult Crisis, IAPT, Therapeutic Acute, Suicide prevention, Problem gambling, Rough Sleeping and Liaison Psychiatry 2. The number of children aged under 18 years from the STP who are autistic, have learning disability or both and are in inpatient care for the treatment of a mental disorder and whose bed is commissioned by NHS England or via a Provider Collaborative 3. Number of Annual Health Checks carried out for persons aged 14+ on GP Learning Disability Register in the period 4. The number of adults aged 18 or over from the CCG who are autistic, have a learning disability or both and who are in inpatient care for treatment of a mental disorder, and whose bed is commissioned by a CCG 5. The number of adults aged 18 or over from the CCG who are autistic, have a learning disability or both and who are in inpatient care for the treatment of a mental disorder, and whose bed is commissioned by NHS England or via a Provider Collaborative	Set out the specific actions that, as a system, you will prioritise over the next 12 months to address the objectives below; 1. Make progress on the delivery of annual health checks and improve the accuracy of GP Learning Disability Registers 2. Reduce reliance on inpatient care for both adults and children with a learning disability 3. Implement 100% of the actions coming out of LeDeR reviews within 6 months of notification Summarise any additional key assumptions that underpin the activity and performance plan submission, highlighting any key risks and issues. 1. AHCs delivered by GPs for patients on the Learning Disability Register 2. Reliance on Inpatient Care for Adults with a learning disability, autism or both 3. Reliance on Inpatient Care for Children with a learning disability, autism or both

G: Continue to develop our approach to population health management, prevent ill-health and address health inequalities

Anticipated 2022/23 activity and performance requirement (based on activity and performance template based 2021/22 H1 or H2) or 2022/23 guidance	Anticipated 2022/23 narrative requirement (based on narrative template based 2021/22 H1 or H2) or 2022/23 guidance
1. Number of personal health budgets that have been in place, at any point during the financial year to date 2. Total number of FTE PCN Network Contract DES funded social prescribing link workers employed in year 3. Total number of FTE CCG funded social prescribing link workers employed in year 4. Total number of social prescribing referrals in year into social prescribing link workers	Set out the specific actions that, as a system, you will prioritise over the next 6 months to address the LTP objectives below: 1. Expansion of smoking cessation services 2. Improved uptake of the NHS diabetes prevention programme 3. Progress on CVD prevention 4. Progress against the LTP high impact actions to support stroke, cardiac and respiratory care 5. Expansion of NHS digital weight management services Summarise the key assumptions that underpin the personalised care activity plan submission (personal health budgets, personalised care and support planning, social prescribing unique patient referrals), highlighting any key risks and issues.

Next steps (starts now)

1. Have named leads against trajectories and narrative sections across the NEL system.
2. Meet as a core planning working group to work through this pack.
3. Agree a consistent methodology across NEL on activity growth and assumptions.
4. Start building month on month trajectories based on end point March 23 target or based on current performance – approach to be agreed across NEL.
5. Start producing/updating our supporting narrative in particular around transformation areas to support delivery of trajectories.
6. We know the template would look very similar to previous planning cycle, therefore start to work up our trajectories using previous templates as a guide.

North East London
Clinical Commissioning Group

Governing Body meeting

26 January 2022

Title of report	Performance Report
Item number	6.1
Author	Archna Mathur, Director of Performance and Assurance
Presented by	Archna Mathur, Director of Performance and Assurance
Contact for further information	archnamathur@nhs.net
Executive summary	This cover sheet aims to provide a high level overview of how NEL ICS is performing against core acute, mental health and out of hospital performance metrics as defined within latest planning guidance. A report is also enclosed for the Out of hospital performance delivery. This exec summary highlights areas of risk to delivery for safe and equitable access of care for the north east London population. **Elective Care** • There is an overall rise in the patient waiting list driven by the non-admitted PTL although a downward trend has been observed in the last 2 weeks accompanied by a decrease in overall backlog numbers and increase in clock stops which is a positive pattern that is not seen in other London ICSs. • The most significant risk is the overall volume of > 104 week waiters at Barts Health and a small volume at BHRUT. A constraint has been anaesthetic workforce, for which plans are in place by way of oversees recruitment and insourcing models. Mutual aid is also in place with BHRUT, Homerton and conversations across London also to support orthopaedics and complex gynae procedures. Performance on next event bookings has also improved providing a greater degree of assurance of meeting the over 104 week trajectory for those that are currently waiting and also for those that may breach by March. • Activity levels are at ~80% for admitted pathways and 93% for non-admitted compared to 19/20 in order to address the current demand and backlogs with the system working collaboratively to increase this. **Cancer**

	• >62/7 backlog overall has started to reduce in the last 6 weeks driven by reductions at BHRUT and Homerton. The numbers of patients with a decision to treat has also increased at both Trusts. • The numbers of patients over 104 days without a decision to treat is also increasing driven by BHRUT. • 2ww are now above pre-pandemic levels and the NEL performance against the new Faster Diagnosis Standard is at 70.2% just below England average of 71%. **Diagnostics** • The overall waiting list has grown across all providers but the backlog for patients waiting over 6 weeks has improved with the most significant improvement at Barts Health. The % of activity being undertaken compared to 19/20 is below the H1 (Half year 1 period April to Sept). The most significant risks are in MRI, Non obstetric ultrasound and CT. **Ambulance Handover Delays** • The target time to offload ambulances is 15mins, with metrics in place also for 30min and 60min handovers, with 60 minute handovers considered as a “breach”. • Queens, KGH and Whipps Cross have daily 60mins breaches leading to loss of hours for ambulance crews whilst they wait to handover **Hospital Flow and discharge** The main reason for ambulance delays is reduced flow through the hospital on account of an inability to place patients awaiting admission in the emergency department. This is often because wards are full and patients have not been discharged. Across North East London, we know that the main reasons for delayed discharge are: • Patients awaiting medical intervention/decision • Awaiting availability of rehabilitation bed in the community • Awaiting availability of a nursing/residential home care bed • Awaiting availability of resource for assessment and start of care at home Trusts and local system are working together on a discharge work stream led by Matthew Trainer to work through solutions. In addition work on pathway 0 discharges (simple discharges) is underway, so each acute site is clear on the volume of pathway 0 discharges required to maintain flow **Mental Health** • Mental Health performance is challenged in a number of metrics as a result of increasing pandemic demand.

	• All IAPT metrics as well as SMI physical health checks, perinatal access and dementia diagnosis are delivering below target but are more challenged in the BHR and Waltham Forest boroughs. **Out of hospital Operating Plan performance** • Primary care appointments: latest figures are for August which demonstrates delivery of appointments above the trajectory levels. • Inpatient care for adults and children with LD/autism is also currently delivering to target levels. • There is a risk to delivery for annual health checks for persons over 14 on the LD register due to challenges in recording in primary care and volume of workload. • Delivery of PHB targets is at risk due to pandemic backlog and trajectories are to be re set to the end of March. • The target for the number of 111 calls referred to SDEC (same day emergency care) is likely to be delivered although a low target was set.
Action required	Note.
Where else has this paper been discussed?	This paper has been discussed at the ICS Executive Committee.
Next steps/ onward reporting	All recovery programmes are in place and reported.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Understanding the performance and drivers of performance across the NEL system is an indicator of equity to quality services, access and delivery of good health outcomes for the population of north east London. Performance against national metrics and comparison across providers/systems in NEL indicates unwarranted variation and supports prioritisation of resources to support reduction in health inequality.
Conflicts of interest	N/A
Strategic fit	• High quality services for patients • Put patient experience at the centre of our delivery • Ensure the best use of resources • Support our people to thrive • Develop our NEL integrated care system • Recover from the pandemic and be prepared for future waves
Impact on finance, performance and quality	As per report.
Risks	The summary above highlights those areas where there is a risk to delivery.
Equality impact	Our focus is to ensure safe and equitable care for all our population

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Out of hospital operating plan performance summary

Operating plan performance summary

Indicator	Summary of performance	Perf	Risk assessment of achievement @ H1	Update available since last report
E.D.19 Planned number of General Practice appointments	• **Sep target: 825,760 | August actual: 932,977** • Exceeding the August target by 49889 appointments. So far we have delivered 3 of the 5 month op plan trajectory, but exceeding the YTD position. • Data not available at borough level therefore unable to understand local variations.		Likely to deliver	Yes
E.K.1a The number of adults aged 18 or over from the CCG who are autistic, have a learning disability or both and who are in inpatient care for treatment of a mental disorder, and whose bed is commissioned by a CCG	• **Q2 target: 24 | Q2 actual: 26** • Not delivering the Q2 target, there is variation across boroughs which is impacting on delivery of the target. • Only Newham and Tower Hamlets have delivered the trajectory in the most current reporting month October with all other boroughs above trajectory.		Unlikely to deliver	Yes
E.K.1b The number of adults aged 18 or over from the CCG who are autistic, have a learning disability or both and who are in inpatient care for the treatment of a mental disorder, and whose bed is commissioned by NHS England or via a Provider Collaborative	• **Q2 target: 22 | Q2 actual: 20** • NEL is currently delivering against the Q2 target, and therefore achieving the operating plan trajectory. • Newham is the only borough over their borough trajectory.		Likely to deliver	Yes
E.K.1c The number of children aged under 18 years from the STP who are autistic, have learning disability or both and are in inpatient care for the treatment of a mental disorder and whose bed is commissioned by NHS England or via a Provider Collaborative	• **Q2 target: 8 | Q2 actual: 10** • NEL is currently above the operating plan trajectory at Q2. • However in previous months have delivered against the trajectory.		Likely to deliver	Yes
E.K.3 Number of Annual Health Checks carried out for persons aged 14+ on GP Learning Disability Register in the period	• **Q2 target: 1873 | Q2 actual: 1682** • All boroughs across NEL are not delivering against this trajectory by exception of one (Waltham Forest) who have delivered their Q2 trajectory. • While we will not deliver the H1 trajectory, this indicator is linked to a payment, and therefore we usually see a huge focus in primary care in Q4 of the year. • Historically NEL have delivered on this in a financial year, and likely to do so by end of year.		Unlikely to deliver	Yes

Indicator	Summary of performance	Perf.	Risk assessment of achievement @ H1	Update available since last report
E.N.1 Number of personal health budgets that have been in place, at any point during the financial year to date **Not in H2**	• **Q2 target: 1289 | Q2 actual: 886** • PHB delivery will be a challenge to deliver in H1. • Reporting of PHBs have been re-instated in Q2 by NHS digital, and is coordinated by NEL through the personalised care programme agenda. We are lower than our op plan trajectory, however this was expected due to the backlog developing during the pandemic. And challenges differ in each of the boroughs.		**Unlikely to deliver**	**No**
E.N.2 Total number of social prescribing referrals in year into social prescribing link workers **Not in H2**	• **Q2 target: 13212 | Q2 actual: *not known at the time of reporting*** • Data to report on this indicator is not readily available. • The NEL development team are developing through discovery the capturing of this information. This is currently in progress.		**Likely to deliver** (please note this is based on soft intelligence, while the data gathering is being developed and may change)	**No**
E.T.1 Count of 2 hour crisis response first care contacts delivered within reporting quarter **Not in H2**	• **Q2 target: 8216 Q2 actual: *not known at the time of reporting*** • Data is being reporting through the new minimum CHS dataset, exploring with CSU on accessing this data through this dataset.		**Likely to deliver**	**No**
E.M.28 Number of calls where the caller was referred into an SDEC service	• **August target: 33.3% (2 calls referred and 6 calls where SDEC was an option) | Q2 actual: *not known at the time of reporting*** • Data not available as the 111 system is unable to book directly to SDEC and therefore unable to count. • Exploring alternative ways on how we maybe able to count this. • However the NEL trajectory is low and therefore we should be able to deliver this trajectory.		**Likely to deliver**	**No**
E.N.3 Total number of active (new and reviewed) PCSPs that have been in place in the financial year to date **Not in H2**	• **Q2 target: 17465 | Q2 actual: *not known at the time of reporting*** • We are not sure how NHSE have count this indicator. • PCSPs are made up of dementia QOF, Antenatal pathway and SNOMED codes in primary care. We are able to provide the dementia QOF numbers, however we are not sure what element of the antenatal pathway is being used and the SNOMED code searches in primary care are showing really low numbers around 200. However we know we have (in the thousands) across NEL care plans with our residents. • Have escalated through ODG to NHSE and have not yet had a response, and have emailed the national lead directly and still no response.			**No**

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Clinical Commissioning Group

NEL Governing Body
26 January 2022

Title of report	Finance Report Month 8
Item number	6.2
Author	Julia Summers, Head of Finance
Presented by	Steve Collins, NEL CCG Acting Chief Finance Officer
Contact for further information	steve.collins5@nhs.net
Executive summary	**Key Issues** NEL CCG have submitted a H2 plan to NHSE and budgets have been set for the full financial year. The CCG plan is a breakeven position. The CCG plan is part of the NEL system plan which is showing a breakeven position. The total full year budget for NEL CCG is £3,926m. At Month 8 (period to end of November 2021), NEL CCG has achieved a break-even position on the core budgets. However, delivery of the break-even position has been reliant on the use of non-recurrent mitigations and contingency funds (covid related) to offset identified budgetary pressures. The CCG is expecting to receive funding of £7.5m relating to HDP/Covid, ERF and WAF expenditure (for month 8, with £32.7m forecast) in line with the NHSE retrospective allocation process. As with previous reporting periods, this is shown as an overspend against the CCG position. There are continuing pressures in activity driven areas, such as acute, primary care and prescribing, that have been managed with the use of non-recurrent measures. These include balance sheet accruals made at year-end in anticipation of pressures on these budgets during 2021/22.
Action required	Note the financial position at month 8 and the risks identified with delivering against plan.

Where else has this paper been discussed?	N/A
Next steps/ onward reporting	Regular reporting to the Governing Body on the financial position.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Delivery of financial plan to support the adequate provision of healthcare services.
Conflicts of interest	No conflicts of interest.
Strategic fit	NEL-wide operational plans have been set on the financial resources available. The report provides an update of financial performance against this plan.
Impact on finance, performance and quality	Delivery of financial plan and meeting control total is a mandated requirement.
Risks	Financial risks are outlined in the paper
Equality impact	N/A

Finance report

1. Introduction

The CCG has undertaken a full review of financial information at Month 8 and reported within timescales to NHSEI.

The attached presentation is intended to inform the Governing Body about the Month 8 financial position.

The paper links to the CCG corporate objective in relation to the delivery of the financial plan.

2. Key messages

The attached presentation includes a summary of the Month 8, year-to-date and forecast position.

The core CCG spend is reported as break even. Additionally, the CCG has incurred spend on the hospital discharge pathway, other allowable Covid spend, winter access funding (WAF) and the elective recovery fund which forms part of the retrospective top up process funded by NHSEI.

NHS contracts are currently paid via a block contract. There are continuing pressures in Month 8 in relation to the independent sector, primary care, prescribing and corporate costs. These have been managed via non recurrent measures.

Potential risks in relation to activity based issues and investment slippage have been flagged. The reporting of risks will be further developed in future reporting periods.

3. Conclusion / Recommendations

The Governing Body is asked to note the content of the Month 8 finance report. Updates will be given at future committee meetings.

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Month 8 Finance Overview Report 21/22

Meeting name: NEL CCG Governing Body
Presenter: Steve Collins
Date: 26 January 2022

Finance Report Month 8

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Month 8 (November 2021) Executive Summary

- The CCG has submitted a H2 plan to NHSE and budgets have been set for the full financial year across the three integrated care partnership systems for NEL CCG. The CCG plan is a break-even position. **The total budget for NEL CCG is £3,926m.**

- A full review of financial information has been undertaken for Month 8 This shows a high level of consistency with the Month 7 reported position. With the exception of the hospital discharge pathway (HDP), Covid, elective recovery fund (ERF) and the Winter Access Fund (WAF), the year-to-date and forecast positions are consistent with H1 reporting and **NEL CCG have reported break-even against the full year plans.**

- As previously reported, budgetary pressures continue with Independent Sector (IS) contracts, prescribing and NEL corporate budgets.

- However delivery of the breakeven position has been reliant on **the use of non-recurrent mitigations (£46m) and accessing CCG Covid contingency funds (£5m).** In total, this has required **£51m of non-recurrent mitigation, £38m of which was expected**. **This is a reduction from Month 7 and reflects an improved forecast with TNW and City and Hackney.**

- The independent sector (IS) planned budget was increased in H2 to reflect the expenditure profile seen in H1. **The month 8 IS forecast has reduced as a result of Barts carrying out some of the elective recovery work themselves**. The current forecast is based on the maximum planned activity and the associated ERF income that this will attract..

- The CCG is expecting to receive funding of **£7.5m (year-to-date position) and £32.7m (forecast) relating to HDP, primary care Covid, winter access funding and ERF** in line with the NHSE retrospective allocation process.

- Additional resources of £9m have been allocated to the CCG in Month 8. Of this £5.5m has been allocated to primary care co-commissioning for winter access funding and Investment and Impact (IIF) funding. The remaining £3.5m has been allocated to programmes including ageing well (£1.2m), mental health winter, IAPT, DWP employment advisors (£1.4 in total) and £0.9m for screening and planned care.

- A level of financial risk has been identified from a commissioning perspective within the financial plan. If this materialises it will be mitigated through appropriate actions and if necessary non-recurrent measures. As discussed in H1 reports, **the CCG needs to be aware of its recurrent underlying position moving into 22/23 and be aware of the impact of this on the ICB and providers.**

Month 8 (November 2021) Executive Summary

- The table below highlights the level of mitigation required for each of the **ICPs in order to achieve a breakeven forecast position.**

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
TOTAL EXPENDITURE	**11.8**	**1.7**	**47.1**	**26.5**	**83.7**
Revenue Resource Limit Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
In Year (Surplus) / Deficit Before Mitigation	**11.8**	**1.7**	**47.1**	**26.5**	**83.7**
Retrospective Funding expected for HDP/Covid & ERF	-3.3	0.0	-2.8	-26.5	-32.7
Adjusted (Surplus) / Deficit after NHSE expected top up	**8.5**	**1.7**	**44.3**	**0.0**	**51.0**
Covid Contingency	-0.9	0.1	-4.2	0.0	-5.0
Non Recurrent Mitigation	-7.6	1.6	-40.0	0.0	-46.0
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

- The Month 8 forecast **assumes that all SDF, MHIS and other specific transformation funds are fully spent**. However, there remains a risk of slippage against a number of these investments as mobilisation in some cases has taken longer than anticipated.

Month 8 Position – *NEL CCG*

- The position before CCG mitigations and after NHSE anticipated top-ups shows **a full year pressure of £51m.**
- **Non-recurrent balance sheet mitigations and covid contingency** have been released into the position to offset CCG overspends (£51m, £38m of this was a planned release).
- This has been necessary to **meet budgetary pressures with the acute independent sector and prescribing.** Other Primary care pressures, i.e. hub arrangements, have been mitigated through the use of specific NHSE funding and topped-up CCG covid contingency funds.
- **The use of non-recurrent mitigations and the anticipated NHSE top-up means that the revised CCG position for H2 is break- even.**
- Appendix 1 includes Integrated Care Partnership (ICP) level information.

NEL CCG Financial Summary H2 2021-22	Month 8				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	1,453.9	1,462.9	9.0		2,172.8	2,186.2	13.4	
Mental Health & LD	265.1	265.2	0.2	2	397.8	397.9	0.1	3
Community Health Services	231.8	238.5	6.7		336.8	355.4	18.6	2
Continuing Care	109.7	109.5	-0.2	3	165.1	163.8	-1.3	3
Other Programme	93.1	93.8	0.7		135.1	136.2	1.1	
Prescribing	166.4	169.2	2.8		250.1	253.1	3.0	
Primary Care Services	54.4	58.8	4.5	2	82.1	88.6	6.5	2
Primary Care Co-Commissioning	227.5	227.5	0.0	3	344.5	352.0	7.5	
Running Costs	25.6	25.6	-0.0	3	38.5	38.5	-0.0	3
Central Reserves	2.2	23.8	21.6		3.5	38.4	34.8	
TOTAL EXPENDITURE	**2,629.7**	**2,674.9**	**45.2**		**3,926.3**	**4,010.0**	**83.7**	
Revenue Resource Limit Total	**-2,629.7**	**-2,629.7**	0.0	3	**-3,926.3**	**-3,926.3**	0.0	3
In Year (Surplus) / Deficit Before Mitigation	**0.0**	**45.2**	**45.2**		**0.0**	**83.7**	**83.7**	
Retrospective Funding expected for HDP/Covid & ERF		-7.5	-7.5	3		-32.7	-32.7	3
Adjusted (Surplus) / Deficit after NHSE expected top up	**0.0**	**37.7**	**37.7**		**0.0**	**51.0**	**51.0**	
Covid Contingency		-3.1	-3.1			-5.0	-5.0	
Non Recurrent Mitigation		-34.6	-34.6			-46.0	-46.0	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

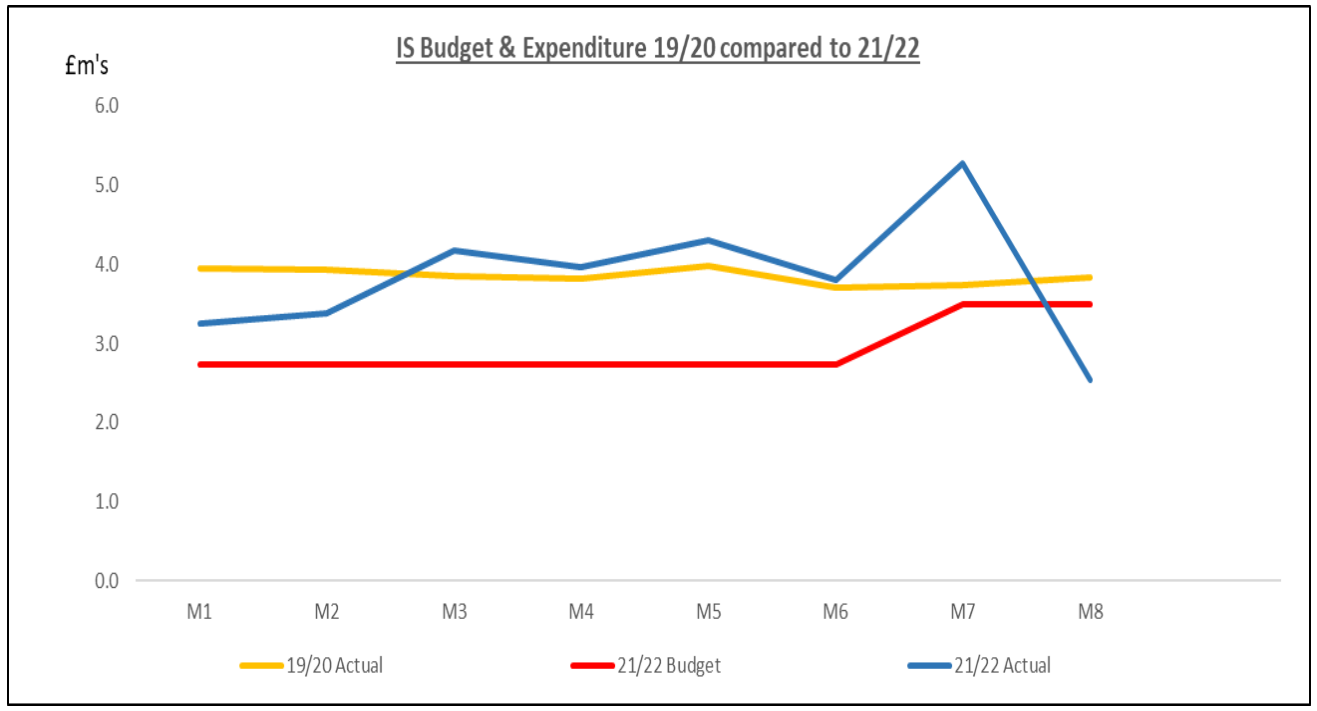
21/22 full year variances – *ICP Breakdown*

- This table shows the forecast ICP variances and the level of the deficit before non-recurrent mitigation. It highlights some consistent trends **across NEL, particularly with regard to acute, prescribing and other programme pressures.**
- NEL CCG is expecting an additional £32.7m of funding (forecast position). £17.7m of this relates to the Hospital discharge programme , **which is reported as a pressure in the Community Health Services line.** £6.2m relates to ERF, £7.4m WAF and £1.4m other Covid.
- Further detail on specific variances relating to acute, continuing care and prescribing can be found on the next few slides.

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
Acute	6.3	0.2	6.9	-0.0	13.4
Mental Health & LD	0.1	-0.0	-0.0	0.0	0.1
Community Health Services	-0.0	-0.2	1.3	17.5	18.6
Continuing Care	0.9	-0.6	-1.6	0.0	-1.3
Other Programme	2.4	-2.1	0.7	0.1	1.1
Prescribing	1.3	0.2	1.5	0.0	3.0
Primary Care Services	0.9	-0.1	4.2	1.5	6.5
Primary Care Co-Commissioning	0.0	0.0	0.0	7.5	7.5
Running Costs	0.0	0.0	-0.0	0.0	-0.0
Central Reserves	0.0	0.8	34.1	0.0	34.8
TOTAL EXPENDITURE	**11.8**	**1.7**	**47.1**	**26.5**	**83.7**
Revenue Resource Limit Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
In Year (Surplus) / Deficit Before Mitigation	**11.8**	**1.7**	**47.1**	**26.5**	**83.7**
Retrospective Funding expected for HDP/Covid & ERF	-3.3	0.0	-2.8	-26.5	-32.7
Adjusted (Surplus) / Deficit after NHSE expected top up	**8.5**	**1.7**	**44.3**	**0.0**	**51.0**
Covid Contingency	-0.9	0.1	-4.2	0.0	-5.0
Non Recurrent Mitigation	-7.6	1.6	-40.0	0.0	-46.0
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

NEL CCG key variances - *Acute*

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
Acute	6.3	0.2	6.9	-0.0	13.4



- Within acute services NHS block contracts are reported as breakeven.
- Forecast overspends are reported **against urgent care (£1.8m), non contract activity (£2.8m) and independent sector (IS) providers (£8.8m).**
- The forecast position on IS has reduced from £11.6m in Month 7. This is as a result of Barts Health choosing not to send activity to the Practice Plus Groups Hospital and planning to deliver the activity themselves. Additionally there has been a reduction to the forecast position of BMI, Spire and Holly House.
- As a result of this the independent sector graph shows that although a large overspend remains, the rate of overspend for Months 7 and 8 combined are broadly in line with plan. This will continue to be monitored and updates provided.
- The current forecast is based on the maximum planned activity. However, actual activity may not continue at these levels. ERF estimated funding of £6.2m is expected against this but to note lower activity rates will mean that the ERF funding will reduce.

NEL CCG key variances – *Continuing Healthcare*

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
Continuing Care	0.9	-0.6	-1.6	0.0	-1.3

BOROUGH	ANNUAL BUDGET £m	FORECAST OUTTURN £m	FORECAST VARIANCE £m
BARKING AND DAGENHAM	18.6	18.4	-0.2
HAVERING	27.9	29.3	1.3
REDBRIDGE	32.5	32.2	-0.3
CITY & HACKNEY	18.3	17.7	-0.6
TOWER HAMLETS	20.1	18.4	-1.6
NEWHAM	19.8	20.2	0.4
WALTHAM FOREST	27.9	27.6	-0.3
NEL CCG	**165.1**	**163.8**	**-1.3**

- The variance by ICP shows that BHR reports a H2 overspend £0.9m, C&H report an underspend of £0.6m and TNW report an underspend of £1.6m. The overall CHC position is, therefore, an underspend of £1.3m.
- The month 8 forecast has deteriorated from the Month 7 reported forecast underspend of £2.6m. **The main driver behind this is BHR ICP which has seen a deterioration of £1.1m**. The current forecast is based on the latest information and represents an **increase in the number of clients needing 1 to 1 and 2 to 1 care**. Additionally there has been **an increase in costs of the packages.** CHC is traditionally volatile and further updates will be given to Committee.
- TNW are reporting a month 8 forecast underspend of £1.6m. **This is based on the latest run rate.**
- **City and Hackney** are reporting a Month 8 forecast underspend of £0.6m. This is consistent with the H1 forecast.

NEL CCG key variances – *Primary Care and Prescribing*

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
Prescribing	1.3	0.2	1.5	0.0	3.0
Primary Care Services	0.9	-0.1	4.2	1.5	6.5
TOTAL PRIMARY CARE	**2.2**	**0.1**	**5.7**	**1.5**	**9.5**

- The total forecast variance on primary care and prescribing is £9.5m (BHR £2.2m, CH £0.1m and TNW £5.7m). The primary care position assumes full use of the winter access funding.
- The prescribing forecast variance is based on the latest available data (month 6).
- The driver behind the overspend is the increased number and in some cases, cost of prescriptions.
- Primary Care Services show a forecast overspend of £6.5m and includes a forecast for reclaimable covid costs of £1.4m.
- The main drivers of the remaining overspend include; Covid service related costs including access (hubs), oxygen and additional costs to support 111 downstream pressures. This has been fully mitigated by the release of the CCG Covid contingency.

NEL CCG key variances - *Other*

1. **Community Health Services (CHS)** – there is a reported forecast overspend of £18.6m on CHS. This largely relates to claimable HDP costs. There are no other major variances to report.

2. **Mental Health** – at Month 8 there is no reported variance against mental health. The MHIS plan has been set for the full financial year and the Month 8 return to NHSE assumes that spend is in line with plan. The majority of SDF and spending review funds (SR) for mental health has transferred to providers for them to deliver the SDF and SR priorities. At Month 8 both ELFT and NELFT have confirmed slippage on the year-to-date position, with recovery against the plan expected by year end. This remains a risk to the system as a proportion of the plans are dependent on successful recruitment.

3. **Central reserves** – there is a reported overspend of £34.8m on central reserves. The driver of this variance relates to a planned efficiency target across NEL. This has been fully mitigated by the planned use of non-recurrent resources. The forecast assumes that all ICP/CCG Covid contingencies are fully utliised.

4. **Corporate Pressures** – there is a reported overspend against the NEL corporate budgets of £1.2m. This is associated with business intelligence software and service arrangements that are no longer being funded from central NHSE resources.

Hospital Discharge Pathway / Covid

Hospital Discharge Pathway

- HDP is reimbursed on actual spend against a notional budget capped at £20.4m for H1 and £17.9m for H2 (total £38.3m) for NEL CCG.
- The forecast position for HDP shows total 21/22 spend of £32.9m Within this forecast, the **H2 claim is reported as £17.7m. H2 spend is, therefore, forecast to be just under the H2 cap of £17.9m. There is a risk that any further increase in forecast costs and the costs of the March tail end will breach the H2 cap.**
- The H2 forecast position has increased by £2.4m between Month 7 and Month 8. The main driver of this is an increase in the forecast of local authority costs.
- **At month 8 there is an additional HDP year-to-date claim of £5.8m, with £17.7m expected for forecast costs.**

	LA YTD M8 £m	CCG YTD M8 £m	Total YTD M8 £m	LA FOT £m	CCG FOT £m	Total YTD £000s
BHR ICP	6.3	1.9	8.3	8.4	4.1	12.5
CH ICP	1.0	0.2	1.1	1.8	0.3	2.0
TNW ICP	4.8	6.9	11.7	8.3	10.1	18.4
Total	**12.1**	**9.0**	**21.1**	**18.4**	**14.5**	**32.9**
HDP Funds received Q1&2			-15.3			-15.3
Outstanding HDP claim			**5.8**			**17.7**

Other Covid

- Other than HDP, the majority of Covid costs are funded within the CCG baseline.
- NEL CCG has a forecast claim of £1.4m in relation to vaccination costs.

Elective Recovery Fund

	Total ERF
Elective Recovery Fund	**£m**
H1	
BHRUT	7.5
Barts Health	12.1
Homerton	3.4
NEL CCG	3.5
Total ERF - H1	**26.4**
Funding distributed - Trusts	-22.9
Funding distributed - NEL CCG	-3.5
Outstanding ERF claim	**0.0**
H2 CCG IS forecast	6.2
Total expected H2 ERF	**6.2**

- ERF plans submitted to NHSE/I captures information from NHS and non-NHS providers. The H1 position resulted in a claim of £26.4m which has been fully reimbursed.
- £22.9m of the total £26.4m was payable to BHRUT, Barts and Homerton.
- The remaining £3.5m was allocated to the CCG to fund the non NHS costs elective recovery costs.
- In Month 8 activity at the independent sector has increased as a result of a transfer of activity from the acute providers. From a system perspective this means that the ERF income expectation in H2 is £6.2m.
- This expectation is based on the latest assumptions about IS activity data. The NEL team are working on this and assumptions may be refined in future months. Further updates will be given to committee as the information becomes available.

Financial Accounts Performance Metrics

- The Better Payment Practice Code (BPPC) performance measure requires 95% or more of invoices, in terms of value and volume to be paid within 30 days of receipt of the invoice, unless there is a dispute. Performance **across NEL CCG** is shown in the table below:

	2021/22 AP8 - NOV 21		2021/22 AP7 - OCT 21		2021/22 Year to date		2020/21 Outturn	
	Number	£000	Number	£000	Number	£000	Number	£000
Non-NHS Payables:								
Total Non-NHS trade invoices paid in the year	7,570	76,569	6,510	70,078	51,051	540,089	89,808	865,136
Total Non-NHS trade invoices paid within target	7,412	75,839	6,235	68,197	48,484	521,531	85,961	824,785
Percentage of non-NHS trade invoices paid within target	98%	99%	96%	97%	95%	97%	96%	95%
NHS Payables:								
Total NHS trade invoices paid in the year	298	226,036	246	248,373	2,474	1,864,465	12,449	2,407,453
Total NHS trade invoices paid within target	257	225,306	245	248,222	2,342	1,857,633	11,472	2,395,694
Percentage of NHS trade invoices paid within target	86%	100%	100%	100%	95%	100%	92%	100%
Combined non NHS and NHS:								
Total Non-NHS trade invoices paid in the year	7,868	302,605	6,756	318,452	53,525	2,404,554	102,257	3,272,589
Total Non-NHS trade invoices paid within target	7,669	301,145	6,480	316,419	50,826	2,379,164	97,433	3,220,479
Percentage of all trade invoices paid within target	97%	100%	96%	99%	95%	99%	95%	98%

- The BPPC targets were met for both NHS and Non NHS in November on the value of invoices target. Performance against the number of invoices cleared has reduced in November due to the clearance of prior year invoices. However, as the value of the invoices was low the performance against value target remains on track.
- Appendix 2 shows the balance sheet position of the CCG.

Summary

- NEL CCG has submitted a break even plan for H2. It is expected that a break-even position will be achieved through the use of non-recurrent mitigations.

- At Month 8 NEL CCG has reported a break-even position on the core budgets, with a reported variance as a result of the outstanding NHSE/I retrospective top-up for HDP, claimable Covid, winter access funding and ERF. The break-even position has been achieved using non recurrent mitigations (forecast mitigations of £51m). Of the £51m non-recurrent mitigations required, £38m was expected within the annual plan.

- NHS contracts continue to be paid on a block basis. However, within the reported position there are emerging risks on the independent sector, prescribing, CHC, NEL corporate costs and in-envelope Covid spend in primary care.

- NEL CCG has received funding for transformation areas. Plans are being developed by transformation leads. At month 8 it is assumed that the funds are fully committed. There is a risk of slippage and delivery against these funds.

- Although the CCG is seeing run rate pressures, these are currently being mitigated by non recurrent resources. This will continue to be updated and further updates will be given to Finance Committee.

Appendix 1 – BHR ICP

BHR ICP Financial Summary H2 2021-22	Month 8				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	439.2	443.6	4.4	1	659.1	665.5	6.3	1
Mental Health & LD	86.6	86.8	0.2	2	129.0	129.1	0.1	3
Community Health Services	66.4	66.4	0.0	3	99.4	99.4	-0.0	3
Continuing Care	51.8	53.7	1.8	1	79.0	79.8	0.9	1
Other Programme	25.3	26.7	1.4	2	37.6	40.0	2.4	2
Prescribing	69.6	70.8	1.1	1	103.8	105.1	1.3	1
Primary Care Services	13.0	13.6	0.5	1	19.4	20.3	0.9	1
Primary Care Co-Commissioning	81.8	81.8	0.0	3	122.5	122.5	0.0	3
Running Costs	10.0	10.0	0.0	3	15.0	15.0	0.0	3
Central Reserves & Efficiency Requirement	-0.0	0.0	0.0	3	0.0	0.0	0.0	3
TOTAL EXPENDITURE	**843.8**	**853.2**	**9.4**	1	**1,264.7**	**1,276.6**	**11.8**	1
Revenue Resource Limit Total	**-843.8**	**-843.8**	0.0	3	**-1,264.7**	**-1,264.7**	0.0	3
In Year (Surplus) / Deficit Before Mitigation	**0.0**	**9.4**	**9.4**	1	**0.0**	**11.8**	**11.8**	1
Retrospective Funding expected for HDP/Covid & ERF		-0.2	-0.2	3		-3.3	-3.3	3
Adjusted (Surplus) / Deficit after NHSE expected top up		**9.3**	**9.3**	1		**8.5**	**8.5**	1
Covid Contingency		-0.5	-0.5			-0.9	-0.9	
Non Recurrent Mitigation		-8.7	-8.7			-7.6	-7.6	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

Appendix 1 – CH ICP

C&H ICP Financial Summary H2 2021-22	Month 8				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	162.0	162.1	0.2	2	242.8	243.0	0.2	2
Mental Health & LD	53.1	53.1	0.0	3	80.1	80.1	0.0	3
Community Health Services	36.3	36.1	-0.2	3	54.1	53.9	-0.2	3
Continuing Care	12.5	11.9	-0.6	3	18.3	17.7	-0.6	3
Other Programme	6.7	5.5	-1.2	3	10.5	8.4	-2.1	3
Prescribing	18.9	19.1	0.2	2	28.6	28.8	0.2	2
Primary Care Services	11.1	11.0	-0.1	3	16.1	16.0	-0.1	3
Primary Care Co-Commissioning	36.0	36.0	0.0	3	53.9	53.9	0.0	3
Running Costs	3.7	3.7	-0.0	3	5.5	5.5	0.0	3
Central Reserves & Efficiency Requirement	-0.8	0.0	0.8	1	-0.8	0.0	0.8	1
TOTAL EXPENDITURE	**339.5**	**338.6**	**0.9**	3	**509.1**	**507.4**	**1.7**	3
Revenue Resource Limit Total	**-339.5**	**-339.5**	0.0	3	**-509.1**	**-509.1**	0.0	3
In Year (Surplus) / Deficit Before Mitigation	**0.0**	**0.9**	**0.9**	1	**0.0**	**1.7**	**1.7**	1
Retrospective Funding expected for HDP/Covid & ERF		0.0	0.0	3		0.0	0.0	3
Adjusted (Surplus) / Deficit		**0.9**	**0.9**	1		**1.7**	**1.7**	1
Covid Contingency		0.1	0.1			0.1	0.1	
Non Recurrent Mitigation		0.8	0.8			1.6	1.6	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

Appendix 1 – TNW ICP

TNW ICP Financial Summary H2 2021-22	Month 8				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	502.7	507.1	4.4	1	754.2	761.1	6.9	1
Mental Health & LD	125.0	125.0	-0.0	3	187.7	187.7	0.0	3
Community Health Services	83.0	84.0	1.0	1	123.7	125.1	1.3	1
Continuing Care	45.4	43.9	-1.5	3	67.8	66.2	-1.6	3
Other Programme	58.9	59.5	0.6	1	84.9	85.6	0.7	1
Prescribing	77.9	79.4	1.5	1	117.7	119.2	1.5	1
Primary Care Services	29.2	31.9	2.6	2	44.0	48.3	4.2	2
Primary Care Co-Commissioning	108.3	108.3	0.0	3	162.2	162.2	0.0	3
Running Costs	12.0	12.0	-0.0	3	18.0	18.0	-0.0	3
Central Reserves & Efficiency Requirement	-20.8	0.0	20.8	1	-34.1	0.0	34.1	1
TOTAL EXPENDITURE	**1,021.7**	**1,051.1**	**29.5**	1	**1,526.2**	**1,573.3**	**47.1**	1
Revenue Resource Limit Total	**-1,021.7**	**-1,021.7**	0.0	3	**-1,526.2**	**-1,526.2**	0.0	3
In Year (Surplus) / Deficit Before Mitigation	**0.0**	**29.5**	**29.5**	1	**0.0**	**47.1**	**47.1**	1
Retrospective Funding expected for HDP/Covid & ERF		-0.1	-0.1	3		-2.8	-2.8	3
Adjusted (Surplus) / Deficit		**29.3**	**29.3**	1		**44.3**	**44.3**	1
Covid Contingency		-2.6	-2.6			-4.2	-4.2	
Non Recurrent Mitigation		-26.7	-26.7			-40.0	-40.0	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

Appendix 1 – ICS Funds

ICS Funds Financial Summary H2 2021-22	Month 8				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	350.0	350.0	-0.0	3	516.7	516.7	0.0	3
Mental Health & LD	0.3	0.3	0.0	3	1.0	1.0	0.0	3
Community Health Services	46.1	52.0	5.9	1	59.5	77.0	17.5	1
Continuing Care	0.0	0.0	0.0	3	0.0	0.0	0.0	3
Other Programme	2.1	2.1	-0.0	3	2.1	2.2	0.1	3
Prescribing	0.0	0.0	0.0	3	0.0	0.0	0.0	3
Primary Care Services	1.0	2.4	1.4	1	2.6	4.1	1.5	1
Primary Care Co-Commissioning	1.4	1.4	-0.0	3	5.9	13.4	7.5	1
Running Costs	0.0	0.0	0.0	3	0.0	0.0	0.0	3
Central Reserves & Efficiency Requirement	23.8	23.8	0.0	3	38.4	38.4	0.0	3
TOTAL EXPENDITURE	**424.7**	**431.9**	**7.2**	1	**626.3**	**652.8**	**26.5**	1
Revenue Resource Limit Total	**-424.7**	**-424.7**	0.0	3	**-626.3**	**-626.3**	0.0	3
In Year (Surplus) / Deficit	**0.0**	**7.2**	**7.2**	1	**0.0**	**26.5**	**26.5**	1
Retrospective Funding expected for HDP/Covid & ERF		-7.2	-7.2	3		-26.5	-26.5	3
Adjusted (Surplus) / Deficit		**0.0**	**0.0**	3		**0.0**	**0.0**	3

Appendix 2 – Balance Sheet

- Total current assets have decreased between Month 7 and 8 as a result of the timing of invoices with local partners (Better Care Fund) and a reduction in cash balances as a result of a November payment run.
- The liabilities decrease relates to a reduction in NHS creditors. The finance teams are continuing to clear down creditors prior to the creation of the ICB and future reductions are expected.

	2021/22 AP8 - NOV 21	2021/22 AP7 - OCT 21	2021/22 Month on month movement
Assets	£'000	£'000	£'000
Total Fixed Assets	1,258	1,307	(50)
Total Intangible Assets	76	80	(5)
Total Non Current Assets	1,333	1,388	(54)
Total Current Assets	6,958	14,510	(7,551)
Total Assets	8,292	15,897	(7,606)
Liabilities			
Total Non Current Liabilities	(907)	(907)	0
Total Current Liabilities	(491,568)	(508,365)	16,797
Total Liabilities	(492,476)	(509,272)	16,797
Total Assets Employed	(484,184)	(493,375)	9,191
Equity	£'000	£'000	£'000
Total Equity	484,184	493,375	(9,191)

North East London
Clinical Commissioning Group

NEL Governing Body meeting

26 January 2022

Title of report	NEL Quality update
Item number	6.3
Author	Chetan Vyas, Director of Quality Development, North East London CCG
Presented by	Diane Jones, Chief Nurse
Contact for further information	Chetan Vyas chetan.vyas1@nhs.net
Executive summary	The report informs the NEL CCG Governing Body of the Quality matters that were discussed at the NEL CCG Quality, Safety and Improvement Committee at the November meeting.
Action required	**Note** the contents of the report **Approve** the Terms of Reference
Where else has this paper been discussed?	Content from this paper has been discussed at the NEL CCG Quality, Safety and Improvement Committee.
Next steps/ onward reporting	To update the content of the report following feedback from the membership focussing on what improvements or steps to improvements have been made. The Committee: • Seeks to provide assurance of internal governance and quality standards where the CCG has responsibility for regulatory standards and statutory requirements • Has an oversight of quality across the NEL system and works to the benefit of NEL patients • Will oversee areas of assurance relating to patient experience.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Through the reporting of key quality metrics the ambition is to identify if there are any inequalities or areas of quality of services provided that need to be improved or drive improvement programmes of work, thereby seeking to reduce health inequalities.
Conflicts of interest	None known.
Strategic fit	To secure high quality services for our population and to put patient experience at the centre of our delivery.
Impact on finance, performance and quality	The report is focussed on improving the quality of services we commission.
Risks	The Committee will review and monitor system wide quality issues in accordance with and advise on risks and mitigations.

	The Committee is responsible for Quality and safety risks on the Governing Body Assurance Framework and agree any action for improvement.
Equality impact	This document relates to all NEL residents in the nine protected characteristics that are covered by the Equality Act 2010 and our Equality Duties.

1.0 Purpose

1.1 The purpose of this report is to update the Board on key Quality matters that were discussed at the North East London Clinical Commissioning Group (NEL CCG) Quality, Safety and Improvement (QSI) Committee on 10 November 2021. The December and January Committee meetings were stood down in line with the corporate request.

2.0 Introduction

2.1 The NEL CCG Quality, Safety and Improvement Committee met on 10 November 2021, with the following areas discussed and debated by the membership:

- National update and Quality functions across NEL ICS
- Primary Care Quality
- Annual Safeguarding Reports 2020/ 2021
- Individual Funding Requests policy harmonisation
- Evidence Based Interventions Programme
- Quality exceptions from the Integrated Care Partnerships
- Terms of Reference.

3.0 Update

3.1 National update

3.1.1 The Committee were presented with an update that outlined a number of documents that had been published that were making reference to Quality functions and how content from these publications were being used to shape NEL ICS discussions regarding Quality and Safety.

3.1.2 The Committee previously had sight of the draft list of Quality and Safety functions across and ICS and were updated how these were being used to shape co-creation conversations with ICS partners through the NEL System Quality Group.

3.1.3 Furthermore, they were informed of the due diligence work that had commenced as part of the NEL ICS Transition Programme to ensure there was an appropriated close down of CCG statutory functions relating to Quality.

3.1.4 An update on the Clinical and Care Leadership Professional Leadership work led by the NEL Director of Strategic Programmes was provided, which is scoping the priorities around what the Model needs to look like across the NEL ICS.

3.1.5 Officers committed to bringing a more detailed update to the January Committee meeting around the due diligence work and also the Quality Governance Framework across the NEL ICS and how that is shaping.

3.2 Primary Care Quality

3.2.1 As per the request of the Committee number of meetings ago, the NEL Senior Responsible Officer for Primary Care presented a very detailed slide deck that outlined

the NEL approach to primary care (General Practice) quality highlighting key activities across NEL and ICP level.

3.2.2 The Committee were informed that the NEL Primary Care Strategy has two overarching aims – High quality General Practice provision and Delivery of Integrated Care with primary care at the centre and this is driven through three main programme areas – Quality, New Models and Workforce.

3.2.3 Thirteen NEL priorities for Quality (subject to local system interpretation and priorities) were also shared as the below visual shows.

NEL priorities for Quality (subject to local system interpretation and priorities)	
1	MDT in every practice for stratified populations at risk of ill-health including: frail elderly; terminal care; housebound, people with multi-morbidities; people with learning and physical disabilities regardless of age.
2	Phlebotomy and pick up twice daily in every practice
3	Enhanced influenza campaign – 'protection for all'
4	Contract, appropriately scaled to meet need (e.g. for virtual ward rounds), with every care home to include, at least: primary care and community nursing; as part of wider system engagement and collaboration
5	Show improvement where ratio WTE GP : 1000 patients is below London average
6	Show improvement where ratio WTE nurse : 1000 patients is below London average
7	Show improvement where ratio WTE other patient facing staff : 1000 is below London average
8	Show improvement in patient experience metrics (GPPS data
9	Embed into practice's BAU systems peer to peer review of potential non-urgent referrals and the undertaking of regular case-based discussion
10	Health-checks for people with a learning disability and people with a severe mental illness
11	Covid-19 testing, tracking and tracing – primary care as part of response coordinated at Borough level
12	Practices continue to work with their PPG groups particularly when developing and evaluating new services (e.g. group consultations, response planning to covid-19 etc
13	Care planning with patients (to include increased use of CMC plans) held by patients and reviewed regularly by partners across health and care systems 24/7

3.2.4 Detailed NEL and ICP level data/ trends in the following areas were discussed and debated with the Committee:

- GP survey results
- Access
- Referral rates
- 111 calls
- Urgent Treatment Centre usage
- Practice staffing per 1000 patients
- Antibiotic prescribing rates
- Practice Care Quality Commission ratings.

3.2.5 The Committee through the presentation how the NEL and ICP Primary Care Teams are seeking to use data and trends from the afore mentioned areas and other work to:

- Reduce the quality variation in primary care across NEL
- Reduce unwarranted inequalities in health outcomes
- Drive an improvement culture through Primary Care (specifically General Practice)
- Support Practices to work more efficiently
- Support Primary Care Networks to lead the development of quality improvement plans and drive improvement and innovation in their respective geographies.

3.2.6 The members felt a good data driven deep dive discussion was held and requested that a regular Primary Care Quality report now forms part of the standard agenda for this meeting going forward which was agreed by the Chair with the Chair of the NEL Primary Care Commissioning Committee (who was invited for the discussion).

3.3 Annual Safeguarding Reports

3.3.1 The Annual Children's, Children Looked After and Adults Safeguarding reports for 2020/ 2021 informed the NEL QSI Committee of how the safeguarding agendas, priorities and programmes of work progressed across the respective Integrated Care Partnership areas, and were presented seeking approval.

3.3.2 The reports outline how safeguarding statutory duties were discharged in collaboration with local children's safeguarding partnerships and Safeguarding Adults Boards, to promote the welfare of adults, children and children looked after in accordance with legislation.

3.3.3 Furthermore, the reports show how all the designated professionals across NEL drove meaningful improvements in the safeguarding space through learning reviews, rapid reviews, serious case reviews , domestic homicide review and child safeguarding practice reviews and safeguarding adults reviews.

3.3.4 The Committee recognised the fantastic work undertaken by all the Designated Professionals, particularly during the Pandemic period and approved all reports.

3.3.5 The reports will now be presented to the NEL CCG Board meeting seeking approval which is a statutory requirement.

3.4 Individual Funding Requests harmonisation

3.4.1 The Committee were informed that the Individual Funding Requests (IFR) policies relating to predecessor CCGs have been harmonised into one NEL CCG IFR Policy top reflect the establishment of NEL CCG and developments/ improvements to the IFR process.

3.4.2 The specific changes were as follows:

- New IFR panel arrangements and Terms of Reference
- Requirement for online applications as agreed through the Once for London IFR proposal
- Triage decisions no longer needing individual CCG approval (agreed previously as part of the Once for London IFR proposal)
- Financial limit for IFR panels of £50k per year.

3.4.3 The Committee approved the new IFR policy, process and Terms of Reference.

3.5 Evidence Based Interventions Programme

3.5.1 During 2018/19, the former Clinical Commissioning Groups (CCGs) within North East London (Barking & Dagenham, Havering, Redbridge, Waltham Forest, Tower Hamlets,

Newham and City & Hackney) aligned the 2 Procedures of Limited Clinical Effectiveness Policies (POLCE) and incorporated the recommendations from the London Choosing Wisely Programme and the National Evidence Based Interventions Wave 1 Programme.

3.5.2 Following a national consultation exercise in the summer of 2020, a new set of recommendations for 31 new interventions was published by the Academy of Medical Royal Colleges in November 2021.

3.5.3 The stated aim of the Evidence-based Interventions programme is to reduce the number of inappropriate interventions carried out by clinicians in the healthcare system and to improve the quality of care patients receive.

3.5.4 In line with the previous changes a Quality, Equality and Health Inequality Impact assessment for North East London. As a national Equality and Health Inequality impact assessment has been carried out and these interventions have since been incorporated into the new 2021/22 National NHS Contract. The national equality impact assessment carried out by the NHS England/Improvement Expert Advisory Committee and AoRMC (Academy of Medical Royal Colleges) see: https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/EBI_2_Equalities_Health_Impact_Assessment_0320.pdf

3.5.5 The focus of the NEL Quality, Equality and Health Inequality Impact Assessment therefore is in the minor variation from the national position which were made by the Clinical Reference Group. The variations are:

- **Knee MRI should not be routinely used to initially investigate suspected meniscal tears in primary care (policy ref: 2U; table 2B)** – variation from this is due to the fact that an intermediate service cannot yet provide this service, a project meeting has been scheduled to address this and it is planned that this change will be implemented in the future. Therefore GPs will continue to make this diagnosis and intermediate care services should educate GPs as part of the pathway. This will mean a continuation of the current referral pathway and not change to this at this point. As such there is no Equality or Quality impact, future plans to implement this are covered in the national impact assessment

- **Imaging for shoulder pain should be offered under the guidance of shoulder specialists where possible (Policy Ref: 2W(i)(ii); Table: 2B)** - Ultrasound is a good imaging modality for rotator cuff pathology especially in primary care, however primary care currently see a lot of shoulder pathology and have been able to manage mostly without imaging and the level of imaging has not been an identified issue in NEL, therefore there are no plans to change the current pathway. There will be continued monitoring to ensure that there is the appropriate use of Ultrasounds and any outliers to this are identified. The monitoring of this is being built into the monitoring system for the implementation of the EBI requirements

- **Adenoids in children with Glue Ear (policy ref: 2D; table 2A)** The final variation is in relation to adenoids in children with Glue ear, the Clinical Review Group decided not to adopt the recommendation while it seeks more information from the national programme. Local ENT consultants did not agree with the guideline and felt the evidence presented by AOMRC was out of date. This has therefore been escalated for national review. Therefore there will be no change in services at this point in this area until best practice is agreed.

3.5.6 The Committee formally approved the recommendations.

3.6 Quality Exceptions from Integrated Care Partnerships

3.6.1 The Committee also heard from Integrated Care Partnership leads for Quality on key exceptions as follows:

City and Hackney

3.6.2 Care Home vaccination rates were positive with the London Borough of Hackney confident that services would be safe with a handful of staff not fully vaccinated. The mitigation in place is that agency staff would be drafted in when needed.

3.6.3 Recent patient experience surveys/ scores remain good in the patch with Emergency Department and Inpatient national surveys showing as positive showing improvement.

Barking and Dagenham, Havering and Redbridge

3.6.4 The Committee were informed that following a number of Serious Incidents relating to patient safety and allegations of abuse, North East London Foundation Trust called an urgent Quality Summit that resulted in an Acute and Rehabilitation Directorate Sunflowers Court Improvement Plan. BHR ICP colleagues attend the internal meetings where updates are provided and are expecting a fuller update to come to the December BHR System Quality and Performance Oversight Group.

3.6.5 As part of the Host Commissioner arrangements for Learning Disabilities/ Autism inpatient services, BHR ICP were informed of concerns relating to non-reported safeguarding concerns and lack of escalation. The issues have been raised with the NEL Integrated Care Director with plans agreed locally to address.

Tower Hamlets, Newham and Waltham Forest

3.6.6 As part of an ongoing complex abuse investigation in Waltham Forest, the Committee were informed that and integrated approach between TNW ICP Safeguarding Professionals, Waltham Forest Integrated Commissioner, NELFT, the NEL CCG Finance and Contracting Team a health offer was commissioned at pace to ensure a trauma informed service was in place until the end of March 2022 with a review to be undertaken in February.

3.6.7 Barts Health reported two Never Events and one Serious Incident relating to maternity services. The Trust has undertaken an action learning review and re-looking at some processes across their sites.

3.6.8 Finally, Queen's Hospital (BHRUT) and Newham Hospital (Barts Health) have recently received unannounced Care Quality Commission visits to maternity services. BHRUT maternity has been downgraded from good to requires improvement and the Trust have been invited to join the Maternity Services Improvement Programme led by NHSE/I. As Newham was a focussed inspection, there was no re-rating and it remains requires improvement. East London Foundation Trust have also been the subject of a CQC inspection and we await further information.

4.0 Terms of Reference

4.1 The Terms of the Reference have been finalised and are presented to the NEL CCG Board and the final version (as appended).

Addition post meeting

5.0 North East London Fertility Policy

5.1 North East London CCG has inherited five Fertility Policies from its predecessor CCGs.

City and Hackney, Tower Hamlets, Newham and Waltham Forest each have a policy, last reviewed in 2014/2015. Barking & Dagenham, Havering and Redbridge have one single policy which was last reviewed in 2017. There are a number of differences between the policies including variation in the age thresholds and numbers of cycles and embryo transfers that are funded.

5.2 In preparation for a north east London wide ICS, we need to harmonise these policies into a single policy for all our patients seeking fertility treatment.
We want to have an equitable and consistent approach to access that reflects the latest clinical practice and research but also takes into account the changing views and attitudes in society. North East London's new fertility policy will need to address a broader range of questions and issues than previously considered.

5.3 The CCG has therefore launched a project to develop a single policy in north east London, this project will include:

- An independent review of the existing policies against the latest guidance and best practice.
- Consideration of a set of options and the impact of implementing them on patient outcomes, service capacity and expenditure.
- Engagement with stakeholders including public health, fertility specialists and service users throughout the process of policy development.

5.4 We expect the policy to be finalised in the Summer of 2022.

Author of report:
Chetan Vyas. Director of Quality Development
North East London Clinical Commissioning Group

NEL CCG – Quality, Safety and Improvement Committee

Terms of Reference

Version – 1.3 Final

NEL Quality, Safety and Improvement Committee

Terms of Reference – May 2021

1. Authority

1.1. These terms of reference are applicable to the NHS North East London CCG ("the CCG") Quality, Safety and Improvement Committee ("the Committee").

1.2. The Committee is constituted as a committee of the CCG's Governing Body. The Committee is established in accordance with the CCG Constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit and responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG's Constitution and Standing Orders.

1.3. The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any Member, officer, employee or agent/consultant who is directed to co-operate with any request made by the Committee.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5. The Committee is authorised to instruct professional advisors and to request the attendance of such advisors and other individuals from outside of the CCG with relevant expertise, where it considers this necessary for or expedient to the exercise of its functions.

1.6. The Committee will undertake 'deep dives' into specific issues that will enable the Committee to gain a greater level of understanding and assurance into specific issues that fall within its remit.

1.7. These terms of reference and the composition of the Committee will, at a minimum, accord with any published national guidance.

2. Purpose of the Committee

2.1 The Quality, Safety and Improvement Committee is a subcommittee of the Governing Body and will examine and report on the quality of clinical services across NEL.

2.2 The Committee will cover:

a) assurance of internal governance and quality standards where the CCG has responsibility for regulatory standards and statutory requirements,

b) an oversight of quality across the NEL system.

2.3 For a) The Committee will be responsible for:

- Oversight of any system wide quality and safety objectives.
- Quality and safety risks on the Board Assurance Framework and agree any action for improvement.
- Receive updates on changes to national policy and gain assurance that these have been appropriately adopted by the relevant organisation within the system.
- Receive performance data on services and review trend and themes data and to seek assurance on actions when there is an impact on quality.
- Oversee the delivery against safeguarding, infection control, complaints and approve CCG statutory reports relating to these.
- Reviewing relevant audit reports and monitor or act on recommendations.
- Receive exception reports from sub committees of the Quality Committee.

2.4 For b) The Committee will be responsible for:

- having oversight of wider ICS Improvement and Transformation plans/ programmes that propose to improve quality of services/ pathways and patient experience and reduce health inequalities across NEL.
- Appropriate assurance and governance in place for system assurance.
- Having a collective view of risks to quality through sharing relevant information, data and intelligence to understand emerging concerns and risks across providers and the system.
- Identifying themes and trends across the system.
- Overseeing the patient experience agenda through complaints status, surveys, etc.
- Ensuring the patient voice is heard across all quality, safety and improvement matters and that patient involvement is the norm in all quality improvement work.

- Reviewing the quality impact assessment process during procurements and contract agreements and when reviewing any business cases.

- Reviewing relevant audit reports and monitor or act on recommendations.

- Approve quality account statements for providers.

- Having an oversight of the quality of primary care (specifically General Practice) and understanding how primary care improvement programmes are driving up the quality of primary care (General Practice).

3. Membership

3.1 The Committee shall be appointed by the Governing Body as set out in the CCG's Constitution.

3.2 The Independent Nurse on the Governing Body, will chair the Committee and must have qualifications, expertise or experience such as to enable the person to express informed views about quality matters.

3.3 There will be other members on the Committee, namely:

- Lay member for Patient and Public Involvement
- The Independent Secondary Care Clinician (Vice Chair)
- Healthwatch/Patient representative
- ICS Chief Nurse
- ICS Director of Performance
- LMS maternity lead
- AHP rep
- Primary care rep
- Local ICP quality leads

Attendees:

- Deputy Director Heads of Continuing Healthcare; Leads for risk; patient experience and other specialists as dictated by agenda topics.

4. Attendance and Quorum

4.1 In addition to the Committee members, the Deputy Director of Continuing Healthcare, and Leads for patient experience and any other relevant parties where appropriate shall generally attend routine meetings of the Committee.

4.2 The ICS Chief Nurse will act as the lead director for the Committee.

4.3 A representative of the Finance team may also be invited to attend meetings of the Committee when the committee is reviewing the quality impact assessment process during procurements and contract agreements and when reviewing any business cases.

4.4 CCG senior employees shall be invited to attend those meetings in which the Committee will consider areas of operation that are their responsibility.

4.5 The Chair of the Governing Body and the Accountable Officer may be invited to attend meetings of the Committee as required.

4.6 The Committee may request the ad-hoc attendance of others to advise it on specific matters within its terms of reference from time to time as appropriate. Where such assistance is sought, any such individual will participate in discussion as an attendee and not a member.

4.7 A quorum shall be five members of which one must be an independent clinician and one an Executive Officer.

5. Frequency of Meetings

5.1 Meetings shall be held at least six times a year with additional meetings where necessary.

5.2 Arrangements for calling meetings will be in writing to the Chair of the Committee with a minimum of ten days' notice.

6. Sub-Committees

6.1 The following are sub-committees of the Committee:

- ICP quality and safety groups/committees for each ICP area
- Safeguarding Committee
- Infection Prevention and Control Groups
- NEL Local Maternity System (LMS)
- Medicines Optimisation Group

7. Administrative Support

7.1 The Director of Corporate Affairs will ensure the provision of suitable administrative support to the Committee and their role will include but not be limited to:

- Collation of all Committee papers and their circulation in a timely manner;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward and issuing draft minutes to the chair of the Committee in a timely manner;
- Advising the Committee as appropriate on best practice, national guidance and other relevant documents.

7.2 The nominated governance manager will be responsible for supporting the chair in forward planning, agenda-setting, follow up of actions and circulation of minutes.

8. Accountability and Reporting Arrangements

8.1 The Committee shall be directly accountable to the Governing Body.

8.2 A summary annual report from the Committee shall be formally submitted, together with recommendations where appropriate, to the Governing Body. The submission to the Governing Body shall include details of work undertaken and any matters in respect of which actions or improvements are needed.

8.3 The approved minutes or a report of each Committee meeting will also be provided to the Governing Body.

9. Conduct of the Committee

9.1 At the beginning of each meeting of the Committee, the chair will ask members whether they have any interests to declare, in accordance with the CCG's Gifts, Hospitality and Declarations of Interests Policy.

9.2 If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the CCG's Conflicts of Interests Policy and Procedure. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

9.3 Decisions can be agreed if the meeting is quorate and will be by a majority of members and, if necessary, by voting at the meeting. If a vote is tied, the chair will have the casting vote.

9.4 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

9.5 Committee papers will be stored and archived.

9.6 When there is an urgent matter where a decision is required outside of the meeting, the chair may make a decision after conferring with at least one other member ("chair's action"). When chair's action has been taken then it must be ratified by the next quorate meeting of the Committee. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

9.7 The Committee will apply best practice in its deliberations and in the decision making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

9.8 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1 The Committee will carry out an annual review of its functioning and provide an annual report to the Governing Body on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference.

10.2 As part of its annual review, the Committee will also consider any specific training or development requirements that Committee members may have and inform the Governing Body of these.

11. Review of Terms of Reference

11.1 The terms of reference of the Committee shall be reviewed by the Governing Body at least annually.

Version Control:

Version: 1.3

Review frequency: Annual
Document Owner: Director of Corporate Affairs

North East London
Clinical Commissioning Group

NEL Governing Body meeting

26 January 2022

Title of report	Annual Safeguarding Reports 2020/ 2021
Item number	6.4
Author	**Reports by:** • Designated Nurses/ Professionals for Adults, Children and Children Looked After, • Designated Doctors for Safeguarding Children, • Named GPs for Safeguarding Adults and Children, • Across north east London • Jessica Juon, previous Head of Safeguarding, TNW **Cover sheet by:** • Chetan Vyas, Director of Quality and Safety, NEL CCG
Presented by	Diane Jones, Chief Nurse
Contact for further information	diane.jones11@nhs.net
Executive summary	The respective Adults, Children's and Children Looked After Annual Safeguarding reports for 2020/ 2021 informs the governing body of how the safeguarding agendas, priorities and programmes of work progressed across the respective three integrated care partnership areas. The reports outline how safeguarding statutory duties were discharged in collaboration with local children's safeguarding partnerships and Safeguarding Adults Boards, to promote the welfare of adults, children and children looked after in accordance with legislation. Furthermore, the reports show how all the designated professionals across NEL drove meaningful improvements in the safeguarding space through learning reviews, rapid reviews, serious case reviews , domestic homicide review and child safeguarding practice reviews and safeguarding adults reviews
Action required	Approve.
Where else has this paper been discussed?	• NEL CCG Quality, Safety and Improvement Committee • City and Hackney Integrated Care Partnership • City and Hackney Extraordinary Safeguarding Assurance Group meeting • TNW Quality, Safety and Improvement Committee • BHR ICP Quality and Performance Oversight Group
Next steps/ onward reporting	N/A

What does this mean for local people? **How does this drive change and reduce health inequalities?**	The issues covered in these reports are related to, and most acutely to people at risk of harm across NEL. The scrutiny of the key safeguarding and learning that has been drawn from the system impacts the priorities for 2021/ 2022, and the ambition is that these will drive improvements for local people.
Conflicts of interest	None known.
Strategic fit	• High quality services for patients • Put patient experience at the centre of our delivery • Ensure the best use of resources • Recover from the pandemic and be prepared for future waves
Impact on finance, performance and quality	To improve the safety of health services across north east London
Risks	These are noted in the annual reports themselves.
Equality impact	The issues covered in these reports are related to, and most acutely to people at risk of harm across NEL. The scrutiny of the key safeguarding and learning that has been drawn from the system impacts the priorities for 2021/ 2022, and the ambition is that these will drive improvements for the local people.

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

BHR SAFEGUARDING ADULTS ANNUAL REPORT 2020 - 2021

INDEX

1. Executive Summary

Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) commissions health services from organisations that provide health services. In London Boroughs of Barking & Dagenham, Havering and Redbridge most healthcare is provided by General Practitioners (GP's) and NHS trusts, but other organisations from the voluntary and private sectors also have contracts to provide some services.

Clinical Commissioning Groups (CCGs) have a duty to take measures to safeguard patients who are unable to protect themselves from abuse and neglect in their commissioned services and across the local health economy. This includes working within a multi-agency framework to take measures to reduce the risk of neglect and abuse and responding where abuse has occurred or is suspected of occurring. CCGs also have duties to take additional measures in establishing effective structures for safeguarding within their organisation. This includes the development of a clear strategy, robust governance arrangements and leadership.

The purpose of this report is to:

- Assure the Governing Body that there are robust and effective adult safeguarding processes in place which reflect national legislation and statutory guidance and demonstrate the organisation's commitment to embedding adult safeguarding.
- Demonstrate how the health contribution to safeguarding and promoting the welfare of adults is discharged across the London Boroughs of Barking & Dagenham, Havering and Redbridge health economies through our commissioning arrangements.
- Inform the Governing Body of the progress made on the key priorities of the year and identify the main issues, risks, and key priorities relating to safeguarding adults at risk within the boroughs of Barking & Dagenham, Havering and Redbridge for the year pending.
- Provide information about national changes which influence, local developments and activity, including safeguarding inspections.

2. Key National changes during year 2020/21

At the end of the March 2020, the World Health Organisation (WHO) declared a global pandemic. The Department of Health in the UK response included a number of easements to UK Legislation and Guidance relating to Safeguarding. The 'Coronavirus Act' came into effect on 25th March 2020 and is intended to remain in force until the end of the Coronavirus Pandemic.

The Coronavirus Act 2020[1] introduced easements to the Care Act 2014[2] in England to enable local authorities to prioritise the services they offer to ensure the most urgent and serious care needs are met, even if this meant not meeting everyone's assessed needs in full or by delaying some assessments. Some non-essential services to meet assessed need had to be reduced or stopped. These predicted service gaps opened up opportunities for exploitation or abuse.

Unlike the Care Act, the Mental Capacity Act (MCA) and the related Deprivation of Liberty Safeguards (DoLS) have not been altered by the emergency Coronavirus Act which went through Parliament in the week beginning 23 March 2020. However, the Government has released supplementary guidance on looking after people who lack mental capacity[3] and the Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus

[1] https://www.legislation.gov.uk/ukpga/2020/7/contents/enacted
[2] https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities

[3] https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity

(COVID-19) pandemic[4] but this guidance is only valid during the COVID-19 pandemic and applies to those caring for adults who lack the relevant mental capacity to consent to their care and treatment. The guidance applies until withdrawn by the Department of Health and Social Care. During the pandemic, the principles of the MCA and the safeguards provided by DoLS still apply.

It is evident that COVID-19 has been a particular threat in care homes, where older people and people with complex health conditions, living in close proximity, are at additional risk. If a person lacks the capacity to decide on their own living arrangements, a best-interests decision need to be made. There has been a significant amount of work undertaken nationally and locally to support staff and protect care home residents and those in supported living.

The Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019[5]. LPS is intended provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements, in England and Wales. Originally it was intended that these would come into force during this financial year but due to the pandemic and other national priorities, it is now intended that full implementation of LPS will occur by April 2022 with some provisions, covering new roles and training, coming into force ahead of that date.

3. BHR CCGs Key Safeguarding Adult priorities and Achievements in 2020/21

In response to the Covid-19 pandemic in March 2020, Safeguarding was identified as a business priority area and the Quality and Safeguarding team at BHR CCGs provided Safeguarding support locally and obtained assurance from local Health providers of their Covid-19 business continuity plans in respect of Safeguarding. The impact of Covid-19 has highlighted vulnerabilities nationally and the themes and learning identified will be a key priority in the coming year.

As the number of coronavirus cases rose rapidly across the country this year, a second national lockdown was introduced on 31st October 2020. Safeguarding adults with care and support needs from abuse and neglect remained a priority. Cohorts of the population were deemed to be more vulnerable to abuse and neglect, as others sought to exploit disadvantages due to age, disability, mental or physical impairment or illness.

Despite the additional pressures on the NHS and Social Care, the tri-borough Safeguarding Adult Boards (SAB's) have continued to comply with legal requirements and followed the advice provided within in the 'The Coronavirus Act 2020'.

BHR CCGs advised Safeguarding teams and the majority of staff to 'work from home' whilst continuing to fulfil Safeguarding requirements. BHR CCGs provided updates to commissioned agencies on the implications of rapidly changing regulations and how to prepare for emerging threats.

Appointment of 2 WTE additional Designated Nurses Adult Safeguarding in November 2020 has significantly improved the staffing resources for Adult Safeguarding across the tri-borough partnership and has enabled closer working with partner agencies and care home providers.

Progress against BHR CCGs Safeguarding Adult Priorities and Key Achievements in 2020/2021 are detailed in section 15 of this document.

[4] https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic

[5] https://www.legislation.gov.uk/ukpga/2019/18/enacted

4. BHR CCGs key Safeguarding Adult team priorities for 2021-2022

- Ensure robust pathways and collaboration between statutory and other provider services.
- Continue to ensure BHR CCGs staff are compliant with safeguarding adults and Prevent training in accordance with the "Adult Safeguarding: Roles and Competencies for Health Care Staff 2018" and that all Continuing Heath Care staff are trained in:
    - ✓ Safeguarding Adult Level 3.
    - ✓ Mental Capacity and Deprivation of Liberty Safeguards
    - ✓ Liberty Protection Safeguards.
- Develop a robust monitoring system for Care Homes with Nursing and ensure that the Local Quality Surveillance Group oversees the quality monitoring of care homes with nursing in 2021/22.
- Ensure that BHR CCGs and provider organisations are resourced, trained and prepared for LPS implementation in April 2022.
- Support for GP practices and the primary care sector in all activities relating to adult safeguarding.
- Review development against the national Safeguarding Adults at Risk Audit Tool
- LeDeR review process to be seemless at the time of transition from Bristol database to the new web-based platform in June 2021, reviews progressed and lessons learned and shared with partner agencies.
- Monitor and support the implementation of recommendations from Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs).
- The impact of Covid-19 has highlighted vulnerabilities nationally and the themes and learning identified will be a key priority.

5. Safeguarding Adult Framework

This annual report is also set within the context of safeguarding responsibilities as defined by the Care Act 2014 which sets out how partner agencies should work together to keep adults at risk of harm, safe from abuse and the governance underpinning adult safeguarding. The Care Act directs organisations to make appropriate enquiries if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom.

The Care Act 2014 sets out a clear legal framework for how the local system should protect adults at risk of abuse or neglect. Section 3 of the Act sets out statutory responsibility for the local authority to integrate care and support between health, local authority and other partners to promote the wellbeing of adults with care and support needs or of carers in its area.

Key legislation relating to Safeguarding Adults includes:

- The Care Act 2014
- Mental Capacity Act 2005
- Human Rights Act 1998
- Modern Slavery Act 2015
- Counter-Terrorism and Security Act 2015
- Mental Health Act 1983

6. Working with Statutory partners

Under Section 43 of the Act each local authority must have a Safeguarding Adult Board (SAB) with an Independent Chair. The CCGs are statutory members of the safeguarding adult board.

LB Barking & Dagenham, Havering and Redbridge Safeguarding Adults Boards (SABs) are the multi-agency statutory partnerships responsible for safeguarding adults at risk across the tri-borough partnership. As statutory partners BHR CCGs work closely with all key stakeholders to

identify where safeguarding practice can be strengthened and outcomes improved. The SAB act as the key mechanism for agreeing how agencies will work together effectively to safeguard and promote the safety and well-being of adults at risk within the local population. During this reporting year, BHR CCGs have pro-actively contributed to and supported the work of the three SABs by providing oversight, from a Health perspective, through our statutory member status.

7. Primary Care

As part of BHR CCGs delegated commissioning responsibilities, it is responsible for supporting and ensuring that the GP services have effective adult safeguarding arrangements and that they are compliant with the Mental Capacity Act 2005 and Care Act 2014.

Designated Nurses Adult Safeguarding contribute to CPD approved GP PTI training to cover a range of topics relating to adult safeguarding in order to support GP knowledge and skills.

8. Care Homes with Nursing

The Local Quality Surveillance Group (LQSG) is chaired by the Designated Nurse for Adult Safeguarding Team and continues to monitor quality and assurance and safeguarding issues in Care Homes with Nursing across the three boroughs.

The CQC is represented at this meeting and regular updates provided about providers concerns. Healthwatch members are also represented at these meetings,

Updates on Care Homes with Nursing are provided in Safeguarding Adult reports and details of specific homes where there are concerns or where restrictions imposed are reported in the monthly CCGs Integrated Safeguarding Assurance Board (ISAB).

9. Safeguarding Training Compliance 2020 – 2021

The 'Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document' was published by the Royal College of Nursing in August 2018. The document is designed to be used in all healthcare organisations and provides a point of reference to help identify and develop the knowledge, skills and competence in safeguarding of the health care workforce.

The CCG has adopted this framework and monitors compliance with training requirements within commissioned services.

BHR CCGs has set health care providers a target of achieving 90% compliance with all Safeguarding Adults training.

Safeguarding Adult training is mandatory for all BHR CCGs staff; the training delivered is face to face and online and is tailored for a commissioning organisation.

Table 1: Barking and Dagenham CCG*:

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SA Level 1	100%	86%	82%	86%
Prevent level 1	100%	78%	78%	86%

Table 2: Havering CCG*:

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SA Level 1	85%	82%	84%	92%
Prevent level 1	69%	69%	72%	84%

Table 3: Redbridge CCG*:

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SA Level 1	86%	93%	86%	94%
Prevent level 1	87%	84%	80%	94%

The safeguarding training compliance for CCG commissioned health care providers of Barking & Dagenham, Havering and Redbridge Adult services from April 2020 – March 2021 is shown in Table 4 - 6.

Table 4: Barking & Dagenham, Havering and Redbridge University Trust:

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SA Level 1	98%	100%	99%	99%
SA Level 2	95%	95%	95%	98%
SA Level 3	93%	93%	85%	100%
MCA & DoLS	96%	86%	88%	99%
Prevent level 1	97%	97%	98%	97%

Table 5: North East London Foundation Trust:

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SA Level A	97%	97%	95%	96%
SA Level B	96%	97%	93%	92%
MCA & DoLS	97%	96%	93%	93%
Prevent level 1	99%	99%	97%	97%
Prevent level 2	98%	98%	97%	90%

Table 6: The Partnership of East London Cooperatives (PELC)*:

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SA level 1	85%	86%	86%	92%
SA level 2	70%	78%	87%	88%
SA level 3	48%	65%	88%	92%
Prevent level 1 & 2	62%	78%	92%	93%

*** MCA and DoLs training is embedded within safeguarding adults training.**

Assurance on compliance with mandatory training requirements is provided in Safeguarding Adult reports which are submitted to at the monthly BHR CCGs ISAB meeting.

10. Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)

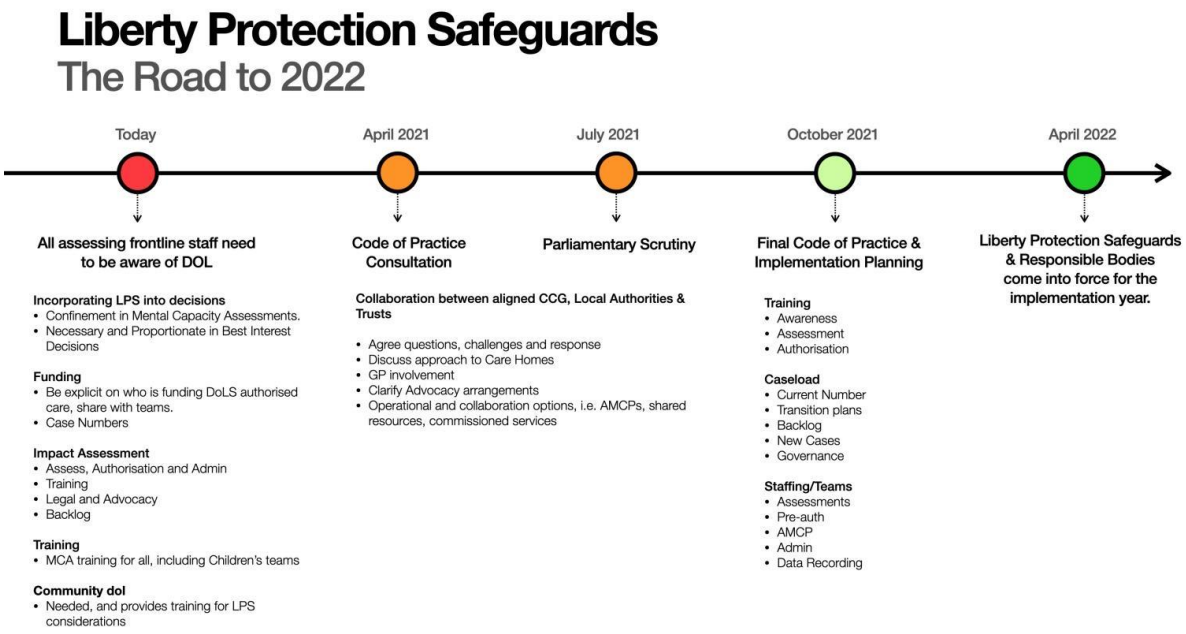
The Mental Capacity Act is a vital piece of legislation to protect patients' human rights. The Act seeks to ensure that any decision made, or action taken, on behalf of someone who lacks capacity to make a decision or act for themselves is made in their best interests and is the least restrictive option. The Act provides a legal framework for health and social care professionals to safeguard a person when they lack capacity to make a specific decision.

BHR CCGs hold responsibility for seeking assurance that the Act is central to the work of each health care provider organisation that it commissions.

In order to meet BHR CCG's responsibilities there are assurance processes to monitor that all health care providers have a named lead professional for MCA, there are up to date policies and procedures in place, and MCA/DoLS is a mandatory training requirement for relevant staff.

Planned milestones for implementation of LPS:

The government has committed to bringing LPS into force to replace the DoLS. It is paramount that implementation of LPS is successful so that the new system provides the safeguards required. It is intended that full implementation of LPS will occur by April 2022 with some provisions, covering new roles and training, coming into force ahead of that date.



Once the Liberty Protection Safeguards come into force, there will still be people who have authorisations in place under the current Deprivation of Liberty Safeguards system and transitional arrangements are being developed, but it is expected that such people will remain under their existing authorisation until it expires. LPS initially will be authorised for a year and can then be authorised for 3 years, where appropriate.

The tri-borough LPS Task and Finish Group have undertaken an assessment of the potential impact that this will have across the boroughs of LBBD, LB Havering and LB Redbridge.

The Continuing Health Care (CHC) Team facilitated a Joint Task-and-Finish group on LPS to consider the workforce & financial implications for the CCG CHC Team last year.

BHR CCGs LPS Action Plan was submitted to the Board in early March 2020 to highlight actions that needed to be progressed. Allocations have been reviewed and discussed at the Integrated Safeguarding Assurance Board (ISAB) meetings and actions to be carried forward to 2021/22 have been agreed.

CHC team have scoped the requirements for potential AMPCs (Approved Mental Capacity Professionals) and a dedicated LPS administrative role to manage database and case records requirements for their team to support the implementation of LPS.

11. Safeguarding Adult Reviews (SARs)

A Safeguarding Adult Review (SAR) is a statutory multi-agency revie w process under the Care Act 2014 which is undertaken when someone has died or suffered serious harm as a result of abuse or neglect and there is reasonable cause for concern that partner agencies or other persons with relevant functions, could have worked together more effectively to safeguard the adult.

The review looks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is to promote effective learning and improvement action to prevent future deaths or serious harm

occurring again. A SAR is completely separate from any investigation being undertaken by the police or coroner.

On conclusion of a SAR, an action plan is drawn up to ensure that the recommendations of the findings are implemented and monitored by the SAB. The CCGs have complied with requests from Safeguarding Adult Boards for contributions to multi-agency actions plans and updates across the three boroughs.

During 2020/21, the Designated Nurses Adult Safeguarding have worked with our statutory partners to contribute to 5 SARs across the tri-borough partnership.

Borough	Number of SARs	Recommendations for CCG / all partners	Action taken by Safeguarding Team
Barking & Dagenham	2	Importance of ensuring robust mental capacity assessments for patients / clients and including them in their documentation.	Designated Nurse Adult Safeguarding continue to emphasis the need for Mental Capacity assessments whenever training is delivered.
Havering	1	This case was reviewed and referred back to LB Enfield for full SAR review but LB Havering had some local recommendations for the CCG which were followed up.	*A letter summarising the SAR findings and recommendations was sent to all GP Practice across the tri-borough partnership from BHR CCGs in September 2020'.*
Redbridge	2	Recommendations from one of the reviews particularly relate to the need for a handover of care when adolescents transfer to adult services. Review arrangements in place locally to enable GP and primary care professionals to have access to dietician or wellbeing whilst they await diagnostic tests or treatment for gastroenterological issues. Review help available locally to proactively support those with co-morbidity conditions to navigate the complex health and care systems, to assist with engagement and reduce the likelihood of self-neglect or organisational disconnect.	These are recent recommendations and these will be followed up and progress reported at monthly BHR CCGs ISAB meetings.

Updates on open SARs are provided in Safeguarding Adult reports which are submitted to the monthly BHR CCGs Integrated Safeguarding Assurance Board (ISAB).

12. Domestic Abuse and Domestic Homicide Reviews

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. This definition includes

violence such as female genital mutilation (FGM), so-called 'honour' crimes, forced marriage, and acts of gender-based violence. Domestic abuse happens across all communities, faiths and cultures.

The CCG is committed to improving the health and wellbeing of their communities and staff and recognise that domestic abuse is a crime, which is an abuse of human rights, is a major public health problem and has severe health consequences for individuals, families and communities.

The CCG recognises the devastating impact of domestic abuse on the physical and emotional health of those exposed to domestic abuse, the majority of whom are women and children. The organisations are therefore committed to ensuring that domestic abuse is recognised and that both patients and staff are provided with information and support to minimise risk.

The Violence Against Women & Girls (VAWG), Domestic Abuse (DA) and Hate Crime team (HC) work developing a community response to prevent domestic abuse and hate crime, protect and support victims and bring offenders to justice.

The Designated Nurses Adult Safeguarding attend the LBBD Domestic Abuse Forum meetings.

The Designated Nurses Adult Safeguarding are responsible for following up specific recommendations for statutory Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) which relate to BHR CCGs.

The Quality & Safeguarding Team have updated their Domestic Abuse Policy which provides advice and guidance for managers of staff members who are victims of Domestic Abuse. and this is due to be presented to the Quality and Performance Committee in March 2021 for ratification.

Domestic Homicide Reviews (DHRs)

Community Safety Partnerships are responsible for undertaking domestic homicide reviews where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a relative, household member or someone he or she has been in an intimate relationship with. A DHR is held with a view to identifying the lessons to be learnt from the death.

The Designated Nurses Adult Safeguarding formed part of the panel meetings for four DHRs commissioned across LB Barking & Dagenham, Havering and Redbridge during this reporting period. The Designated Nurse Adult Safeguarding also provided support to the GP practices involved in these cases. The BHR CCGs Safeguarding Adults team will continue to form part of the safeguarding statutory reviews undertaken across the borough.

During 2020/21, the Designated Nurses Adult Safeguarding have worked with our statutory partners to contribute to 5 DHRs across the tri-borough partnership. There are currently 3 DHR awaiting approval from the Home Office and 2 were approved and published between September and January 2021. Of the 5 DHRs:

Borough	Number of DHRs	Recommendations for CCG / all partners	Action taken by Safeguarding Team
Barking & Dagenham	1	Identify how people in the LB of Barking and Dagenham gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.	BHR CCGs Safeguarding team have recently updated their Domestic Abuse Policy for staff and this is currently pending sign off by the Quality Performance Committee.

Havering	2	One of the recommendations from one of these reviews include the need for further domestic abuse training and awareness for staff in a number of organisations.	BHR CCGs Safeguarding team have recently updated their Domestic Abuse Policy which is currently pending sign off by the Quality Performance Committee.
Redbridge	2	Both the DHRs undertaken by LB Redbridge Comminity Safety Partnership areof approval are in the final stages of completion. Both related to Domestic Abuse and homicide and recommended training or awareness raising to ensure a greater knowledge and understanding of domestic abuse processes and/or services for agencies involved.	BHR CCGs Safeguarding team have facilitated training for GPs across the tri-Borough Partnership and updated the Domestic Abuse Policy which is currently pending sign off by the Quality Performance Committee.

Updates on DHRs which are currently being reviewed are provided in Safeguarding Adult reports which are submitted to the monthly BHR CCGs ISAB.

13. Prevent

The Government's counter-terrorism strategy is known as CONTEST. Prevent is part of the strategy and its aim is to stop people becoming terrorists or supporting terrorism.The 4 key principles of CONTEST are:

- **Pursue**: to stop terrorist attacks
- **Prevent:** to stop people becoming terrorists or supporting terrorism
- **Protect:** to strengthen our protection against a terrorist attack
- **Prepare**: to mitigate the impact of a terrorist attack.

The Revised Prevent duty guidance: for England and Wales statutory guidance was updated in April 2019.

NHS health providers in the boroughs of Barking & Dagenham, Havering and Redbridge provide assurance to the CCGs that they are compliant with Prevent training and reporting requirements in their Safeguarding reports.

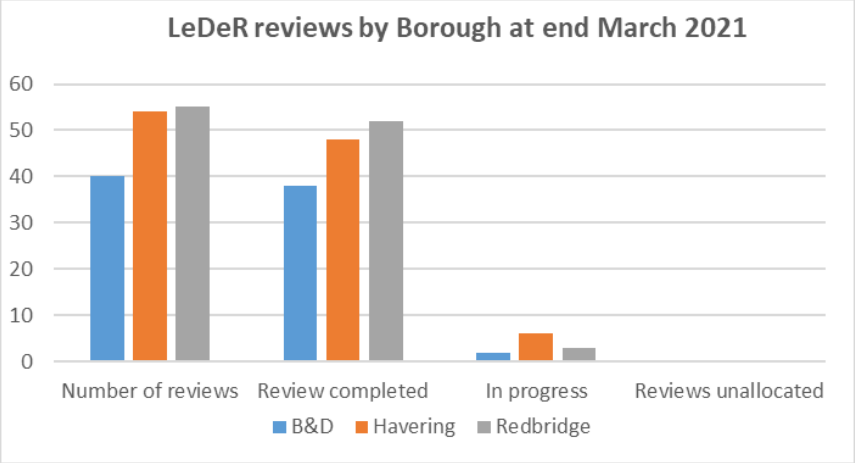
14. Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities.

The Designated Nurse Adult Safeguarding (Havering) is the Local Area Coordinator (LAC) for the tri-borough partnership and as such is responsible signing off completed reviews and identifying and sharing lessons learned, good practice and areas where care could be improved. Beatrice Kivengea, NEL Project Lead continues to support the allocation of LeDeR reviews and reporting to NHSE.

Within the context of national progress with LeDeR reviews, the Boroughs of Barking & Dagenham, Havering and Redbridge are progressing well with LeDeR reviews overall.

There has been significant progress with allocation and completion of LeDeR reviews over the past year as shown in the graph below:



The position with local LeDeR reviews as of end March 2021 was that there were 149 cases allocated to BHR CCG over the previous 4 years of which:

- 138 were completed
- 11 were progress
- 0 were unallocated.

There have been a disproportionate number of deaths amongst the Learning Disability population reported since the outbreak of the Covid19 Pandemic across London and nationally. During the early stages of the Pandemic LB Barking & Dagenham, Havering & Redbridge reported 18 deaths where the cause of death was reported to be Covid related, but between June and October 2020 there were no further Covid19 related LeDeR deaths reported. This would suggest that protective measures put in place for residents living in Care Homes and Supported Living accommodation have reduced this risk.

Covid19 Report 2020/21

	Covid19 Wave 1					Covid19 wave 2					
LOCATION/CCG	Mar-20	Apr-20	May-20	Total as at May 20		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total as at Mar-21
Barking & Dagenham	0	3	0	**3**		0	4	1	3	0	**8**
Havering	0	9	0	**9**		0	2	2	1	0	**5**
Redbridge	0	5	1	**6**		1	0	5	1	0	**7**
Total	0	17	1	**18**		1	6	8	5	0	**20**

A total of 38 covid19 linked deaths were reported during the year 2020/21 across BHR:

- 18 deaths were reported during wave 1 (between March and May 2020)
- 20 deaths during in wave 2, which is between November and end of March 2021.

In March 2021, the Designated Nurse for Adult Safeguarding and the North East London (NEL) LeDeR Project Lead shared the learning from NEL LeDeR COVID-19 related deaths with the tri-borough Safeguarding Adult Boards. Updates on progress with LeDeR case reviews are provided in Safeguarding Adult reports which are submitted to the monthly BHR CCGs ISAB meeting.

15.0 Progress against 2020/21 BHR CCGs Safeguarding Adult Priorities and Key Achievements

Priority	Status	Additional information
Ensure robust pathways and collaboration between statutory and other provider services.	Achieved	BHR CCGs have pro-actively contributed to and supported the work of the three SABs by providing oversight, from a Health perspective, through our statutory member status. The three Designated Nurses Adult Safeguarding represent the CCG at the Safeguarding Adult Board meetings and sub-groups for their respective boroughs.
Ensure CCGs staff safeguarding adults and Prevent training compliance and that all Continuing Heath Care staff are trained in: • Safeguarding Adult Level 3. • Mental Capacity and Deprivation of Liberty Safeguards • Liberty Protection Safeguards.	Partially Achieved	Overall training compliance has deteriorated for staff working in all three CCGs towards the end of the financial year. Assurance is required that all Continuing Heath Care staff are trained in: • Safeguarding Adult Level 3. • Mental Capacity and Deprivation of Liberty Safeguards To date this has not been included in the BHR CCGs mandatory training matrix despite requests for this to be done.
Introduce a robust process to monitor that Continuing Health Care (CHC) team adhere to MCA Code of Practice for clients who are CCG funded.	Achieved	The Designated Nurse Adult Safeguarding undertook training for the Continuing Health Care team and awareness has improved. Clients who are CCG funded are provided with patient care in accordance with MCA Code of Practice.
Robust mechanisms for monitoring quality, safeguarding, mental capacity assessments and Deprivation of Liberty Safeguards in Care Homes with Nursing across the tri-borough partnership.	Achieved	The Designated Nurse Adult Safeguarding (Havering) chairs the Local Quality Surveillance Group (LQSG) which continues to monitor quality and assurance and safeguarding issues in Care Homes with Nursing across the three boroughs with representation from CQC and regular updates provided about provider concerns. Updates on Care Homes with Nursing have been provided in Safeguarding at ISAB meeting each month. The Designated Nurse Adult Safeguarding has worked closely with local authority colleagues in conducting quality assurance and safeguarding visits to care homes with nursing providers.
Ensure action plans are progressed to embed learning within Provider Services and GP Practices from Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs).	Achieved	The Designated Nurses Adult Safeguarding are responsible for following up specific recommendations for statutory Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs). Requests from SABs for progress updates have been complied with. The Quality & Safeguarding Team have updated their Domestic Abuse Policy which provides advice and

		guidance for managers of staff members who are victims of Domestic Abuse which was approved by the BHR system Quality & Performance Committee on 19/03/2021.
Further develop existing processes to ensure that mental capacity and transition from DoLS to LPS processes are robustly embedded within the CCG and provider organisations.	Partially Achieved	There is a tri-borough LPS Task and Finish Group which has undertaken an assessment of the potential impact that this will have across the boroughs of LBBD, LB Havering and LB Redbridge. Further work is planned and the taskgroup are planning to meet on 26th March 2021 to scope further work required.
Address workforce issues in relation to shortfall in staffing levels for Adult Safeguarding and to meet the Royal College of Nursing Guidance.	Achieved	A business case was submitted to the BHR CCGs management team and this was approved in June 2020. The posts were advertised and an additional 2 WTE Designated Nurses Adult Safeguarding were appointed in November 2020 which means that staffing resources for Adult Safeguarding across the tri-borough partnership now meet the recommendations outlined in Royal College of Nursing 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (August 2018). This has significantly improved the staffing resources for Adult Safeguarding across the tri-borough partnership and will enable closer working with partner agencies and care home providers.
Support for GP practices and the primary care sector in all activities relating to adult safeguarding.	Achieved	The Designated Nurse Adult Safeguarding has previously delivered CPD approved GP PTI training for Safeguarding Adults, MCA / DoLS, Prevent and Domestic Abuse in all three boroughs. We have not been notified of any available dates for these GP training sessions recently. As soon as we are notified of available dates the Designated Nurses will offer to deliver training.

16. 2021 / 2022 BHR CCGs Safeguarding Adults Priorities

The following are the priorities set for 2021 / 2022 for safeguarding adults:

Priority	Rationale	Action being taken	Outcomes / deliverables	Timescales
Ensure robust pathways and collaboration between statutory and other provider services.	Integrated health and care system should be a priority for the CCGs. BHR CCGs are required to ensure there is CCG representation at the tri-borough Safeguarding Adult Boards (SABs) and all the relevant sub groups of the SAB.	BHR CCGs is represented at the Safeguarding Adult Boards in the Boroughs of Barking & Dagenham, Havering and Redbridge and their subgroups. Each of the SABs have included sections from BHR CCGs Safeguarding team in their Safeguarding Adult Annual Reports which are available on their respective websites which provides a summary of national and local developments and priorities in the safeguarding of adults at risk. BHR CCGs sent contributions to each of the SABs for their annual reports 2019/20.	The Designated Nurses Adult Safeguarding represents the CCGs at their respective local SAB and all the relevant sub groups of the SAB. The Designated Nurse Adult Safeguarding represents the CCGs at Prevent and Modern Slavery forums, homelessness and self-neglect working groups.	Ongoing
Continue to ensure BHR CCGs staff are compliant with safeguarding adults and Prevent training and that all Continuing Heath Care staff are trained in:	Safeguarding Adults and Prevent level 1 is mandatory training for all CCG staff. Safeguarding Adult Level 3, Mental Capacity and Deprivation of Liberty Safeguards is also a mandatory requirement for all Clinical staff.	The Designated Nurse Adult Safeguarding provides updates on BHR CCGs training compliance in monthly ISAB reports. The CHC team staff have been sent links to e-training and have been asked to ensure that they are compliant with training requirements.	All staff to be trained to required level in all mandatory Safeguarding Adult subjects.	October 2021

• Safeguarding Adult Level 3. • Mental Capacity and Deprivation of Liberty Safeguards.				
Develop a robust monitoring system for Care Homes with Nursing and ensure that the Local Quality Surveillance Group oversees the quality monitoring of care homes with nursing in 2021/22.	Care Home Quality Assurance is required to ensure that people living in care homes are receiving quality care and that concerns are raised where abuse or neglect is occurring and that Safeguarding requirements are met.	The Local Quality Surveillance Committee is chaired by the Designated Nurse Adult Safeguarding (Havering) and continues to monitor quality and assurance and safeguarding issues in Care Homes with Nursing across the three boroughs. Updates on Care Homes with Nursing are provided in Safeguarding Adult reports and details of specific homes where there are concerns or where restrictions imposed are reported in the monthly CCGs ISAB meetings.	Tool developed to provide assurance report for BHR CCGs that Safeguarding Adult requirements are met.	End March 2021
Ensure that BHR CCGs and provider organisations are resourced, trained and prepared for LPS implementation in April 2022.	The Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019. LPS implementation is expected to take place by April 2022 with some provisions, covering new roles and training, coming into force ahead of that date.	The Designated Nurses Adult Safeguarding attends the tri-borough LPS Task and Finish Group which has undertaken an assessment of the potential impact that the Liberty Protection Safeguards will have across the boroughs of Barking & Dagenham, Havering and Redbridge. CHC team have scoped the requirements for potential AMPCs (Approved Mental Capacity	Assurance received from provider trusts that they are resourced, trained and prepared for LPS implementation in April 2022. BHR CCGs CHC team resourced and trained to undertake comlex LPS assessments for an	End March 2021

		Professionals) and a dedicated LPS administrative role to manage database and case records requirements for their team to support the implementation of LPS when they come into force in April 2021.	increased number of clients.	
Support for GP practices and the primary care sector in all activities relating to adult safeguarding.	The CCG must prioritise the need for GP practices to be sufficiently skilled to respond to adult safeguarding concerns. Regular programme of mandatory Safeguarding Adult training provided for GPs in relation to: • Safeguarding Adults • Domestic Abuse • Mental Capacity Assessments • Prevent.	The Designated Nurse Adult Safeguarding has previously delivered CPD approved GP PTI training for Safeguarding Adults, MCA / DoLS, Prevent and Domestic Abuse in all three boroughs. We have not been notified of any available dates for these GP training sessions recently. As soon as we are notified of available dates the Designated Nurses will offer to deliver training.	GP practices staff to be trained to respond to safeguarding adult concerns and engage in enquires as required. Designated Nurse Adult Safeguarding to deliver training to GPs across the borough pending appointment of a Named GP who can train GP Practice staff across the tri-borough footprint and support them with Safeguarding Adult knowledge and expertise.	End September 2021
Review development against the national Safeguarding Adults at Risk Audit Tool (SARAT).	This is requested by the relevant Safeguarding Boards and completed by all partner agencies in order to monitor providers compliance with the Care Act 2014.	The Designated Nurses Adult Safeguarding comply with requests for evidence from the Chairs of the SABs when it is requested.	During 2020/21 the Chairs of the SABs have agreed to postpone the completion of the Safeguarding Adults at Risk Audit Tool for this financial year until a later date.	End September 2021

LeDeR review process to be seemless at the time of transition from Bristol database to the new web-based platform in June 2021, reviews progressed and lessons learned and shared with partner agencies.	LeDeR reviews will be accessible to Local Area Coordinators and Reviewers and they will have undertaken necessary training to navigate the new web-based system. Reports and recommendations will continue to be shared with partner agencies.	The Designated Nurse Adult Safeguarding (Havering) is the Local Area Cordinator for BHR LeDeR reviews. There has been significant progress in allocation and progression of LeDeR reviews to date. The Designated Nurse Adult Safeguarding (Havering) provides regular updates on LeDeR reviews on a quarterly basis. The Designated Nurse Adult Safeguarding (Havering) attends the NEL LeDeR group and will work with them to ensure a smooth transition to the new web-based platform.	Lessons learned and recommendations from LeDeR reviews shared with partner agencies to facilitate improve care and support to residents who have a Learning Disability.	June 2021
Monitor and support the implementation of recommendations from Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs).	SARs and DHRs are statutory reviews and the recommendations are intended to improve practice and organisational responses.	BHR CCGs Safeguarding team have facilitated training for GPs across the tri-Borough Partnership and updated the Domestic Abuse Policy which is currently pending sign off by the Quality Performance Committee.	Designated Nurses Adult Safeguarding will attend the relevant SAB SAR subgroups and Community Safety Partnership meetings, to monitor any SAR / DHR action plans and to facilitate the implementation of any actions allocated to the relevant CCG.	December 2021

The themes and learning from the impact of Covid-19 on vulnerable adults will be a key priority.	The impact of Covid-19 has highlighted vulnerabilities nationally.	The Designated Nurses Adult Safeguarding are now represented at a number of national and London wide workstream meetings focusing on learning and priorities for action for safeguarding, domestic abuse, suicide reduction and modern slavery. The Designated Nurse Adult Safeguarding (Havering) co-chaired a working group in March 2021 to review the key priorities for year 2021/22.	There will be shared learning which can be shared with local statutory partners and SABs.	Ongoing

17. Summary

This report demonstrates that BHR CCGs continue to meet statutory obligations to safeguard adults at risk in the borough. Our aim is to keep the people we serve safe in our health and social care services. We are committed to partnership working and a key objective is to work as collaboratively as possible with the people we provide services for, with stakeholders and commissioned services.

It is our priority to ensure that the safeguarding message is at the top of the agenda across health and social care. Additionally, we want members of the public to understand what safeguarding is and how to report any issues and concerns they may have.

The Governing Body is asked to receive the safeguarding adults report for information and assurance that effective safeguarding systems and processes are in place for BHR CCGs. The priorities for 2021/22 focus on where improvements will further ensure that there are effective systems in place to safeguard people in Barking Dagenham, Havering and Redbridge.

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Appendix 1

Performance Indicator Key

Not Assured	There is no evidence to suggest that services are performing at the expected level of compliance in line with statutory guidance, local policy or KPIs	Red
Partially assured	There is limited evidence that services are performing at the expected level of compliance in line with statutory guidance, local policy or KPIs	Amber
Assured	There is sufficient evidence that services are performing at the expected level of compliance in line with statutory guidance, local policy or KPIs	Green
Fully assured	There is sufficient and consistent evidence that services are performing at the expected level of compliance in line with statutory guidance, local policy or KPIs	Blue

North East London
Clinical Commissioning Group

BHR Safeguarding Children Annual Report

2020-2021

Paul Archer – Designated Nurse for Safeguarding Children and Looked After Children (Havering
Kate Byrne – Designated Nurse for Safeguarding Children and Looked After Children (Barking and Dagenham)
Sue Nichols – Designated Nurse for Safeguarding Children and Looked After Children (Redbridge)

1. Executive Summary

1.1 This is the eighth safeguarding children annual report and reflects the work undertaken to ensure delivery of the safeguarding children priorities that were agreed for 2020-2022.

1.2 The report is written to provide assurance to the BHR ICP Quality & Performance Committee that North East London Clinical Commissioning Group (NEL CCG) is discharging its statutory responsibility to safeguard and promote the welfare of children across the Barking and Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP).

1.3 The report will address the following areas:

- Progress of the 2020-2022 priorities
- Identified risks
- Mitigating actions
- Additional priorities for 2021-2022

1.4 The BHR ICP Quality & Performance Committee is asked to:

- Review and discuss the safeguarding children agenda outlined in this report.
- Suggest any additional actions that are required for further improvement and assurance.

2. Purpose of the Report

2.1 This report provides the BHR ICP Quality & Performance Committee with an overview of the safeguarding children activity across the BHR health economy during 2020-2021. The report reviews the work completed throughout the financial year, providing assurance that BHR CCG (now merged with the two other systems to create NEL CCG) has discharged its statutory responsibility within the BHR health economy to safeguard the welfare of children across the health services it commissions.

2.2 The report also highlights risks within the safeguarding children agenda and demonstrates how the safeguarding team within the BHR system are managing and mitigating the risks.

2.3 Additional information is included about national changes and legislation, as well as local developments in relation to proposed implementation of the integrated care system (ICS).

3 Background

3.1 In the 2019-2020 annual report the safeguarding team, in conjunction with the local safeguarding partnerships, developed the following five priorities for 2020-2022:

- Supporting the GP federations in discharging their statutory functions for safeguarding children
- Ensuring that safeguarding children are adequately considered in moving towards a single ICS
- Ensuring that the CCG understands the impact that Covid-19 has had on safeguarding children and effectively manages these impacts
- Strengthen how the health economy contributes to the local safeguarding children partnerships
- To provide strategic oversight and scrutiny on the delivery of the child death requirements

3.2 Each of these priorities will be discussed in detail in their respective sections and will provide a narrative on the work undertaken by the CCG to deliver these priorities during 2020-2021.

4 Supporting the GP federations in discharging their statutory functions for safeguarding children

4.1 Prior to Covid-19 there were significant challenges in engaging primary care in safeguarding activity, especially around attending initial child protection conferences (ICPC) or providing a report.

4.2 Since the local authorities have been hosting ICPCs virtually, there has been an improving engagement from primary care in both attendance and report provision.

4.3 The GP safeguarding leads fora has continued virtually throughout the year with a significant improvement in GP attendance and engagement. These fora have been supported by the named GP, nurse consultant, and designated professionals.

4.4 The designated professionals, named GP and nurse consultant have supported primary care in delivering safeguarding sessions at the borough based protected learning event/initiative which were positively evaluated.

4.5 The CCG convened a joint meeting between safeguarding, quality and primary care to discuss high level safeguarding risks within primary care and implement mitigating actions.

4.6 The Named GP and nurse consultant have published and distributed the GP hand book for safeguarding children following consultation with the safeguarding team.

5 Ensuring that safeguarding children is adequately considered in moving towards the ICS

5.1 In 2018 the designated professionals across north east London came together to discuss system wide issues at the request of the London region head of safeguarding. This was in preparation in moving towards a sustainability and transformation partnership (STP) and to standardise practice and policy. The STP arrangements have since been superseded by moving to a CCG and latterly into the ICS.

5.2 Out of this work stream came the NELCA designated professionals meeting which was also extended to include named GPs/consultant nurses within the CCGs. The outputs of this meeting were the NELCA wide workplan, risk register, priorities and policy development.

5.3 The NELCA meeting had a direct reporting line to the accountable officer in provide them with strategic oversight of key safeguarding risks. The membership of the meeting was extended in 2020 to include the interim chief nurse who took over chairing responsibilities.

5.4 Following a change in the interim chief nurse arrangements, it was agreed that the following five work streams should be addressed in preparation for safeguarding system transition to the ICS across the wider health economy:

- Health and wellbeing
- Safeguarding new priorities
- Governance arrangements
- Data/dashboard
- Covid learning

5.5 These workstreams will be initiated in 2021/2022 and will be reported on in the next annual report.

6 Ensuring that the CCG understands the impact of Covid-19 on safeguarding children and effectively manages the impact

6.1 The NELCA designated professionals developed a risk register in light of the covid-19 pandemic to identify and manage risk in relation to the impact on children.

6.2 This was monitored and updated monthly to understand the emerging risks and to demonstrate how these risks were mitigated.

6.3 The high-level risks identified were escalated to the senior management team and fed back to NHSE/I via the safeguarding sub-cell.

6.4 The highest priority areas identified through the risk register were as follows:

- Access to healthcare
- Domestic abuse
- Social isolation

- Mental health problems
- The unseen child
- Risk of online abuse
- The impact of redeployed staff
- CDOP process delayed
- Impact of child bereavement following the death of family members
- Access to education and healthcare for SEND children
- Lack of information sharing of vulnerable children in a timely manner
- Impact of post-natal depression and social isolation on mother and family

6.5 Many of these risks have since been downgraded as mitigating actions have been implemented and children have returned to face-to-face education and health appointments.

6.6 In order to effectively capture the voice and experiences of children during the pandemic across BHR, the CCG communication team launched a survey in July 2020. The results of this was disseminated to the safeguarding team and informed understanding of the experience of children.

6.7 A follow-up survey was launched in November 2020 which was extended across the NEL footprint and was disseminated in January 2021. The communication team used a variety of platforms to engage with young people in participating in the survey.

6.8 The survey asked five key questions of children which were developed by young people.

6.9 The results of the first survey identified the following:

- The majority of children reported feeling good or okay during the first lockdown
- Children reported their biggest concerns around school/education, friendships, family, physical health, and mental health concerns.
- Their biggest concern for the future was in relation to education.

6.10 The results of the second survey identified the following:

- The significant number of young people reported not feeling good. The number of young people who reported feeling good was attributed to attending school again.
- 18% of young people reported receiving mental health support. However, the number of young people reporting feeling bad was 29%
- 1 in 5 young people reported that they did not know how to access mental health support.

6.11 The survey results were disseminated widely across all agencies and the communication team promoted and sign posted mental health services for children in response to the identified experiences of children in the survey.

7 Strengthen how the health economy contributes to the local safeguarding children partnerships

7.1 This priority will be addressed in full under section 11.

8 To provide strategic oversight and scrutiny on the delivery of the child death requirements

8.1 In 2016 the Wood report was published, which outlined proposed changes to the safeguarding children system including significant changes to the child death review process.

8.2 Following the enactment of the Children and Social Work Act (2017) new statutory guidance was published in 2018. The published documents are "*Working Together to Safeguard Children*" (2018) and the "*Child Death Review Process*" (October 2018). These documents mandated the statutory responsibility and guidance for the introduction of the new Child Death Review processes.

8.3 The new legislation transferred the statutory responsibility for child death reviews from the Department for Education to the Department of Health and Social Care. The child death review partners are identified as the local authority and the CCG.

8.4 To ensure that the BHR footprint effectively moved towards the new system, an executive meeting for child death reviews was established in November 2018. The purpose of this meeting was to bring together the relevant partners to progress the work-stream. It was agreed that going forward BHR CCGs would host the Child Death Overview Panel element of the new CDR process.

8.5 In ensuring that the new CDR processes were delivered within the statutory timeframes, an interim joint funded project lead was recruited by the CCGs. This role was supported by the Designated Doctor for Child Death and Designated Nurse for Safeguarding Children and Looked After Children to provide clinical leadership and expert technical support. However, due to financial constraints this post ceased prior to the submission of the CDR plan on the 29th June 2019.

8.6 A steering group was established with key operational partners to progress the implementation of the new CDR arrangements.

8.7 To support the new statutory requirements NHSE commissioned a web-based system for the collection of the child death review information. This system, known as the eCDOP platform supports the collation and data-handling of child deaths which feeds into the National Child Mortality Database. The eCDOP platform was introduced across the BHR footprint in 2018 and was funded by Healthy London Partnership (HLP) for both 2018/2019 and 2019/2020. Funding for eCDOP was been identified for 2020/2021 from local CDR partners.

8.8 The CCGs submitted a business case for the creation of a CDOP manager and CDOP co-ordinator. These posts were joint funded equally between the CCGs and the three local authorities as outlined in published CDR plans.

8.9 The CDOP co-ordinator and CDOP manager came into post in November 2020 and are now managing the CDOP process and closing down legacy cases that occurred during the transition period.

8.10 The CDOP manager has produced an annual report for 2020-2021 which outlines in further detail the activity of the BHR CDOP.

9 Intercollegiate Guidance

9.1 On the 31 January 2019 the Royal College of Nursing published the updated '*Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*' which replaces the previous 2014 version.

9.2 A copy of the guidance can be accessed here: https://www.rcn.org.uk/professional-development/publications/007-366

9.3 This intercollegiate guidance provides a clear framework which identifies the competencies required for all healthcare staff. Levels 1-3 relate to different occupational groups, while level 4 and 5 are related to specific roles. This version of the framework also includes specific detail for chief executives, chairs, board members including executives, non-executive and lay members.

9.4 The guidance also outlines clear role descriptions for specialist safeguarding/child protection professionals including the required resources to fulfil these functions.

9.5 This guidance relates to safeguarding children only and does not include looked after children, which has its own intercollegiate guidance.

9.6 The tables below outline the current provision of the safeguarding children resource within the CCGs benchmarked against the intercollegiate document.

Table 1: Designated Doctor for Safeguarding Children

CCG area	Child Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	63,547	3 PAs per week	4.5 – 5 PAs per week
Havering	67,100	2 PAs per week on an interim basis	4.5 – 5 PAs per week
Redbridge	82,600	3 PAs per week	4.5 – 5 PAs per week

Table 2: Named GPs for Safeguarding Children

CCG area	Total Borough Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	212,906	2 PAs per week	2 PAs per 220,000 total population
Havering	254,300	2 PAs per week	2 PAs per 220,000 total population
Redbridge	304,200	3 PAs per week provided by consultant nurse	2 PAs per 220,000 total population

Table 3: Designated Nurses for Safeguarding Children

CCG area	Child Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	63,547	0.5 WTE (1 WTE shared between safeguarding children and looked after children)	1 dedicated WTE designated nurse per 70,000 child population
Havering	67,100	0.5 WTE (1WTE shared between safeguarding children and looked after children)	1 dedicated WTE designated nurse per 70,000 child population
Redbridge	82,600	0.5 WTE (1WTE shared between safeguarding children and looked after children)	1 dedicated WTE designated nurse per 70,000 child population

Table 4: Administrative support

CCG area	Child Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	63,547	1 WTE admin post shared across safeguarding children, safeguarding adults, and looked after children across the three boroughs	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population
Havering	67,100	As above	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population
Redbridge	82,600	As above	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population

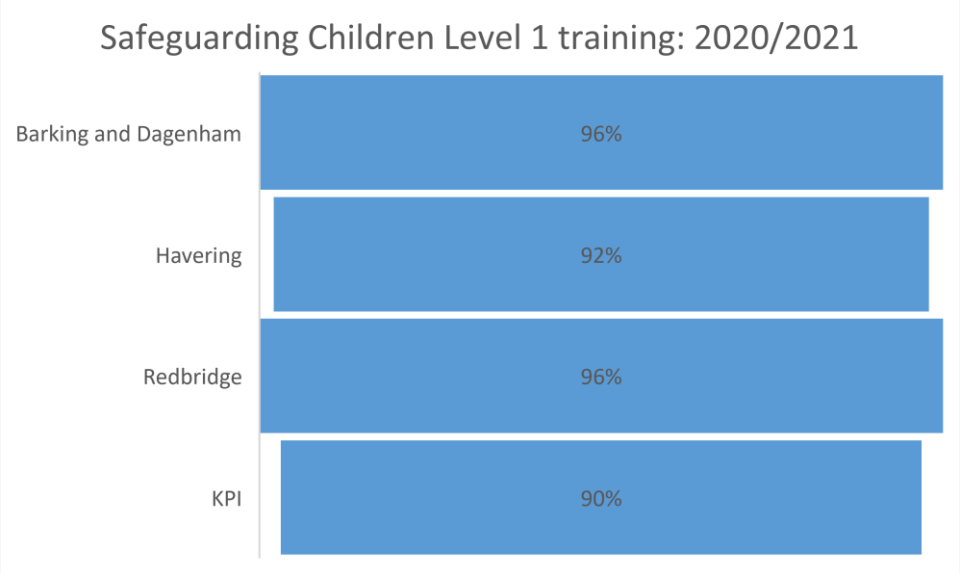
9.7 It is recognised that BHR economy is non-compliant with the intercollegiate guidance in terms of whole-time equivalent posts.

9.8 To mitigate risk, it is important to note that all the designated professionals across the BHR footprint work closely together and function as a fully integrated team. This enables work to be streamlined and restricts the amount of duplication across the BHR footprint.

10 Mandatory Training Compliance

10.1 In line with statutory guidance, all CCG staff are required to undertake safeguarding children level 1 training on a three-yearly basis. The CCG have an internally set KPI of 90% of all staff.

10.2 The chart below demonstrates that by year end of 2020/2021, all three borough areas had achieved compliance for safeguarding children level 1 training in accordance with the internal KPI.



10.3 In addition to the level 1 training, the named and designated professionals within the CCG are required to undertake additional training at level 4/5. The CCG is fully compliant with these requirements having all staff attending the required hours.

11 Local Developments

11.1 The following will provide narrative on borough-based developments within the 2020-2021 financial year and will also provide assurance how the CCG is working towards the priority as set out in section 7 of this report.

11.2 **Barking and Dagenham**

11.2.1 In April 2020, the Director of Children's Services also convened a weekly Covid 19 meeting with the CCG, health providers and leaders across services in the local authority to discuss evolving concerns in relation to service delivery and emerging safeguarding concerns.

11.2.2 During the pandemic Barking and Dagenham Safeguarding Children Executive Group (CCG, LA and the Met Police) continued to meet on a regular basis. During this period the following priorities were agreed:

- Strengthen multi-agency working to protect and safeguard vulnerable children and young people from all forms of exploitation

- Strengthen multi-agency working in the early identification and support for children at risk of suffering from harm resulting from neglect and domestic violence
- Safeguard children with additional needs and promote their welfare, Including children with additional needs, such as those with learning disabilities and mental health concerns
- Protect vulnerable children and young people from sexual abuse
- Embed our Safeguarding structure and Independent Scrutiny arrangements
- Respond to the impact of the COVID-19 pandemic (workforce, children and their families).

11.2.3 BDSCP cross cutting priorities are to understand the lived experience of the child; improve their lived experience and outcomes as a result of service involvement and evidence the impact made.

11.2.4 In February 2021, the Barking and Dagenham Safeguarding Children Partnership group meeting was convened with representation from across all agencies. It is expected that the Independent Scrutineer, once appointed, will chair this meeting.

11.2.5 The Neglect and Early Help Delivery Group was convened during 2020. This group leads on shaping Barking and Dagenham's response to addressing children, young people and their families living with neglect. The group ensures that there is clear application of thresholds, referral pathways, multi-disciplinary assessment tools and evidence-based interventions which are outcome focussed, thereby needing to oversee the development and implementation of the Early Help improvement programme and strategy that will be partnership wide. It will ensure children and their families receive the right help, at the right time, from the right people.

11.2.6 The Child Sexual Abuse (CSA) Safeguarding Delivery Group was set up to improve practice across the Borough to bring about consistent and better identification, assessment, intervention, health care and justice outcomes for children and young people who suffer sexual abuse, including their families affected by CSA. The CSA Safeguarding Delivery Group is responsible for producing the CSA safeguarding strategy, including systems and processes to ensure good quality practice, and will drive improvement work in partnership with the Centre of Expertise on CSA. The CSA delivery group is supported by professional from NEL CCG and Bart's Health Trust.

11.2.7 Child G. In early 2021 a Practice Learning Review was commissioned by the Barking & Dagenham Safeguarding Children Partnership to understand the circumstances surrounding the death of Child G on 14th March 2018 and the response of the

various agencies involved. This review is ongoing and will be reported in the next Annual Report.

11.3 **Havering**

11.3.1 **Child G**. In June 2020 an 11-year-old child suffered a cardiac arrest at home and subsequently died. At the time of her death, she was receiving services from Havering local authority and NELFT.

11.3.2 On the 30th June 2020, the HSCP's multi-agency case review working group met to complete a Rapid Review into the circumstances around Child G's death, following a referral of this case both to the group and to the National Child Safeguarding Practice Review Panel from Havering's Principal Social Worker.

11.3.3 It was decided that the threshold for a child safeguarding practice review was not met, however it was decided that there was significant learning to be obtained from holding a learning event.

11.3.4 On the 28th July 2020 a learning event was undertaken which identified the following areas of concern:

- Recognition of weight management as an issue amongst professionals.
- Over-reliance on parents proactively engaging with health services.
- Insufficient attention to the voice of the child.
- A lack of analysis in referrals made to MASH.
- New intelligence not changing the trajectory of cases.
- The exclusion of health services from Children In Need meetings.
- A lack of communication between CAMHS and Children's Social Care.

11.3.5 The CCG, NELFT and public health have since established the obesity pathway meeting which is delivering on the recommendations from the learning review.

11.3.6 **Launch of adolescent strategy**. Following an increase in serious youth violence in Havering, Havering Safeguarding Children Partnership (HSCP) in conjunction with key partners began delivery on a safeguarding strategy.

11.3.7 The strategy was formally launched in 2021 and outlined the following five priority areas:

- Reviewing and updating operational arrangements for exploitation and missing.
- Developing the multi-disciplinary integrated adolescent safeguarding service.

- Take collective responsibility to join up our data analysis and information sharing.
- Coproduce a vibrant, positive safety campaign with young people and communities.
- Create innovative training and development opportunities to build capacity across the partnership for early intervention and adolescent safeguarding.

11.3.8 The partnership will continue to drive this work-stream forward in the coming year to ensure the strategy is effectively embedded in practice.

11.3.9 HSCP priorities. The HSCP has developed the following objectives that the partnership will work towards throughout the next two years:

- Objective 1: Mitigate the impact of the Covid-19 outbreak on the physical and psychological wellbeing of children and families by addressing known impact and seeking to prevent any further negative impact.
- Objective 2: Maximise direct professional access to children and their families, and mitigate the impact of any continuing limitations to professional access to children (for example, due to virtual health service consultations or children not returning to school) on the ability of the multi-agency partnership to recognise and respond to indicators of persistent neglect.
- Objective 3: Understand how effectively the multi-agency safeguarding system is reaching and affecting Black and minority ethnic communities in Havering, and explain or address any disproportionalities.
- Objective 4: Support children in Havering to return to school, including a strategy to maximise school attendance and engagement in education.
- Objective 5: Support staff in the three statutory partner agencies and across the multi-agency partnership to manage the changes in the demand on services, in terms of both volume and complexity.

11.3.10 To support the work of the HSCP, the CCG is leading on objective 2 and has began the development of a neglect strategy in partnership with the local authority.

11.3.11 Focus groups were held in January and February 2021 to review the proposed neglect toolkit and to obtain feedback from frontline practitioners in relation to the picture of neglect in Havering.

11.3.12 The neglect strategy document is nearing completion and will include tools developed by the obesity pathway meeting to ensure that all aspects of neglect are considered and safeguarding concerns are managed appropriately.

11.4 **Redbridge**

11.4.1 Due to the impact of Covid-19 the Redbridge Safeguarding Children Partnership (RSCP) meeting was cancelled on the 5 May 2020. At the Redbridge Safeguarding Children Partnership (RSCP) meeting held on 14 July 2020 the first part of this discussion related to the Safeguarding Risk Register, which had been compiled in consultation with partner agencies in an attempt to identify the key safeguarding risks during the pandemic, monitor what is being done, and look at whether each risk is improving or getting worse.

11.4.2 A group of senior leaders from multi-agency partners had agreed the register at the end of May and then 'RAG' (red/amber/green) rated it. Five risks were identified as high/red risks which members were invited to discuss which took place

- Risk 1: Increased stress on families leads to increase in abuse and neglect.
- Risk 3: New cases of abuse and neglect are not effectively recognised or referred due to lack of professional, family and community contact.
- Risk 5: High vulnerability of babies and young children to abuse, compounded by lockdown and closure of early years settings.
- Risk 6: Young people at risk of deteriorating mental health and wellbeing, with reduced access to services.
- Risk 7: Children and young people at increased risk as a result of increase in parental mental ill-health.

11.4.3 The RSCP meeting was informed as to the status of the CCG in terms of safeguarding children. At the commencement of lockdown on 23 March 2020 up until July 2020 CCG maintained contact online, and maintained their safeguarding function at full capacity. There had been twice weekly senior management meetings to identify emerging health themes. There has been frequent dialogue with colleagues across North East London (NEL).

11.4.4 The CCG has compiled its own safeguarding risk log. NEL designated safeguarding leads were represented at NHSEI (NHS England and NHS Improvement) sub cell meetings. Designated professionals across BHR were involved in national conferences during the early weeks of Covid-19 and raised issues regarding health attendance and redeployment of staff.

11.4.5 **SEND Children**. The Designated Clinical Officer for Special Educational Needs and Disability (SEND) within the CCG and the Senior Nurse for paediatrics Continuing Health Care (CHC) worked with partners from the local authorities and education services across the three boroughs to identify children with additional needs to enable support and meet any additional needs.

11.4.6 **Audits and self-assessments**. The RSCP have developed a self-assessment tool in response to the report by the Child Safeguarding Practice Review Panel, 'It was hard to escape – safeguarding children at risk of criminal exploitation'. The date for completion has been put back from February 2021 due to the 2nd wave of Covid-19 and pressure on resources, now confirmed as the end of May 2021.

11.4.7 The RSCP agreed child sexual abuse in the family environment as a priority for 2020 – 2021. This priority linked into a previous Joint Targeted Area Inspection (JTAI) in relation to child sexual abuse (CSA). Although Redbridge was not part of that JTAI, the resulting report found nine areas for improvement of practice in the area of CSA in the family. The RSCP developed a multi-agency self-assessment tool for CSA which has was disseminated to partner agencies for completion in January 2021. The findings will be presented to the July 2021 RSCP meeting.

11.4.8 During the fourth quarter of 2020-2021 a multi-agency BHR Safeguarding Children Partnership suicidal ideation and suicidal intent audit was commenced. The audit comprises of fifteen cases, five from each of the three BHR boroughs.

11.4.9 **Learning review re: two child suicides**. An Internal Learning Review (ILR) report was tabled at the Redbridge Safeguarding Children Partnership (RSCP) meeting on 14 July 2020. An Internal Learning Review (ILR) was undertaken following two cases of child suicides, unrelated, in Redbridge that occurred in 2019. The Review consisted of a case audit, undertaken by each agency/service that the children were known to and then a Round Table Learning Event, was held on 10 March 2020, followed by the complication of a report in the first quarter of 2020. The full report remains confidential although the findings and recommendations will be shared at the Redbridge Learning and Development subgroup for action. The recommendations focus on professional curiosity and encouraging attendance at training, particularly on cultural awareness.

11.4.10 **Rapid Review Meeting**: Following the unexpected death of a child in Waltham Forest it became apparent that the family had moved from Redbridge in October 2020 and the child was known to Redbridge Children's Social Care Services.

11.4.11 A Rapid Review meeting was held by RSCP on 09/02/2021. As the child died in Waltham Forest they had also held a Rapid Review meeting on 18/01/2021. Following the RCSP Rapid Review meeting a report was compiled and submitted to the BHR Safeguarding Children Partners for onward submission to the National Child Safeguarding Practice Review Panel. Recommendation: Did not meet the criteria for a Child Safeguarding Practice Review.

11.4.12 The response from the National Child Safeguarding Practice Panel dated 16/03/2021 following the consideration of the case by the Panel on 09/03/2021.

11.4.13 The Panels response: LCSPR should commission a proportionate review into the case that focusses on trying to understand what systemically has not worked to safeguard and protect the child and their siblings. The Panel also offered a meeting with one of the Panel members if further discussion was felt necessary. This offer of a further discussion is to be taken up by BHR Safeguarding Children Board.

12 Key Priorities for 2021-2022

12.1 In addition to the priorities identified previously for 2020-2022, the following new priorities have been identified for 2021-2022:

- To undertake a training needs analysis across the BHR footprint to ensure that all CCG staff are being trained in safeguarding children at the correct level.
- Delivery of the five workstreams as identified by the interim chief nurse.

13 Resources/Investment

13.1 There are no additional resource implications/revenue or capital costs arising from this report.

14 Sustainability

14.1 Further improvements are required to effectively safeguard children across the BHR footprint, this will have a positive impact on the long-term outcomes for children and families within the three boroughs.

15 Equalities

15.1 This report has considered the CCGs equality duty but has not identified any areas that are likely to impact on equality or human rights.

16 Risks

16.1 The CCG is not currently compliant with intercollegiate guidance for safeguarding children as outlined in section 9.

17 Managing Conflicts of Interest

17.1 There are no conflicts of interest identified in this report.

NHS
North East London
Clinical Commissioning Group

BHR Looked After Children Annual Report

2020-2021

Paul Archer – Designated Nurse for Safeguarding Children and Looked After Children (Havering
Kate Byrne – Designated Nurse for Safeguarding Children and Looked After Children (Barking and Dagenham)
Sue Nichols – Designated Nurse for Safeguarding Children and Looked After Children (Redbridge)
Dr Sophie Niall – Designated Doctor for Looked After Children (Barking and Dagenham, Havering, and Redbridge)

1. Executive Summary

1.1 This is the eighth looked after children annual report and reflects the work undertaken to ensure delivery of the looked after children priorities that were agreed for 2020-2022.

1.2 The report is written to provide assurance to the BHR ICP Quality & Performance Oversight Group that NEL CCG is discharging its statutory responsibility to safeguard and promote the welfare of looked after children across the Barking and Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP).

1.3 The report will address the following areas:

- Progress of the 2020-2022 priorities
- Identified risks
- Mitigating actions
- Additional priorities for 2021-2022

1.4 The BHR ICP Quality & Performance Oversight Group is asked to:

- Review and discuss the looked after children agenda outlined in this report.
- Suggest any additional actions that are required for further improvement and assurance.

2. Purpose of the Report

2.1 This report provides the BHR ICP Quality & Performance Oversight Group with an overview of LAC across the BHR health economy during 2020/2021. The report reviews the work across the year, giving assurance that the CCG has discharged its statutory responsibility to safeguard and promote the welfare of children and meet the health needs of LAC across the health services it commissions.

2.2 Although safeguarding children is comprehensively discussed in the safeguarding children annual report, it is important to acknowledge that LAC and safeguarding are intertwined as children move between different parts of the child protection system.

2.3 The report will also highlight risks within the LAC agenda and demonstrate how the safeguarding and LAC team within the CCG has managed and mitigated the risks working closely with system partners.

3 Background

3.1 In 2019-2020 annual report the LAC team developed the following five priorities for 2020-2022:

- The CCG will support the local authorities and NELFT in ensuring the timeliness of initial and review health assessments.
- To refresh the RHA audit tool to ensure informative, qualitative data is captured.
- To continue to support providers in improving the quality of health assessments.
- To understand the impact of Covid-19 on the LAC population.
- To ensure the CCG continues to meet its statutory responsibilities for looked after children.

3.2 Each of these priorities will be discussed in detail in their respective sections and will provide a narrative on the work undertaken by the CCG to deliver these priorities during 2020-2021.

4 The CCG will support the local authorities and NELFT in ensuring the timeliness of initial and review health assessments.

4.1 This priority will be covered in full in section 11.

5 To refresh the RHA audit tool to ensure informative, qualitative data is captured.

5.1 Following on from the October 2019 RHA audit, the designated nurses refreshed the audit tool to capture meaningful data. This included qualitative and quantitative data.

5.2 During this time Barking and Dagenham changed their review health assessment paperwork from CoramBAAF to a locally developed health assessment.

5.3 During 2020-2021 a quality audit was paused due to service pressure, staff redeployment, and other quality related workstreams.

5.4 It is anticipated that the audit will be reinstated in 2021-2022.

6 To continue to support providers in improving the quality of health assessments.

6.1 While progress has been hampered, initiatives established to investigate and address longstanding concerns associated with the IHA service are being actively supported by the Designated Doctor.

6.2 New clinical personnel within the provider trust, combined with increased focus and dialogue around this issue, are identifying additional concerns impacting patient safety and that potentially extend beyond that of the paediatric service

7 To understand the impact of Covid-19 on the LAC population.

7.1 The NELCA designated professionals developed a risk register in light of the covid-19 pandemic to identify and manage risk in relation to the impact on looked after children. This formed part of the overarching NELCA safeguarding risk register.

7.2 This was monitored and updated monthly to understand the emerging risks and to demonstrate how these risks were mitigated.

7.3 The high-level risks identified were escalated to the senior management team and fed back to NHSE/I via the safeguarding sub-cell.

7.4 The highest priority areas identified through the risk register were as follows:

- Health assessments being held virtually rather than face-to-face
- Impact of redeployed staff
- Reduced access to health accesses
- Access to dental health
- Access to immunisations
- Increase in poor mental health
- Reduced oversight of LAC placed outside the BHR
- Risk of reduces identification and access to health services for unaccompanied asylum seekers
- Foster carers and prospective adaptors unable to access face-to-face medicals which resulted in self-declaration forms. This may have resulted in significant medical information not being shared.

7.5 Risks have been reassessed throughout the pandemic and mitigating actions have been implemented. Health services have adopted a blended approach to appointments using virtual and face-to-face methods to improve engagement with children and carers.

7.6 In order to effectively capture the voice and experiences of children during the pandemic across BHR, the CCG communication team launched a survey in July 2020. This included engaging with the children in care councils across BHR to ensure looked after children's views were included. The results of the was disseminated to the safeguarding team and informed understanding of the experience of children.

7.7 A follow-up survey was launched in November 2020 which was extended across the NEL footprint and was disseminated in January 2021. In order to better understand the experiences of looked after children, the safeguarding team requested looked after children specific results. The communication team used a variety of platforms to engage with young people in participating in the survey.

7.8 The survey asked five key questions of children which were developed by young people.

7.9 The results of the first survey identified the following:

- The majority of children reported feeling good or okay during the first lockdown
- Children reported their biggest concerns around school/education, friendships, family, physical health, and mental health concerns.
- Their biggest concern for the future was in relation to education.

7.10 The results of the second survey identified the following:

- The significant number of young people reported not feeling good. The number of young people who reported feeling good was attributed to attending school again.
- 18% of young people reported receiving mental health support. However, the number of young people reporting feeling bad was 29%
- 1 in 5 young people reported that they did not know how to access mental health support.

7.11 The survey results were disseminated widely across all agencies and the communication team promoted and sign posted mental health services for children in response to the identified experiences of children in the survey.

8 To ensure the CCG continues to meet its statutory responsibilities for looked after children.

8.1 The CCG has robust processes in place to ensure that LAC placement notifications are processed in line with statutory guidance. Any escalations are addressed appropriately to ensure correct information is shared with the appropriate CCG/provider areas. This activity is monitored via the CCGs LAC database to ensure a robust audit trail.

8.2 The designated nurses have regular clinical contact with the specialist nurses for LAC to offer support and explore themes and trends within the caseloads. The sessions are also utilised to provide professional development to the specialist nurses for LAC.

8.3 The designated doctor for LAC continues to be available for supervision support to any named LAC doctors within the provider trust as and when the named doctor function is deployed.

8.4 The designated nurses continue to engage with the CCGs children's commissioning team to ensure that looked after children's health needs are being met regardless of where they are placed in the country. The children's commissioning team meet with the designated professionals on a monthly basis at the CCG LAC improvement group to highlight any challenges and to drive forward service development.

8.5 Due to the pandemic, reporting of KPIs was suspended during 2020-2021. Unvalidated data from the provider has been shared with the designated professionals by the CSU. However, through the LAC health sub-groups and partnership working, robust dashboards are being developed to provide

assurance that the provider are undertaking health assessments in a timely manner.

8.6 Due to the pandemic the CCG LAC improvement group was paused. This meeting was recommenced in February 2021 and will continue to meet regularly going forward. The governance arrangement for this meeting provide assurance to both the ISAB and corporate parenting groups where escalations are shared and managed.

9 Intercollegiate Guidance

9.1 In December 2020 the Royal College of Nursing published the updated '*Looked After Children: Roles and Competencies for Healthcare Staff*' which replaces the previous 2015 version.

9.2 A copy of the guidance can be accessed here: https://www.rcn.org.uk/professional-development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486

9.3 This intercollegiate guidance provides a clear framework which identifies the competencies required for all healthcare staff. Levels 1-3 relate to different occupational groups, while level 4 and 5 are related to specific roles. This version of the framework also includes specific detail for chief executives, chairs, board members including executives, non-executive and lay members.

9.4 The guidance also outlines clear role descriptions for specialist looked after children professionals including the required resources to fulfil these functions.

9.5 This guidance relates to looked after children only and does not include safeguarding children, which has its own intercollegiate guidance.

9.6 The tables below outline the current provision of the looked children resource within the CCG benchmarked against the intercollegiate document.

Table 1: Designated Doctor for Looked After Children

CCG area	Child Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	63,547	2 PAs per week	0.2 WTE (2 PAs) per 400 LAC population
Havering	67,100	2 PAs per week on an interim basis	0.2 WTE (2 PAs) per 400 LAC population
Redbridge	82,600	2 PAs per week	0.2 WTE (2 PAs) per 400 LAC population

Table 2: Designated Nurses for Safeguarding Children

CCG area	Child Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	63,547	0.5 WTE (1 WTE shared between safeguarding children and looked after children)	1 dedicated WTE designated nurse per 70,000 child population
Havering	67,100	0.5 WTE (1WTE shared between safeguarding children and looked after children)	1 dedicated WTE designated nurse per 70,000 child population
Redbridge	82,600	0.5 WTE (1WTE shared between safeguarding children and looked after children)	1 dedicated WTE designated nurse per 70,000 child population

Table 3: Administrative support

CCG area	Child Population	Current Resource	Resource according to intercollegiate guidance
Barking and Dagenham	63,547	1 WTE admin post shared across safeguarding children, safeguarding adults, and looked after children across the three boroughs	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population
Havering	67,100	As above	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population
Redbridge	82,600	As above	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population

9.7 It is recognised that the BHR economy is non-compliant with the intercollegiate guidance in terms of whole time equivalent designated professionals and administrative support.

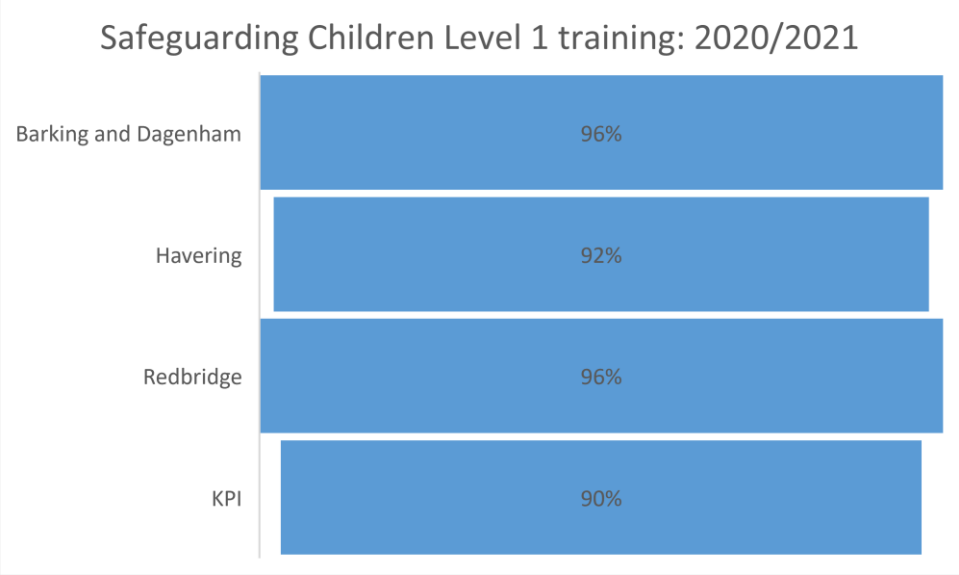
9.8 To mitigate risk, it is important to note that all the designated professionals across the BHR footprint work closely together and function as a fully

integrated team. This enables work to be streamlined and restricts the amount of duplication across the BHR footprint.

10 Mandatory Training Compliance

10.1 In line with statutory guidance, all CCG staff are required to undertake safeguarding children level 1 training on a three-yearly basis. Looked after children feature in this training to ensure staff understand what a looked after child is and some of the challenges they may face. The CCG have an internally set KPI of 90% of all staff.

10.2 The chart below demonstrates that by year end of 2020/2021, all three borough areas had achieved compliance for safeguarding children level 1 training in accordance with the internal KPI.



10.3 In addition to the level 1 training, designated professionals within the CCG are required to be trained at level 5. The CCG designated professionals are 100% compliant with their level 5 training.

11 Local Developments

11.1 The following will provide narrative on borough-based developments within the 2020-2021 financial year and will also provide assurance how the CCG is working towards the priority as set out in section 4 of this report.

11.2 **Barking and Dagenham**

11.2.1 End of year data suggests that Barking and Dagenham is responsible for 392 Looked After Children. Of these children 16% are aged 0-4 years, 13% 5-9 years, 42% are between 10-15 years and 29% aged between 16-17 years. The 10-15 and 16-17 age group is over represented within Children's Social Care. The largest difference is seen between the 16-17 age group. 29% of the children in care within LBBD are aged between 16 and 17 in comparison to 16- and 17-year olds accounting for only 9% of the under 18 local population.

11.2.2 During 2020/21 Barking and Dagenham LAC Zoning meeting continued to meet to discuss any system barriers in relation to delay in completion of Initial Health Assessments. Delay in submitting paperwork from children's social care to NELFT, lack of interpreters, delay in returning the completed assessment to children's social care and on occasion capacity of the Named Doctor for LAC to complete assessments have contributed to delays for looked after children to have their initial health assessment within the statutory time frame. These concerns have been escalated appropriately.

11.2.3 The LAC Health Subgroup, convened in October 2019, continued to meet monthly during 2020/21 to ensure grip and traction was maintained across the partnership in relation to the health needs of LAC.

11.2.4 For 2020/21 all Barking and Dagenham looked after children had their review health assessment in a timely manner.

11.2.5 In November 2020, the National Implementation Advisor for Care Leavers from the Department of Education, visited Barking and Dagenham to initiate a conversation in relation to the Care Leaver offer. It was apparent during this conversation and subsequent feedback that the health care leaver offer was not robust. Funding for a care leaver health practitioner has been secured via the CCG and local authority and recruitment processes are underway.

11.2.6 The LAC Specialist nurse is working with participation officers from the local authority and the Children in Care council, Skittlz to agree a meaningful health passport for care leavers.

11.2.7 Work is ongoing to understand the health needs of the looked after children. The will be reported in the next annual report.

11.2.8 Access to dental health services has been a challenge for Looked After Children during the pandemic. This had been escalated to national networks for designated professionals and also to the Chief Dental Officer who confirmed that this is a national issue.

11.3 **Havering**

11.3.1 The Havering Zoning meetings continue to take place on a monthly basis and are used to track and risk assess the caseload. Although the designated nurse does not attend these meetings, escalations are made appropriately where system barriers are identified, and mitigating actions are undertaken to ensure fair access to health services.

11.3.2 The LAC Health Sub group was stood down during the pandemic but has since recommenced and continue to meet on a quarterly basis. The LAC health data is scrutinised at this meeting to ensure ongoing compliance against KPIs and nationally agreed standards. Additionally, service developments are discussed and implemented via the group. The outputs of this meeting feed into the Havering corporate parenting panel.

11.3.3 It has been identified that the current arrangements for a health passport is not fit for purpose and is out of date. There are concerns that in the current format there is not an electronic version available

and there is a risk that the passport could be lost or damaged. Initial discussions have taken place to explore alternative arrangements and Havering hope to work with Barking and Dagenham in updating and improving on the health passport offer.

11.3.4 There has historically been an ongoing issue with the timeliness of initial health assessments being completed and returned to the local authority in 20 working days. One of the barriers seem to be the signing of consent for the IHA when the child was placed under a section 20 arrangement. To address this, the CCG worked with Havering local authority to develop a combined IHA/Section 20 consent form that was used at the point a child comes into care. It is anticipated that this will have a positive outcome of IHA compliance once normal data reporting resumes post lockdown.

11.3.5 NELFT have reported that review health assessment compliance was over 95% for 2020/2021 with the 5% representing children who have either refused to have their health assessment or were missing from care and therefore were not able to be contacted. NELFT has been using a blended approach to health assessments with video/telephone appointments as well as face-to-face. This has enabled the LAC nurses to engage with children who previously were challenging to engage with and has also increased the activity of the LAC service as limited travel has been needed.

11.4 **Redbridge**

11.4.1 Redbridge NELFT LAC Health team initially undertook IHAs and RHAs virtually or via telephone. Following the first lockdown a blended approach was adopted to undertaking IHAs these were performed via a one-hour telephone contact, with a face to face thirty-minute appointment being offered for a physical assessment following the telephone contact. RHAs were undertaken virtually and face to face if deemed appropriate.

11.4.2 The Health and LAC subgroup comprising of representatives from Children's Social Care LBR, NELFT and the CCG for Redbridge was re-established in November 2020, chaired jointly by the Designated Nurse for LAC and the LBR Service Manager for LAC, the minute taker is employed by LBR. The meetings take place on a monthly basis.

11.4.3 LAC developments**:**

- Introduction of Zoning meetings commencing January 2021 and scheduled monthly.
- Joint NELFT and LBR post created for a LAC data analyst funded by LBR.
- Early stages in the development of a non-engagement pathway for IHAs.

11.4.4 At the Corporate Parenting Advisory Panel meeting January 2021, a multi-agency LAC report in relation to the low number of IHAs undertaken within 20 working days, was requested with contributions from partner agencies for presentation at the next Corporate Parenting Advisory Panel on 28 April 2021.

12 Key Priorities for 2021-2022

12.1 In addition to the priorities identified previously for 2020-2022, the following priorities have been identified for 2021-2022:

- To strengthen the health care leaver's offer.
- To better understand the health needs of the local LAC population.
- To strengthen the implementation of the health passport offer across Barking and Dagenham, and Havering.

13 Resources/Investment

13.1 There are no additional resource implications/revenue or capital costs arising from this report

14 Sustainability

14.1 Further improvements are required to effectively deliver the looked after children agenda across the BHR footprint, this will have a positive impact on the long-term outcomes for children and families within the three boroughs.

15 Equalities

15.1 This report has considered the CCGs equality duty but has not identified any areas that are likely to impact on equality or human rights.

16 Risks

16.1 There is a risk to looked after children if they do not receive a timely health assessment.

16.2 There is a lack of oversight of KPI compliance due to the availability of validated data.

17 Managing Conflicts of Interest

17.1 There are no conflicts of interest identified in this report.

North East London
Clinical Commissioning Group

Barking and Dagenham, Havering and Redbridge Child Death Overview Panel Report 2019-2021

A report on organisational arrangements, operations, statistical analysis and commentary

April 2019- March 2021

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1. INTRODUCTION

The death of a child at any age is a devastating event for the parents, carers, siblings, friends and the communities they lived in. It is crucial that we have robust support and review systems in place to understand why a child death has occurred, provide appropriate support to the bereaved and draw learning from individual cases to prevent, where possible, future deaths.

Since 2008, it has been a requirement of The Children Act 2004, that all deaths of children up to the age of 18 years, are reviewed by a Child Death Overview Panel (CDOP) in the borough in which they resided.

Following changes introduced in the Children and Social Work Act 2017 and the subsequent Child Death Review Statutory and Operational Guidance 2018, the responsibility for child death review shifted from Local Safeguarding Children Boards (LSCBs) to local authorities and Clinical Commissioning Groups (CCGs) known as Child Death Review Partners (1). A second key change is to move to a footprint yielding sufficient deaths for review (effectively between 60 and 150 per annum) to allow identification of local patterns regarding cause of death, underlying modifiable factors and monitor trends overtime.

The three Local Authorities LB Havering, LB Barking & Dagenham, LB Redbridge and the Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Group (CCG) agreed to strengthen local working and develop a new Child Death Review System. The Barking and Dagenham, Havering and Redbridge Child Death Overview Panel (BHR CDOP) began work in October 2019, putting processes in place across our system to comply with the guidance and embedding the use of eCDOP an online case management and reporting system). As the 2019-20 year was a period of transition, this is the first report of the BHR CDOP and covers the period April 2019 to March 2021.

1- The Child Death Review Statutory and Operational Guidance states. “Child death review partners” (“CDR partners”) are defined in section 16Q of the Children Act 2004 and means, in relation to a local authority area in England, the local authority and any CCG for an area any part of which falls within the local authority area. CDR partners for two or more local authority areas in England may agree that their areas should be treated as a single area”.

2. Overview of BHR Child Death Review Process

2.1. The BHR Child Death Overview Panel

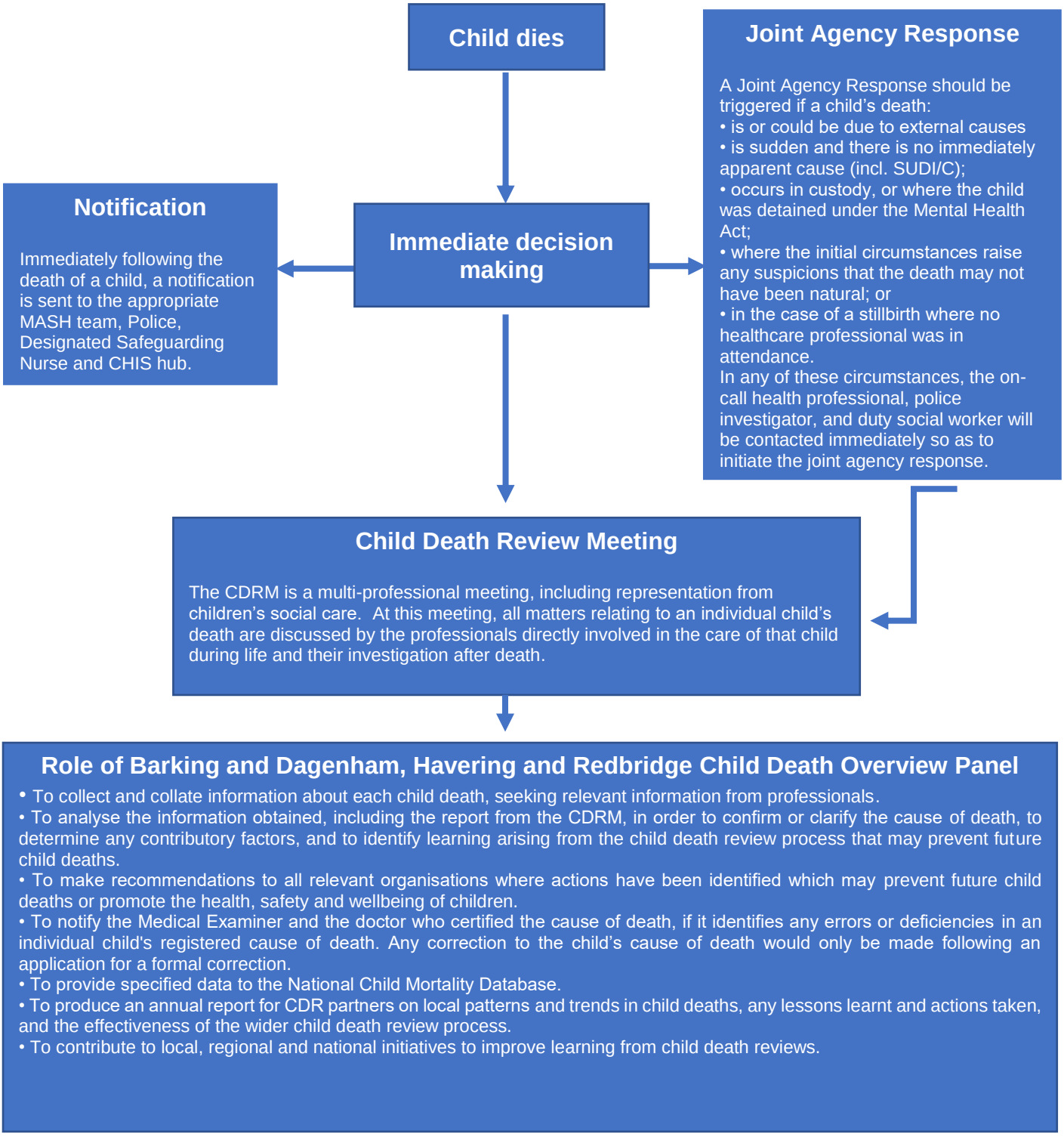
The review at Barking and Dagenham, Havering and Redbridge CDOP, is intended to be the final, independent scrutiny of a child’s death by professionals with no responsibility for the child during their life.

All information presented at CDOP is anonymised.

The BHR CDOP will in each case classify the cause of death, identify contributory factors, reach a decision about whether the death was modifiable, identify any modifiable factors (those which can be changed through national or local interventions) and make recommendations to prevent future similar deaths. The role of the CDOP is further explained in the flowchart 2.2.

2.2. Flow Chart

The flow chart below illustrates the BHR Child Death Review Process.



2.3. Panel Membership

The panel has a multi-agency membership of Child Death Overview Panel Partners from

the consolidated Child Death Overview Panels of Barking and Dagenham, Havering and Redbridge. Other professionals are invited to attend for specific cases.

The core membership and representation of the Barking and Dagenham, Havering and Redbridge Child Death Overview Panel is;

BHR CDOP PANEL
Chair, Deputy Nurse Director, NHS North East London Clinical Commissioning Group (BHR ICP)
Consultant Paediatrician, Designated Doctor for Safeguarding and Child Death Overview Panel
Detective Inspector, Metropolitan Police
Head of Service, Children's Services, London Borough Barking and Dagenham
Head of Universal Children's Services, Redbridge, North East London Foundation Trust
Named Midwife, Safeguarding & Lead Midwife for CDR & Harmful Practices, Barking, Havering and Redbridge University Hospitals NHS Trust
Manager, Redbridge MASH London Borough of Redbridge
Named Professional, Safeguarding Children, North East London Foundation Trust
Named Professional, Safeguarding Children, North East London Foundation Trust
Designated Nurse for Safeguarding and LAC (Barking and Dagenham) NHS North East London Clinical Commissioning Group
Safeguarding Children's Liaison Nurse, Barking, Havering and Redbridge University Hospitals NHS Trust
Partnership Manager, Redbridge Safeguarding Children Partnership
Quality Assurance Head of Service, London borough of Havering
Director of Public Health, Barking and Dagenham
Integrated Care Director for Barking and Dagenham, North East London Foundation Trust
Designated Nurse for Safeguarding and LAC (Havering) NHS North East London Clinical Commissioning Group
Barking and Dagenham and Havering, Named GP Safeguarding Children
Designated Nurse for Safeguarding and LAC (Redbridge) NHS North East London Clinical Commissioning Group
Director of Care, Haven House Hospice
BHR Child Death Overview Panel (CDOP) Manager, NHS North East London Clinical Commissioning Group
BHR Child Death Overview Panel (CDOP) Co-Ordinator, NHS North East London Clinical Commissioning Group

2.4. National Child Mortality Database

The CDOP provides data to the National Child Mortality Database (NCMD). The purpose of collating information on Child Deaths nationally, is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

The NCMD have recently used this data to produce a report, Child Mortality and Social Deprivation. This report, which is based on data for children who died between April 2019 and March 2020 in England, finds a clear association between the risk of child death and the level of deprivation (for all categories of death except cancer). This analysis has prompted a review of the child death review forms and several recommendations have been made. One such recommendation is to add specific structured questions on social deprivation to ensure that CDOPs consider poverty and social inequalities as they review the deaths.

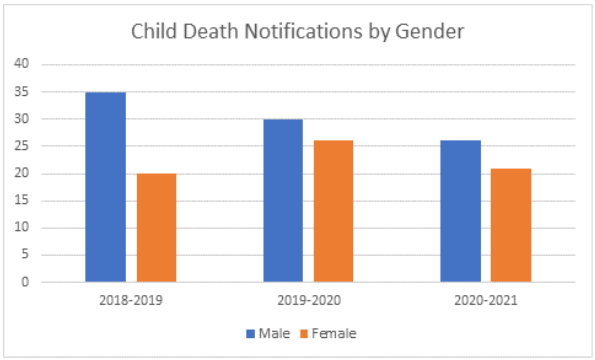
3. New Notifications of Child Deaths 2019 – 21

This section summarises data from all deaths notified to the BHR CDOP between 1st April 2019 and 31st March 2021. It includes all children who are normally resident in the BHR area (regardless of where they died). This data is drawn from the database of Notifications to CDOP (Form A from the National Data Set).

The BHR CDOP was notified of 56 child deaths in 2019-20 and 47 child deaths in 2020-21. Although there was a drop of notifications in the 2020-21 year, this does not form clear statistical significance as the CDOP would expect year on year fluctuation due to the low numbers reported; <60 deaths per annum.

3.1. Child Death Notifications by Gender

In 2019-21, notifications in respect of male children were recorded as higher than female, a trend which has continued from previous years. This is similar to the national picture; the Child Death Review Data: Year ending 31 March 2020 highlighted that males represented just over half of child death reviews (56%).

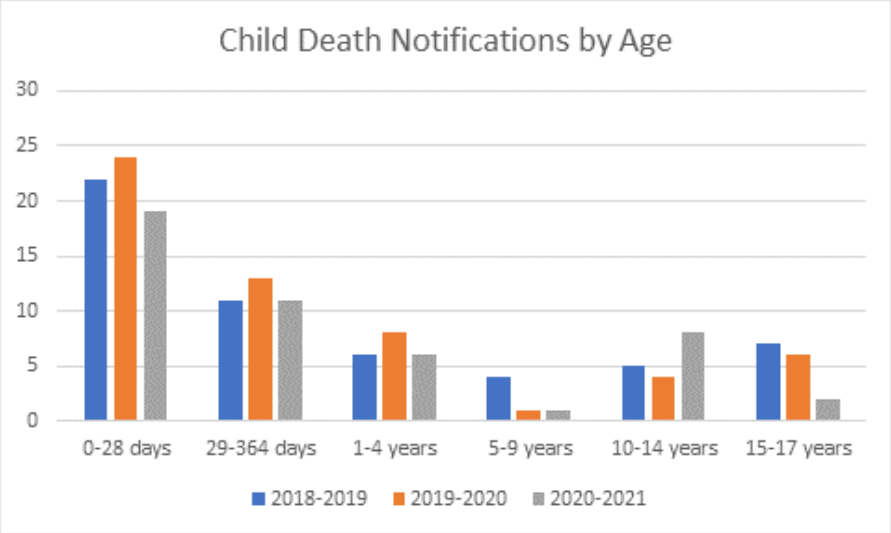


Graph 1: Child Death Notifications by Gender

3.2. Child Death Notifications by Age

Across 2019-2021, the highest number of new notifications was received for the age range 0-28 days, which represented 41% of the overall notifications. The second largest category was the 28-364 days age group. Together, deaths where the child was aged under 1 represented 70% of child deaths reviewed during 2019-21.

This is similar to the national picture; Child Death Review Data: Year ending 31 March 2020 highlighted that deaths occurring in the neonatal period (0–28 days) represented the largest proportion of deaths reviewed (41%) and a further 591 (22%) deaths were within the 28-364 days age group.



Graph 2: Child Death Notifications by Age

4. Child deaths Reviewed by The BHR Child Death Overview Panel

The BHR CDOP is currently meeting on a monthly basis.

The panel is informed by the referral of a standardised report analysis form from the Child Death Review Meeting (CDRM). The BHR CDOP conducts an independent multi-agency scrutiny of the report from the Child Death Review Meeting partners by senior professionals with no named responsibility for the care of the child during their life with representation.

The number of notifications and reviews differ as the cases reviewed include deaths notified in previous years but not reviewed until the current year. This anomaly is due, firstly to the need to review legacy cases and secondly due to the time taken to review the circumstances of each death following notification. This can be significant in the event of an inquest or criminal proceedings.

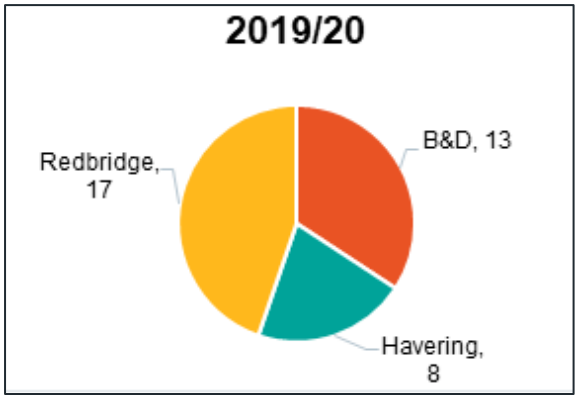
4.1. Total Number of Child Deaths Reviewed by BHR CDOP

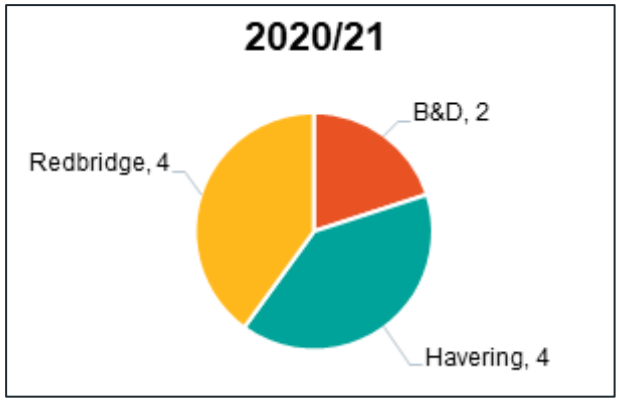
There has been a reduced number of child deaths, reviewed in both 2019-2020 and 2020-21 years for two reasons. Firstly, 2019-20 was a transition year and the newly appointed CDOP manager and CDOP coordinator did not come into post until November 2020. Secondly two panels were cancelled during 2020-21, due to the effects of COVID-19 and the redeployment of key members of staff.

This is similar to the national picture, The NCMD Child Death Review Data: Year ending 31 March 2020 highlighted a decrease in the number of reviews and noted, "the decrease in the number of reviews for 2019-20 is likely because fewer CDOP meetings took place whilst they were working under transitional arrangements. In addition, many CDOP meetings were cancelled in March 2020 due to the response to the COVID-19 pandemic".

Table 1- Number of Child Deaths Reviewed by BHR CDOP

	2019/20	2020/21
Barking and Dagenham	13	2
Havering	8	4
Redbridge	17	4
BHR Total	38	10





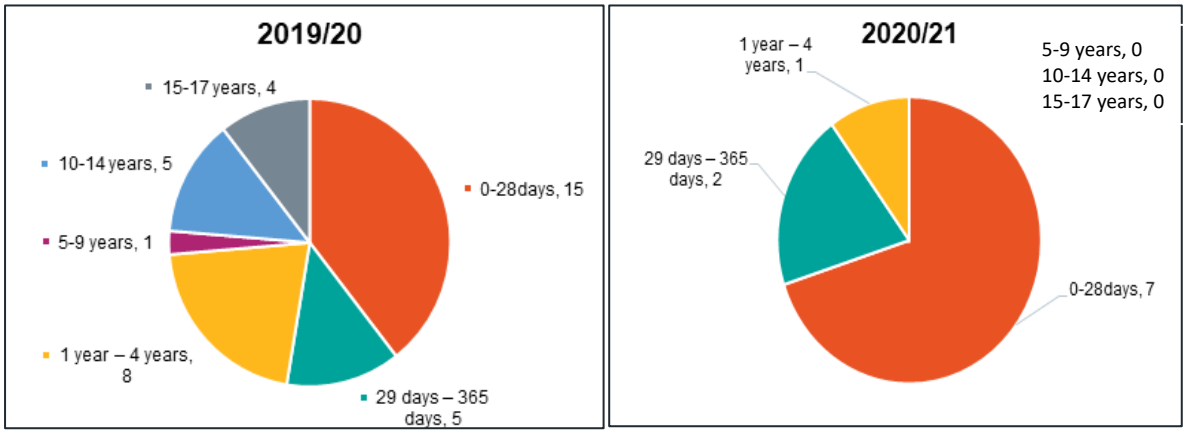
4.2. Age of child at time of death

The highest number of cases reviewed by the BHR CDOP, was for the age range 0-28 days. This trend continued from previous years and is similar to the national picture.
The ONS Child and infant mortality in England and Wales: 2019, highlight that although nationally the number of infant and child deaths was the lowest since records began in 1980, the neonatal mortality rate (aged under 28 days) was 2.8 deaths per 1,000 live births in England and Wales, a rate which has remained the same since 2017.

Table 2 – Age of child at time of death

	2019/20	2020/21
0-28days	15	7
29 days – 365 days	5	2
1 year – 4 years	8	1

5-9 years	1	0
10-14 years	5	0
15-17 years	4	0

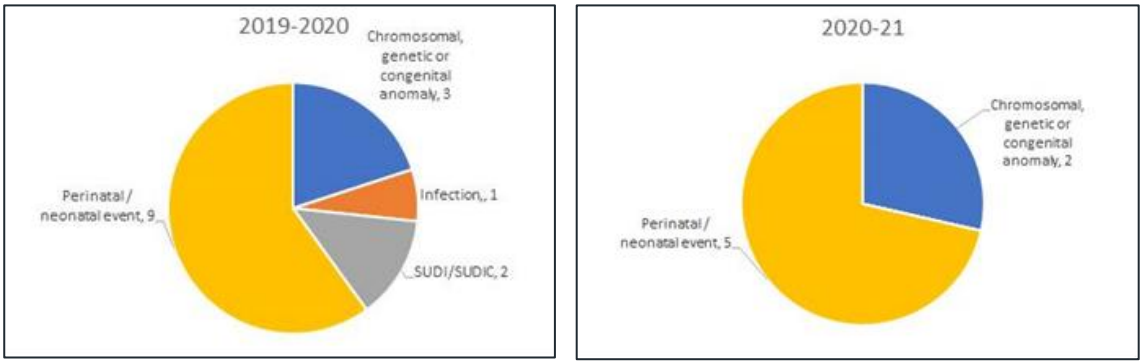


4.3. Neonatal Deaths (aged under 28 days)

Neonatal Deaths have been reviewed in light of national concerns raised regarding maternity care. No neonatal death was linked to maternity care. Graph 3 shows the categorisation of Neonatal Deaths (aged under 28 days).

The high levels of deaths categorised as Chromosomal, Genetic or Congenital Anomaly, demonstrates a link to Consanguinity.

Graph 3: Categorisation of Neonatal Deaths



In 2019-20, there were 5 deaths reviewed, involving extremely premature births (under 24 weeks completed gestation).

In 2020-21, there were 2 deaths reviewed, involving extremely premature births (under 24 weeks completed gestation).

The ONS Child and infant mortality in England and Wales: 2019, suggest the increase in the proportion of live births under 24 weeks completed gestation has contributed to an increase in the neonatal mortality rate from 2.5 deaths per 1,000 live births in 2014 to 2.8 in 2019.

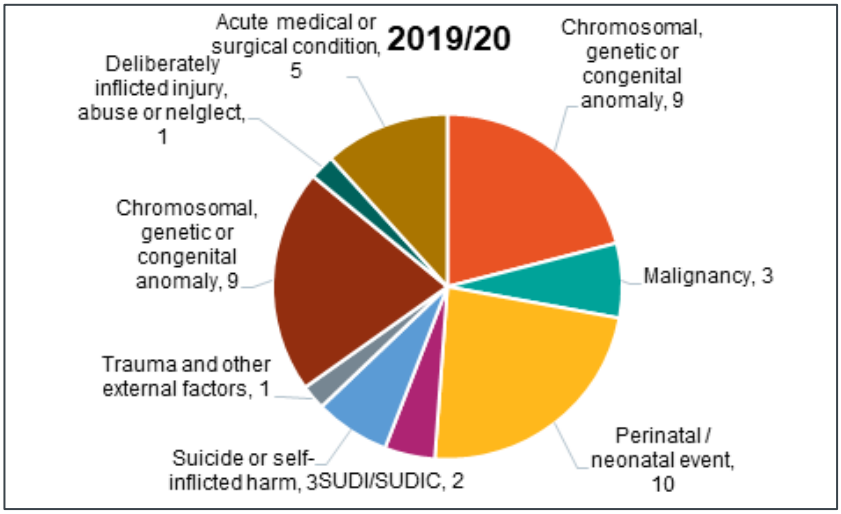
4.4. Category of child deaths

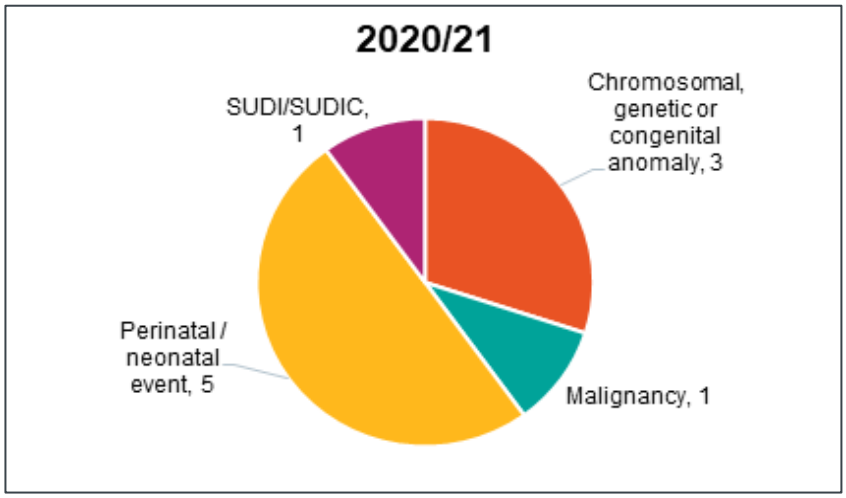
During the CDOP meeting, panel members categorise a child's death according to nationally defined categories that are determined by the Department of Health. During 2019-21 the largest number of deaths were categorised as perinatal/neonatal event followed by chromosomal, genetic and congenital anomalies. Again, these findings are reflective of the national picture. The NCMD Child Death Review Data: Year ending 31 March 2020 reports (31%) recorded a primary category of "perinatal/neonatal event", and (25%) recorded a primary category of "chromosomal, genetic and congenital anomalies.

Across 2019-21, BHR CDOP reviewed 3 cases which were categorised as suicide or deliberate self-inflicted harm. This is an area for current concern nationally, as the ONS report; Why have suicide levels risen among young people? highlights that whilst the 10 to 24-year age range continue to have low numbers of deaths and the lowest rates of suicide when compared to other age groups, in recent years they have seen some of the largest increases in their rates. The rate among 10 to 24-year-old females has increased by 83% since 2012 to its highest recorded level in 2018. Males of the same age also saw a 25% increase in their rate from the previous year.

Table 6 - Category of child deaths

		2019/20	2020/21
1	Deliberately inflicted injury, abuse or neglect.	1	0
2	Suicide or deliberate self-inflicted harm.	3	0
3	Trauma and other external factors.	1	0
4	Malignancy.	3	1
5	Acute medical or surgical condition.	5	0
6	Chronic medical condition.	0	0
7	Chromosomal, genetic and congenital anomalies.	9	3
8	Perinatal/neonatal event. (0-28 days)	10	5
9	Infection.	4	0
10	Sudden unexpected, unexplained death.	2	1



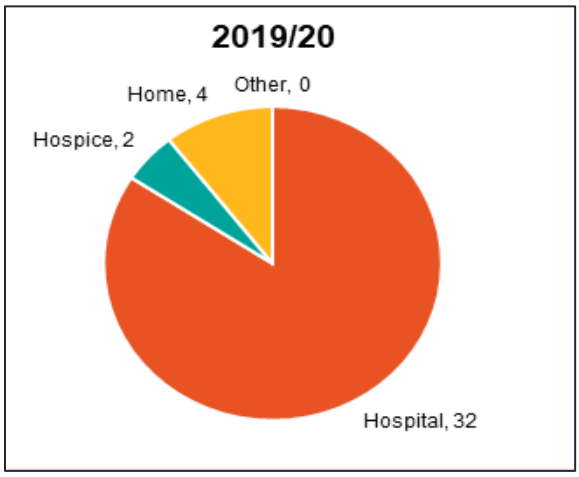


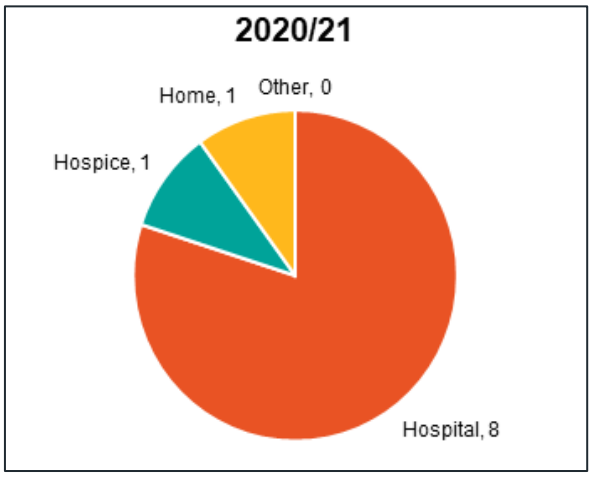
4.5. Place of Death

The majority of children die in hospital, reflecting the pattern of previous years.

Table 3 - Place of Death

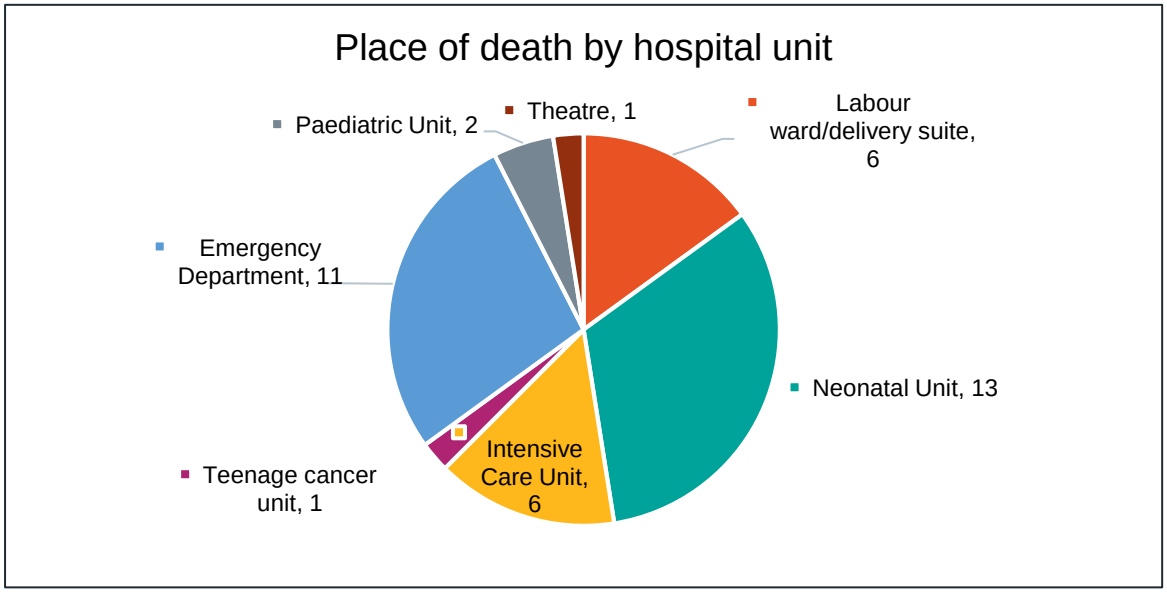
	2019/20	2020/21
Hospital	32	8
Hospice	2	1
Home	4	1
Other	0	0





This also mirrors the national picture, the NCMD Child Death Review Data:Year ending 31 March 2020 reported that 70% of the deaths reviewed occurred in a hospital Trust whilst 20%of deaths reviewed had occurred at home or another private residence.

The chart below illustrates the place of death within an acute hospital setting.



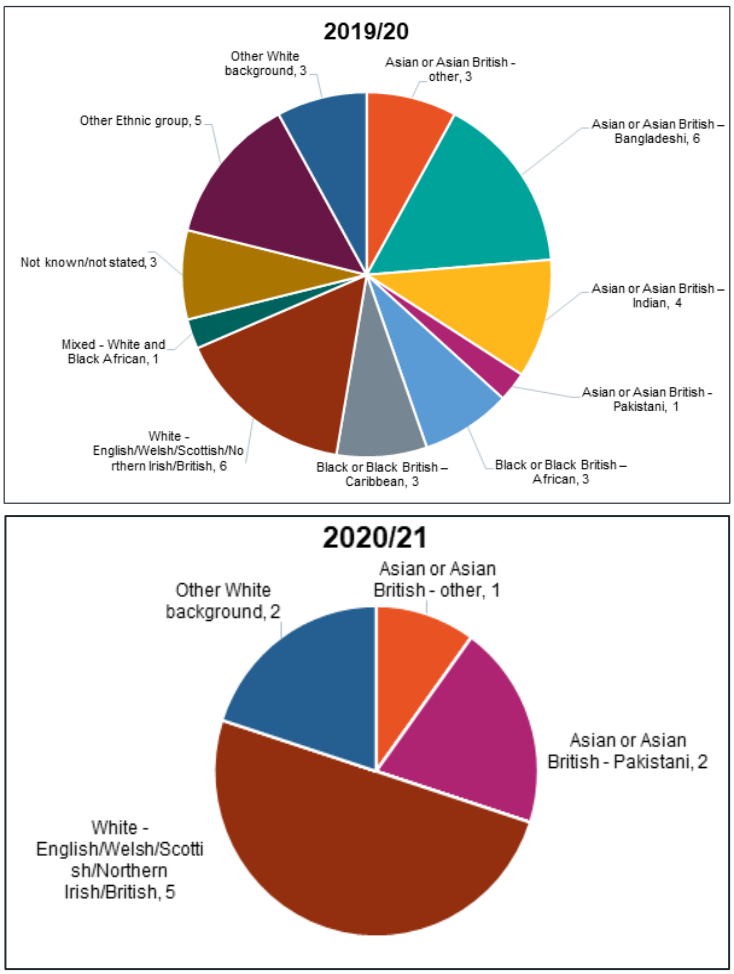
Graph 4: Place of death by hospital unit

4.6. Ethnicity

Table 4. highlights the ethnic origin of the children whose cases have been reviewed by BHR CDOP. The range of ethnicities reflects the diversity of the BHR area.

Table 4 - Number and % of deaths by ethnicity

Ethnicity	2019/20	2020/21
Asian or Asian British - Any other Asian background	3	1
Asian or Asian British – Bangladeshi	6	0
Asian or Asian British – Indian	4	0
Asian or Asian British - Pakistani	1	2
Black or Black British – African	3	0
Black or Black British – Caribbean	3	0
White - English/Welsh/Scottish/Northern Irish/British	6	5
Mixed - White and Black African	1	0
Not known/not stated	3	0
Other Ethnic group	5	0
Other White background	3	2



4.7. Modifiable Factors

Modifiable factors are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'. Nationally the proportion of deaths which were assessed as having modifiable factors remains at 31% in 2019/2020. In the BHR area in 2019/2021 an average of 18% of cases were considered to have modifiable factors, including:

- Consanguinity
- Co-sleeping
- Suicide
- Drowning
- Murder (occurred abroad)

Table 5 – Modifiable Factors

2019/20		2020/21	
Modifiable	Non- Modifiable	Modifiable	Non- Modifiable
7	31	2	8

The panel explores deaths where modifiable factors occur, in order to learn lessons and influence changes and prevent similar occurrences' in the future. Panel members are tasked with taking the learning from these cases and sharing it widely within their organisations in order that multi-agency partners are aware of the risk factors when supporting and advising parents and carers.

4.8. Summary of CDOP key findings during 2019-20

- The need to continue to work sensitively with local communities with regards to the risks associated with consanguinity. A leaflet is available, Children's health and parents related by blood, produced by Redbridge CDOP which is available on the Redbridge Safeguarding Children Partnership website alongside information for parents and professionals. It is planned to share this information more widely with CDOP's across East London.

- The need to reinforce the safe sleeping message at all contacts with parents of infants less than 1 year, is seen as a priority and events are proposed to highlight safe sleeping messages with Health Visitors. Information for parents and professionals is available from the Lullaby Trust. The Child Safeguarding Practice Review Panel carried out a review in 2020, Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm, which highlighted learning and recommendations.

- The need for ongoing safety education around children and water. Guidance and advice for parents is published by The Royal Lifesaving Society.

- Following an increase in the number of suicides the BHR Safeguarding Partnership is carrying out a multi-agency audit of suicidal ideation and suicidal intent.

5. Priorities for 2021-22

In the next year the CDR CDOP will concentrate on embedding the new process, working closely with partners and colleagues to implement a robust support and review system. The priorities for 2021-22 are;

- To take forward themed CDOP panels. A themed panel involves examining child deaths attributed to the same/similar cause of death at a CDOP meeting to support greater learning and promote the sharing of best practice. In addition to the panel members, colleagues with specialist expertise will be invited. It is proposed to hold themed panels examining SUDI, Teenage Suicide and Pre-term births
- Continue to work closely with colleagues from neighbouring CDOPs, to develop a coordinated approach to sharing local learning?
- Support the Tower Hamlets, Newham and Waltham Forest, City and Hackney and Barking and Dagenham, Havering and Redbridge Child Death Review Systems After Action Review.
- Maintain good working relationships with hospital-based CDR partners, to ensure the process is implemented efficiently. Quarterly meetings will be established with hospital CDR teams, to develop practice and share expertise, across the CDR system.

North East London
Clinical Commissioning Group

City and Hackney Integrated Care Partnership (ICP)
Extraordinary Safeguarding Assurance Group Meeting

Thursday 7 October 2021 via Microsoft Teams

Document	Safeguarding Children Annual Report 2020/21
Item number	3
Version	
Author(s)	Mary Lee Dr Nick Lessof
Presenter(s)	
Purpose	*The Safeguarding Children Annual Report 2020/21 provides an opportunity for us in NEL CCG City and Hackney to consider how health agencies are delivering on the duty to safeguard and promote the wellbeing of all children in City and Hackney as required under Section 11 of the Children Act 2004.*
Background	*This report provides an update on the progress made against the safeguarding children priorities agreed in 2019/20. It also provides an overview on how we have worked with City and Hackney Safeguarding Children Partnership and our health care providers to support our workforce and high-quality safeguarding practice across our health and social systems. The report concludes with a summary of our key risks, priorities and focus areas for 2021/22.*
Recommendations	1. To note and provide feedback.

NHS
North East London
Clinical Commissioning Group

NEL Clinical Commissioning Group

City and Hackney

Safeguarding Children Annual Report 2020/21

Date	July 2021
Prepared By	Mary Lee Designated Nurse Safeguarding Children Dr Nick Lessof Designated Doctor Safeguarding Children

Contents:

1. Introduction

The Safeguarding Children Annual Report 2020/21 provides an opportunity for us in NEL CCG City and Hackney to consider how health agencies are delivering on the duty to safeguard and promote the wellbeing of all children in City and Hackney as required under Section 11 of the Children Act 2004.

This report provides an update on the progress made against the safeguarding children priorities agreed in 2019/20. It also provides an overview on how we have worked with City and Hackney Safeguarding Children Partnership and our health care providers to support our workforce and high quality safeguarding practice across our health and social systems. The report concludes with a summary of our key risks, priorities and focus areas for 2021/22.

A separate annual report has been written for Looked After Children.

2. Impact of the pandemic

The Covid 19 pandemic has tested the resilience of organisations to adapt and change to maintain service delivery. Safeguarding children has never been more challenging and the emerging evidence of the impact of the pandemic and lockdown on the health and wellbeing of children indicates that it will remain a key public health issue for years to come.

The pandemic highlighted the invisibility of vulnerable children and the increase in safeguarding risks that they faced. Throughout the series of lockdowns there was restricted access to services and reduced school attendances for all children, coupled with parental perception that it was unsafe for them and their children to use health services even when they were ill because of their fears of getting Covid.

The issues reported nationally were reflected locally i.e., an increase in domestic abuse notifications. Paediatricians reported a significant reduction in children attending emergency department with an associated reduction in child protection referrals. Some children presented very late and seriously ill when they should have been seen earlier. Despite the reduction in presentations, when children presented they had quite significant safeguarding issues for example in the first lockdown there was an increase in the number of children under one with head injuries, one of which resulted in a children safeguarding practice review being undertaken locally. There has been an increase in children with emotional disorders (e.g., eating disorders) and over a 50 percent increase in CAMHS referrals. The pandemic has had and will continue to have an adverse impact on the health and wellbeing of children

3. Accountability, Governance and Assurance Arrangements

The NHS England and Improvement Safeguarding Assurance Framework 2019 sets out the responsibilities for the different parts of the health and social care system and key individuals.

These include:

- To ensure a clear line of accountability for safeguarding that is reflected in the CCG governance arrangements,
- To secure the expertise of Designated Professionals on behalf of the local health system and to undertake regular capacity review against the Intercollegiate Document for Safeguarding Children and Intercollegiate Document for Looked After Children.

- To ensure Designated Professionals are embedded in the clinical decision-making of the CCG to influence local thinking and practice within the local health economy.
- To ensure safeguarding and Mental Capacity Act requirements are considered in the new Integrated Care Systems (ICS) and Primary Care Networks (PCNS) place based system leadership
- To gain safeguarding assurance from all commissioned services, both NHS and independent health care providers.
- To co-operate with requests from Local Authorities to undertake health assessments for children in care without undue delay to ensure they receive the support and services required.

During this period of reporting, our Managing Director held the role of executive lead for safeguarding children. He was supported by our GP Clinical Board Lead for Safeguarding, a Governing Body Lay Member, Designated Professionals and Named GP for Safeguarding Children.

Our executive lead for safeguarding, Clinical GP Board Lead for safeguarding and designated professionals fulfil the CCG's statutory duty to be represented on the City and Hackney Safeguarding Children Partnership (CHSCP) Strategic Leadership Team (SLT) & Executive meetings. The CHSCP is the key statutory body for agreeing how organisations work together to safeguard and promote the welfare of children and young people in City and Hackney, and for ensuring the effectiveness of what they do.
City and Hackney CCG holds a Safeguarding Assurance Group (SAG) that provides internal assurance to the CCG regarding safeguarding children. The SAG is chaired by a Board Non-Executive Director who reports to the Governing Body. The group is attended by our Managing Director and Clinical GP Board Lead for Safeguarding Children. The group met 3 times during 2021/22 and reviewed safeguarding children reports prepared by our designated professionals. These reports provided details on both national and local safeguarding children issues, potential risks and mitigations to reduce risks that have been identified. On a quarterly basis, our designated professionals also provided key safeguarding children updates to the CCG Quality Committee.

Throughout 2020/21, our designated professionals have provided safeguarding leadership to the CCG and our health care providers via a number of processes and activities. These include:

- Safeguarding supervision sessions with Named Nurses/Doctors for Safeguarding Children;
- Quarterly safeguarding children dashboard meetings with neighbouring designated nurses and health care providers;
- Health care provider Safeguarding Committees;
- Health care provider safeguarding audits;
- Health care provider safeguarding annual reports;
- Ofsted/CQC Inspections; and
- Serious incident reporting

Set out in Table: 1 below is our designated professionals and Named GP capacity that has been benchmarked against the Safeguarding and Looked After Children Intercollegiate documents as of October 2020:

Table 1: CCG Designated Professionals and Named GP Capacity.

Safeguarding Roles	City Child/LAC/ Population	Hackney Child/LAC/ Population	Capacity	Intercollegiate guidance Compliance
Designated Doctor for Safeguarding Children	-	-	2 PAs(4 agreed)	4.5 – 5 PAs (programmed activity) per week
Designated Nurse for Safeguarding Children	1453*	63,655*	1 WTE	1 WTE Designated Nurse per 70,000 child population
Designated Doctor for Looked After Children	25	435	2	0.2 WTE per 400 Looked after children
Designated Nurse for Looked After Children	1453	63,655	0.6 WTE	1 WTE Designated Nurse per 70,000 child population
Named GP	8706	279,665	2	2 PAs per 220,000 total population
Safeguarding Administrative Support	1453	63,655	Resource is shared between 2 work streams and safeguarding	0.5 WTE for safeguarding and 0.5 WTE for LAC per 70,000 child population

*Approx...

We have reviewed our designated doctor PA's and increased these to 4PA's. However, due to our designated doctor's other work commitments and job plan he has not been able to increase these at the current moment. The designated professionals work closely as a team and prioritise the workload accordingly to reduce this risk.

Our capacity for the Looked After Children is only partially compliant with the intercollegiate guidance. We have reduced this risk by our Designated Nurse for Looked After Children working collaboratively with her counterparts within our North East London and by adopting a team approach to support. We continue to recognise that effective safeguarding provision requires local context but there are identified areas we can work collectively on.

The administrative support capacity is not compliant with the guidance but additional resource is available to our designated professionals as and when required.

4. Progress against 2019/20 Priorities & Achievements

Over the past year we have made good progress against the safeguarding priorities we agreed in 2020/21. These achievements are described in the context of the government declaring a national emergency and lockdown to protect against the spread of COVID-19 in March 2020. The impact of COVID 19 has been a dominant feature in this reporting year.

The strategy of staying at home and social distancing to stop the NHS becoming overwhelmed and to reduce deaths from COVID-19 has resulted in unprecedented challenges to the way we work together to prioritise our vulnerable children and ensure that they continue to be safeguarded.

In 2020/21, we agreed five priorities to enable the CCG to continue its commitment to support strategic system wide changes that would ensure our workforce deliver high quality safeguarding practice. These include:

1. To ensure safeguarding children is robustly considered as we move towards a single Integrated Care System and Primary Care Networks.
2. To support the City and Hackney Safeguarding Partnership to understand and manage the impact of COVID19 pandemic to children and our workforce.
3. To review the new CDOP arrangements and consider how we capture the feedback from families.
4. To develop and facilitate safeguarding training programme for Primary Care Networks and neighbourhoods.
5. To continue to work collaboratively with all safeguarding leads across NEL to learn from and support each other and to design a safeguarding system that protects and supports the vulnerable in our population.

4.1To ensure safeguarding children is robustly considered as we move towards a single Integrated Care System and local integrated care partnership.

In line with the NHS 10 year plan, the move towards integrated care Systems (ICS) and Integrated Care Partnerships (ICP) is underway. In April 2021, City and Hackney CCG was dissolved and became part of NEL CCG.

The impact of COVID 19 and the resulting risks to children were appreciated early on in the pandemic. Safeguarding leads from across the North East London CCGs came together initially on a weekly basis. Collectively we reviewed risks and shared intelligence to safeguard and support children and families.

A new role of Chief Nurse for Quality and Safeguarding was established at NEL CCG level during this year. Prior to her appointment a safeguarding forum was established which identified 5 task and finish groups to review safeguarding at NEL level.

The groups are:

- Health and wellbeing of staff
- Data capture
- Safeguarding governance
- Safeguarding priorities
- NEL Covid 19 learning

Working at NEL level enables us to support each system with shared learning and resources but not forgetting that local context is essential to safeguarding children and families.

4.2 To support the City and Hackney Safeguarding Partnership to understand and manage the impact of COVID19 pandemic to children and our workforce.

The City and Hackney Safeguarding Children Partnership (CHSCP) is set out below.

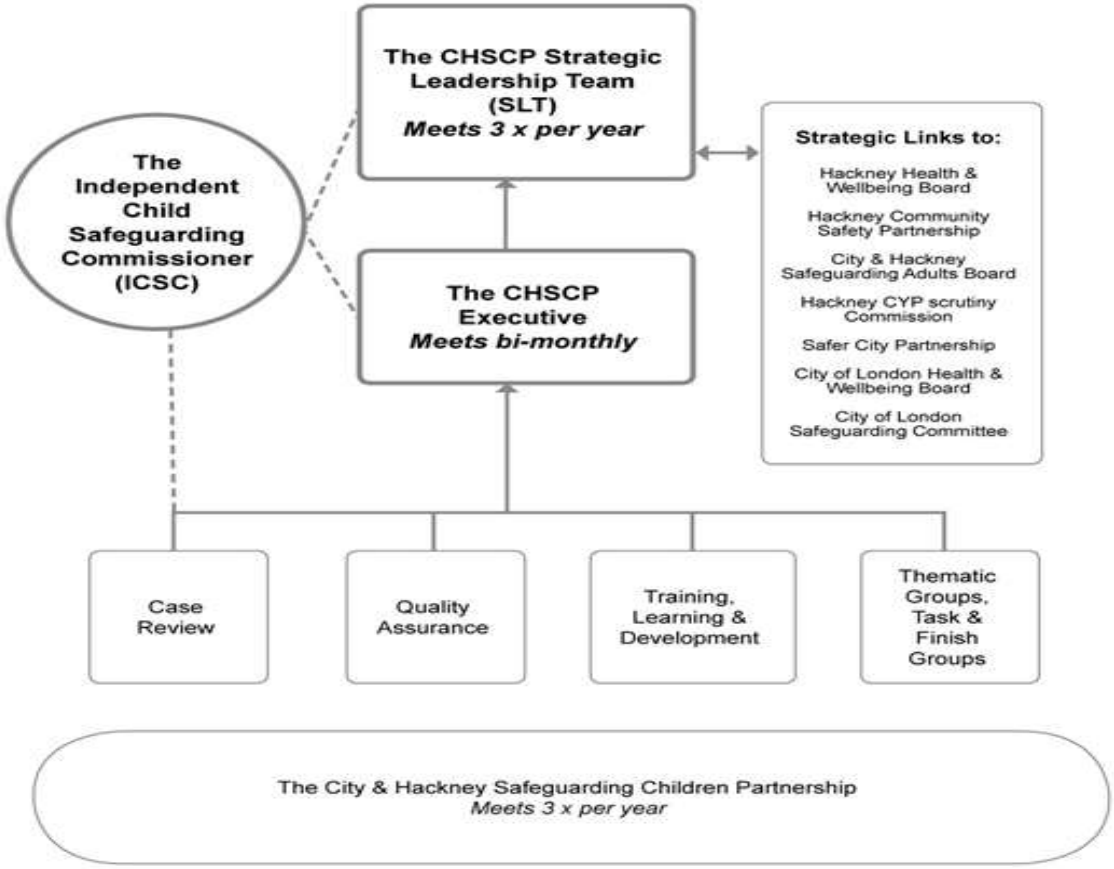


Figure 1: City and Hackney Safeguarding Children Partnership Structure

In response to COVID-19, the Independent Child Safeguarding Commissioner held multi-agency strategic oversight groups across both City of London and in Hackney and requested partners to report on the following:

- Partners were asked to provide an overview on the scope of the contingencies that they have in place and any contingency testing undertaken, the risks identified and any alternative approaches of practice developed;
- Partners were asked to consider the health and wellbeing of staff and how they are being looked after, including the sufficiency of staffing levels, protective clothing, and access to occupational health, homeworking and communication channels; and
- Clarification was requested on how partners are delivering face to face services in respect of multi-agency safeguarding practice.

The CHSCP Strategic Leadership Team continues to maintain oversight of multi-agency safeguarding practice and contingency arrangements of individual agencies. The transformation Director currently represents the CCG on the CHSCP senior leadership team.

4.3 To support the implementation of the new Child Death Review (CDR) arrangements with health and local authority partners across the Waltham Forest, Newham, Tower Hamlets and City and Hackney.

Working Together 2018 and additional operational guidance entitled Child Death Review (2018) named the local authority and CCG as statutory child death review partners. The aim of national guidance is to standardise outputs from child death reviews as much as possible by setting out key features of a robust child death review process. This includes formal collaboration between the CCG with neighbouring areas to ensure that child death reviews are undertaken at greater scale.

The purpose of the child death review system is to:

- Prevent child deaths by understanding what the health and well-being causes of child deaths are; and
- Take a holistic look of the inequalities that cause death of children.

The features of our new CDR arrangements include:

- One over-arching Child Death Overview Panel (CDOP);
- A centralised Hub team co-ordinating the Waltham Forest, Newham and Tower Hamlets to form WEL and City & Hackney –CDR System;
- Standard processes & the use of e-CDOP to manage activity & outputs and
- Collaboration with the voluntary and community sector (VCS) for key working and ongoing family bereavement support.

Our partnership agreement for the new CDR arrangements is currently out for review by the respective statutory partners prior to being signed off.

The new arrangements place significant additional responsibility on health providers and also require that families are supported through this review process. In City and Hackney we have secured additional funding to recruit a Child Death Review Nurse to support families during this traumatic time. This post also supports the Designated Doctor for Child Deaths at Homerton Hospital. The post has been operational since Jan 2021 and positive feedback has been received. See Appendix 1

A Child Death Review after action review has been conducted in the last year by an independent consultant. This review commended the role of the child death review nurse at the Homerton both in supporting and receiving feedback from families and in the smooth running of the child death review meetings taking place in the Homerton. The after action review recommends similar resource in BARTS and also recommends that scene of collapse visits could be undertaken by an appropriately trained health care professional (currently undertaken at Homerton by paediatrician) but could be done by nurse with specific training in forensics which police have offered to support

4.4 To develop and facilitate safeguarding training programme for Primary Care Networks and neighbourhoods.

Serious Case Reviews (now replaced with Child Safeguarding Practice Reviews) are the responsibility of the CHSCP to undertake and oversee to ensure a self-improving dynamic system that supports high quality

safeguarding practice to promote the welfare and safety of children. Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed.

The purpose of SCRs is to understand why things happened as they did, in order to improve our response in the future and prevent similar incidents from reoccurring. It is usual practice to involve the subject, family and practitioners where possible. When the SCR criteria has not been met, our CHSCP has undertaken multi-agency case reviews to identify good practice and key learning to improve safeguarding practice and or arrangements. .

For the past year, our designated nurse has chaired the CHSCP Training, Learning and Development Subgroup. This group is responsible for the development, delivery and evaluation of the CHSCP multi-agency training programme. A range of learning events were held to disseminate key findings and lessons from the 2020/21 learning reviews including:

- CHSCP 'Things You Should Know' (TUSK) briefings;
- multi-agency seminars and training sessions;
- GP Safeguarding Leads reflective sessions;
- GP Level 3 training sessions;
- GP Newsletter;
- CHSCP website; and
- City and Hackney GP Portal.

We have set out in Table: 2 an overview of the reviews commissioned by CHSCP during 2020/21 and the progress of these as of July 2021.

Initial learning that we have identified from these reviews that are near completion include:

- The importance of hearing the 'voice of the child' and understanding their lived experiences.
- The need for professionals to show more curiosity and challenge and escalate concerns if they have concerns.
- On-going need for professionals to develop confidence to have difficult conversations with parents and colleagues.
- The importance of having a holistic view of family health needs and care and understanding how this information may impact on care delivery and safeguarding of children.
- Rethinking of children not brought to appointments.

We have been promoting a rethinking of children not brought to health appointments from 'did not attend' to 'was not brought'. Using this wording acknowledges that children need an adult to take them to appointments and that if they miss appointments professionals should look at the reasons behind it and consider if there are any safeguarding or welfare issues. We have asked our health care providers to review their policies in line with this. Through our CHSCP, we have promoted a 'was not brought' video that illustrates the need to rethink how we manage children not brought to appointments.

We have raised awareness of the need for professionals to show more curiosity, challenge and escalate concerns. We have disseminated this CHSCP briefing to GP Practices and GP Practice Safeguarding Leads. This briefing is also available to primary care staff via the GP Portal.

Table 2: CHSCP Serious Case Reviews & Multi-agency Case Reviews 2020/21

Review	Summary	Progress/status
Serious Case Review Child A	**Child A:** Concerns in relation to Child P receiving large quantities of opiates over a significant period of time. The Serious Case Review (SCR) of Child A report sets out a range of findings and recommendations for practice improvement, including: • Practitioners did not consistently listen to the voice of Child A, so as to understand Child A's perspective, concerns and feelings in order to undertake a meaningful assessment. • Some of Child A's reported symptoms were responded to without any objective assessment by health professionals. • There was an absence of a lead professional to co-ordinate and communicate the input of different agencies. • The absence of a local chronic pain team contributed to the inadequate monitoring and supervision of Child A's long-term medication. • There were weaknesses in practice to monitor the repeated postponement or cancellation of Child A's health appointments by the parents. • There was an insufficient response in meeting Child A's educational needs. • Practitioners insufficiently challenged and escalated their concerns about Child A.	Report published Jan 2021
Serious Case Review Child B	**Child B:** In May 2015, Child B was admitted to hospital and had his big toe amputated. The professional opinion from health was that the infection that led to the amputation was preventable. Child B was not brought to a number of health appointments. Had he been, then it is likely the infection would have been appropriately treated and managed. The Serious Case Review of Child B report sets out a range of findings and recommendations for practice improvement, including: • Children not being brought to appointments is an indicator of potential neglect. • Effective and child focused safeguarding practice with disabled	Report published April 2021

	children ensures they are seen, heard and helped • The focus on engaging parents and carers to support disabled children is key, but this should not dilute professional challenge when needed. • Multi-agency working, information sharing and understanding the responsibilities of others can be complex. Clear systems and processes can support effective child focussed safeguarding practice. • The need for professionals to think family and think fathers.	
Serious Case Review Child C	**Child C:** In May 2019, Child C was 15 year old when he died as a result of being stabbed whilst in the street. **The Serious Case Review (SCR) of Child C** makes nine findings and sets out recommendations for practice improvement. • Exclusion from mainstream school can heighten risk • exclusion from mainstream school is seen as a trigger point for risk of serious harm • Permanent exclusion can be 'a trigger for a significant escalation of risk'. Education settings need access to local intelligence • Pupil Referral Units (PRU) and Alternative Education Provision (AP) have minimal influence over which children are placed in their facilities. This can result in young people who live in rival gang areas being in the same classroom. • Whilst staff had a good understanding of the needs of individual pupils, the risk dynamic created by the cohort of pupils was less understood. • A focus on the individual child is important. When working with children who are victims of serious youth violence, emphasis needs to be placed on their individual needs. • For young people from black and minority ethnic backgrounds, practitioners should explore what their racial and cultural identity means for them in the context of where they are growing up and how they live their lives on a daily basis. It is essential that practitioners are confident to explore these issues, have a good understanding of the implications and can tailor plans appropriately. • Clarity is needed about interventions to mitigate extra-familial risk • Whilst local procedures were followed, the difference this made to Child C's outcomes is less tangible. The review recognises that at	Report published Dec 2020

	the time of Child C's death, multi-agency contextual safeguarding practice in response to extra□familial risk was new and developing. It is also important to recognise that the circumstances involving Child C were complex and extremely challenging. • Developing positive relationships with young people is important • Inconsistent judgements about risk creates uncertainty • Poor case recording can directly impact on practice	
Serious Case Review Child I	**Child I:** Alleged perpetrator involved in the stabbing of Child C died whilst on remand at Youth Offending Institution. The SCR of Child I When looking at Child I's life in the context of criminal activity, serious youth violence and exploitation, a number of themes are present, The SCR has not sought to repeat many of those findings that have already been established from a range of comprehensive reviews, rather it focuses on a limited number of areas upon which the SCR believes the local partnership should apply focus. • Practitioners not only need to recognise and respond to well-established 'critical moments', but 'subtle moments' too; moments that might present clear opportunities to help and protect a child. • We know much about the circumstances in which risk relating to exploitation, criminality and serious youth violence is predictably going to increase. Despite this knowledge, practice does not always accrue the benefits of a coherent multi-agency approach. • Where children are identified as needing early help, it is important that parents and carers fully understand what this involves in respect of a coordinated, multi-agency approach to help and protection. Without this understanding, they may be hindered in their ability to provide informed consent.	Report published July 2021
LCSPR Child Q	This Local Child Safeguarding Practice Review (LCSPR) involves an incident involving a strip search undertaken on Child Q, a 15-year-old female child, whilst on her school premises in December 2020. The Police in Schools Officer recommended that the school call 101 and ask for a female officer to attend to search Child Q. On arrival, following a pat down of clothing (no cannabis found), Child Q was escorted by two female officers to the school's medical room to be searched. No appropriate adult attended this search. Child Q's mother was not contacted in advance. No cannabis was found as a result of this search.	Review underway

CSPR Child R	The practice review was commissioned by City and Hackney safeguarding children partnership following a serious incident notification and rapid review of Child R. This 2year old child suffered a serious head injury soon after the family moved to Hackney. The Review analyses how services were delivered to Child R and his mother and also considered information prior to Child R's birth which is deemed relevant to the review.	Report in draft

4.5 To continue to work collaboratively with all safeguarding leads across NEL to learn from and support each other and to design a safeguarding system that protects and supports the vulnerable in our population.

Working together with colleagues within NEL our designated professionals have written the following policies to support our staff to recognise and take actions to safeguard and promote the wellbeing of children:

- Safeguarding Children and Adults Procedures;
- Safeguarding Children and Adult Supervision Policy; and
- Domestic Abuse Policy and Procedures.

All of the policies developed have been informed and are aligned to local priorities and the needs of our residents.

Over the last year we have updated both the safeguarding intranet page and GP portal. We have added the following additional resources:

- RCGP Supplementary Guide to Safeguarding Training Requirements for Primary Care
- RCGP Child Safeguarding Tool Kit
- DOH FGM Safeguarding Risk Assessments
- Rethinking Did Not Attend video
- Things you should know link (CHSCP briefings)

We also set up a safeguarding section on the COVID-19 essential information webpage. To this we added safeguarding COVID-19 resources for GP Practice Safeguarding Leads and GP Practices.

4.6 Key Achievements for 2020-2021

Over the past year we are proud to have:

- Assisted the CHSCP to deliver the partnership's 2020/21 priorities.

- Worked with our local health and local authority partners to reduce the risk to children seen in unscheduled health care settings following the switch off of the national child protection information sharing system following the cyber-attack in Hackney in Dec 2020. Sharing the learning from this on regional and national platforms.

- Commissioned the role of the child death review nurse at Homerton to provide support to the child death review process and importantly to be a point of contact for bereaved families.
- Worked with Homerton to oversee and monitor the Primary Care MARAC (Multi Agency Risk Assessment Conference) Liaison Service which has was highly commended for the Health Service Journal Patient Safety Award for Safeguarding Initiative.

- Delivered safeguarding supervision to our Named professionals in the different parts of the health system.

- Worked with public health to oversee and monitor the IRIS programme to support primary care teams with domestic abuse.

- Supported and advised on complex cases escalated by named professionals and or partner agencies.

- Attended and actively contributed to the London region and national designated professionals networks.

- Developed City & Hackney's integrated Childhood Adversity, Trauma and Resilience (ChATR) Programme. Our vision is a community in which children who are at risk of or have experienced trauma receive the right support at the right time, giving them the best possible opportunity for a healthy future. See Appendix 2

- Neighbourhood Programme

  Through the City and Hackney Neighbourhoods programme we have been progressing a number of projects that aim to strengthen knowledge and understanding of practitioners working within neighbourhoods and strengthen pathways through services.
  We have revised the processes of involving Primary Care in multi-agency discussions regarding 0-5 years children and their families so that GPs are better linked in and we have been testing strengthening links and pathways between services working with vulnerable adults and services for children and young people.
  We are also progressing a project that aims to strengthen links between Primary Care and Schools with the aim that by the end of the next financial year, all Primary Schools will have a named contact at their Local GP Practices and there is a pathway for Schools to draw on expertise concerning children who are absent from School or who have specific, complex or chronic health needs.

  By the end of the academic year this should look like:
  - A named contact for Schools and their local GPs to have a direct line of communication to increase dialogue between both expertise
  - Clear pathways for managing health concerns within the school using GP advice
  - A directory of GP contacts and named School contacts produced, so that with consent, respective parties can contact a child's GP to input into multi-agency discussions concerning children's wellbeing

For children, young people and families this should mean health needs are being picked up earlier and families are being better supported through COVID anxieties to ensure children's absence from School is avoided or minimised.

5. Voices of Children, Young People and Families

Only when we receive feedback from children, young people and families can we truly be confident that the services we provide are making a positive difference to the lived experiences of children and families. Hearing the voices of our children and their families help our health care providers to continually look at ways to improve their experiences of services.

5.1 CAMHS patient participation event in Feb 2021

East London Foundation Trust undertook a CAMHS patient participation event in Feb 2021. The group was attended by 10 young people aged 14-17 years. The group was held to seek out service user's perspectives of safeguarding issues, what they viewed as risks to their wellbeing and how ELFT staff could help to keep them safe. Appendix 3 shows the feedback from this event.

5.2 System Influencer work

Engagement and co-production with young people is a CCG Children Young People Maternity and Family (CYPMF) Integrated work stream transformation priority. With this priority in mind, the work stream piloted a Young People's System Influencer programme between November 2020 and February 2021. A group of 10 young people aged 16-25 were recruited from existing engagement groups and employed for 7 weeks to co-produce projects to influence systems. Each of these young people was assigned two experienced 'System Mentors' who offered support and guidance throughout the delivery of their projects. The young people were also supported to take on their 'System Influencer' roles through another programme role, 'Peer Mentors'. The two Peer Mentors were young people, slightly older than the System Influencers, who acted as a bridge between the influencers and the mentors. The majority of the System Influencers delivered a number of projects touching on issues such as how young people access health and wellbeing support, evaluation of current models of youth engagement by the council and VCS organisations, a project aimed at young black people who are involved in the youth justice system which used art as a tool to explore experiences of trauma, and engagement on the CYP City and Hackney Emotional Health & Wellbeing Strategy. The programme was extremely positively evaluated with plenty of learning to take forward as part of the delivery of the next phase. There is currently a joint financial proposal in development between Health Watch and LBH/NEL CCG in order to secure funding for two posts to support the delivery of the mainstreamed programme; one of these is a young person's post. Current plans are for the next phase to begin in quarter 3 of 2021/22.

Link to the video: https://vimeo.com/528304055

6.0 Safeguarding Children Training Compliance 2020/21

We have worked together with our health care providers to ensure that we have a competent and confident workforce to identify and support vulnerable children. This includes staff working in CHCCG and primary care.

We have set our safeguarding children training compliance target at 85% or above for all levels. The overall compliance level for CHCCG and our health care providers was as follows:

Table 3: City and Hackney NHS Clinical Commissioning Group Training Compliance

Safeguarding Children Training Level	2018/19	2019/20	2020/21
Level 1	88%	90%	91%

Table 4: Homerton University Hospital NHS Foundation Trust Training Compliance

Safeguarding Children Training Level	2018/19	2019/20	2020/21
Level 1	96%	97%	97%
Level 2	87%	92%	86%
Level 3	80%	83%	81%

Table 5: East London Foundation NHS Trust Training Compliance

Safeguarding Children Training Level	2018/19	2019/20	2020/21
Level 1	88%	96%	92%
Level 2	78%	88%	86%
Level 3	63%	67%	60%

Table 6: General Practice and Primary Care

Training	Number of sessions	Number of primary care staff trained
Level 3	1	88
IRIS		
GP Safeguarding Leads Reflective Forum		

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Due to the COVID-19 restrictions all of our provider health care safeguarding teams have adapted their safeguarding training programme and supervision sessions to adhere to the social distancing requirements. Achieving compliance with Level 3 has been a very significant challenge for ELFT due to the large volume of additional staff mapped to receive this training following revisions of the national guidance. This has been closely monitored by the Trust's safeguarding committee meetings and our contractual processes

The impact of safeguarding children training delivered is evident from health care staff seeking advice and escalating complex cases to Named and Designated professionals.

The feedback received from health care staff attending the different safeguarding training sessions has been very positive. Here are some examples of what staff said:

7. External Inspections

7.1 Care Quality Commission (CQC)

Due to the unprecedented Covid 19 pandemic CQC routine inspections were suspended, and the focus was on supporting health providers to provide safe care.

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7.2 Office for Standards in Education, Children's Services and Skills (Ofsted)

There were no Ofsted inspections conducted during this reporting timeframe

8.0 Health Care Provider Safeguarding Practice

As a commissioner of health care services and Safeguarding Partner we have a statutory responsibility to co-ordinate and monitor the effectiveness of our health care provider safeguarding practice. However, any challenges and risks to safeguarding children are also monitored through the reporting and governance structures of each Trust. Our designated professionals are invited to each of the Trust's safeguarding committees to provide safeguarding leadership, challenge and support.

Over the past year our health care providers are proud to have achieved the following:

8.1 Homerton NHS Foundation Trust

Services provided by Homerton NHS Foundation Trust are available HERE

Key Achievements in 2020/21

- Staff in the SCT were not redeployed and continued to provide a safe and effective service by providing expert advice and support to staff, supervision and training and representing the trust at external strategic safeguarding children meetings. This approach was in line with NHSE guidance on prioritisation of services.

- The Primary Care MARAC Liaison Service won a highly commended in the HSJ Patient Safety Committee in November 2020.
- When CPIS was deactivated for Hackney due to the cyber-attack on their Information System – the service provided assurance to NHSE that the workarounds put in place ensured that vulnerable children were not slipping through the net. This audit will form part of the submission on the national enquiry into the management of Covid.
- Published Safeguarding in a Pandemic Newsletter and contributed to the trust Was Not Brought Policy cited as good practice and posted on CHSCP website: https://chscp.org.uk/was-not-brought/

Challenges/Risks

- Increased breadth of safeguarding agenda.
- Increased regulatory demand within fixed resource.
- Child Health Information service.
- Impact of COVID-19 on safeguarding children.
- Consultant Paediatrician Capacity

Focus area for 2021/22

The Homerton Safeguarding Children Work Plan is informed by:

- NHSE Accountability and Assurance Framework (2015)
- Learning from national and local Serious Case Reviews, Case Reviews and Multi-Agency Case Audits
- HUHFT Safeguarding & Regulation Children Committee Priorities
- City and Hackney Safeguarding Children Board Partnership Priorities:

8.2 East London NHS Foundation Trust (ELFT)

Services provided by East London NHS Foundation Trust available HERE

Key achievements 2020/21

Embedding a new approach to safeguarding children training and supervision

- Ensuring all ELFT staff have had uninterrupted access to safeguarding advice and support throughout the pandemic
- Improved data collection systems to identify safeguarding themes and demographic data of the safeguarding cohort
- Close partnership working demonstrated in participation of multi-agency audits, case reviews, information sharing agreements and escalation of concerns
- Increased accuracy of key performance data
- Furthered access to multiple record keeping systems across the trust
- Positive feedback regarding the quality of safeguarding children supervision.
- Joint working alongside the safeguarding adult team within the Domestic Abuse steering group to promote the Think Family approach.

Challenges/Risks

- Low level 3 safeguarding children training compliance
- Increased complexity of safeguarding issues associated with the pandemic

- Multiple systems in use across trust leads to potential of consistency in reporting data and some staff accessing records.

Focus areas for 2021/ 22

- To meet the training trajectory for safeguarding children level 3 training bought about by the changes to the intercollegiate guidance.
- Ensure any challenges associated with future peaks of Covid can be mitigated
- To work towards unifying safeguarding reporting data across several systems
- To maintain visibility at partnership meetings
- To ensure that the Trust 'Think Family' ethos and professional curiosity is embedded into everyday practice
- Continue to embed organisational learning through mandatory training, from serious incidents and adult/child reviews
- Making safeguarding personal and the demonstrating the voice of the child has been considered.

Ensuring all mapped services are supported to receive safeguarding children supervision

8.3 Barts Health NHS Foundation Trust

Details of services provided by Barts Health are available HERE

Key achievements 2020/21:

- Literature review of safeguarding supervision and policy updated accordingly
- Safeguarding Training Policy has been updated
- Throughout the pandemic safeguarding team have maintained physical and visible presence across the hospital sites.
- Safeguarding weeks were run on each site which included:
    - Professional Curiosity
    - Voice of Child
    - Child focused safeguarding
    - Difficult conversations and professional challenge
- Short term funding was agreed by CCG to support the recruitment of liaison post at NUH
- Development of Microsoft Teams virtual training which compliments the e-learning for health

Challenges/Risks

- Safeguarding children supervision compliance - this is monitored monthly at the site safeguarding meetings with exception reports to the Trust operational meetings and development plans in place
- Whilst there has been some audits completed. It is recognised there is a need to increase audit activity for 2021-22
- Safeguarding children training compliance – the target compliance is 85% however there are areas of the Trust where compliance is as low as 66% so there is need to remain vigilant with monitoring training compliance and any hotspots
- The Child Death process and the interface with WELC CDR Hub this has remained a risk for 2020/21

Focus areas for 2021/22:

- Embed the revised training proposal

- To have an effective child death process across BH and WEL
- To work with partners to implement a standardised referral form for safeguarding children referrals from Barts Health to children social care
- Ensure robust implementations of actions and recommendations from SCRs
- Continue to increase compliance with supervision and training
- Deliver audit programme
- Analysis of equalities data to inform practice changes
- Participation in the shaping of the Integrate Care System across North East London for Safeguarding

Continue to strengthen the visibility of safeguarding children at hospital based meetings. To ensure the hospitals are using the knowledge from the experts to drive local improvements in service delivery.

8.4 GP Member Practices

We continue to recognise the importance of supporting primary care with all aspects of safeguarding children, so in addition to our Named GP capacity we extended our Primary Care Named Nurse role to February 2022.

Due to COVID 19 we had to stop our face to face Level 3 safeguarding training programme but were able to develop and facilitate virtual training that 88 primary care staff accessed. Feedback received from the participants was positive, below are some examples:

"I found the discussion around emailing images of children particularly interesting and informative, especially in a time where the majority of our consultations are done remotely."

"It was an excellent session and it was particularly helpful in terms of safeguarding legal pitfalls with new ways of remote working. The break out rooms were great in terms of addressing the particular cases and safeguarding issues."

"Good update relevant to current times with Covid, remote consulting and migrant challenges addressed. Good accessibility with being on online."

"Difficult to do these things on virtual media. I think the presenters did what they could - there is a limit."

As well as the level 3 training, we assisted and or facilitated with other learning and development events including:

- Virtual IRIS programme to ensure children and families affected by domestic abuse were able to access support via primary care.
- Two sessions at the Practitioner Forum on the impact/learning of the COVID -19 pandemic on safeguarding children.
- Safe & Together Education webinar (that introduced a framework for working with domestic violence survivors and intervening with domestic violence perpetrators in order to enhance the safety and well-being of children).
- One session at the Practitioner Forum on the challenges resulting from the cyberattack to London Borough of Hackney, safeguarding referral pathways and advice and support available to staff.

Key achievements 2019/20

- *We have worked with public health and partners agencies to adapt the NHS COVID 19 Domestic Abuse Rapid Read and disseminated this to our GP Practices.*

- We have worked with IRIS programme to hold weekly drop in domestic abuse Q &A sessions to support our GP practices.
- We facilitated virtual GP Safeguarding leads Reflective sessions.
- We raised awareness of the IRIS and Primary Care MARAC Liaison Service to safeguard and promote the wellbeing of women and children.
- We provided advice to GP's on specific safeguarding cases either on the phone or via email.
- We worked with NHS Digital, RCGP and Named GPs to reduce risk from EMIS Patient Access & Domestic Abuse Codes.
- We worked with Named GP's across NELCA producing documentation to support GP's regarding the use and storage of intimate images of U18's.
- We have pushed for the roll out Child Protection Information Sharing (CHIS) to GP Practices and have agreement for this to be included in phase 2 of the programme.
- We have worked with the Director of Primary Care and NEL STP Chief Nurse to gain approval for NEL Safeguarding Incentive Scheme in relation to reports requested by the local authority

Focus area for Priorities for 2020/21:

- NELCA wide PC SG LIS - increase in returns to children's social care re: conference reports
- Implementation of IMR/SCR learning
- Level 3 training – opioid prescribing, was not brought, CSA, contextual safeguarding
- GP Safeguarding Leads Reflective sessions
- Safeguarding page on NEL intranet.
- working with the children's team and MH to increase services for adolescents in C&H

9. CCG Safeguarding Challenge/Risks

Risk	Mitigating action taken/proposed	RAG Rating
Potentially significant increased demand for CAMHS support increased pressure on T4 beds, and increasing crisis and ED presentations, which is also reflected across NEL and London. Many services are seeing a large risk in the number of referrals, particularly Tier 3 CAMHS, Eating Disorders and Crisis. In addition, specialist CAMHS have raised a risk of staff absence through sick leave due to workload.	1.CAMHs have responded flexibly to support families during the peak of COVID Robust contingency plans in place for this to continue. This includes: • Solid governance structures, • RAG rating patients, children and families, • Introduction of online support • New services in development. 2. Impacts of the pandemic on adolescent and CYP mental health, with T4 beds at capacity and increasing presentations. This is being addressed at NEL, with: • A new crisis group working with the provider collaborative. • An Integrated discharge planning group has been set up to meet fortnightly (with C&H, Newham and Tower Hamlets) with reps from health, education and social care to strengthen	15

	the community offer. Several new services are supporting families online (Kooth, Helios) and • We are developing plans for an integrated T3.5 service. 3. Through WAMHS we are writing to schools to encourage them to use their linked clinician for consultation so that, where possible, cases can be held through school intervention and referral to range of agencies, making sure referrals to CAMHS are appropriate. 4. MHST has extended its offer beyond its original scope of Wave 1 WAMHS schools, to invite all schools to universal parent support and training groups (primary & secondary), as well as groups for secondary age children. 5. This risk and mitigation is continuing to be monitored closely and is now also reporting to the Integrated Emotional Health and Wellbeing Partnership.	
Loss of child protection information sharing (CPIS) data due to cyber -attack in Hackney council. This means that information regarding children, young people and unborn who are the subject of a child protection plan or are LAC may not be available to clinicians to inform assessment at unscheduled care appointments.	1. All providers have issued detailed guidance to staff relating to clinical presentation and absence of CPIS data 2. Safeguarding alerts are added to children and pregnant women's records as appropriate (information shared between LB Hackney and hospital safeguarding teams) 3. Detailed audits completed (May 2021) which give assurance re mitigation measures 4. Reports, audits and assurance provided to NHSE/I and NHS Digital national CPIS board May 2021 and to be repeated in September. 5. Report and audits shared with CHSCP 6. NHS Digital working with LB Hackney around reinstatement process.	6

Our local safeguarding risk register aligns to the CCG Board Assurance Framework and is a standing item on the Safeguarding Assurance Group meeting agenda.

10. Priorities for 2021 – 2022

We have identified a number of key priorities to ensure that we continue to safeguard and promote the welfare of children as we move to a more integrated health and social care system:

- To ensure safeguarding children is robustly considered as we move towards a single Integrated Care System and Primary Care Networks.

- To support the City and Hackney Safeguarding Partnership to understand and manage the impact of COVID19 pandemic to children and our workforce.
- To review the new CDOP arrangements and consider how we capture the feedback from families.
- Develop and facilitate safeguarding training programme for Primary Care Networks and neighbourhoods.
- To continue to work collaboratively with all safeguarding leads across NELCA to learn from and support each other and to design a safeguarding system that protects and supports the vulnerable in our population.

Appendix 1

Report on the work of the CDR Nurse 26th August 2021

Activities carried out so far

1) ***Made links with stakeholders throughout Homerton University Hospital (HUH)***
   - ◊ *LeDeR Nurse (Learning Disabilities Mortality Review)*
   - ◊ *Bereavement midwives*
   - ◊ *Coronial offices*
   - ◊ *CDR WELC (Child Death Review Team Waltham forest, East London, City and Hackney)*
   - ◊ *Designated doctor*
   - ◊ *Chaplaincy*
   - ◊ *Consultants and staff on Neonatal and Paediatric Units*
   - ◊ *Local bereavement services*
   - ◊ *Practitioners across the Trust with Community services.*
   - ◊ *Links with bereavement/CDRs GOSH, UCLH, BHDR*
   - ◊ *Public Health*
   - ◊ *Some GP surgeries. (Lea Surgery, Well St, Dalston Practice)*
   - ◊ *Written a piece to be submitted in GP Forum Newsletter*
   - ◊ *Paediatric A+E staff*

Plans

- ◊ *To work at ensuring adult teams caring for 16 -18-year-olds are aware of their responsibilities with regard to CDR process.*

Case Studies

Case Study 1

Mother of a 9 year old child who died January 2020 in Gambia. Family returned to UK 3 months after his death.

The family had been referred to CSC before moving to Gambia and outcome of section 47 remains unknown.

GP came to know about the death when mother re registered but did not realise that a notification needed to be made to CDR WELC.

When this was discovered GP was guided by CDR Nurse on how to submit notification and learning about process gratefully accepted. At this point no professionals had seen the death certificate.

Home visit made to family. Death certificate seen.

Mother very distraught and keen to have support. Had been told by GP that St Josephs was only accepting referrals for relatives of patients at the hospice.

CDR Nurse had met with Sharon Cornford / Bereavement Services Manager at St

Impact of role

Quote from: Bereaved mother

This is really helpful and I am forever grateful

Quote from; a parent who was bereaved 3 years ago and who had strong feelings about feeling left out of the CDR process at the time.

I feel listened to for the first time

Quote from a doctor on A+E who saw a sibling of child who had died in disturbing circumstances. Sibling suffering from a

I am so happy that your post exists and that you are there for this family and obviously all the others who you work with. I didn't know about the role of Child Death Review and it is so important.

◊ *To meet with mortuary staff.* ◊ *To attend a GP forum.* ***2) Embedding the role within the organisation – becoming the Single Point of Contact by*** ◊ ***Newsletters, Twitter, meeting and seeking people out*** ◊ ***Supporting staff with individual cases that may have affected staff, helping to answer practitioners queries regarding ECDOP and in relation to the process and their responsibilities within it*** ***3) Scoping the understanding and practitioners' knowledge of the child death review process.*** ◊ ***Through meeting with practitioners from various services within HUH:*** ▪ ***HVS*** ▪ ***School Nurses*** ▪ ***Therapists*** ▪ ***Keyworkers*** ▪ ***Children's Community Nursing Team (CCNT)*** ▪ ***Neonatal Unit***	***Josephs as part of induction and knew that this was not*** ***currently the case so made a referral and mother was accepted for services.*** ***12 year old son who also suffers from asthma was not in school as the only offers made for a place were at too far a distance from home. CDR Nurse wrote a letter supporting an offer of a place at a nearby school. He is now settled at Moss Bourne Victoria Park*** ***GP had referred him to First Steps for bereavement counselling t mother's request.*** ***School Nurse alerted to this child's situation both in terms of his asthma and regarding his emotional wellbeing. He has since had an asthma care plan written.*** ***Liaison also with 1 year old daughter's HV. MAT referral as mother struggling to get to Children's Centre Activities.*** ***Older son referred to attend Football Camp run by BADU in the summer holidays.*** <u>Case Study 2.</u>	Quote from a practitioner who emailed to get advice about ECDOP. Thank you very much! This clarifies the process for me as I was a bit confused The thing is… clinicians come and go out of a sick child's life but a parent is always there, so it is important to speak to us! Quote from respondent to questionnaire sent to parents regarding their experience of the process.

4) Identifying gaps in awareness, knowledge and experience around the process.

For example

- ◊ ***Some services were using out of date information in their Pathways/Action Plans***
- ◊ ***Reporting forms that have been inadequately completed possibly due to lack of awareness as to how the information is used***

Good examples of completed reporting forms identified seen by some practitioners who have had some previous involvement and were able to build on their experiences for learning.

5) Scope bereavement support available locally, within HUH, and nationally

There has been a massive demand on Bereavement Counselling this year. The way in which it can be delivered has also been impacted by Covid-19 as this is currently only available on-line, which is not always the most appropriate delivery method for young children. The impact of this is that

Young mother attended A/N unit at Queens hospital in Romford with reduced foetal movements and baby sadly died following an emergency caesarean. Had had obstetric care at HUH.

CDR nurse liaised with both bereavement midwives at Queens and HUH. Both said that mother had declined bereavement support from them saying to Queens that she was getting it from HUH and the other way round.

When I spoke to mother, she explained that she didn't really like the idea of counselling and said that she was getting support from family. We talked through the benefits of talking to someone outside the family and she said she still wasn't ready. I asked her to keep my number and to call if wanted to.

She calls or texts me regularly and although still not ready to be referred for counselling is more open to the idea.

She wanted a copy of the scan pictures as she had not got any. With a lot of help from the midwives at HUH I was able to get some sent to her

She has lots of queries and questions in relation to what may have caused her

I am so happy that your post exists I didn't know about the role of Child Death Review and it is so important.

I didn't know there was a Child Death Review process

Quote from a bereaved parent about the usefulness of having the opportunity to contribute to the process.

Quote from: Designated Dr for Child Deaths

The CDR Nurse role has been an invaluable addition to the CDR team for City and Hackney, meeting gaps in bereavement provision, giving a voice to families and forming crucial local links between professionals involved in the death review process. The work being done has unmasked existing unmet needs and has demonstrated the value of embedding the post for the long term.

parents need more support. ***Scoping how we can make this better locally has involved developing a resource for families by:*** ◊ ***Making contact with several bereavement organisations*** ◊ ***Updating resource lists*** ◊ ***Identifying which services run what services or groups, which have waiting lists*** ◊ ***Receiving recommended services from other bereaved parents*** ***This is an ongoing process.*** ***6) Supporting parents through the Child Death Review process*** ◊ ***Contacted every parent whose child has unfortunately died and is open to a CDR to explain the CDR process and offer support.*** ***7) Surveying families to ask about their experience of the CDR process*** ***This indicated a lack of knowledge about the process among families prior to the CDR Nurse being in post.*** ***8) Reviewing open cases with the Designated Doctor*** ***This is also an opportunity to chase up information and reports from , for***	baby to die. I contacted the bereavement midwife at Queens and a meeting for her and her husband to attend at Queens was arranged to meet with a consultant obstetrician, a neonatologist and a bereavement midwife. This increased parents understanding of the cause of the problems and subsequent death of their baby and allayed some of mother's fears that she was somehow to blame. <u>Case Study 3</u> Mother of an 8 year old child who suffered an apparent self-inflicted accidental death at home. Visited at home 10 months following the incident. Family remain living at the property where the incident took place. Has only recently been given priority status to move. Having to come home to the property every day is having an impact on all of the family members particularly the next youngest child's emotional well-being. It has started to cause her to have some	

example: reporting forms Perinatal Mortality Review Tool (PMRT) Post Mortems (PMs) outcomes from Root Cause Analysis (RCAS) or Health Care Services Investigation Branch (HSIBS) Serious Incident (SI) ***9) Working closely with colleagues in the WELC CDR*** ◊ ***Supporting them with local information*** ◊ ***Using influencing skills to improve communication with practitioners*** ***Colleagues have been very supportive and informative around the practicalities of the process.*** ***10) Attending key child death meetings JARs, CDRMs and CDOP*** ◊ ***Contributing information – particularly in relation to the parent's voice.*** ***11) Developed training package on new child death arrangements*** ◊ ***Including advice on completion of forms on ECDOP and the role of CDR Nurse*** ◊ ***Delivered this to safeguarding***	physical symptoms. Mother is very low in mood and unable to contemplate seeking emotional support until they have been moved. Youngest daughter has been referred to local HUH services There is local sports and activities project (BADU) manager who has known and has worked with the family since prior to the accident and was supporting the family. They were involved due to some behavioural concerns at school for the child who died. The older two children are active members of the sports project. CDR Nurse has requested further support for the family from BADU and mother is now attending twice weekly exercise sessions and youngest daughter who is not very sporty is starting a mentoring programme with them. The worker was invited to the CDRM as it is recognised that representatives at these meetings should not just be from health and the wider partnership but also from other spheres. He made a valuable contribution to the meeting resulting in a letter being sent by Jim Gamble (**Independent Child Safeguarding Commissioner**) to Hackney housing. The letter requested that families	

children operational forum, joint safeguarding meeting, paediatric team and neonatologists. ***12) Providing Paediatric A+E staff with written information to share with parents following the death of a child.*** ◊ ***When a Child Dies Booklet*** ◊ ***A Loss Like no Other leaflet*** ◊ ***Leaflet outlining the CDR process*** ## *Next steps* ◊ ***Ensure that learning from deaths becomes part of the culture of local organisations. This will involve thematic analysis of lessons learned in liaison with the Director of Public Health and the CDOP co-ordinator*** ◊ ***Undertake training and develop role of JAR Nurse – to attend 'scene of collapse' with the police to obtain a detailed description of home environment and situation.***	experiencing a traumatic loss such as this within a Hackney home are given higher priority. The local housing support officer, the Project Manager from BADU, the doctor from A+E at HUH and CDR Nurse are all supporting housing application jointly. ***Case study 4*** ***I was contacted by a therapist who had been sent an invite to a CDRM from CDR WELC. The email only had a numeric CDR Case Number identifying the child due to be discussed. The Therapist was unable to identify who the child was and\when I was able to tell them – they were upset. They explained that this was a child who had been well known to services and that therapies had felt criticised at the JAR and that they as a team had been traumatised by his death. Receiving the email in this way had felt insensitive.*** ***I was able to ask the CDR WELC Team to ensure that invitations to CDRMs make the child more identifiable and put an explanation in the email about what they being invited to and the purpose of the meeting***	

This would increase the available resources for this role. ◊ *Develop a London Forum for CDR Nurses, building on links made with other CDR Nurses in London and further afield* ◊ *Attend the quarterly nurses for child death review peer network meeting* *Involvement in these networks will enable sharing of good practice.* ◊ *Looking at contributing to a 'Sim' to support staff on actions to take following the death of a child.* *This would ensure knowledge and skills were developed in an area that requires additional sensitivity and care and where there is thankfully there is not frequent opportunity to learn 'on the job'.*		

Other

The WEL and C&H and BHR Child Death Review Systems: Action Review, Report, June 2021
The following are extracts from the report which highlight the benefits of the CDR Nurse role:

The workshop participants responded to this question by discussing the good practice which appears to be in place in Homerton Hospital – where the CDRMs are working well. The meetings are convened by Homerton CDR Nurse/SPOC and the WEL and C&H CDR Hub.

Also, that attendance at the scene of collapse provides an opportunity for a health professional to offer early family support. This is happening from Homerton Hospital, where consultants are doing the scene of collapse visits.

Whilst face-to-face information is not being gathered, the WEL and C&H CDR Hub team is sending feedback questionnaires to families in the WEL and C&H footprint, except for families in City & Hackney – who are being contacted by the Homerton CDR SPOC/nurse

Recommendations which are being met or have the potential to meet by having a CDR Nurse in post:

1. CDR SPOC: Barts Health Trust should appoint a CDR SPOC to assist the WEL and C&H, BHR and other CDR/CDOP teams with the arrangements for CDRMs and coordinating the CDRM chairing. ✓
2. Scene of collapse visits: the CCG and Provider Trusts in WEL and C&H and BHR should make arrangements for scene of collapse visits to be undertaken by appropriately trained health practitioners as an integral part of both CDR footprints. ✓
6. Keyworker: the local authorities in WEL and C&H appoint should a Family Liaison Worker (keyworker) and both footprints should systematically gather feedback from families about the circumstances of their child's death and their experience of the CDR process; and use this feedback to improve services and the CDR systems. ✓

CDR Nurse Role was featured in the Homerton Let's Talk About Death Newsletter:

Let's Talk About Death

Issue 12, August 2021

Homerton University Hospital NHS
NHS Foundation Trust

End of life care best practice reminder: *USE THE SWAN*

The Swan symbolises the model we use to enhance our care for patients at the end of life.
The model emphasises:
- Team **recognition** of the last phase of life
- **Discussion** with patients and families to support them through out the end of life and dying process
- Recording **individualised** end of life care plans in the patient record

How we think about end of life care is important:
- *AVOID* end of life care along generic 'pathways'
- *STRIVE FOR* 'Individualised End of Life Care Planning' in a shared process with patients and their loved ones

For more information see: 'More Care, Less Pathway: A Review of the Liverpool Care Pathway' via this link:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

LET'S MEET Deborah Sherr: Child Death Review Nurse for City & Hackney

Deborah started this role in January 2021. She contributes to the regional and national Child Death Review process.
In the role she:
- **Assists** families access bereavement support
- **Supports** families going through the child death review process
- **Feeds back** meeting outcomes to families
- **Guides** health practitioners in contributing to the child death review process.

Case study:

BEST PRACTICE REMINDER: treatment escalation plans

When completing treatment escalation plans we must ensure following the principles of the Mental Capacity Act, especially patient **autonomy** and assessment of **capacity**.
As well as the TEP decision, it is important to record the **capacity assessment** and the evidence for the decision.
Try to **enter as much detail as possible** in the freetext boxes to explain decision making.

Resus Status Recorded

NEW PROCESS UPDATE: learning from lives and deaths of people with a learning disability and autism

Formerly the "**L**earning from **D**eaths **R**eview", **LeDeR** aims to improve the care and address health inequalities of people with a learning disability. They review the care of patients with a learning disability who have died. New this year **this now includes patients with autism.**

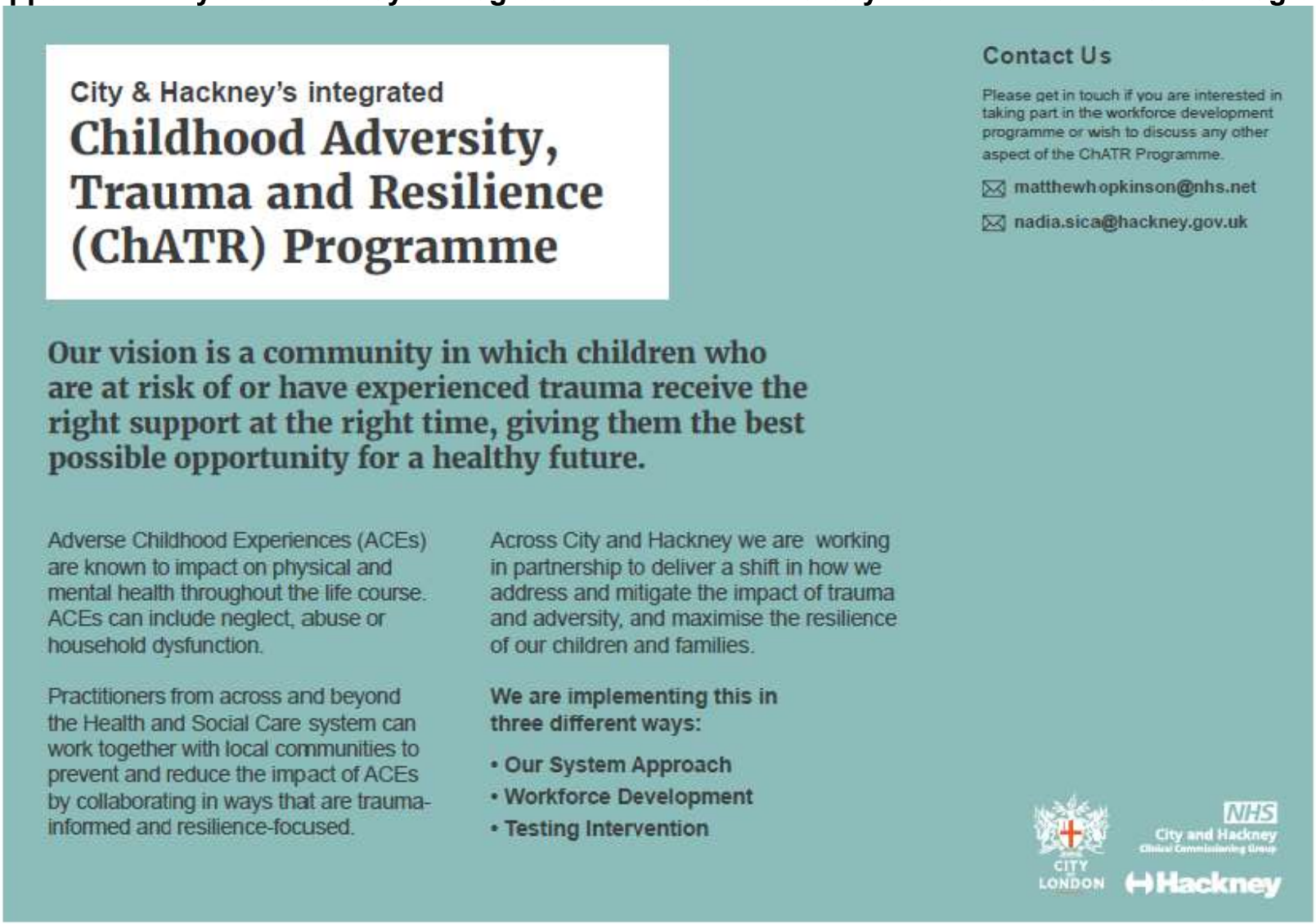
LeDeR should be notified of any death of a person with a **learning disability or autism**, and as of **June 2021** this should now be done via their website: https://leder.nhs.uk/report

National Audit of Care at the End of Life

Please tell us your thoughts!

The Trust is now undertaking the 3rd NACEL audit. This involves:
- Auditing patient records
- Questionnaires sent to relatives

Appendix 2 City and Hackney's Integrated Childhood Adversity Trauma and Resilience Programme



Our System Approach

We are creating an integrated, system-wide approach in City & Hackney based on shared principles drawn from trauma-informed practice and innovation around tackling Adverse Childhood Experiences.

Leadership Commitment – Our strategic approach is endorsed by the leadership of the London Borough of Hackney, the City of London Corporation, City & Hackney Clinical Commissioning Group, and the City & Hackney Safeguarding Children Partnership.

Partner Buy-in – The approach has been developed in partnership with more than 50 local service providers, clinicians and practice experts representing a wide range of services. The project team will continue to engage with disciplines to ensure meaningful culture change.

Co-produced in partnership with our children and families – Lived experience is essential to our understanding of how to drive change. In development is an engagement plan informed by recommendations of the Hackney Young Futures Commission. This work is supported by the System Influencer project which engages with young people in our communities.

Workforce Development

Raising awareness of childhood adversity, trauma and resilience in City & Hackney through developing:

- Understanding of how to support children, families and practitioners in a trauma-informed way.
- Awareness of early intervention services to reduce the need for onward referral.
- Multi-disciplinary collaboration amongst practitioners drawing on multiple perspectives and increasing consistency in approach.
- Sharing of best practice to enable practitioners to provide holistic and integrated relational care.
- Continuous dialogue to generate improvements in pathways and processes that enable transformation which is systemic and trauma-informed.

Support and development for our Workforce:

ChATR Training Courses – In-depth, multi-disciplinary professional development courses focused on supporting children and families with the challenges faced across the life course, informed by the latest evidence.

ChATR Resource Portal – An online hub of videos, articles and publications for use by practitioners.

Community of Practice – An ongoing peer-led forum for practitioners to share resources, experiences and mutual support.

Testing Interventions

Developing and testing interventions to prevent, intervene early and mitigate the impact of Adverse Childhood Experiences, and build resilience in individuals, families and communities.

Interventions will be informed by the latest evidence and emerging needs and will support the delivery of shared strategic objectives.

Trauma-informed Child Protection Conferences – Working with the Safeguarding & Learning and the Change Support Teams in the London Borough of Hackney to develop and pilot a new approach to Child Protection Conferences. The approach will translate the core principles of trauma-informed practice into transformational processes and procedures that put children and families at the centre of the work.

Further interventions to be developed through 2021

CITY OF LONDON

NHS City and Hackney Clinical Commissioning Group

Hackney

Appendix 3

East London NHS
NHS Foundation Trust

Safeguarding Children Team – People Participation Event 2nd February 2021

Background:
A CAMHS patient participation group was held to seek out service user's perspective of safeguarding issues, what they view as risks to their wellbeing and how ELFT staff can help to keep them safe.

The group was attended by 10 young people, aged 14-17.

During focus group the young people were able to express self either verbally on zoom or using chat box.

Group was facilitated by people participation leads and Maura Hubbard and Tim Bull (Safeguarding Children Team)

Themes:
- Confidentiality and consent
- Contextual safeguarding
- Safeguarding adults issues
- Definition of safeguarding
- Barriers to engaging with children social care
- Young people feeling safe
- Professional assumptions

Confidentiality and consent:
An understanding of when confidentiality had to be overridden and wanting to be informed before this happened.

Contextual safeguarding:
Identification of CSE and county line activity, what consent in relationships should look like and able to identify what to do if exposed to online grooming or online abuse.

Professional assumptions
We explored how professionals can make assumptions about what is best for a young person and how this can be rectified?
Responses included
•Regular meetings with young people
•Listen to young person
•Give them time
•Give them more information

Barriers to engaging with children social care.
•Negative stereotypes image of Children Social care.
•"Referral is sometimes the wrong thing to do"
•One young person was positive regarding CSC - keeping families together, housing access, education
•Parents being notified when they don't want them to be.
•Clash of culture between parents and children.
•Referral to CSC punitive
• Poor communication

Definition of safeguarding
Young people were able to give clear definition of the term safeguarding. Responses included
• regulation,
• professional place for safety of service users & staff,
• service users not feeling threatened ,
•Advocacy and a human right.

Safeguarding adults issues
Interestingly one of the young people could identify where they would seek help, if they are worried about an adult suffering harm.

When explored further there appeared to be a fear of sharing secrets within family, being disloyal to family members and implications of asking for help.

Young people feeling safe
Signpost to support service and building trusting relationship with staff.
How can a young person let a professional know they feel unsafe if can`t use their voice?
Responses ranged from
- Sign language,
- writing down thoughts,
- art therapy,
- using non-verbal cues
- young person speaking in the third person

North East London
Clinical Commissioning Group

City and Hackney Integrated Care Partnership
Extraordinary Safeguarding Assurance Group
Thursday 7 October 2021 via Microsoft Teams

Document	Safeguarding Adults Annual Report 2020/21
Item number	4
Version	
Author(s)	Mary O'Reardon
Presenter(s)	Mary O'Reardon
Purpose	For the group to note the report and support the strategic plan
Background	The Safeguarding Adults Manager has complied an annual report for the 2020/21 year which includes strategic priorities for 2021/22
Recommendations	1. To note the report and provide feedback.

North East London
Clinical Commissioning Group

NHS City and Hackney Clinical Commissioning Group Safeguarding Adults Annual Report 2020/21

01/09/2021

Mary O'Reardon

North East London
Clinical Commissioning Group

Contents

1. Introduction

Context

The 20/21 period coincided with the most challenging period of the Coronavirus pandemic. The impact of Covid-19 has brought illness, grief, loss and isolation to all members of the community, and the impact on the NHS has been unprecedented. At the end of this financial year the infection rates, hospital admissions and Covid related deaths are all steadily declining. Along with the well-established vaccination programme, the impact of Covid-19 on the provision of health and social care services is finally beginning to lessen.

The introduction of the Coronavirus Act in March 2020[1] has seen the Care Act 2014[2] duties temporarily move from being mandatory to discretionary although safeguarding adults remains a Local Authority statutory duty[3].

City and Hackney Clinical Commissioning Group (CCG) has continued to deliver its safeguarding responsibilities and develop leadership of preventative safeguarding activity.

City and Hackney CCG have developed and strengthened adult safeguarding in 2020/21 with a number of significant achievements. In the 2019/20 annual report we identified five key priorities. We are pleased to report all of these have been actioned although some still remain under development.

- Ensuring we embed adult safeguarding, making safeguarding personal and Think Family in our neighbourhood arrangements, primary care networks and new Neighbourhood Health and Care Alliance
- Develop a new assurance framework for people in receipt of care who are placed outside City and Hackney e.g. care home residents, people in supported living.
- Prepare to deliver the new requirements of the Liberty Protection Safeguards and ensure they are appropriate and robust for our local integrated working arrangements across north east London
- Develop a programme of safeguarding adult's level 3 training for GPs that can be delivered virtually.
- Appoint a named GP for Safeguarding Adults.

[1] http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted
[2] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[3] https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities

2. CCG adult safeguarding arrangements and how services are assured in 20/21

The CCG Designated Adults Safeguarding Manager (DASM) is the lead for adult safeguarding in City and Hackney.

The CCG named Doctor for adult safeguarding is an integral part of safeguarding leadership in the CCG, who would be expected to contribute to the City and Hackney Safeguarding Adults Board (CHSAB) and lead on SARs that involve primary care. This position is currently vacant. The post was advertised in April 2020 but unfortunately the closing date corresponded with the initial impact of COVID consequently delaying the recruitment process. There are plans to re advertise the role in 2021.

Executive level safeguarding leadership is provided by the Board GP with responsibility for safeguarding, the CCG Managing Director and CCG Accountable Officer.

CCGs are required to have a Prevent Lead who can act in accordance with Section 26 of the Counterterrorism and Security Act 2015 (the Act)[4] and a Mental Capacity Act Lead. The Designated Adult Safeguarding Manager performs both these functions.

For 2020/21 the CCG had a Safeguarding Assurance Group (SAG) Chaired by a Board Non-Executive Director with a membership that reflects the CCG's commissioning arrangements and includes the CCG Managing Director.

An adult safeguarding report was prepared quarterly for the Safeguarding Adults Group (SAG) by the DASM. This report commented on the effectiveness of the CCG safeguarding adults' systems and kept the SAG informed of all issues relevant to safeguarding and promoting wellbeing. The Chair of the SAG reported to the governing body following each SAG meeting.

The CCG is a statutory member of the City and Hackney Safeguarding Adults Board and works in partnership with the London Borough of Hackney (LBH), the City of London Corporation (CoL) and Police as the three statutory partners to jointly fulfil our statutory safeguarding responsibilities towards adults. The CCG regularly and consistently attends Board meetings, is a member of its various subgroups, and contributes to these meetings and activities. The CCG had 100% attendance at Board meetings in 2020/21.

The CCG uses, triangulates and benchmarks a range of data to quality assure local providers including national and local data on incidents, serious incidents, complaints, NHS safety thermometer, safeguarding reports and referrals, referral to treatment times, occupancy levels in mental health wards, peer reviews, mortality data, staff safeguarding training levels, staff vacancies and turnover, patient feedback, staff satisfaction and engagement, Care Quality Commission (CQC) reports, GP quality alerts and CQC ratings. This data is used to maintain and improve quality of care and safeguard adults at risk of harm. The data is reported quarterly to the CCG Board and actions are taken where concerns are identified.
In April 2021 the CCG merged with six other CCGs to become the North East London Commissioning Alliance. The DASM is actively engaged in developing revised governance structures that will work efficiently within the larger NEL structure.

[4] http://www.legislation.gov.uk/ukpga/2015/6/contents/enacted

3. CCG key achievements in 2020/2021

3.1 Training

Mandatory training for safeguarding adults is provided by the CCG in line with Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate document. [5]

The CCG has ensured that staff training is provided online for level one adult safeguarding and awareness of the Mental Capacity Act, DOLS and Prevent training is also available. During 2020/2021 training compliance was a 94%.

The CCG provides Adult Safeguarding Level 3 training to primary care, and due to the COVID environment, this training was delivered virtually in 2020/ 21. This format proved to be very effective as the training received positive feedback and was attended by over 160 attendees.

The CCG continue to offer Adult Safeguarding training and development to all City and Hackney GPs including:

- Provision of statutory Level 3 Adult Safeguarding Training for GPs.
- Bespoke level 3 training sessions provided at GP practice level when requested.
- Provision of specialist Safeguarding Masterclasses for example 'Masterclass on Executive Capacity'
- DASM attending GP practice meetings or network meetings when requested.
- Joint Children and Adults Safeguarding Reflective fora for GPs who hold safeguarding lead roles within their surgeries.
- Regular dissemination of learning updates including Learning from Safeguarding Adult Reviews (SARs), and specific support to provider agencies in achieving action arising from SARs where relevant.

3.2 Learning Disabilities and Autism

In 2020/21 the Covid Pandemic highlighted many issues and inequalities in the learning disabled and autistic populations, which required an immediate response. There is still much work to be done around some of these inequalities but response from Joint Commissioning and Specialist Services included the following:

- Quick Reviews of Covid related deaths to implement and share learning via the LeDeR Review Programme
- Welfare checks on all service users completed by the Integrated Learning Disabilities Service
- Development of a welfare script for GPs to complete with learning disabled people on their register.
- Commissioning & Quality Assurance undertaking provider welfare checks and hosting Virtual Provider Forums to share learning and support.

[5] https://www.rcn.org.uk/professional-development/publications/pub-007069

- Development of a Winter Planning Handbook
- Development of Online Resources to support those working with Learning Disabled or Autistic people. This is something that will evolve further as an accessibility toolkit that can be rolled out more widely.
- Work with Autistic Experts by Experience to understand the covid impact particularly in relation to mental health.

There were many positives during the year too. GPs achieved their targets of 75% to complete annual checks of learning disabled people.
In 2020, both the City & Hackney Strategy for Learning Disabled People and The City & Hackney Autism Strategy were approved and work is already underway to implement actions from these.

3.3 Working with partners to identify and prevent safeguarding concerns

The CCG, CQC, CoL and the LBH continue to work together via their **Information Sharing Forum** which meets quarterly with the aim of sharing and addressing any risks to quality in the services they commission including Hackney social care providers. During Covid 19 the meetings were increased to weekly in order to allow for sharing of concerns.

The DASM is an active member of the London Borough of Hackney **High-Risk Panel** to support primary care engagement with this forum and develop creative approaches to working across complex safeguarding cases.
The DASM meets with the SGA Leads in ELFT, HUH and Barts to provide 1-1 support to discuss complex and challenging cases and where necessary engage with agencies to escalate concerns

In addition, and in response to COVID, the DASMs across east London arranged a fortnightly meeting for all the provider SGA leads and the DASMs to come together to discuss and review any concerns and highlight any areas of good practice. The providers and DASMs have found that this meeting is helpful and supportive and has encouraged collaborative partnership working.

3.4 MARAC

The CCG continues to support the innovative work of the MARAC (Multi Agency Risk Assessment Conference – managing domestic violence) liaison nurse role (MLN), linking primary care practice staff with the MARAC to enable safe information sharing and enhance GP multi-agency working in relation to domestic violence.

The MLN represents the GP at the conference and is able to answer questions from the multi-agency team regarding the health and wellbeing of the patients as well as advocacy regarding the impact of the victims health needs have on increasing their vulnerability. The MLS responds to GP feedback by obtaining GP comments and opinions regarding the service via Survey Monkey. The response rates from GP's continue to meet the Key Performance Indicator target of 85% and averages between 86-96%.

The MLN attends Significant Case Reviews meetings for cases that have been 'near misses' for domestic homicide or where the safety plan was not robust enough to offer protection to the victim and their dependants resulting in further injury.

MLN supports delivery of training to GP's alongside the Senior Advocate from IRIS (Identification and Referral to Improve Safety). The service has continued throughout the pandemic and has been able to respond well to ensure cover for an increasing workload including increased referral to MARAC by GP's and other professionals, increased complex cases requiring professionals meetings and/or MLN presence at complex case forums and an increase in 'near miss' and domestic homicide reviews.

The MLS won the accolade of 'highly commended' in the 2020 Health Service Journal Safeguarding Awards.

3.5 Mental Capacity Act and risks to quality

The DASM is the Mental Capacity Act 2005 [6](MCA) lead within the CCG and holds responsibility for maintaining quality and development in relation to all MCA activities. Due to the unprecedented challenges of COVID 19 the implementation of the Liberty Protection Safeguard (LPS) will be delayed until April 2022. The DASM engages with the cross London CCG safeguarding network to ensure that City and Hackney CCG have access to the most up to date legal developments.

3.6 Named GP for Safeguarding Adults

Unfortunately the post has been vacant since April 2020. The post was revised in March 2020 and advertised but there were no suitable applications. The DASM receives GP Clinical Lead support from the CCG GP Board member for Adult Safeguarding. Due to the pandemic, recruitment has been put on hold but the CCG will aim to advertise this role in 2021/22.

4. City and Hackney Safeguarding Adults Board

The CHSAB partnership consists of representation from:

- London Borough of Hackney ASC
- City of London Corporation
- City & Hackney CCG
- Homerton University Hospital
- Barts Health NHS Trust
- East London NHS Foundation Trust
- London Fire Brigade
- Metropolitan Police
- City of London Police
- Older People's Reference Group
- Hackney Healthwatch
- City of London Healthwatch
- City & Hackney Public Health

[6] http://www.legislation.gov.uk/ukpga/2005/9/contents

- Hackney Council for Voluntary Services
- National Probation Service
- Housing Providers
- Safeguarding Children's Partnership
- London Ambulance Service
- CHSAB Business Support

The CHSAB has established eight multi-agency subgroups to help it deliver on its objectives and annual priorities. During 2019/20 the Quality Assurance Subgroup was chaired by the CCG Head of Quality.

The overall structure is illustrated below:

4.1 Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews

Under section 44 of the Care Act 2014, a SAR should take place where an adult has i) died or suffered serious harm, ii) it is suspected or known that was due to neglect or abuse and iii) there is concern that agencies could have worked better to protect the adult from harm.

The CCG contributed to two SARs which were both published in early 2021. These related to the life of Mr MS and Mr EF, both were Hackney residents who had died in challenging circumstances. Mr MS had resident in Hackney in various forms of short term accommodation, and also street homeless at intervals over thirty years. He was known to many health and social care services who sought to support him in managing his deteriorating physical health, and his mental health needs. Sadly, Mr MS passed away at a bus stop where he had reportedly slept for the previous few days and nights. The CHSAB commissioned a SAR to establish the circumstances that led to MS's death and to consider whether the services who sought to support might have worked differently in the year prior to his death. Among the many recommendations, the report felt that in this instance there was a lack of co-ordinated multi-agency working, an underuse of the Mental Capacity Act, and at times a lack of professional curiosity in seeking to engage someone who refused services. The learning from this report has been shared via a number of CHSAB learning events, and also by the DASM attending GP clinic meetings to present the findings.

Mr EF was an older resident of Hackney who had been living independently with support from family and a social care package for several years. He passed away at home following a fire at his apartment – the cause of the fire was reported to be burning incense sticks. The CHSAB commissioned a learning review into the circumstances of Mr EF death. It was immediately noted that his experiences appeared to be very similar to those of a previous resident whose death was examined via a SAR. The purpose of the EF learning review was to consider the circumstances of Mr EF's experiences and to examine whether the previous SAR had impacted on service delivery in this instance. In essence – had the learning from the previous SAR effected any change in the systems that sought to care for Mr EF? The review was published and learning shared again via practitioner events, and by the DASM visiting GP clinic meetings. Following the publication of these two reports, the CHSAB formed a Task and Finish group to examine SAR learning and innovate to ensure that learning is embedded within organisations. The DASM has been appointed chair of this Task and Finish Group.

In 2020/21 the DASM joined the panel of a Domestic Homicide review (DHR) following the death of a woman who had resident in Hackney for a short period before her death. The DHR commenced but paused to allow for the criminal investigation to complete.

4.2 Safeguarding Data

The safeguarding data for the year 2020-21 is presented separately for the two authorities.

City of London Safeguarding Activity-Summary

Concerns Raised	Led to Sec. 42	Concluded Cases	Outcomes Expressed	Outcomes Achieved or partially achieved	Outcomes not achieved
57	38	43	24	23	1

The most common form of abuse reported during 2020/21 was neglect and acts of omission. The data showed a significant rise in the number of reported safeguarding concerns involving domestic abuse. Financial abuse has declined as a cause of harm for the second year in a row. This may indicate that prevention of financial abuse is improving. It may also indicate that, since the pandemic has commenced, there has been an increase in other forms of abuse, in particular neglect, domestic abuse and self-neglect.

The number of DoLS applications remained stable from the previous year with a recording of 39 DOLs requests.

London Borough of Hackney Safeguarding Activity.

Summary

Unfortunately due to the Cyberattack on London Borough of Hackney, the Safeguarding Adults Board was only available to access data from the past six months. However, the available data does suggest that there has been an increase in the number of safeguarding concerns being referred into Adult Social Care. This is consistent with data collected by the Local Government Association as part of their Covid-19 Safeguarding Adults Insight Project (https://www.local.gov.uk/covid-19-safeguarding-adults-insightproject), which collected real time data on safeguarding from Local Authorities across England during the pandemic. This data showed generally that there was an initial decrease in safeguarding when the lockdown occurred and this increased as the lockdown eased. The general trend identified that there were largely more safeguarding concerns reported during 2020/21 than previous years. In the absence of annual quantitative data, the SAB have reported key updates from safeguarding partners.

London Borough of Hackney Section 42 enquiries by type of abuse

The data provided by the CH SAB suggests that there have been significant increases in neglect and acts of omission, although it is noted that last year's figures were lower than they would usually be. This information appears to substantiate concerns raised by the Board's partners that a number of residents were inadvertently caused harm as they were unable to see practitioners face-to-face over the lockdown period. When they did subsequently attend services, a number of residents did exhibit signs of neglect.

Key Safeguarding themes from safeguarding partners.

The Board's monthly executive group meetings offered an opportunity for partners to discuss and explore safeguarding themes that arose over the course of the financial year and the Covid-19 pandemic. The following themes were identified:

1) During the initial lockdown period in response to the first wave of Covid-19 there was a decrease in safeguarding concerns reported to Adult Social Care, however this number increased once lockdown eased, with the number of concerns being higher than average.

2) There was an increase in domestic abuse referrals to the Domestic Abuse Intervention Service and a noted increase in domestic abuse being identified by mental health services. Police did however confirm that they were dealing with broadly consistent levels of domestic abuse.

3) During the first lockdown period, while some organisations continued to deliver services as close to normal as possible, others moved to remote or virtual working, and meetings have not stopped for many services. For some services there has been a reduction in face-to-face meetings. There was an increase in face-to-face services during the second lockdown compared to during the first lockdown period. There were concerns around inadvertent harm caused to individuals where there has been a lack of contact, such as the deterioration in people's conditions or safeguarding issues not being identified. London Borough of Hackney adult social care provided assurance that they were quality-assuring visits to ensure that these were appropriately carried out and these risks were mitigated.

4) Voluntary sector services and London Borough of Hackney were aware that new groups of residents were presenting in need of support, in particular there has been an increased use of food banks, numbers of people newly experiencing homelessness and increases in the numbers of people experiencing social isolation.

5) There was an increase in numbers of people reporting anxiety to the voluntary sector, advocacy and mental health services. It was noted that there was a significant increase in calls to crisis and helplines during the lockdown periods, although this had not necessarily translated into an increase of safeguarding concerns being reported. During the first lockdown there was a cluster of suicides in Hackney, which have been investigated by East London Foundation Trust. Furthermore, Thrive also has anticipated an increase in suicides as a result of sudden poverty and deprivation caused by the Covid-19 outbreak. There has already been an increase in referrals to in-patient mental health services.

6) There was an increase in calls concerning Covid-19 scams, and it appears that a number of people have been targeted by sophisticated scams, often relating to the vaccination programme.

7) There were concerns reported by a number of agencies about the impact of Covid-19 on family and close friend carers. There were specific concerns about carers having to take on additional responsibilities during this time, without additional support being offered in some cases.

8) There have been increased reports of self-neglect, potentially due to a lack of support and social interaction / social motivation over the lockdown periods.

9) There have been reported increases in cuckooing (Cuckooing is where people take over a person's home and use it for their own purposes, exploiting the individual at the same time.) It is not clear whether this increase has been due to increased instances of cuckooing or increased reporting of this amongst professionals.

5. Plans and challenges for 2021/2022

In the 2019/2020 Annual Report specific priorities were presented for 2020/2021. All of these priorities have been tackled, with several completed and some ongoing work set to continue.

Identified Priorities for 2020/2021	Our Progress
Ensuring we embed adult safeguarding, making safeguarding personal and Think Family in our neighbourhood arrangements, primary care networks and new Neighbourhood Health and Care Alliance.	This has been achieved with safeguarding a regular agenda item at the neighbourhood network meeting. The DASM continues to work with the CCG to support the evolution of safeguarding practice via the network meeting.
Appoint a named GP for Safeguarding Adults.	Unfortunately the recruitment was unsuccessful and recruitment has been paused. However the DASM liaises with the CCG Board Clinical Lead for Safeguarding in relation to primary care safeguarding matters.
Develop a programme of SGA level 3 training for GPs that can be delivered virtually.	This has been achieved. Over 150 participants attended two sessions in October 2020. In addition the CCG provided a Master Class on 'Executive Capacity' and quarterly safeguarding reflective forums.
Developing in partnership with NEL colleagues the new requirements of the Liberty	This has been achieved. The DASM is an active member of the NEL safeguarding adult's network. NEL are seeking to

Protection Safeguards and ensuring they are appropriate and robust for our local integrated working arrangements across east London	appoint a LPS project worker to support the early development stage of LPS provision.
Develop a new assurance framework for people in receipt of care who are placed outside City and Hackney e.g. care home residents and people in supported living	The CCG has strengthened the information sharing forum that is currently operating very effectively. The aim for 21/22 is to extend the effectiveness of this forum across NEL and seek to develop a NEL wide information Sharing Forum.

5.1 The main priorities for 2021/2022

- To shape and support the implementation of Adult Safeguarding Frameworks at NEL CCG, ICP and ICS
- To use the NEL safeguarding network to support information sharing forum and strengthen safeguarding assurance mechanisms
- Prepare for Liberty Protection Safeguards and support the CCG with developing structures for new statutory responsibilities
- Continue to develop the Adult Safeguarding Training offer via virtual learning sessions.
- To Support the strategic plans of the SAB to strengthen the systems response to Transitional Safeguarding and the complexity of challenges facing young care leavers.
- To support and strengthen the partners learning from SARs, DHRs and Sis in the context of evolving organisational structures.

Mary O'Reardon
Designated Adult Safeguarding Manager, City and Hackney CCG and
Jenny Singleton, Head of Quality

North East London
Clinical Commissioning Group

TNW Clinical Commissioning Groups: Safeguarding Annual Report 2020/21

About

This Integrated Annual Report brings together the collective work of the WEL CCGs Safeguarding Teams throughout the financial year 2020-2021. As well as drawing out key themes from the previous year, it sets out ambitions and proposals for the year to come, 2021-2022.

This report focuses on:

- **Safeguarding adults**
- **Safeguarding children and young people**
- **Safeguarding children looked after**

The report is intended to assure the NEL CCG Governing Body that all commissioned providers are meeting their legislative safeguarding obligations and working in partnership to drive safeguarding practice across the health economy.

In a step towards the establishment of a new CCG, for North East London (NEL), in April 2021; Newham, Tower Hamlets and Waltham Forest came together in order to form WEL CCGs, in 2019/20. During the reporting year, WEL was renamed Tower Hamlets, Newham and Waltham Forest (TNW) Integrated Care Partnership (ICP). The terms NEL, WEL and TNW and are therefore used interchangeably within the report.

The report updates the Governing Body on the safeguarding achievements, outputs and outcomes and initiatives to improve the health and wellbeing of local people during the reporting period. This includes the CCGs' response to local and national priorities, areas of challenge, good practice and collaborative working. Qualitative and quantitative data from Trust provider and partnerships has been incorporated into this report.

Assumptions and terms used in this report:

- **BAME** is the term we use for Black and Minority Ethnic
- **BARTS** is the term we use for Barts Health NHS Trust
- **Children Looked After** is the umbrella term that we use, across the WEL footprint, to describe looked after children, children in care or child with care experience[1]. The terminology that is preferred by the local authority has been incorporated into Borough level elements of this report. These are looked after children, children looked after and child with care experience for Newham, Tower Hamlets and Waltham Forest respectively.
- **DHR** is the term we use for Domestic Homicide Review
- **ELFT** is the term we use for East London Foundation Trust
- **IICSA** is the term we use for the Independent Inquiry into Child Sexual Abuse
- **IRIS** is the term we use for the Identify and Referral to Improve Safety programme
- **LeDeR** is the term we use Learning Disability Mortality Review
- **MASH** is the term we use for Multi Agency Safeguarding Hub
- **MOPAC** is the term we use for The Mayor's Office for Policing and Crime
- **NEL** is the term we use for the boroughs of Newham, Tower Hamlets and Waltham Forest plus the City of London and Hackney and the boroughs of Barking, Dagenham, Havering and Redbridge
- **NELCA** is the term we use for the NHS North East London Care Alliance
- **NUHT** is the term we use for Newham University Hospital
- **SAR** is the term we use for Safeguarding Adult Reviews
- **SCR** is the term we use for Safeguarding Children Reviews
- **UASC** is the term we use Unaccompanied Asylum Seeking Children
- **WEL** is the term we use for the London Boroughs of Newham, Tower Hamlets and Waltham Forest
- **WRAP** is the term we use for Workshop to Raise Awareness of Prevent
- **YOS** is the term we use for the Youth Offending Service

[1] https://www.tactcare.org.uk/content/uploads/2019/03/TACT-Language-that-cares-2019_online.pdf

Contents

Executive Summary

In a step towards the establishment of a new CCG for North East London in April 2021; Newham, Tower Hamlets and Waltham Forest (TNW) collaborated closely, within an Integrated Care Partnership, during the reporting year.

This created a more effective partnership with providers of hospital, community and mental health care and increased the focus on local residents, ensuring that their wellbeing is prioritised and helping them find the relevant services at the right time. Integral to this, was our approach to safeguarding; promoting welfare and protecting people from harm.

Our geographic area has been heavily impacted by the pandemic. We faced unprecedented challenge to health and care services, bringing intense pressure and radical change to systems and organisations. In response to these challenges, we planned, prioritised and upheld our safeguarding principles. We supported the vaccine rollout while at the same time shaping a new organisation and maintaining the highest safeguarding standards.

Covid-19 has deepened the long standing commitment, in the TNW quality directorate, to smart and efficient ways of working. The safeguarding team was pushed quickly towards agile, remote working that made the best use of time and resource. We simplified systems, distilled priorities, developed a blended menu of training and supervision, and ensured these efficiencies will be sustained in the long term.

Although the pandemic is not yet over, we thank and pay tribute to all our health and care staff across TNW for their incredible commitment and dedication during the pandemic. We have seen some outstanding practice delivered during the most challenging of circumstances and we are extremely grateful to each and every person for their work.

The intensity and pace of working under pandemic conditions accelerated the development of working relationships between agencies. We will build on this strength in the coming year.

Our safeguarding approach focusses on the following three cohorts of people

- Adults at risk, such as those receiving care in their own home, people experiencing multi-exclusion homelessness, and those with learning disabilities
- Children and young people
- Children looked after

Our achievements over the last year

In response to high numbers of people experiencing multiple exclusion homelessness, and some ≥ 1000 asylum seekers housed in temporary accommodation in NEL[2], we developed a resource pack for outreach practitioners and the long term hostel staff. This enabled staff to spot and stop the signs of abuse, keeping people safer

Given that the three TNW partnerships are in the top 30 areas for NHS hospital admissions for assault with sharp object in the period of April to September 2020, we produced a report, and attended a learning event in Westminster regarding **adolescent exploitation and serious youth violence.** This deepened the focus on serious youth violence, and galvanised the partnership to work together more effectively

[2] Quarter three snapshot

In order to strengthen internal relationships, embedded safeguarding in pathway planning and safeguarding local people, the team streamed monthly safeguarding video blogs across TNW CCG

We supported the local vaccine roll out, whilst maintaining a focus on critical safeguarding programmes of work

Created a single point of contact for the TNW safeguarding team as part of a wider continuity plan to ensure that safeguarding concerns received a timely and robust response

Developed a simplified overview of the child death review procedures for health colleagues so that professionals are better able to navigate the system and avoid delay for grieving families

Improved the health and wellbeing of people with learning disabilities by enhancing the LeDeR system for reviewing and sharing learning, which improved performance in NEL and allowed the system to meet NHSE LeDeR compliance targets

Led on the virtual platforming of the annual safeguarding adult's conference, with a focus on multi-agency learning from the local safeguarding Adult Reviews, in order to strengthen safeguarding systems for the betterment of people's lives

Worked with safeguarding partners, commissioners, clinicians and local people to analyse and implement the learning from safeguarding adult reviews, domestic homicide reviews and child Safeguarding Practice Reviews; including multiple-exclusion homelessness learning following Safeguarding Adult Review Peggy in Newham. People experiencing multiple-exclusion homelessness in Newham are safer as a result of SAR Peggy

Developed a TNW supervision framework, which will enable us to provide high quality, standardised, and psychology informed supervision for designated professionals. This approach promotes better health and wellbeing for designates and puts them in a stronger position to meet local need

Promoted the voice of the person and child to ensure that no decision is made about children, without children, through a range of approaches including:

- Collaborative commissioning
- Quality assurance of health assessments
- Promoting the voice of the person within the Court of Protection
- Ensured that the voice of the child was loud and clear in safeguarding reviews
- Conducted an audit of the voice for the child for the Newham safeguarding children partnership

Strengthened domestic abuse pathways in order to keep people safer by:

- Supporting the enhancement of domestic abuse services in the Acute Barts Health NHS Trust
- Established and led a domestic abuse safeguarding priority group in Tower Hamlets
- Coordinating IRIS training

Improved our performance against the statutory target for Initial Health Assessments, in Tower Hamlets, by 27%, between Q1 and Q3. This mitigated the risk of health inequalities for children looked after

Established processes to support the delivery of continuing health care in accordance with the Mental Capacity Act by representing the CCGs in the Court of Protection. By doing this, adult designates promoted the best interest of adults with care and support needs – often when no one else was speaking up on their behalf

Worked decisively and collaboratively to ensure that people were lawfully deprived of their liberty both now and in the future when Deprivation of Liberty Safeguards are implemented. Keeping the voice of the person at the heart of our work

Our priorities for 2021/22

The safeguarding landscape has changed immeasurably due to the pandemic. In the coming year, the team will continue to innovate and drive the highest standards with local partners and colleagues in the health economy. We will re-double our efforts to build equitable systems as the NHS works to recover and restore services. We will uphold safeguarding values, and place local people at the heart of our work.

Whilst the UK Covid-19 alert reduced from level three to two in May 2021, Covid-19 is still circulating and it remains a major pandemic globally. We cannot discount the risk of a further lockdown. We will ensure that the lessons learned from 2020/21, are built into future plans.

In order to build on the progress that we have made in 2020/21, these are some of the focus areas for 2021/2022:

1. Prioritise complex cases that feature safeguarding concerns and represent the CCG at the Court of Protection to ensure that lawful decisions are made on behalf of people who do not have the capacity to make certain decisions for themselves

2. Support a system response to an exponential increase in safeguarding referrals

3. Standardise the children looked after notification process across the TNW ICP footprint

4. Collaborate with public health and the partnership to improve the uptake of immunisations for children placed in and out of borough

5. Deliver the TNW Liberty Protection Safeguard implementation plan in collaboration and with the voice of local people at its heart

6. Drive continuous improvements through completing, supporting and embedding the learning from safeguarding reviews. The CCG will lead a number of these reviews in the coming year, including:

   - ✓ A local learning review in relation to domestic abuse and on-line gaming in Tower Hamlets
   - ✓ A thematic review of children looked after in Newham
   - ✓ A thematic review of deaths resulting from house fires in Waltham Forest

7. Embed a TNW supervision framework, which will enable us to provide high quality, standardised, and psychology informed supervision for designated professionals

8. Developing a standard operating procedure for safeguarding adult reviews, child death reviews, rapid reviews and domestic homicide reviews

9. Make robust arrangements for the implementation of the Liberty Protection Safeguards to ensure that patients are lawfully deprived of their liberty and the CCG fulfils its legal responsibilities in line with Mental Capacity Act 2005

10. Maintain and further develop the stronger working relationships born out of the pandemic and ensure that the lessons learned from 2020/21, are built into future plans

11. Ensure that safeguarding functions develop as we move into the transition phase of an ICS across NEL

Risk and Mitigations

The TNW quality and assurance governance structure enables us to seek assurance on risk and mitigation. A risk and mitigation log is presented to the TNW CCGs Safeguarding Committee on a quarterly basis, and to the TNW CCGs Quality and Safety Committee on request. Below are examples of the key risks and mitigations in place for safeguarding across TNW, which are explored more fully within the risk log itself.

Risk: Impact of the Covid-19 Pandemic on children and young people's mental health and emotional wellbeing

Mitigation: Multi-agency partners have are coordinated their response to increased levels of mental health and emotional wellbeing need. Designated professionals continue to support the transforming care pathway, reducing the risk of admission for children and adults with a mental health difficulty alongside learning disability and autism. NEL CAMHS alliance meetings have taken precedence during the pandemic, and phase three of the NHS restore plan has been implemented. Mental health support teams are being embedded in schools and colleges and additional funding has been made available to extend the children and young people's crisis and out of hours service.

Risk: Outstanding physical examination and treatment pathways, for unaccompanied asylum seekers and all TNW children looked after

Mitigation: Whilst there have been capacity issues in one area of the system, designated professionals have supported provider colleagues to prioritise this element of the pathway. A resource has been produced to highlight the importance of face to face appointments with children and young people. Meetings took place between the CCG and Provider on a fortnightly basis during the Pandemic in order to shape and implement provider recovery / restoration plans.

Risk: Ensuring that people are lawfully deprived of their liberty through robust Deprivation of Liberty Safeguards

Mitigation: TNW designated professionals are coordinating a multi-agency implementation plan for Liberty Protection Safeguards (LPS). Designated professionals for adults are leading place-based implementation groups; and a tool has been developed to assess every individual in receipt of continuing health care funding. In preparation for the code of practice, the team will prioritise complex cases that feature safeguarding concerns and represent the CCG at the Court of Protection to ensure that lawful decisions are made on behalf of people who do not have the capacity to make certain decisions for themselves.

Risk: The TNW team faced a series of changes during the reporting year due to redeployment, sickness and recruitment. This posed a risk to the team's capacity to discharge the CCGs statutory safeguarding duties

Mitigation: In response to this challenge, the team worked together in order to deliver an agile service across the TNW footprint. The team established a Monday morning huddle, in which they celebrated success, identified tasks on the critical path and agreed how to support one another. This raised moral and enabled the team to prioritise and target their efforts. The team further mitigated the risk by agile working. As an example of this, there was a period of time when one adult designate delivered a service to all three boroughs, and one safeguarding support officer supported all nine portfolios. A number of new members of staff also joined the team during the pandemic and have done remarkably well to establish key relationships internally and across the partnership. The team continues to build and grow with local people at its heart.

Understanding Need

Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest is projected to grow by circa 270,000 – the size of a new London borough[3]. Hospitals and emergency departments face unprecedented demand for services and pressures continue to grow. Effective planning is essential given the duty placed on NHS organisations and agencies, including clinical commissioning groups and NHS Trusts, to safeguard children and young people and adults at risk of harm[4].

While some children who grow up in low-income households will go on to achieve their full potential, many others will not. Poverty places strains on family life and excludes both children and adults from the everyday activities with their peers and key opportunities that can protect people from harm. Tower Hamlets, Newham and Waltham Forest fall within the 20% most deprived districts/unitary authorities in England and between 16-20% of TNW children live in low income families.

2020-21 was and continues to be the most challenging year the health and care system has ever had to contend with. As well as managing the health service response to Covid-19, 2021 has been an extraordinary year with the pandemic shining a light on the true extent of health inequality in our population. Many of our north east London boroughs have high levels of deprivation and inequality. We have a long and rich history in terms of ethnic diversity, with more than 50% of our population identifying as Black, Asian and ethnic minority.

Life expectancy in our boroughs have for some time been amongst the lowest in England, though that is more to do with environmental factors and deprivation in the area than a reflection on the quality of healthcare[5]. North east London experienced high rates of mortality during the pandemic, with some communities more effected than others. Research has shown that inequalities in mortality are primarily driven by differences in exposure and infection. Socio-demographic factors explained some of the elevated risks of people from Bangladeshi and Pakistani backgrounds in the first and second waves. Differences in occupational exposure could also account for some of the differences in mortality between groups[6].

The strength of feeling demonstrated in movements nationally such as Black Lives Matter coupled with the findings of national NHS staff survey and workforce, race, equality standard reports, show how much more we have to do to understand and address current and historic inequalities for both our population and our workforce.

The TNW Integrated Care Partnership has responded to the pandemic, restarted elective care and rolled out a large scale vaccination programme at pace. As of April 2021, the Covid-19 vaccination programme in north east London had given nearly 700,000 vaccinations. This is an incredible achievement and testament to everyone who worked so hard to get the vaccine programme up and running. We posted over 40 videos featuring local people, faith leaders and NHS staff. The videos are designed for a variety of communities, explaining the vaccine and the importance of having it.

[3] https://data.gov.uk/dataset/61b02ce5-24ab-46ae-a9a8-3c7d734f75e7/2013-round-population-projections
[4] https://www.legislation.gov.uk/ukpga/2014/23/contents
[5] https://www.walthamforestccg.nhs.uk/downloads/aboutus/publications/governingbodymeetings/2016/TST-Part-2-Main report.pdf#:~:text=These%20document%20the%20scale%20of%20the%20challenge%20facing,to%20plan%20for%20the%20increased%20demand%20on%20services.
[6] https://www.medrxiv.org/content/10.1101/2021.02.03.21251004v1

Accountability and Assurance

The NHS Long Term Plan (LTP) clearly set out the direction of travel for commissioning. The intention is that: 'by April 2021 all of England will be covered by Integrated Care Systems, involving a CCG or CCGs working together with partners to ensure a streamlined and single set of commissioning decisions at a system level'[7].

CCGs are responsible in law for the safeguarding element of services they commission. As commissioners of local health services, CCGs need to assure themselves that organisations from which they commission have effective safeguarding arrangements in place. It is essential that safeguarding is considered within new integrated systems, however, currently the responsibility to provide safeguarding services still sits with CCGs[8].

In a step towards an integrated care system, Newham, Tower Hamlets and Newham came together to form WEL CCGs in November 2019. The WEL CCGs Safeguarding Committee was subsequently established together with the supporting governance arrangements and frameworks and is chaired by the WEL CCGs Governing Body Nurse with the lead for safeguarding. This committee reports to the WEL CCGs Quality and Safety Committee, a sub-committee of the Governing Body and chaired by the WEL CCGs Governing Body Nurse with the lead for quality.

A new CCG for North East London was established in April 2021, at which time WEL CCGs became the Tower Hamlets, Newham and Waltham Forest Integrated Care Partnership (TNW ICP). The supporting governance arrangements and frameworks continued to be chaired by the Governing Body Nurse with the lead for safeguarding. This committee continues to report to the TNW Quality and Safety Committee, a sub-committee of the NEL Governing Body and chaired by the TNW Governing Body Nurse with the lead for quality.

The TNW Director of Quality and Safety is the Executive Lead for safeguarding adults, children and children looked after. As set out in the NHS Safeguarding Accountability and Assurance Framework, there is a clear line of accountability for safeguarding as reflected in the CCG governance arrangements. The named Executive Lead takes overall leadership responsibility for safeguarding in WEL.

The TNW CCGs Safeguarding Executive meets regularly with the designated professionals to review adult, children, and children in care safeguarding across the footprint. The TNW Safeguarding Committee receives an exception report from each of the local systems within the three boroughs in order to provide oversight. This holds all providers to account for their safeguarding systems and performance; audit programmes; engagement with the Prevent strategy; compliance with the Mental Capacity Act and ensure compliance with national and local safeguarding guidance.

Safeguarding assurance throughout 2020/21 has also been obtained through the following processes:

- Other Contract Monitoring Meetings (e.g. Service Performance Review and Technical Sub-group)
- Overview of Provider Serious Incidents
- Provider safeguarding committees (attendance of CCG members)
- Site Quality visits
- Audits

As part of the Integrated Care System and sustainability and transformation plan work streams, the designated safeguarding professionals for the eight north London CCGs collaborate closely to review safeguarding policies, systems and documents. The aim is to standardise safeguarding policies across NEL where possible.

[7] https://www.longtermplan.nhs.uk/

[8] https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf-1.pdf

Legal Framework

The NHS England Accountability and Assurance framework (2019) sets out responsibilities of each part of the system and the key individuals who work within it. Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice. Regardless of the developing context, all health organisations are required to adhere to the legislation set out in the safeguarding children, young people and adults at risk in the NHS: safeguarding accountability and assurance framework.

Relevant legislation for safeguarding practice includes the Crime and Disorder Act (1998), the Female Genital Mutilation Act (2003), the Mental Capacity Act (2005), and the Equality Act (2010).

For safeguarding adults, The Care Act 2014 sets out how partner agencies should work together to keep adults at risk of harm, safe from abuse. The Care Act asks organisations to make appropriate enquiries if it believes an adult is subject to, or at risk of, abuse or neglect. Section 43 of the Act states that each local authority must provide a Safeguarding Adult Board (SAB) with an independent chair. The CCG is a statutory member of the safeguarding adult board.

The CCG follows the 6 safeguarding principles enshrined within the Care Act 2014:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

Further legislation relating to safeguarding adults includes:

- Mental Capacity Act 2005 /Amendment Act 2019
- Human Rights Act 1998
- Modern Slavery Act 2015
- Counter-Terrorism and Security Act 2015
- Mental Health Act 1983

Key to safeguarding children is the United Nations Convention of the Rights of Children (1989), the Children Act (1989 and 2004), the Children and Families Act (2014), the Children and Social Work Act (2017) and the Health and Social Care Act (2021), which introduced the first legal duties about health inequalities

The definition of safeguarding children within Working Together to Safeguard Children (2018) is:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

The purpose of 'Working Together to Safeguard Children', is to share the importance of an inter-agency approach to safeguarding. This guidance was created after many instances of children not being kept safe due to the failure of different agencies to communicate and work together. The tragic death of Victoria Climbie and the subsequent Inquiry, serve as a sad example of this. Working Together provides guidance around multiagency safeguarding arrangements, which are now led by three safeguarding partners (Local Authority, Police and the CCG). It emphasises the principle that safeguarding is everyone's responsibility.

Significant legislation for children looked after is governed by:

- Promoting the health and well-being of looked-after children. DFE and DOH (2015)
- Looked After Children: Knowledge, Skills and Competences of Healthcare Staff. Intercollegiate Role Framework. March 2015. (Revised version expected March 2020)

Tower Hamlets Safeguarding

In 2019 the estimated population of Tower Hamlets was 324,745, and the borough had the fastest growing population nationally. The borough is the second most densely populated local authority area (Office of National Statistics, 2019), and continues to have one of the fastest growing populations nationally. Tower Hamlets' population density is currently 16,237 persons per square kilometre which ranks Tower Hamlets as the most densely populated local authority area in the country. The Borough has the seventh highest housing waiting list nationally with Black and Minority Ethnic (BAME) households accounting for 78% of all households on the list.

Tower Hamlets is one of the 20% most deprived local authorities in England and about 30.3% (16,475) children live-in low-income families. The Covid-19 pandemic has had a significant impact on worklessness, which may have long term impacts on the extent and nature of poverty and deprivation within the borough. 44% of older people live in income deprived households, the highest proportion in England and more than double the average[9]. The unemployment rate is 9.7% compared with 5.3% in Greater London and 4.4% in England. Rates of common mental health disorders are high at 22.8% in Tower Hamlets compared to 19.3 and 16.9% in London and England respectively[10]. However, in 2018/19, some 45.8% of state educated children in Tower Hamlets achieved a strong pass in GCSE English and Maths grades 9-4, compared to just 43.4% in all of England[11].

Tower Hamlets is unique in many ways, it has a very diverse population, and one of the largest Bangladeshi communities in the country. Over 69% of our population are from a minority ethnic group, more than 90 languages are spoken and ranked as the 16th most ethnically diverse local authority in England out of 325 local authorities. We are seeing the makeup of Tower Hamlets changing and the borough becoming more dynamic. The borough's two largest ethnic groups are the White British and the Bangladeshi populations, each accounting form one third of the population. Tower Hamlets has the largest Bangladeshi population in the country. Tower Hamlets has the highest number of Muslim residents in the country. Around 38% of the residents are Muslim, compared with 13% in London.

The borough has a fairly even split between male residents (52.1%) and female residents (47.9%). Whilst life expectancy for both men and women in Tower Hamlets is similar to the England average (Public Health England, 2019) it is 11.4 years lower for men and 4.8 years lower for women in the most deprived areas of Tower Hamlets than in the least deprived areas. Children in Tower Hamlets are more likely to be overweight or obese at year 6 than the average in London and England. The rate for alcohol-specific hospital admissions among under 18 year olds is lower than the average for England, though the rates of newly diagnosed sexually transmitted infections (STI) are higher.

Overall crime rates in Tower Hamlets are the sixth highest in London, though Tower Hamlets has the second highest rate of anti-social behaviour reports and the fifth highest rate of domestic abuse offences.

[9] Borough profile (towerhamlets.gov.uk)
[10] https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132696/pat/6/par/E12000007/ati/202/are/E09000025/cid/4
[11] https://data.london.gov.uk/dataset/gcse-results-by-borough

Tower Hamlets Safeguarding - Adults

Whilst the focus of this section is primarily on Tower Hamlets, for 2020/2021 it is important to highlight that north east London (NEL) CCGs are now aligned within one single operating model, which provides an invaluable opportunity for the safeguarding adult's agenda to be enhanced further, inclusive of opportunities to work collectively with adult and children leads on key areas of safeguarding.

The Tower Hamlets SAB published two safeguarding adult reviews (SARs) within the reporting year (Miss E and Mr B), two more were commissioned and currently awaiting publication (Mrs N and Mrs O), a joint thematic SAR was commissioned and lead by Newham SAB (HC One) which is yet to be published. These focused on a wide range of safeguarding issues including; self-neglect, complex health needs, learning disabilities, pressure ulcers, suicide and neglect. The SAB successfully engaged highly experienced SAR authors who highlighted keys areas for further learning and development across the safeguarding partnership.

Tower Hamlets is currently the second highest borough in London (behind Redbridge) for Domestic Homicide Reviews (DHR). During the last year there have been 3 DHR's which are currently with the Home Office for sign off and will be released for publication in 2021/2022. The learning from these reviews will influence ongoing improvements to domestic abuse work across the borough through various strategic forums as will the introduction of the landmark Domestic Abuse Bill which received Royal Assent on the 29th April 2021. It is legislation that now recognises the scope of domestic abuse – including economic abuse and coercive or controlling behaviour for the first time. Victims will now be protected from cross-examination by their abusers in a courtroom, and it brings in a new criminal offence of non-fatal strangulation. It also creates the integral role of the Domestic Abuse Commissioner and it highlights and reinforces the message that there is no one victim – domestic abuse can and does affect anyone. For the first time, children will be recognised as victims of domestic abuse, not just as witnesses. The Bill also brings a mandatory duty for employers to provide care and support for their employees who suffer abuse which has the potential to make a significant practical difference to victims and survivors alike[12].

In the new financial year the role of the designated professional for safeguarding adults will include the responsibility of the Local Area Contact for LeDeR reviews which aligns with the roles of the designated professional for safeguarding adults across the NEL network. Learning from LeDeR reviews will be a key focus in the coming year as well as supporting reviewers to complete reviews on the new LeDeR platform.

During the uncertain times of the pandemic, the communities of Tower Hamlets continued to come together to respond longstanding and emerging challenges. It was evident at an early stage that Covid-19 would bring unprecedented and lasting consequences and sadly, devastating outcomes. The local response to the pandemic across the safeguarding partnership has been exceptional and encouraging to see so many volunteers, community groups, health and social care partners working together across our diverse communities to tackle that Covid-19.

The following sections aim to highlight the key areas of work completed for the period 2020-2021 and priority areas of work for 2021-2022.

[12] Domestic Abuse Bill: Committee Stage, House of Lords | Hestia

Tower Hamlets safeguarding adults highlights

The current designated professional for safeguarding adults came into post in quarter four and is working with partners to continue developing safeguarding adults work streams. 	Preparation for the implementation and step change into **Liberty Protection Safeguards** continues in Tower Hamlets via the multi-agency steering group consisting of key stakeholders, accessing training and the development of the time-bound TNW implementation plan.	The Tower Hamlets Learning Disabilities and Health Conference was delivered in October and December of 2020 with a high number of attendees. The Learning from SAR's and LeDeR Reviews Conference and was co-produced and co-delivered by the CCG and Local Authority, fostering partnership and collaborative working between agencies. The conference pulled out key messages from the deaths of service users and highlighted the learning points for practitioners to take forward, including annual health checks, mental capacity and support for families.

Key achievements

- The named GP for adult safeguarding across WEL CCGs is now in post in Tower Hamlets and is working in partnership with multi-agency partners of the SAB to safeguard adults at risk and drive strategic improvements across the borough and WEL footprint
- Liberty Protection Safeguard multi-agency implementation steering group is working to ensure that all agencies are prepared for the implementation date and have systems in place for people to be lawfully deprived of their liberty. Workshops have been undertaken to develop risk stratification tools in line with scoping exercises to identify people funded by the CCG, identify risk areas and the impact on workload.
- Relaunch of IRIS in the borough and the support that this will provide in terms of identifying and responding to domestic abuse. There were 38 referrals from 17 different surgeries, 8 cases were referred to MARAC, and 5 cases were referred to Children's Social Care, 2 cases to Adult Social Care. 67% of victims mentioned that they found the support provided by the advocate-educator helpful, 89% victims and survivors said they feel safer and tend to agree that they felt safer as a result of the support.
- Designated Professionals represented the voice of the person in the Court of Protection in relation to best interests and safeguarding concerns.

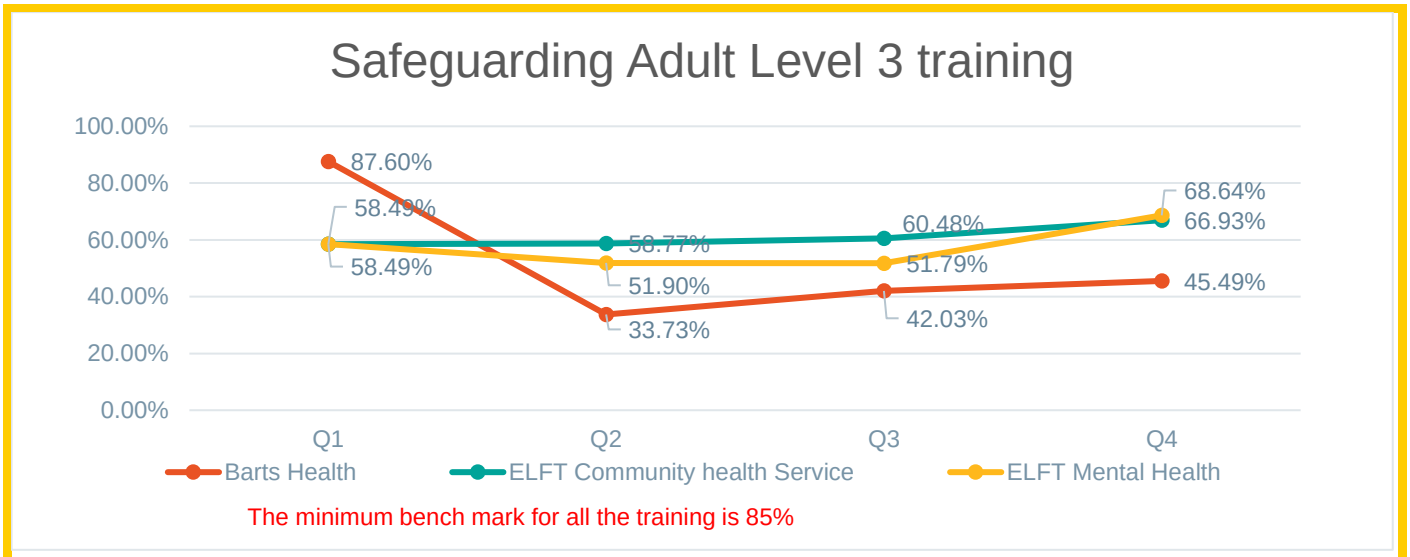
Training and compliance

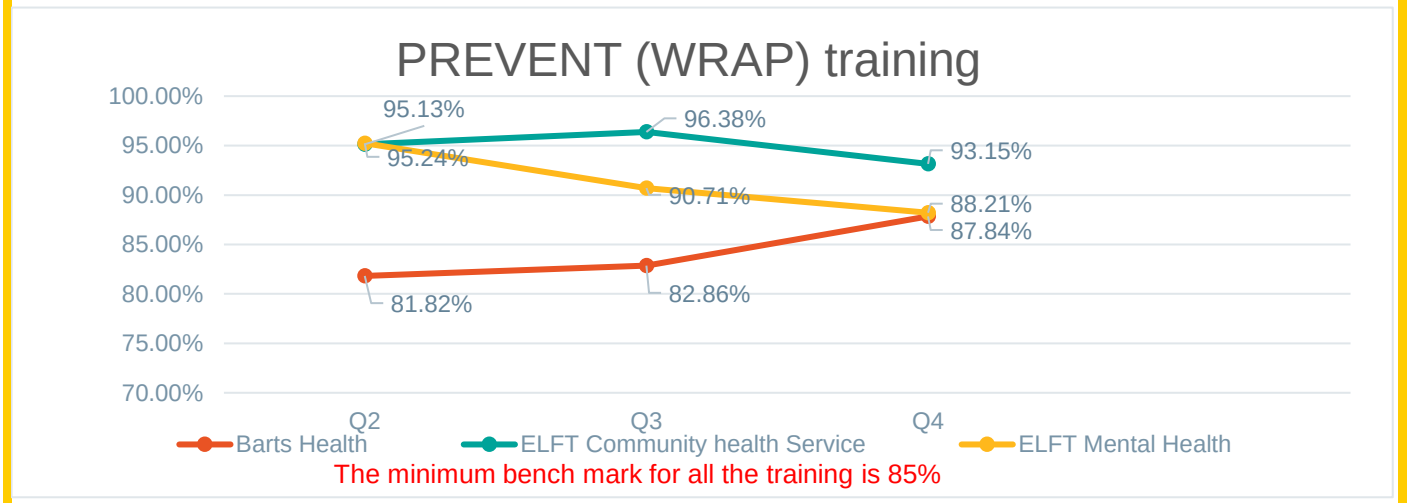
ELFT - Community Health Service

Safeguarding training	Q1	Q2	Q3	Q4
Level 2	94.29%	87.32%	90.41%	94.74%
Level 3	58.49%	58.77%	60.48%	66.93%
WRAP	94.26%	95.13%	96.38%	93.15%

ELFT - Mental Health Services

Safeguarding training	Q1	Q2	Q3	Q4
Level 2	91.94%	85.33%	88.77%	92.47%
Level 3	51.44%	51.90%	51.79%	68.64%
WRAP	91.72%	95.24%	90.71%	88.21%





"I have to carry out s42 enquiries so it is useful to have the information around safeguarding. I know who to ask about safeguarding in the trust"

"More confident in recognising and following up on safeguarding- being more proactive in looking at situations with a safeguarding perspective in mind"

''It will embolden me to use professional curiosity effectively."

"In my role there is a likely possibility of encountering risk and need to contact safeguarding, I am also expected to assess risk and communicate risk so very helpful knowing about all the people who I can reach out to."

Barts Health NHS Trust - Royal London Hospital & Mile End Hospital

**Note that all providers are working to ensure that Level 3 safeguarding is in place for their organisations by September 2021.*

Safeguarding training	**Q1**	**Q2**	**Q3**	**Q4**
Level 2	92.04%	87.88%	83.57%	88.11%
Level 3	Not recorded	33.73%	44.19%	45.49%
WRAP	78.95%	81.82%	83.43%	87.84%

GP's and Primary Care

GP training has been delivered by the named GP's for children and adult safeguarding for Primary Care colleagues in Tower Hamlets, Newham and Waltham Forest. The training was compliant to the intercollegiate Level 3 standard and delivered jointly by adult and children named GP's to encourage a Think Family approach. The training was 3 hours long and had a pleasing 147 delegates. Topics covered include: advocacy and translation, domestic abuse and IRIS services, MCA and vaccinations.
Feedback from the Named GP's from the IRIS Steering Group advises that training uptake has increased amongst Primary Care, however notably there is still a high number of DHR's being processed in the Borough.

How we captured the voice of the person

1. The designated Professional works closely with the Local Authority and health providers to ensure that complex safeguarding cases are escalated as needed with a clear focus on best outcomes for those at risk
2. The provision of supervision and advisory support to health providers ensures that the designated professional maintains a clear focus on the person at risk, their experiences and desired outcomes which is central to the principles of Making Safeguarding Personal as outlined in the Care Act 2014
3. The designated professional is a core member of the SAB and its four subgroups. The role chairs the community engagement subgroup which provides a fundamental opportunity to affect and influence improvements in safeguarding adults e.g. supporting safeguarding adult's conference where the focus for 2020 was learning from SARs, the focus for 2021 is All Age Exploitation. The role also sits on the panels for all SARs and Domestic Homicide Reviews (DHRs).

In the last year, we have

1. WEL CCG has transitioned into NEL CCG and are collectively considering how best to address some of the issues affecting all seven boroughs e.g. implementation of the LPS
2. Launched the Liberty Protection Safeguards Implementation Group which focuses on ensuring readiness for implementation date
3. To further enhance the local understanding of the implementation of LPS and the Mental Capacity Act, a two day specialist bespoke training opportunity was provided for both adults and children safeguarding teams. The training supports level 4 compliance as per the RCN intercollegiate document and enables the local offer of enhanced safeguarding responses to complex Court of Protection cases and safeguarding issues.
4. Collaboration with NHSI/E enabled a 2 hour training session from Paul McCann around the PREVENT agenda and radicalisation which provided updates to both safeguarding adults and children teams around current threat levels, new ideologies and signs and symbols used by radicalistic groups.

This year we will

1. Ensure that robust arrangements are in place for the implementation of the Liberty Protection Safeguards which will focus on the operational and strategic priorities required for people to be lawfully deprived of their liberty
2. Lead on the virtual platforming of the annual safeguarding adults and children conference. The focus of the conference is tackling challenging and complex areas of safeguarding, guest speakers will cover topics such as safeguarding in a digital world, Learning from DHR's, learning from safeguarding adult reviews, Unaccompanied asylum seeking children and a special guest speaker to talk about their lived experience of child marriage and FGM.
3. Focus on the development of the following key strategies as a statutory SAB

partner - transitions, all age exploitation and closer links with Children's partnership around joint priorities e.g. domestic abuse

4. The designated professional for safeguarding adults will co-chair the community engagement subgroup which provides an opportunity to capture the voice of the community, raise awareness of pertinent safeguarding issues and ultimately influence improvements in safeguarding adults

Case study

WT was admitted with severe heart failure and has a background of personality disorder and polysubstance misuse. WT presented with behaviours that challenge which were supported by the ward multi-disciplinary team, in particularly to the Nursing Team. WT continued to spend significant amounts of time off the ward despite a behavioural plan. It was thought that his problematic use of substances and impulsivity are key issues impacting on his compliance with his cardiology treatment.

Several concerns were raised that WT was at risk of imminent death should he continue to abscond and use illicit substances. There was discussion with legal services, high intensity service, social care, lead nurse and the CCG safeguarding lead about the use of legislation in order to keep WT safe.

The options discussed included use of MCA, DOLS, MHA and Inherent jurisdiction:

- Inherent jurisdiction: advised by legal this was not appropriate for this case (No element of coercion and control).
- MHA: Did not met the criteria to be held under the MHA had been assessed by Psychiatry
- Lacked capacity to consent to "staying in hospital for the purpose of care and treatment" therefore a DOLS application was submitted which was self-authorised for 14 days.

Urgent assessments were undertaken from the Local authority regarding DOLS and it was agreed that WT was to remain in hospital for period of DOLS assessment. S12 assessment and BIA assessment completed which concluded that there are no less restrictive options available due to the seriousness of harm that WT could come to if not subject to the proposed Deprivation of Liberty Safeguards and a 3 month DOLS authorisation was granted.

WT is now being nursed with 1:1 Registered Mental Health Nurse and Security support. Patient records state that WT "appeared in good spirits, he does feel a bit restricted in relation to care but does not appear to be having withdrawal symptoms, he engages well in conversation and asking appropriately about other members of staff."

Tower Hamlets Safeguarding – Children and Young People

According to the ONS mid-year population estimates, the borough's population was 308,000 in June 2017. Between June 2016 and June 2017 alone, the borough gained an estimated 7,000 residents - that is equivalent to 20 additional residents every day.

Tower Hamlets is now thought to be home to around 317,000 people. It has a very diverse population including one of the largest Bangladeshi communities in the country.

Tower Hamlets' population doubled in the past thirty years, making the borough the fastest growing local authority in the UK and remains the second most densely populated local authority in the country, after Islington. In 2019 Tower Hamlets was home to 79, 600 children and young people from the age of 0 to 19 years.

Across NEL CCG

- Tower Hamlets has the lowest percentage of under 18s (22%)
- Tower Hamlets has the second highest Income Deprivation Affecting Children (IDACI) score in London. In NEL, 5 boroughs are above the London and England IDACI score.
- Tower Hamlets, along with 5 of the other NEL CCG boroughs has Income Deprivation Affecting Children (IDACI) scores above the London and England average. Tower Hamlets has the second highest in London.
- In relation to the Social, Emotional and Mental Health (SEMH) needs of school pupils in the UK, Tower Hamlets(3.1%) is one of three 3 boroughs with a score above the London average (2.6%) for the percentage of school pupils that have SEMH needs.

In February 2021 there were 261 children and young people with child protection plans. There had been a rise in this number during the summer (303 in June 2020) which was primarily caused by the understandable reluctance of agencies to end CP plans during lock-down with only limited levels of support. The changes to these figures throughout the last year remain in line with statistical neighbors.

Working Together to Safeguard Children (2018), the Intercollegiate Training Guidance (2019) and Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2019) all informed the CCG and partnership approach during the reporting year.

The revised safeguarding children partnership arrangements, launched in September 2019, continues to develop and respond to local issues. The full THSCP Published Arrangements can be found on the Tower Hamlets Council Website.

The final transition from safeguarding children board to safeguarding children partnership occurred in early 2020 with a revised structure and terms of reference for the sub groups. Going forward the structure includes the:

- Executive Leadership Group
- Quality Assurance and Performance Monitoring Subgroup
- Vulnerable Young People Sub-Group which also incorporates the Priority Task & Finish Group: All age exploitation

There are also:

- THSCP: Priority Task & Finish Group: Staying Safe Online
- THSCP: Priority Task and Finish Group: Domestic Abuse
- All age exploitation

The CCG is represented at all of the above groups.

The CCG continues to contribute to the Tower Hamlets Safeguarding Children Partnership (THSCP) at the executive board and sub- groups. The executive board is attended by the NEL Director of Quality and Safety and the Head of Safeguarding the THSCP sub groups are attended by the designated professionals and named GP.

THSCP has agreed the new Partnership Priorities. Partnership consultations and feedback events were held, which included workshops with practitioners and the wider partnership. Alongside these events, there were other activities including, engagement with Children and Young People, scrutiny of multi-agency data, review of single agency audits, rapid review outcomes and Independent Scrutineer feedback.

These priorities will take shape as task and finish groups early next year.

Domestic Abuse and the Impact on Children and Young People – Led by the CCG	Staying Safe Online – Led by the Police	Exploitation and Adolescent Safeguarding (Joint with the SAB)– Led by children's social care and a SAB representative.

Child sexual abuse pathways
Work has continued with the establishment of the Child Sexual Abuse Hub (CSA Hub), based at the Royal London Hospital, which takes referrals from all eight Boroughs within NEL CCG. Referrals are made to the CSA HUB by the Multi-Agency Safeguarding Hub (MASH) where children and young people receive the Paediatric offer together with the offer of 'Tiger Light' which is the Emotional Wellbeing Support Service (Barnado's).

The numbers of referrals by three of the Boroughs including Tower Hamlets have fallen and numbers have undoubtedly been impacted by Covid-19. However, it has become evident that a communications drive is necessary across the workforce, in particular children's social care, to ensure that all social workers are aware of the service and the benefits to children and young people.

During Covid-19, Tiger Light has found that virtual appointments has enabled practitioners to hold higher caseloads and have been well received by young people. The service is working on being able to offer a 'blended offer' now that schools have returned.

The interim designated nurse will work alongside partners to raise the profile of the CSA Hub

Independent Inquiry on Child Sexual Abuse (IICSA): Tower Hamlets
Tower Hamlets have now been involved in three separate investigations by the Independent Inquiry on Child Sexual Abuse (IICSA). Following an investigation, that did not involve the CCG, a report was published in 2019 in respect of historic abuse which took place at St Leonard's, a children home run by LBTH from the 1940s-1980s. The report into this investigation was published in 2019 and LBTH's approach was positively commented on by the Inquiry. The Inquiry was particularly positive about the pro-active way in which we had supported victims during the 1990's and early 2000's.

Child Safeguarding Practice Reviews (CSPR)
During this financial year there have been:

- 2 Serious Case Reviews (SCRs) published. There cases were initiated as SCRs under the previous guidance. Work on the recommendations/actions for the CCG is progressing well and is near completion.
- 1 Thematic review of "troubled lives, tragic consequences" (2014) is in progress. This review aims to understand issues affecting older children to support system learning and academic research.
- 1 Local Learning Review commenced and is progressing with the CCG leading this review.
- 1 Rapid Review – the THSCP Executive Group has agreed with the recommendation to take this case forward as a Local Learning Review and this will begin once a response has been received from the National Panel.
- 1 Rapid Review – the post-mortem report is awaited but this case is likely to require a review.

The designated nurse works closely with THSCP to oversee the health involvement and contribution to the CSPR processes within the borough. Also, along with the named GPs, they also work on the required actions for CCG recommendations.

Child Death Review Processes

The CCG has joint responsibility with local authority for Child Death Review Panel processes. Tower Hamlets have signed up to eCDOP, an electronic administrative system to share data regionally and nationally for learning purposes. The CCG was a key member of the steering group to develop the WEL and City and Hackney child death arrangements and the Child Death Review Hub. Work continues to embed these arrangements and ensure that all families receive a wraparound service on the death of a child, that learning is implemented quickly and that all providers of health services are aware of their roles and responsibilities to support this new framework.

The designated nurse and interim designated nurse have been working with colleagues from the Child Death Review Hub to support the review of the implementation of the child death review processes in WEL & City and Hackney and BHR. An Independent Consultant has been commissioned to undergo the review which includes questionnaires, workshops and individual interviews with professionals across the health workforce. The report and the findings will be shared mid-2021.

The Interim designated nurse has developed an overview document simplifying the stages child death review processes and what is required of professionals at each stage. The document has been shared widely with health colleagues.

Health Contributions

Health continues to contribute to safeguarding processes through referrals to Multiagency Safeguarding Hub (MASH), information sharing, attendance at case conference, core groups or child in need meetings and Multi Agency Risk Assessment Conferencing (MARAC).

The CCG commissions services from Barts Health Trust to deliver child protection medical and looked after children health assessments. The CCG commissions services from East London Foundation Trust to deliver CAMHS services.

Tower Hamlets safeguarding children and young people highlights

Liaising with commissioners, service leads and providers, working towards more integrated work around the CYP and family e.g. input into ongoing QI project “Improving CAMHS & Primary Care liaison”.	Tower Hamlets has provided a new remote GP service called Health spot. This GP service is specifically for the well-being of children and young adults.

Key achievements

- Development of a simplified overview of the child death review processes and what is required of professionals at each stage. This has been shared widely with health colleagues.
- The CCG participated in an NHSE audit on mental health provision for children who receive social care support. This helped identify gaps in integrated working and provision, which will be addressed though local development plans. The designated professionals and named GPs are working with children and young people commissioners to support this work
- With the move from face to face appointments to virtual consultations the Named GP’s in NEL collaborated in producing guidance tackling the handling of digital imagery of U18’s. 3 documents were circulated to all GP’s which summarised the guidance from the RCGP, MDU and RCGP on virtual consultations and requests and storage of intimate imagery of children.
- The named GP’s have provided virtual training to over 180 GP’s and other primary care staff at Level 3. This training session received excellent feedback and was scored 4.5 out of 5 stars by participants. Despite the numbers, there was success in the aim to provide useful, practical training focussing on current issues colleagues were facing during the pandemic
- Regular GP practice children’s safeguarding leads meetings are held to support primary care in their Safeguarding duties.
- Development and delivery of virtual training for safeguarding Level 3 to GPs
- Non accidental injury review - national concerns about an increase in non-accidental injury has been born out in Tower Hamlets. As a result of this, the designated doctor reviewed the acute response to five recent cases in Tower Hamlets and gained assurance that the responses to

- Those cases were appropriate. The designated nurse for CLA gained assurance in relation to preventative and community responses to non-accidental injuries, which is robust. However she identified that more needs to be done to develop the local multi-agency protocol, which was a recommendation for 'Serious Case Review Adam'. Work on this began during the reporting period.
- Good partnership working across Tower Hamlets throughout the period of the Covid-19 pandemic with CCG representatives involved in all key safeguarding meetings, work themes etc.
- Made significant progress in the work to complete CCG recommendations and actions from the older serious case reviews.

Training and compliance

CCG

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	74%	78%	78.6%	75%
Level 4	100%	100%	100%	100%
Level 5	100%	100%	100%	100%

The designated nurse safeguarding children is working with the CCG Organisational Development Team on strategies to improve the levels of CCG staff compliance with safeguarding and Prevent Training

East London Foundation Trust

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	93%	92%	90%	88%
Level 2	91%	90%	87%	88%
Level 3	63%	71%	69%	67%
Level 4	100%	100%	100%	100%

Barts Health Trust

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	92%	91%	92%	90%
Level 2	89%	88%	90%	88%
Level 3	79%	80%	79%	55.5%
Level 4	100%	100%	100%	100%

ELFT & Bart's Health Trust both have plans in place to address areas of poor compliance with safeguarding and 'Prevent' training.

How we captured the voice of the child and young person

1. The views and opinions of children and young people inform all stages of the commissioning cycle, from service reviews, planning and development, to delivery and evaluation. Our revised safeguarding through commissioning policy sets out how we do this
2. Children and young people are represented at the THT Partnership, TH community engagement strategy, the local co production Framework and children's and young people's engagement forums
3. The views and opinions of children and young people inform all stages of the commissioning cycle, from service reviews, planning and development, to delivery and evaluation. Our revised safeguarding through commissioning policy sets out how we do this
4. Children and young people are represented at the THT Partnership, TH community engagement strategy, the local co production Framework and children's and young people's engagement forums
5. Feedback from children and young people is central to Barnardo's Tiger light service, which provides emotional support to children who have experienced sexual abuse
6. The integrated adolescent hub in a youth centre called "Health Spot" continues the important work with children and young people. Feedback from children and young people accessing the HUB is encouraged.
7. In order to shape mental health services in schools, the CCG and CAMHS facilitate bespoke co-production projects with the Health Watch young influencers
8. The CCG participated in an NHSE audit on mental health provision for children who receive social care support. This helped identify gaps in integrated working and provision, which will be addressed though local development plans. The designated professionals and named GPs are working with children and young people commissioners to support this work

Celebrating Success - Listening to Children & Young People

In February 2021 East London NHS Foundation Trust safeguarding children team held their "People Participation Event". A CAMHS patient participation group was held to seek out service user's perspective of safeguarding issues, what they view as risks to their wellbeing and how ELFT staff can help to keep them safe. The group was attended by 10 young people, aged 14-17. During focus group the young people were able to express self either verbally on zoom or using chat box.

Group was facilitated by people participation leads and Maura Hubbard and Tim Bull (safeguarding children team)

Themes discussed with the children and young people:

- Confidentiality and consent
- Contextual safeguarding
- Safeguarding adults issues
- Definition of safeguarding
- Barriers to engaging with children social care
- Young people feeling safe
- Professional assumptions

Professional assumptions
We explored how professionals can make assumptions about what is best for a young person and how this can be rectified?
Responses included
- Regular meetings with young people
- Listen to young person
- Give them time

Barriers to engaging with children social care.
Responses:
- Negative stereotypes image of Children Social care.
- "Referral" is sometimes the wrong thing to do"
- One young person was positive regarding CSC - keeping families together, housing access, education
- Parents being notified when they don't want them to be.
- Clash of culture between parents and children.
- Referral to CSC punitive
- Poor communication

Young people feeling safe
Signpost to support service and building trusting relationship with staff.
How can a young person let a professional know they feel unsafe if can`t use their voice?
Responses ranged from
- Sign language,
- Writing down thoughts,
- Art therapy, Using non-verbal cues
- Young person speaking in the third person

Safeguarding Adult's Issues
Interestingly, one of the young people could identify where they would seek help, if they are worried about an adult suffering harm. When explored further there appeared to be a fear of sharing secrets within family, being disloyal to family members and implications of asking for help.

In the last year, we have

1. Supported the implementation of the revised THSCP arrangements including review of the Local Learning approach and the Rapid Review processes.
2. Contributed to Serious Case Reviews and embedded the learning from these reviews
3. Designated professionals and named GPs have contributed to partnership audits, review of children subject to child protection plans and case conference appeals, as well as thematic and case reviews
4. Developed an overview document simplifying the stages child death review processes and what is required of professionals at each stage. The document has been shared widely with health colleagues.
5. The Named GPs have highlighted at national and local level the inequalities and barriers facing CYP with digital access to healthcare and continue to collaborate with NHS England and commissioners in raising the profile of YP voice which has highlighted the inequities. Current work involves ensuring due regard to removal of access barriers is evident in procurement of online consultation platforms
6. Through the Local Incentive Scheme (LIS) works and as repeatedly highlighted in SCRs the named GPs are continuing to scope and promote working together with health visitor and school nurse colleagues through MDT meetings to promote joined up community health offer.
7. We are supporting practices to improve record keeping and also timely processing of reports when requested from Social Care, in particular, through development of cSG administrators within primary care in line with the Royal College of General Practitioners (RCGP) child safeguarding (cSG) toolkit. We have worked and continue to do so with the CEG to refine emis cSG templates to improve coding and data collection.
8. We have continued to refine the TH primary care cSG flow chart including highlighting and promoting to colleagues the early help hub offer, clarification on who to contact when and how.
9. We have prepared information summarising the NICE guidelines on the management of depression in children and young people. This was discussed in the level 3 training and this year the prescribing of antidepressants in children will become part of an audit for primary care. This was in response to the tragic suicide of a child in a neighbouring borough
10. 'Child Not Brought for Appt Policy' (CNBA) has been embedded within GP Practices
11. Tower Hamlets has provided a new remote GP service called Health spot. This GP service is specifically for the well-being of children and young adults.

This year we will:

1. Ensure that the rights and voices of children and young people are central to our work
2. Continue to work in partnership with provider organisations to ensure that safeguarding children and young people services continue to meet appropriate standards of care and delivery. This will be across the broader TNW/NEL health economy.
3. Continue to work with partners across the broader TNW/NEL health economy to implement learning from Covid-19 and meet the demands for services as a result of Covid-19.
4. Take steps to improve the CCG staff compliance levels for Level 1 safeguarding children and Prevent training.
5. Contribute to the communications drive to raise the profile of the CSA Hub
6. Continue the work with Primary Care to promote working together with health visitor and school nurse colleagues through MDT meetings which will include scoping how well this process is embedded across Tower Hamlets.
7. Raise 'Health' colleagues' awareness and understanding of the Rapid Review Process and work with THSCP to develop a protocol/flowchart to assist.
8. The designated nurse will become take up the role of Chair of the Rapid Review Panel
9. Review and agree Governance Arrangements both locally and across NEL CCG
10. Continue to support health providers and primary care to achieve and maintain appropriate levels of compliance in safeguarding children, Prevent training and safeguarding supervision of

practitioners as services recover from the effects of the Covid-19 pandemic

11. Continue to contribute to Case Reviews and embedding the learning from these reviews

Tower Hamlets Safeguarding – Children Looked After

The CCG has a duty to work together with the local authority, police and local partners to safeguard children and promote the welfare of all children in their area[13]. This involves working together to develop happy, healthy children who reach their potential. This duty includes the commissioning of statutory initial and review health assessments (IHA, RHA) to meet the health needs of all children who are looked after by Tower Hamlets and children who live within Tower Hamlets whilst under the care of other local authorities.

Every child should grow up able to reach their full potential and for some children this is achieved by being taken into local authority care. Statistically children who are looked after are less likely to realise their full potential with poorer health and educational outcomes. They are at higher risk of teenage pregnancy, substance misuse, special educational needs and early entry into the justice system.

At the beginning of April 2020, there were 80,080 children who were looked after within England, of which 307 were looked after by Tower Hamlets local authority. This was an increase from 286 children that were looked after on 31st March 2018, (see table in children looked after highlights). This has been consistent across the last financial year. There are 42 children who are looked after per 10,000 children in Tower Hamlets, which is lower than the London average of 49 per 10,000 children and England average of 67 per 10,000 children[14].

The CCG has a contractual arrangement with Barts Health Trust NHS Trust to employ the designated doctor for children looked after and they are also the provider of the children looked after service. This service provides the delivery of initial and review health assessments within statutory timeframes. At present the service does not have a named nurse for children looked after which is nationally recommended,[15] and the post of designated doctor for children looked after is currently vacant. During early 2020/21 the role of designated nurse for children looked after was introduced and there was joint oversight by the designated safeguarding nurse with the support from designated safeguarding doctor and head of safeguarding for TNW CCGs.

There have been no CQC child looked after and safeguarding inspections or joint targeted area inspections during the report timeframe. Nationally there has been a reduction in inspections due to social distancing and the Covid-19 pandemic.

Performance

- Due to the Covid-19 pandemic national government guidance was introduced in March 2020 to limit face to face health contact, to assist in minimising the spread of Covid-19. This resulted in some of the initial and majority of review health assessments being delivered virtually. In Tower Hamlets, face to face IHAs recommenced in September 2020 and the named doctor reviewed any previous virtual IHAs to ensure that there was previous/future face to face medical contact to validate the IHA.
- Mechanisms are in place to review data on a monthly basis, which suggests that delays in children being seen within 20 working days are isolated within a month rather than across the quarter. When there are delays in CYP being seen within 20 working days this is likely due to higher levels of entrants to care at that time, which impacts the time taken for children's social care to send the referral and possible delays in the child being assessed.
- Provider performance data in the reporting year showed that there was a transition in how RHAs were delivered. Due to responding to social distancing measures the introduction of virtual assessments began in March 2020 and continued throughout the reporting year. At the beginning of the financial year the RHAs were predominantly telephone based which then transitioned to video RHAs in the latter half of the financial year. RHAs were triaged by nursing staff and there were minimal RHAs that were delivered face to face.
- Staff were also redeployed within the service provider and the CCG to support with the impact of Covid-19. To ensure that there was effective communication between partners the CLA & Care Leavers Health and Wellbeing Steering Group increased from quarterly meetings to bi-monthly.

[13] https://www.legislation.gov.uk/ukpga/2017/16
[14] https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions/2020
[15] Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing (rcn.org.uk)

Tower Hamlets safeguarding children looked after highlights:

Overall, during 2020/21 the performance demonstrates **positive partnership working** to support timely health assessments.

		2018	2019	2020
England	Number of children looked after	75,370	78,140	80,080
	Population estimate	11,866,960	11,954,620	12,023,570
	Rate per 10 000 children aged under 18 years	64	65	67
London	Number of children looked after	9,880	10,020	10,010
	Population estimate	2,001,360	2,022,020	2,032,430
	Rate per 10 000 children aged under 18 years	49	50	49
Tower Hamlets	Number of children looked after	286	329	307
	Population estimate	68,403	70,973	72,290
	Rate per 10 000 children aged under 18 years	42	46	42

Children looked after numbers and rates per 10,000 children aged under 18 years' for Children looked after at 31 March each year in England, London and Tower Hamlets between 2018 and 2020

Performance

Indicator	Target	Q1	Q2	Q3	Q4
Referrals Received - initial health assessments within 5 working days of child entering care (of the total due for IHA in month)		43%	64%	51%	74%
Percentage (%) of initial health assessment completed within 28 days of child entering care (due in reporting quarter)	80%	62%	88%	89%	82%
% of review health assessments completed by 6 months of last assessment for 0-4 year olds	90%	44%	96%	59%	100%
% of review health assessments completed within 12 months of last assessments for 5-17 year olds.	90%	61%	79%	97%	87%

Across the financial year there has been improvement in IHA referrals being shared with health within 5 working days. Where there is a low percentage of health assessments delivered this is primarily due to a high denominator in that quarter. The health team have been proactive in delivering health assessments on time and when there is delay this is usually due to the carer/child requesting a change of appointment or young person declining the offer of a health assessment.

Key achievements

- A continued partnership within the CLA & Care Leavers Health and Wellbeing Steering Group. This enables a multi-professional approach for the strategic planning of the needs and outcomes of children who are looked after. During the reporting year a large focus was on the Covid-19 response and the views of the child. There was increased work with CLICC (Children Living in Care Council).
- The CCG developed guidelines to support risk stratification and delivery of virtual health assessments. These were updated with each government change to social distancing. The guidelines supported the provider with risk assessment for the CYP that would benefit from face to face contact. The guidelines were also shared with multi-agency partners so that they could contribute towards decision making of the prioritisation of health needs for the children who are looked after.

- A literature review into the pros and cons of virtual health contacts. This supported more reflective discussions about virtual and face to face health assessments. The literature review was followed with a video blog and '7-minute' briefing document to aid learning and support multi-agency partners.
- Strengthening the voice of health through attendance of the corporate parenting board and presenting the annual report. This has raised the profile of health and has ensured that the subject of health and health partners are inclusive in conversation regarding children who are looked after.

How we captured the voice of the child and young person

1. Quality assurance of health assessments ensures that the voice of the child has been captured.
2. Multi-professional relationships have improved through the CLA & Care Leavers Health and Wellbeing Steering Group, which has enabled the voice of the child to be shared amongst professionals. When the voice of the child is shared between partners this allows services to adapt to meet the needs of the CYP.
3. Liaison with the children living in care council with care leaver attendance at the Corporate Parenting Board and the introduction of the 'wish list'. The 'wish list' is the CYPs views on what is working within services for children who are looked after and what can be improved. The wish list validates their views and provides an evidence base for professionals to integrate into their practice.

In the last year, we have:

1. Ensure effective partnership working with commissioner and provider to map the service which supported the identified gap of the need for a named nurse for children looked after.
2. Effectively minimise the spread of Covid-19 by transitioning contacts through virtual platforms.
3. Worked effectively with fellow designated nurses within NEL to update the risk stratification and guidelines to support the delivery of virtual health assessments in a timely manner following the government changes to social distancing.
4. Highlighted the value of face to face contact through a video blog, '7 minute briefing' document and an IHA audit has evidenced that physical and emotional needs are better assessed through face to face contact.
5. Raised the profile of health within the Corporate Parenting Board, through attendance and contribution to the Corporate Parenting Annual Report. This has allowed the multi-agency professionals to keep health within their thought process when decision making.
6. Ensured that the voice of the child is captured, and listened to, through different sources such as health assessments and the Corporate Parenting Board.

This year we will

1. Advise and support the recovery and restoration of the children looked after health service following the impact of Covid-19.
2. Continue to work with the commissioner and providers around the capacity, timeliness and quality of the health assessments through service mapping and to ensure compliance with statutory guidance, with the progression of a business case for a named nurse.
3. Maintain the use of virtual health assessments for those children who do not wish to actively engage with a clinic appointment so that individual health needs can be met.
4. Maintain and further increase contact with children who are looked after to support decision making with items such as the Health Passport.
5. Progress the local offer with the implementation of an App and combine this within the Health Passport pathway.
6. Embed learning from local Ofsted inspections to support evidence pathways, such as a pathway to support children and young people with special educational needs. It is anticipated that Tower Hamlets will be having a SEND inspection within the next financial year.
7. Pilot a Health Profile for the local Children Looked After population to determine the local health need.

8. Advise and support the recovery and restoration of the children looked after health service following the impact of Covid-19.
9. Continue to work with the commissioner and providers around the capacity, timeliness and quality of the health assessments through service mapping and to ensure compliance with statutory guidance, with the progression of a business case for a named nurse.
10. Advise and support the recovery and restoration of the children looked after health service following the impact of Covid-19.
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13. Maintain and further increase contact with children who are looked after to support decision making with items such as the Health Passport.
14. Progress the local offer with the implementation of an App and combine this within the Health Passport pathway.
15. Embed learning from local Ofsted inspections to support evidence pathways, such as a pathway to support children and young people with special educational needs. It is anticipated that Tower Hamlets will be having a SEND inspection within the next financial year.
16. Pilot a Health Profile for the local Children Looked After population to determine the local health need.
17. Increase the uptake of immunisations and dental health attendance and identify any barriers.
18. Strengthening links with acute and primary care to improve their knowledge of children looked after through:
    - Training with GPs
    - Supporting the provider service with a local training offer
    - Promote the health of children looked after through maintaining strategic oversight of the health of the children looked after population by attending multi-agency partner meetings.

Voice of the Child Study

Headlines: The youth participation team worked jointly with CLICC (Children Living in Care Council) and asked the young people to generate key actions that they would like the Corporate Parenting Board to address.

Their Wish List included:

- Wrap around Service - a lead professional to make sure all services come together for the young person
- Smooth Transition - services don't work together and so transitioning from one place/situation to another doesn't always go smoothly
- Creating CLICC Ambassadors - so they can advocate on behalf of others and become real voices for them
- Training and Development for social workers - social workers aren't always trained up adequately in the services that young people need
- Oyster cards (free travel) – some young people have free travel and others don't.
- Local Offer – needs to be refreshed and updated
- Staff Rapport – Young people want staff consistency
- Referral Fatigue – Young people want to stop the constant referrals from one agency to another without support.
- Mindfulness – MH Support/Counselling. Young people don't always like to go to CAMHS because of the stigma attached to mental health. The word 'mental' can put some of them off.

Impact and outcome: The wish list was presented by a care leaver to the Corporate Parenting Board which allowed the care leaver to have open discussion and provide scenarios that determined some of the content within the presentation. To hear the presentation from someone with experience of care has further validated the local need within Tower Hamlets. The wish list has implemented within the action plan of the CLA and Care Leaver Health and Wellbeing Steering Group.

Learning points: The development of pathways, guidelines and services need to refer to the wish list to

ensure that the wishes are acknowledged and addressed within service changes. CLICC will continue to be consulted key areas of development, such as the Health Passport. Arrangements are currently being made for the local health team to attend a children in care council meeting for them to share experiences and ideas.

Newham Safeguarding

The London Borough of Newham has a population of 352,005 – the third largest borough population in London. Children make up 24.6 % (86,567) of the population. This 'young' borough has a median age of 31.9 years, which is lower than the London average of 35.3 years.

Newham is one of the most deprived boroughs in England with 20.1% (15,300) children living in low income families. The unemployment rate is 6.2% compared with 5.3% in London and 4.4% in England. Rates of common mental health disorders are high at 23.9% in Newham compared to 19.3% and 16.9% in London and England respectively. However, in 2018/19, some 46.7% of state educated children in Newham achieved a strong pass in GCSE English and Maths grades 9-4 in, compared to just 43.4% in all of England.

Along with Brent, Newham has the most diverse population in the UK, although the distribution of ethnic groups is uneven across the borough. There is wide variation in the ethnic composition: over a third of East Ham North's population is Indian (38%); a fifth of the population of Canning Town North and Custom House is African; and the largest Bangladeshi clusters are found in Little Ilford (20%) and Manor Park (19%). According to Greater London Authority ethnicity projections, there is an uneven distribution of white and other ethnic groups across the age range. As a general trend, the proportion of White, Black Caribbean, and Indian population within each age band increases with age; whereas the proportions of the population which are Black African, Pakistani, and Bangladeshi decrease through the age bands.

Childhood obesity is an issue of concern in Newham, with 27.7% (1,286) of children in Year 6 classified as obese. This level of obesity is exceeds the average for England and should be considered in conjunction with the rate of diabetes diagnosis for people aged 17 years, which also exceeds the average rate in England.

Crime in Newham is comparable to other London boroughs with anti-social behaviour and violence and sexual offences being the highest recorded crimes. During 2019/20 serious youth violence has been a safeguarding concern with five serious safeguarding incidents notified to the National Child Safeguarding Practice Review Panel. Key learning from these cases will be cascaded out to practitioners across the Newham workforce in 2020/21.

Newham Safeguarding: Adults

The purpose of this report is to provide assurance to the CCG Governing Body that the CCG has robust and effective adult safeguarding processes in place that reflect national legislation and statutory guidance, and demonstrate the commitment of the organisation to embed adult safeguarding both internally and within its commissioning functions.

In quarter four, the Covid-19 pandemic began to challenge the health economy and partnership to evaluate the existing process and procedures for safeguarding adults with care and support needs. While the pandemic has shown how we can all pull together and support our communities, sadly it also means that abuse and neglect can be harder to spot. People may have fast become more vulnerable to abuse and neglect in a pandemic context as others may seek to exploit disadvantages due to age, disability, mental or physical impairment or illness[16].

In response to the Covid-19 pandemic, work was undertaken swiftly to collaborate, establish new ways of working, and maintain a focus on safeguarding adults. Newham set plans in train to establish a virtual safeguarding partnership forum, and a domestic abuse working group. A north east London safeguarding adult's forum was also established. It brought together designated professionals, NHS providers, named professionals and system leads to review current safeguarding themes and trends within NHS organisations.

The forum focused on a range of work streams including:

- Identification of barriers and constraint
- Platform for support and information sharing
- Scoping agile training solutions
- Complex case discussion
- Changes to safeguarding legislations and procedures

Outlined within the report is an overview of the safeguarding adult's achievements during 2020 - 2021 and the key priorities and focus areas for 2021/2022.

Newham safeguarding adults highlights

50 GPs attended a virtual **domestic abuse workshop** designed by Hestia.

Professionals discussed the increased risks due to Covid-19 and scoped local services support in Q4.

Recruited to designated professional for safeguarding adults post. Post holder started in quarter four. Work commenced on collaborative work with both Newham partners and neighbouring CCGs within the TNW footprint on key priorities and work streams.

The ELFT safeguarding team developed an **Electronic Safeguarding Journal**. This continues to be an effective approach to connecting with front line staff to ensure that they are supported and updated with relevant key safeguarding information.

In response to high numbers of people experiencing multiple exclusion homelessness, and over 1000 asylum seekers being housed in temporary accommodation in NEL, we developmental a resource pack that included key guidance and contact information for homelessness outreach practitioners and the long term hostel staff.

[16] https://www.scie.org.uk/care-providers/coronavirus-covid-19/safeguarding

Key achievements

Cygnet: Newham become the responsible commissioner for Cygnet. Strong links were built between the CCG & provider to promote continued development.

SAR'S & DHR's: These continue to be a priority with strong collaborative working maintained during the pandemic to ensure that these cases were effectively explored in the SAB arena. The team ensured that the person's journey was understood and lessons learned identified and shared.

Homelessness: This is a significant issue in Newham, which was further heightened by the Covid-19 pandemic. As part of the CCG & NSGAB homelessness featured strongly with the SAR's that were competed, which included SAR Peggy, Cartina & Amir. A resource pack has been developed to support the ongoing work with people experiencing homelessness.

Transition into adulthood: Safeguarding in the transition into adulthood space was identified as a join priority for the adult and children safeguarding board. Professionals were empowered to explore the principles of transition. Following elevator pitches, and by popular vote, the SEND pathway was selected for initial focus. This work was established during the reporting year and will gain traction 2021/22.

Learning Disability Mortality Review (LeDeR): This has continued to be a priority and reviews have been completed and signed off in a timely manner. Significant learning has come from the LeDeR reviews resulting in cases being approved for SAR's.

Person in position of trust (PiPoT): The 3 NEL boroughs join up as part of the NHS England working group reviewing the need and function of PiPot, which mirrors the role of the LADO.

Training and compliance

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Barts Health NUH	Level 1: 90.98% Level 2: 89.38% Level 3: 18.36% WRAP: 79.69%	Level 1: 89.74% Level 2: 88.12% Level 3: 33.81% WRAP: 79.17%	Level 1: 88.78% Level 2: 86.65% Level 3: 32.12 WRAP: 79.17%	Level 1: 89.32% Level 2: 86.99 Level 3: 50.06% WRAP: 81.5%
ELFT Newham Borough (CHS)	Level 1&2: 85.44% Level 3: 57.02% WRAP: 92.34%	Level 1&2: 89.15% Level 3: 54.11% WRAP: 92.92%	Level 1&2: 91.48% Level 3: 65.20% WRAP: 96.28%	Level 1&2: 89.78% Level 3: 72.86% WRAP: 95.05%
ELFT Newham Borough (AMH)	Level 1&2: 87.04% Level 3: 50% WRAP: 92.39%	Level 1&2: 84.66% Level 3: 48% WRAP: 92.65%	Level 1&2: 92.27% Level 3: 52.99% WRAP: 89.29%	Level 1&2: 89.50% Level 3: 70.29% WRAP: 89.50%
Newham CCG (Level 1&2)	81.66%	83.88%	82.66%	75.66%

How we captured the voice of the person

1. Fulfilling the CCG's statutory responsibilities to the court of protection by ensuring that patient's voice is central to complex legal cases
2. Mental Capacity Assessment deep dive and audit to improve practice
3. Implementing a CCG process to identify all Continuing Health Care funded patients, in supported living/own accommodation, who lack mental capacity. This will enable the CCG to seek court of protection approval of deprivation of liberty in the patient's best interest
4. Consultation with Newham victims and survivors of domestic abuse to increase awareness and support services for patients and professionals in primary care
5. Participate in taking SAR & DHR proposals to the safeguarding adults board and fully support the process ensuring the persons lived experience is explored, heard and forms part of a robust learning process

In the last year, we have

1. Ensure that safeguarding adults with care and support needs related to abuse and neglect remains a priority in a Covid-19 landscape.
2. Lead on the virtual platforming of the annual safeguarding adult's conference (which had to be postponed due to Covid-19). The focus of the conference is multi-agency learning from the SARs completed in the borough.
3. Ensure that robust arrangements are in place for the implementation of the Liberty Protection Safeguards, which will focus on the operational and strategic priorities required so patients are lawfully deprived of their liberty.
4. Strengthen the LeDeR system of reviewing and sharing lessons learned. Including improving work at an STP level and reaching compliance with NHSE LeDeR targets.

This year we will

1. Learning from SAR's DHR's & LeDeR reviews both locally and across the sector involving CCG & Provider outcomes.
2. Collaborative working with CSU, CHC & CCG working to strengthen the process for court of protection and escalation of complex cases including safeguarding issues.
3. LPS: Adults & Children's safeguarding to continue with scoping activity for people needing LPS. Ensure that robust arrangements are in place for the implementation of the Liberty Protection Safeguards, which will focus on the operational and strategic priorities required so patients are lawfully deprived of their liberty.

Case study

Kelly was 41 years old and was very well known to social services, police and mental health services and homeless teams and outreach workers. She had a diagnosis of paranoid schizophrenia, emotionally unstable personality disorder EUPD and poly substance misuse and history of detention under the Mental Health Act 1983 (2007).

At the time of her death Kelly had 3 adult children who had previously been removed from her care.

Kelly was street homeless despite many attempts to engage and provide her with accommodation. She was severely self-neglected, dirty and malodorous with blisters on her feet. Kelly had been sectioned under the MH Act several times.

Despite being under section Kelly absconded on numerous occasions as an inpatient and would be reported as a missing person.

Kelly's life is reported to be chaotic, with her behaviours becoming more and more erratic, which made her extremely vulnerable to exploitation and harm.

The day before the government specification to house everyone rough sleeping, Kelly was found murdered.

Kelly's death lead to a safeguarding adult review. Significant learning was identified for people with multiple exclusions and complex health needs.

The full report and findings can be found on the following link
https://www.newham.gov.uk/health-adult-social-care/safeguarding/3

Newham Safeguarding: Children and Young People

Newham Safeguarding
This year has seen unprecedented challenges, not just due to Covid- 19, national "lock downs" and the effects on children's safeguarding, but the internal workforce has also experienced challenges. Staff shortages and redeployment to support the vaccine programme placed additional pressure on the team. This led to valuable learning, which has informed work streams across Newham and the wider safeguarding team. As a result, the team is better able to support one another, identify critical work streams, and deliver agile responses.

Developments and changes include:
- Working collectively across adults and children's safeguarding
- Improved oversight of safeguarding reviews thanks to the development and mobilisation of a centralised data tracking system that provides pathways to individual case information. This improves visibility at a glance, and supports timely and agile reporting

More to do in Newham
There is more to do to streamline and centralise systems to ensure robust arrangements, this includes:
- Strengthening multi-agency safeguarding across systems
- Developing a health specific safeguarding communication framework, which is short, clear and smart; using the "7 minute briefings" as well as health specific information
- Centralising a health data set and dashboards, again as succinct and efficient approach that reduces the pressure on staff time. Analysis is the critical feature for service planning and prevention

Inequalities
Newham has been disproportionately affected by Covid-19 with a devastating death toll. Covid-19 resulted in additional people receiving benefits and an increased demand for essential services. The Pandemic has exacerbated inequalities in many areas, not least of which is mental health.

The Healthy London Partnerships highlighted inequalities across the sector. Highlights for Newham included produced a snapshot overview of Children and Young People's Mental Health Inequalities across North East London (NEL), as highlighted below.

Deprivation
The ***Income Deprivation Affecting Children Index*** (***IDACI***) measures the proportion of all children aged 0 to 15 living in income is an index of deprivation deprived families which, highlights where deprivation is most affecting children. Newham has an IDACI score above the London and England average (i.e. more deprivation).

The data emphasises the rich ethnic diversity within Newham, with Asian and Asian British constituting 47% of the population. Newham also has the second highest number of under 25 year olds in North East London.

Estimate Number of children with mental health needs
Newham has a significantly number of children and young people with mental health distress, which makes child mental health a priority for Newham.

Children Safeguarding Partnership
As accountable partners, Newham CCG continues to have legal responsibility for safeguarding across the health economy, which includes services that the CCG does and does not commission. The CCG fulfilled their statutory responsibility during the reporting year.

NSCP Priorities 2021/22
The partnership comprises of the CCG, Police and Local Authority. The partnership undertook a priority setting process in February 2020. These priorities are set out below. They complement emerging priorities that result from Rapid Reviews, Serious Case Reviews and their associated learning.

Vision

Making the best place for children and young people. All young people in Newham will:

- Grow up healthy, happy and safe
- Flourish in our schools
- Benefit from training and employment opportunities
- Play an active role in our community

Objectives

- To coordinate what is done by each agency to safeguard and promote the welfare of children
- To ensure the effectiveness of what is done by each agency and by agencies working together

Underpinning principles

- Think Family
- That Newham is a trauma-informed borough (led by Health and Wellbeing Board)
- A focus on mitigating the impact of Adverse Childhood Experience (led by Health and Wellbeing Board)
- The NSCP aims to be a mature, high trust partnership in which conflicts are resolved through conversation. This means
- A culture of early identification and referral to partners agencies
- Open and transparent dialogue between partner agencies
- Respect
- Handling disagreements through conversation which seek to arrive at a joint understanding
- No weak link in the 'professional supply chain' to a child

Priorities

1. All age exploitation - joint with Newham Safeguarding Adults Board

The NSCP will co-ordinate and drive forward multi-agency programmes and interventions in Newham, which combat exploitation in all its forms e.g. financial abuse, modern slavery, sexual exploitation, criminal exploitation, and radicalisation. By raising awareness and making the borough a safer place to live**.**

2. Transitions - joint with Newham Safeguarding Adults Board

The safeguarding in the transition into adulthood space was identified as a join priority for the adult and children safeguarding board. The partnership will empower vulnerable young people to move from child to adulthood in a safe and positive way, supported by their families. Multi-agency professionals came together to explore the principles of transition. Following elevator pitches, and by popular vote, the SEND pathway was selected for initial focus. This work was established during the reporting year and will gain traction 2021/22.

3. Communication and Engagement

We will ensure that the views of children and young people, and their parents and carers, contribute to developing best practice, and that frontline staff and managers are integral to informing learning and improvement.

4. Promoting Practice Improvement

We will drive practice improvements that build on all aspects of evidence based practice and what we know to be useful when assessing. We will uphold this commitment at every stage in the commissioning cycle.

In addition to the above, the NSCP will seek assurance with regard to:

a) Domestic violence and abuse - seeking assurance from Community Safety partners through the domestic violence and sexual abuse board that safeguarding issues are considered throughout the response to domestic violence and abuse.

b) Children and young people feeling safe - which was a key element of the feedback from children and young people. We will ensure that we are aligned with and support the delivery of the priorities and activities of the Youth Safety Board

c) Voice of young person - seeking assurance from partners and agencies that there is ongoing engagement with children and young people in order to influence practice, priority setting and decision making

d) Road to recovery - as the country comes out of lockdown, the NSCP will seek assurances that the system is coping with the anticipated increase in referrals and ensuring high quality service provision.

Newham health specific 2021/22 priorities include:

- Improving training compliance, specifically CCG and CAMHS
- Sharing health messaging and learning from reviews
- Newham to forward plan "voice of the child" safeguarding programme
- Data collection working across NEL to develop meaningful data sets
- Information sharing – CPIS next stage roll out
- Serious youth violence and exploitation
- Domestic abuse

Child Death Reviews

The WELC (Newham, Tower Hamlets, Waltham Forest, and City Hackney & Hackney) eCDOP has continued to function during 2020-21. The sign of arrangements has been delayed due to Covid 19, which formally affects managerial and staffing arrangements, however operationally the eCDOP systems and processes have been successfully embedded.

Newham Child Safeguarding Practice Reviews 2020-2021 (CSPR)

Newham Safeguarding Children Partnership (NSCP) is responsible for undertaking a child safeguarding practice review (CSPR), after a child dies or is seriously injured and abuse or neglect is known or suspected to identify learning and lessons to help prevent similar incidents from happening in the future.

The process for decision making is with the three legally accountable partners; the Local Authority, Police and us in the CCG.

Following a serious incident or death there is a Rapid Review. A Rapid Review is to gather facts to ensure child safety and to identify local learning. Some Reviews require ongoing information gathering and analysis as a CSPR, to identify learning that may have both local and national relevance.

Child reviews from previous years that have been continued or completed include:
One child death where the publication of the final report has been delayed due to criminal proceeding, however learning has been completed. Another review that is being led by Tameside has been completed.

During 2020-21 there were three deaths related to safeguarding concerns one adolescent suicide, one due to adolescent violence and the third child was neglect.

The Rapid Reviews undertaken between July 2019-March 2021 have identified the following themes:

- Adolescent Exploitation and Contextual Safeguarding
- Child sexual abuse and exploitation
- Domestic Abuse
- Harmful sexual behaviour to other children
- Neglect
- Physical abuse

Dissemination of Learning:

NSCP '7 Minute Briefings' https://www.newhamscp.org.uk/7-minute-briefings-intro/ produced include:

- Neglect
- Social Media and mental health wellbeing
- Keeping Young People Safe

General Practice

This year Newham general practice have highlighted at a national level the inequalities and barriers facing children with digital access to healthcare. The team are working with local and national colleagues to mitigate these risks.

Owing to the Pandemic, face to face appointments became virtual consultations during the reporting year. The Named GP's in NEL collaborated in producing guidance to ensure the safe handling of digital imagery of under 18's. Three documents were circulated to all GP's which summarised the guidance from the

Royal College General Practice, Medical Defence Union on virtual consultations and requests and storage of intimate imagery of children.

The lead safeguarding GP's have provided virtual training to GP's and practice nurses at Level 3. There were 2 sessions arranged on Domestic abuse which were facilitated by the CCG but ran by Hestia.

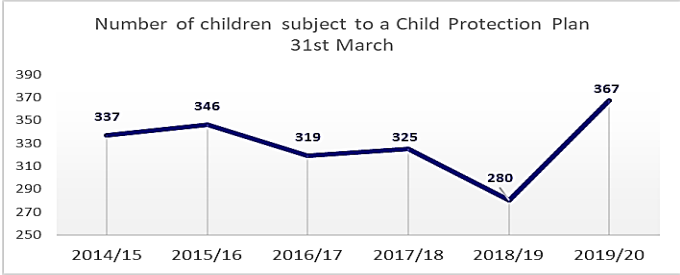
The children and adults named GP's have met with the safeguarding leads in individual practices to disseminate information from local safeguarding reviews and answer queries.

The named GP has sat on CDOP, LADO, rapid review and rapid response meetings, serious case review (safeguarding practice review) / local learning review panels as well as the relevant CCG and partnership meetings. There are regular meetings with children's social care to promote communication and partnership working.

The safeguarding team continues to provide clinical advice to GP's and practice nurses.

Children's Assurance

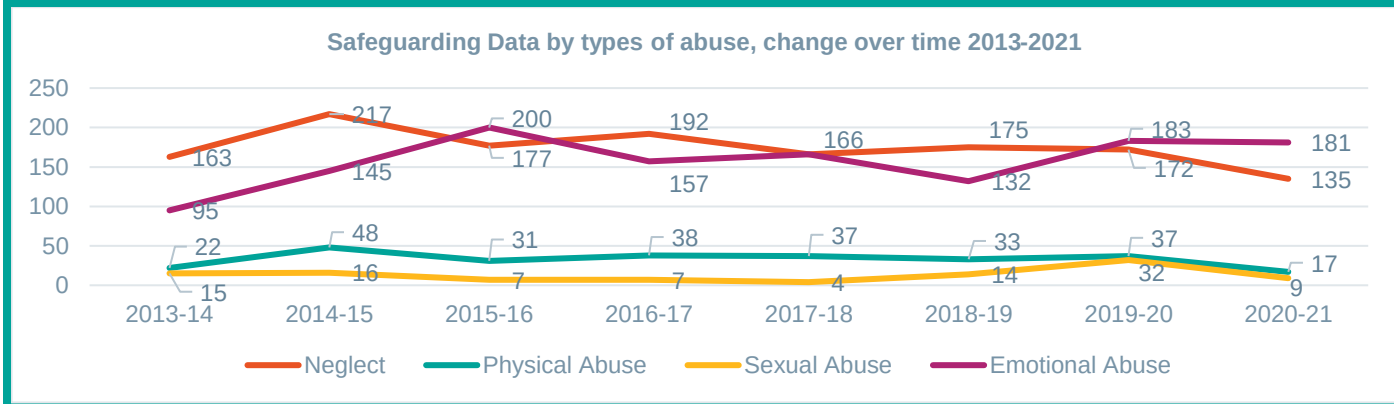
Newham safeguarding children and young people highlights:

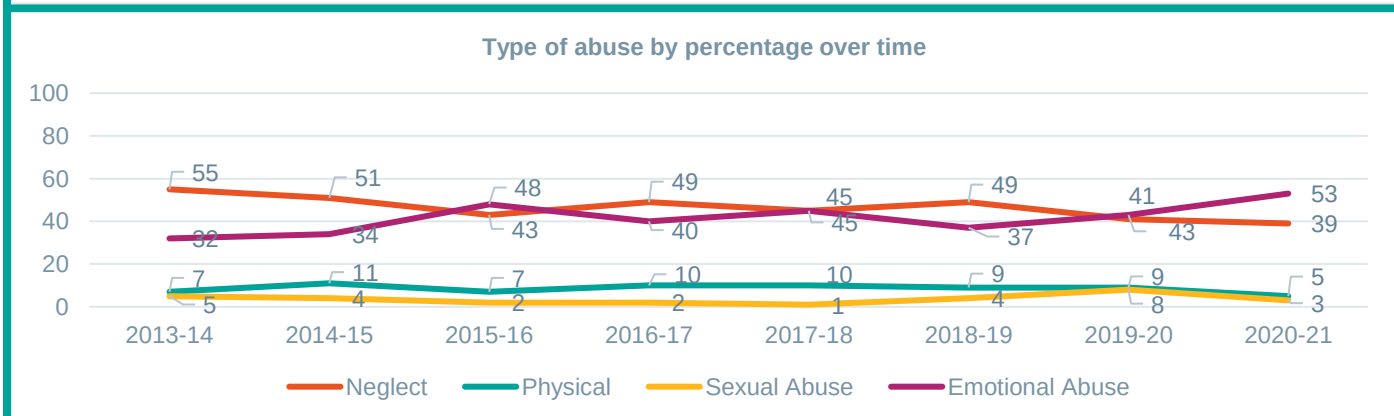


Snap shop data 31 March 2021*

206 Child Protection Plans (CPP) commenced in the last 6 months.

189 CPP ended in the last 6 months





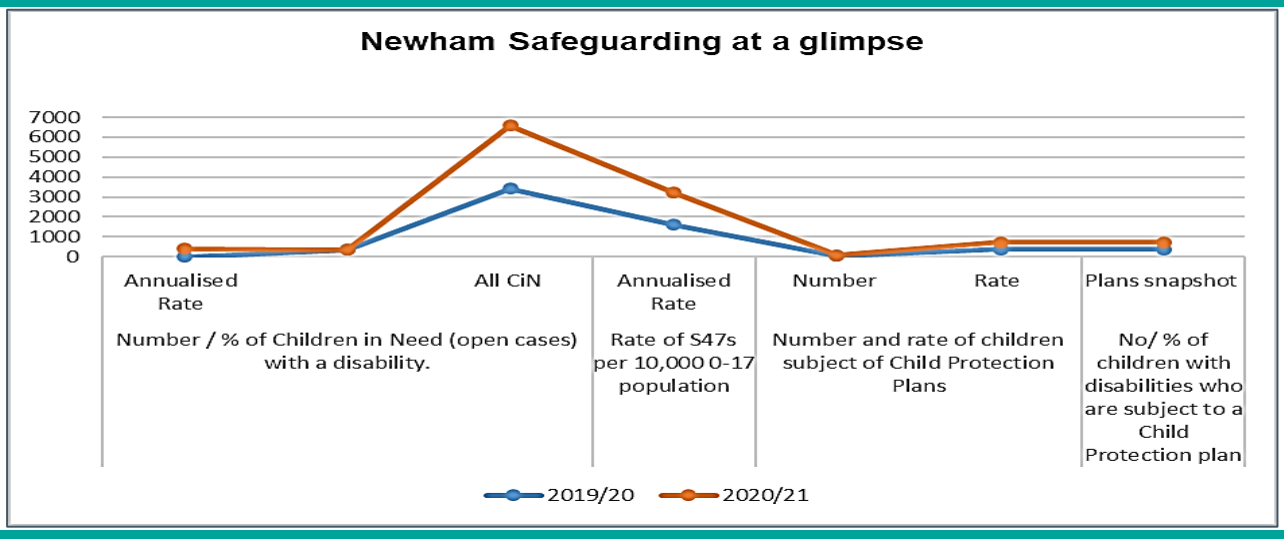
Prevent
In 2020-21 there were 7 referrals to Prevent for under-18s none required referral to Channel panel. Onward referrals make to SO15 (counter-terrorism police) as required. Depending on the outcome of this, a referral to Channel may be made for a personalised in-depth programme of work.

Partnership working
There were 8902 contacts in Newham Social Care during the reporting year, of those, 19% were generated by health with 18% converted into referrals. This conversation percentage indicates that health are correctly identifying children requiring social care support.
Of the referrals there were 4424 Males (50%) 4042 Females (45%) and 436 Other (not shown) (5%)

*Children's services Analysis Tool (ChAT) from 01/10/2020 to 31/03/2021

Newham Safeguarding at a glimpse

Indicator		2019/20	2020/21
Number / % of Children in Need (open cases) with a disability.	Annualised Rate	355	390
	All CiN	3409	3170
Rate of S47s per 10,000 0-17 population	Annualised Rate	1600	1614
Number and rate of children subject of Child Protection Plans	Number	42	43
	Rate	367	368
No/ % of children with disabilities who are subject to a Child Protection plan	Plans snapshot	367	368



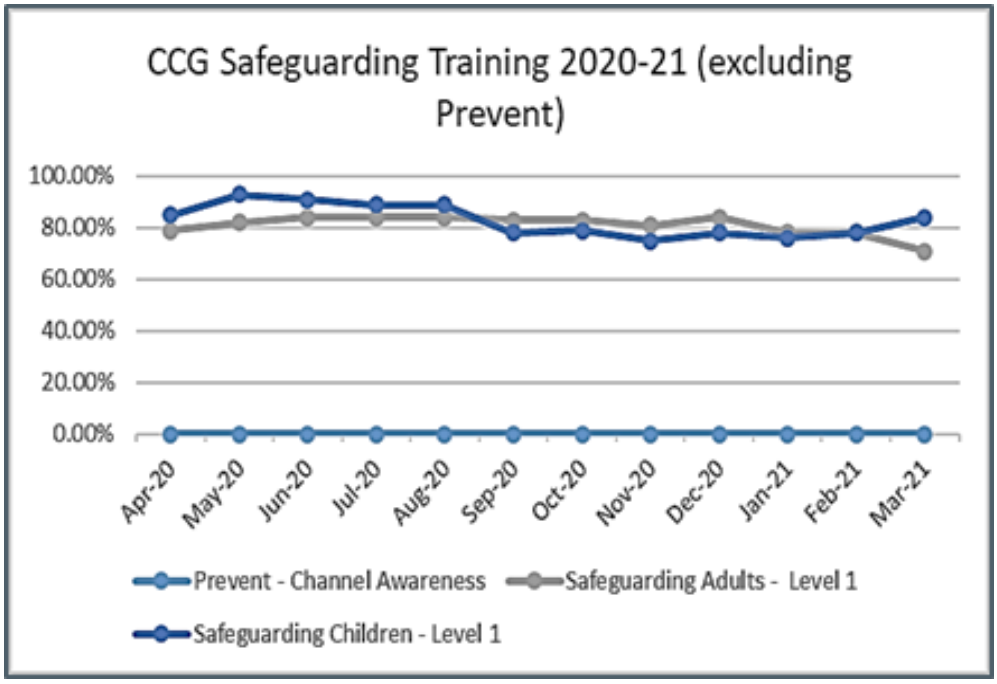
Key achievements:

- Newham CCG revised and reviewed the safeguarding tracker, shared with Tower Hamlets and Waltham Forest (TNW ICP) to track and monitor rapid reviews and the implementation safeguarding health learning across the health economy
- Worked in the partnership successfully completing learning reviews with contributions to the 7 minute learning programme of work for Neglect, Social Media and Mental Wellbeing and Keeping Young People Safe https://www.newhamscp.org.uk/7-minute-briefings-intro/
- Managed safeguarding demands despite the constraints imposed with the Covid-19 pandemic

Training and compliance:

CCG NHS Newham safeguarding training target for the CCG and providers is 85% compliance.
CCG training achievement 2020-21. Quarters one and two training target was successfully met, this reduced over the second half of the year, the last month of quarter 4 showing an indication of an upward turn. No Prevent data is collected.

2020-2021	Safeguarding Children - Level 1
Apr-20	85.00%
May-20	93.00%
Jun-20	91.00%
Jul-20	89.00%
Aug-20	89.00%
Sep-20	78.00%
Oct-20	79.00%
Nov-20	75.00%
Dec-20	78.00%
Jan-21	76.00%
Feb-21	78.00%
Mar-21	84.00%



NHS Newham CCG training achievement 2020-21 remains just below the 85% target, which may have been due to Covid-19 and staff capacity and or re-deployment affecting the achievement.

Supervision During quarter 3 supervision was reviewed and revised due to designate absence and Covid-19 redeployment. 12 safeguarding professionals were identified as requiring supervision, 58% received supervision during quarter 4. Covid-19 and safeguarding operational demands was the cause of the low uptake and one person was on maternity leave.

General Practice and Primary Care
Named GP's have prepared information summarising the NICE guidelines on the management of depression in children and young people. This was discussed in the level 3 training and this year the prescribing of antidepressants in children will become part of an audit for primary care. This was in response to the tragic death of a child in our borough.

CCG Commissioned Services:
The safeguarding training compliance for CCG commissioned health care providers, and London Borough of Newham (LBN) 0-19 service, is as follows:

Table 1: **East London Foundation Trust (Newham)** Training Compliance 2020/21
Level 2, 3 and level 3 specialist remains below target. Meetings are in place to discuss improvement plans.

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	91%	92%	95%	92%
Level 2	88%	83%	88%	60%
Level 3	57%	62%	85%	60%
Level 3 Specialist	80%	81%	76%	69%
Level 4	100%	100%	100%	100%
LAC Level 4	100%	100%	100%	100%

Table 2: Barts Health NHS Trust (Newham University Hospital) Training Compliance 2020/21
Quarter 3 showed a fall in achievement, reported as due to Covid-19 training transferring to online. Face to face training is recommenced and a revision of the training needs analysis.

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	93.7%	92.8%	91.9%	*Awaiting data*
Level 2	91.5%	91.8%	90.3%	*Awaiting data*
Level 3	84.6%	81.7%	83.1%	*Awaiting data*
Level 4	100%	100%	100%	*Awaiting data*

Richard House Trust Year End Training Compliance Year End March 2021
Safeguarding children
Level 1: 72 %
Reasons for 28% non-compliance included new starters and furloughed staff that only recently returned. The interim designated nurse is supporting Richard house with their training and supervision models.

Training Level	Staff Compliance
Level 1	72%
Level 3 (Clinical staff)	100%

How we captured the voice of the person

1. **Review of the health voice of the child….**
   During Nov-Dec 2020 the CCG carried out surveys in relation to Covid-19 and how this has been affecting them. Key findings included:
   - The majority felt well/good. 17.5% said they were not feeling great and 6.5% saying they felt really bad.
   - Main concerns (which reflected national findings) identified across all 157 children were:
     - Education worries
     - Staying safe from Covid-19 virus
     - Mental health
     - Friendships and family
     - Emotional / mental health support
     - Of those who said they were supported with their mental health they reported this came from, family and friends, school counselling and the GP.
     - When asked if they knew where to get help 80% said they did.
2. **Survey of how young people are feeling in North East London CCG's Summary report. January 2021**
   - Responders: 1,113 living in NEL. Age range 11–16 years. Survey responders reflected NEL diversity.
   - Findings included- emotional health highlighted by nearly a third of young people, key findings as in the previous slide and additions:
   - Alluding to education and exam stress
   - Almost 1.4 saying they felt stressed
   - 1 in 4 young people are worried about money in the future**.**
3. **East London Foundation Trust – provider:**
   Have commenced (2021) a programme if communication with children and young people to inform safeguarding services areas such as confidentiality have arisen as early themes.

In the last year, we have

1. Contributed to Serious Case Reviews and embedded the learning from these reviews
2. Produced a submission, and attended a learning event in Westminster regarding adolescent exploitation and serious youth violence; given that the three TNW partnerships are in the top 30 areas for NHS hospital admissions for assault with sharp object in the period of April to September 2020
3. Conducted a Newham health economy review of the voice of the child, with an emphasis on the difference made by child consultation

4. Supported the partnership to identify priorities and led an adult and children's joint safeguarding priority on preparation for adulthood and independence
5. Provided blended and agile training solutions in a pandemic context, which included bite size seven minute briefings

This year Newham 2021/22 Safeguarding Priorities are:

1. Collaborating with CAMHS to enhance safeguarding systems
2. Identify ways to improve Newham training and supervision, including Prevent
3. Return to the new normal way of working following Covid-19 pandemic whilst maintaining preparation for future "lock downs"
4. Continue to work with the safeguarding partnership with our partners
5. Develop the safeguarding network within the newly formed Integrated Care System with our safeguarding colleagues in NELCA
6. Promote the health and wellbeing of children in care through robust oversight and scrutiny of service provision and the prompt referral and escalation of cases meeting the threshold for serious safeguarding incidents
7. Continuously improving practice through the sharing and embedding learning from rapid reviews and Local CSPRs. This includes contributing to the NSCP work stream of 7 minute briefings
8. Communication with health partners to work with communications to identifying the most effective way to highlight and share safeguarding messages

Case study

St Giles
Turning a past into a future

Continue to work in Newham University Hospital linking with children who attend the Accident & Emergency Department. This is only possible due to the Consultant in Emergency Medicine and Paediatric Emergency Medicine who is the St Giles champion, proactively supporting and 'embedding' St Giles into the A&E Department.

St Giles raise awareness with the medical staff by delivering presentations about the service, which includes young people's perspectives. This is done formally and on the 'shop floor'. By being present in A&E, St Giles have built positive relationships with the medical staff, which increases the rates of referrals. St Giles attend the safeguarding meetings, and have a close working relationship with the safeguarding team.

St Giles (St.G) and Newham University Hospital
Case Study 1.
Emergency Department Team (ED) recognised that Child A was potentially involved with violence and introduced the St Giles workers. This enabled disclosure that Child A was a victim of violence and feared for his safety. Work subsequently took place and child A now feels safe.

Case Study 2.
This child was identified by the ED team and linked Child B with the St.G. Child B felt let down by all professionals and disengaged. This is being fed back to CAMHS (one of the professional groups named by child B) for learning.

Newham Safeguarding: Children Looked After (Looked After Children)

Newham CCG is the responsible commissioner of health services for Newham looked after children and care leavers. It has corporate parenting responsibilities and statutory duties as outlined in Promoting the Health and Well-being of Looked After Children (2015)[17] and the Children and Social Care Act (2017)[18]. Newham CCG works very closely with a range of agencies to ensure that looked after children and young people are able to access the support that they need. The CCG is driven to identify health needs early, and ensure children have access to timely and appropriate services to meet their health and holistic needs.

Newham Local Authority was responsible for a total of 410 looked after children at the end of March 2020, this was an increase of 8% from the previous year. The majority of these children were looked after under a full care order (48%), though 31% were accommodated via a section 20 voluntarily agreement. 39% of this cohort were female, compared to 61% male. The majority of this cohort of children were aged 10-15 years old (35.3%) and 16-18 years old (34.8%).

33% of the 410 looked after children continue to live in Newham; this is a 7% decrease from last year. 53% are placed out of the borough and care is provided by the host local authority, GP services and the looked after children health team in the borough of residence (source: Azeus reporting LBN). To reduce disruption to schooling and to maintain access to family and friends, the local authority aims to place children within 20 miles of their family homes. Some children are placed out of borough because they require a level of type of support that is only available out of borough.

Children who are placed out of borough should still be able to access health services, without delay in order to achieve good health outcomes. All Newham looked after children should have access to timely and appropriate holistic health assessments, which informs their health care plan. This plan should identify health needs and specify how these needs will be met. This includes access to specialist services. All children coming under the care of the local authority will receive an initial health assessment and a health care plan within 20 working days of a child becoming looked after. The initial assessment (IHA)[19] is completed by a medical practitioner. Thereafter, children over five years will receive an annual health review by a specialist looked after children's nurse. Children under five years will receive a six-monthly review health assessment (RHA) delivered again by a medical practitioner.

Unaccompanied Asylum Seeking Children (UASC)

Unaccompanied Asylum Seeking Children (UASC) arriving in the UK often experience complex mental health needs. Many of these young people they have suffered significant trauma often fleeing from violence and conflicts of war. Their experience of travelling to the UK will have been traumatic and will have significant impact on their emotional wellbeing. Medical health assessments are undertaken by the Newham Looked After Children Health Team with appropriate interpreter support. The medical assessment covers common issues which are recognised in this population including sleep, diet, history of trauma, sexual health, emotional well-being and risk of infectious disease. There were 58 unaccompanied asylum seeking children in the care of Newham Local Authority at the end of March 2021, representing 15% of children looked after in Newham.

Covid-19 Pandemic health impact on children looked after health assessments

North East London designated nurses for Children Looked After (CLA) developed IHA/RHA risk stratification guidance for CCG and providers. WEL CCGs followed the NHSE and NHSI Covid-19 prioritisation within community health services guidance 2020[20] regarding what health assessments should continue and how and what assessments may need to be prioritised for face to face. Regular commissioner and provider meetings have continued to take place where CLA are discussed and quality assurance processes remained in place. Virtual health assessments are recorded on the Rio health system and copies sent to Social Worker, GP and other involved professionals.

17 Promoting the health and wellbeing of looked after children (Department for education, department for health and social care 2015.

18 Children and Social Care Act (HM Government 2017)

19 For health assessments, SDQ and Health Passport – please refer to: Promoting the Health and wellbeing of looked after children (DfE, DoH 2015).

20 Covid-19 Prioritisation within Community Health Services (NHSE and NHSI March 2020)

Strengths and difficulties questionnaires
Children aged 4-17 years old are offered a Strengths and Difficulties Questionnaire (SDQ). This questionnaire services a range of purposes for the team around the child. It supports nurses and doctors to gain some insight into a child's emotional health and well-being. The SDQ provides a baseline which then can lead to a more in-depth assessment if required.

Health passport and health summary
Care leavers are supported to develop strategies for emotional literacy and regulation. However, separation, trauma and loss during childhood can result in additional support needs. Young people are provided with a summary of all their health records up to their 18th birthday, including genetic background and details of illness and treatments, and details on how they can access a full copy of the information if required. Information needs to be given to care leavers sensitively and with support, with an opportunity to discuss it with health professionals. Young people leaving care should be able to continue to obtain health advice and services, and know how to do so.

In Newham, if a young person declines to attend their final statutory health assessment, they are offered the choice of having a written copy of their basic medical history (such as immunisations and childhood illnesses). A health professional, in partnership with the young person's social worker, should ensure that the young person knows how to obtain their social care and detailed health history. Newham looked after children, including those placed out of borough, can obtain a copy of their health passport / health summary from their GP.

Newham Ofsted inspection: focused visit to Newham children's services, 20th-22nd October, 2020.
Newham's Ofsted inspection included reference to health arrangements for looked after children and care leavers.

Key elements of feedback for health were:

'Most children and young people in care or leaving care continue to have their health needs, including emotional health, identified and met as much as possible during the pandemic. Risk assessments in relation to any health vulnerabilities have been completed, and the completion of virtual health assessments means that children's health needs are identified. Emotional health support is quickly mobilised when required. The health offer to care leavers is less clearly defined and communicated, which means that some care leavers are not aware of the services on offer to them. More needs to be done to ensure that all care leavers have copies of their health histories."

There is a clear process in place between ELFT and LBN to ensure that every young person 16 years and above receives a health passport and a health summary before turning 18 years of age. These documents are recorded on the electronic health record system and with consent from the young person, the health summary is also uploaded on to Azeus (LBN, electronic record system).

Collaborative working between LBN and ELFT to identify those care leavers 18-25 years who had not (through audit processes) shown a recorded entry in their Rio health record or on Azeus, that they were offered or received a health passport and health history summary. A process was established to retrospectively provide those young people identified with a health passport and information on how to obtain their health history summary from the LAC Health team.
Recruitment of an emotional health and wellbeing nurse for Care Leavers as part of the Care Leavers Offer for Newham.

Work is currently underway between ELFT, LBN and Care Leavers to refresh the health passport documents.

Performance relating to initial and review health assessments (table 1).
The looked after children health team commenced using video consultation software to perform IHAs where appropriate and feasible as well as using telephone consultations during the initial Covid-19 lockdown. This ensured they continued to engage with children and their carers during this challenging period. Newham's 'was not brought' rate for health assessments reduced slightly during this time and some hard to reach young people began to engage with health professionals. This enabled the provider to continue to meet their statutory obligations. For a child who had not been seen within 3 months by a doctor and had taken part in a telephone/video IHA they were invited to a face-to-face follow up appointment to support the physical part of the health assessment in accordance with recovery plans (RCPCH, June 2020)[21].The Looked After Children

doctors and nurses offered virtual consultations for children and young people placed out of borough early in the pandemic when provision of services nationally were unclear.

The following work was undertaken by the CCG with partners in order to improve performance:
The CCG are addressing late notifications of children coming into care with the local authority with a sharp focus on meeting the 20 day timeframe of IHAs and timely referrals to specialist services. This is an area for improvement which features on the action plan as part of the work of the joint looked after children meeting group chaired by Newham CCG.

Downward trends in performance are being explored within the partnership and are being monitored and addressed through the joint action plan as part of the ongoing joint looked after children meeting group. A process is in place to escalate concerns, to the local authority head of service for looked after children, when a young person is not brought. As part of the joint children looked after meeting agenda, the group will scope ways to engage young people and emphasise the importance of health assessments.

The CCG is encouraging specialist children looked after nurses to offer appointments that do not interfere with the school day, at appropriate times and places that are convenient for children.

ELFT looked after children team have introduced a process to monitor all health assessments that are due and to follow-up with "out of borough" providers to ensure compliance with statutory timeframes. The digital methods used to maintain contact with children and carers have proved effective. Face to face appointments are offered if the child or young person is living within a 20 mile radius of Newham and are risk assessed as safe to do so in line with the National Covid-19 guidance.

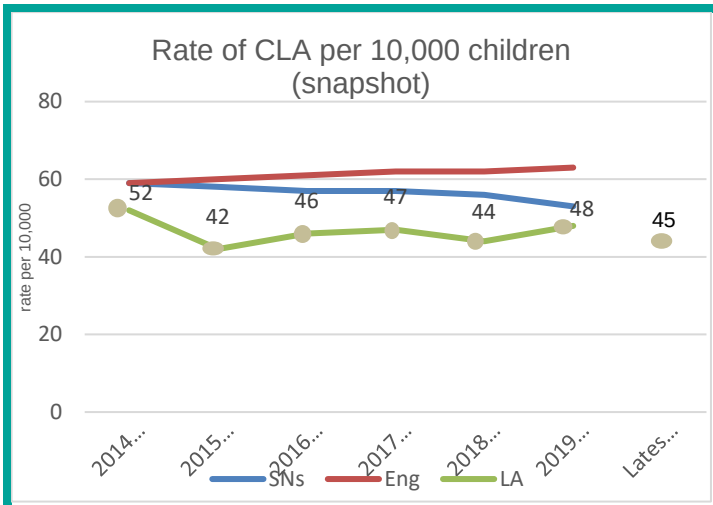
The designated nurse for children looked after quality assures all health assessments for children placed out of borough, which includes virtual assessments and telephone reviews, to ensure that quality standards are met[22]. If Issues arise around poor quality, they are addressed by the children looked after health team in the borough of residence and escalated when required.

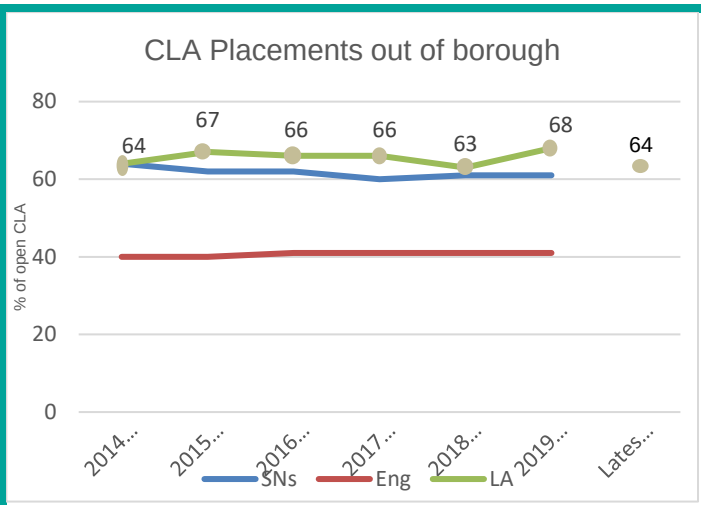
Newham's children looked after health team have embedded the use of SDQs in initial and review health assessments. They work closely with CAMHs to address support needs identified through this process.

Newham safeguarding children looked after highlights

Indicator	Q1	Q2	Q3	Q4
IHA Requested	32	32	30	35
IHA Completed	23	31	24	24
IHA %	72	97	80	69
RHA Requested	89	83	67	71
RHA Completed	75	68	59	59
RHA %	84	82	88	83

[5] RCPCH (2020) Looked after Children Services in Covid-19 Pandemic recovery plans – statement.
[6] Specific, measurable, achievable, realistic, timely.





source: Azeus reporting LBN

Key achievements

- Developed guidance for the NHS provider organisations across WEL CCGs regarding the management of initial and review health assessments for children looked after in response to Covid-19 and Lockdown.
- The designated nurses for children looked after across North East London (NEL) developed a flow chart for foster carers to identify if they had signs and symptoms of Covid-19 and how to self-isolate. This was shared with the children looked after health teams and social care teams across NEL.
- Streamlining of policies and processes across the WEL footprint to share innovation and best practice for children looked after
- Significant improvement in performance of the 20 working day process for IHAs. The key performance indictor for this metric is 85% and for Q2 (July-September) the children looked after health team reached 86-100% for IHAs.

Training and compliance

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
LAC Training Level 3 uptake	100%	100%	100%	33%
LAC Training Level 4 uptake	100%	100%	100%	0%

How we captured the voice of the child and young person

1. The voice of the child is assessed as part of the holistic health assessment
2. The BAAF (British Association for Adoption & Fostering) assessment framework incorporates the wishes and feelings of the child or young person
3. Patient Report Experience Measure Survey (PREMs) is completed by the looked after children health team at every face to face contact and responses are reported monthly. The PREMS have been reviewed and re-worded based on feedback from looked after children
4. A team of professionals in the joint meeting for looked after children are looking at ways to better engage young people in health assessments and increase their understanding of the benefits of these assessments
5. The CCG has encouraged the specialist looked after children nurses to offer appointments at appropriate times and places that are convenient for young people, which promotes their agency and choice. These should be outside of school time where possible.

In the last year, we have

1. Secured funding for recruitment of an emotional health and wellbeing nurse for care leavers as part of the care leaver's offer in Newham. The specifications of this role were developed collaboratively with safeguarding partner organisations and care leavers. Nurse in post April 2021.
2. Developed and expanded the UASC health offer. ELFT secured 1 year's funding from the Bart's Charitable Trust and the UASC pilot project commenced in 2020 with the recruitment of a health improvement practitioner and CAMHS resource. Due to the positive impact and outcomes so far of the pilot, funding is being sort for this service to be securely embedded in Newham.
3. Better understanding of children's experiences of social media communications and virtual health assessments to shape future approaches. The named doctor facilitated a discussion session with the members of the children in care council to capture their experiences of lockdown and Covid-19 and their views experiences of virtual and telephone contacts versus face to face. This lead to service redesign of the health assessment forms and offering greater flexibility of appointments for school age children to avoid disruption during the school day.
4. Strengthened the process for mental health screening offered at Initial health assessments including the use of the SDQ screening tool. This has enabled emotional health needs to be assessed at an earlier stage and more timely referrals to appropriate services made.
5. Facilitated a named nurse led telephone health advice service for care leavers during the initial Covid-19 Lockdown to support with their concerns around health and wellbeing in relation to the pandemic. This service was set up in partnership with Newham local authority. Care leavers who wanted to access the service were referred to the named nurse by their social worker.
6. As part of the transforming care pathway, CETR's have commenced for young people with autism and learning disabilities to ensure a more robust multi-agency approach with health and care services. This ensures that health outcomes and care planning is reviewed in a multi-agency meeting on an agreed timescale to share information and discuss health and social needs. Young people and carers / parents are invited to attend the meeting if appropriate.
7. Revised the health assessment templates to ensure that language used in health assessments reflect children and young people's views / voice and the assessment is more service user friendly.

This year we will

1. Develop further the role of the emotional health and well-being nurse for care leavers to expand the service from 18-25 years (currently 18-21 years)
2. Ensure health is included in the innovation project for the establishment of a children's residential home in Newham. To support children and young people to access appropriate health services in a timely manner to improve health outcomes.
3. Jointly work with public health and the safeguarding partnership to improve immunisation, dental and vision screening uptake for both Newham children placed in and out of borough.
4. Work collaboratively with the local authority in placement decisions for high risk and extremely vulnerable children to ensure children feel safe and have access to appropriate care and services to achieve good health and wellbeing outcomes.
5. Work in partnership with the children in care council / care leavers to redesign health passports, ensuring that they are effective in allowing young people to confidently access health services in the right way, at the right time, with a particular focus on transition into adulthood

Case study

Case headlines: A 16 year old unaccompanied asylum seeking young person was placed with foster carer, out of borough. The young person needed dental treatment, though the carer was unable to register and secure appointment with her own dental practice.

Assessment and intervention: The UASC health improvement practitioner supported the foster carer to explore other dental practices in the area due to language barrier.

Impact and outcome: The health improvement practitioner was able to support the arrangement of the initial assessment and x-ray. A second appointment was arranged for a tooth extraction which had been causing the young person pain and discomfort. The young person was placed out of borough therefore the practitioner searched using Google to make ensure the dental practice was conveniently located for the foster carer. Using google maps, the practitioner when was then able to relayed the location to the foster carer to help direct her as the practitioner was not familiar with the area either. The practitioner also arranged an optician's appointment in close proximity of the dental practice the same day to make it convenient for them to attend the appointments on the same day.

Learning points: Collaborative working with the foster carer and allied health professionals to meet the young person's dental and vision health needs.

Waltham Forest Safeguarding

Waltham Forest is home to an estimated 271,200 residents and 104,000 households. It has a young age structure with a higher proportion of children and working-age residents compared to the UK. The average age of Waltham Forest residents is 34.5 years compared to the national average of 39.9 years. This is thought to be driven by the high levels of international migration and high birth rates.

Ranking 35th out of 326 in England, Waltham Forest sits just above the lower 10% of the most deprived local authorities. Its position has improved from 2010 when the borough ranked 15th most deprived in the country. Out of 33 London boroughs, Waltham Forest currently ranks 7th most deprived. The employment rate for the working-age population, aged 16-64, in the 12 months to December 2015 was 73.1%, which is close to the London average of 73.0%.

35%of children were reportedly living in poverty as of late 2013, which is higher than the UK average of 16%. The unemployment rate is 3.9% compared with 5.3% in London and 4.4% in England. Rates of common mental health disorders are high at 22.5% in Waltham Forest compared to 19.3 and 16.9% in London and England respectively[23]. In 2018/19, 42.7% of state educated children in Waltham Forest achieved a strong pass in GCSE English and Maths grades 9-4 in, compared to 43.4% in all of England[24].

Waltham Forest is one of the most ethnically diverse areas in London. Around two thirds of residents, 68%, are from a minority ethnic background (other than White British/Irish), compared to 58% in London as a whole. Overall, White British/Irish is the largest ethnic group (32%) in the borough, compared to an average of 42% in London. This is followed by Asian/Asian British (21%), Other White (18%) and Black/Black British groups (17%) – all accounting for a higher share than on average across London. Residents with mixed/multiple ethnicities and those categorised in any other ethnic group each account for 6% of the population, similar to the London average.

23.4% of children in Waltham Forest experience childhood obesity, which is just under the London average. The rate for alcohol-specific hospital admissions among those under 18 is better than the average for England. Breastfeeding and smoking in pregnancy are also better than the England average.

The Metropolitan Police recorded a total of 21,740 crimes between April 2015 and March 2016, an increase of 4.6%on the year before[25]. The top three types of crimes in Waltham Forest in the year up to March 2016 were:

- Theft and handling, which includes theft of and from a vehicle, shoplifting, theft from a person etc. (34% of all crime)
- Violence against the person (33% of all crime)
- Burglary (10% of all crime)

The borough's monthly crime rate from April 2015 to March 2016 was 6.8 per 1,000 people, lower than the average crime rate for London (7.2).

[23] https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132696/pat/6/par/E12000007/ati/202/are/E09000025/cid/4
[24] https://data.london.gov.uk/dataset/gcse-results-by-borough
[25] https://www.walthamforest.gov.uk/content/statistics-about-borough

Waltham Forest: Safeguarding Adults

Covid-19 was declared a global pandemic in mid-March 2020 and has continued to be important feature to highlight in this report. Whilst the impact of Covid-19 was felt across the health economy, the TNW safeguarding team continued to focus on adults at risk of harm and partnership working. As a wider safeguarding approach, it was important to consider and highlight the potential hidden harms experienced by families as a result of the pandemic, and to recognise lessons learnt from the first Covid-19 lockdown as the country experienced further increases in restrictions due to infection rates rising. Within Waltham Forest, there was an established 'Think Family' approach to safeguarding, which sought to promote effective, joined up working and acknowledge new types of risks that were emerging throughout this enduring period of global pandemic. In response to the Covid -19 pandemic, the CCG continued to establish more collaborative ways of working in order to maintain a focus on safeguarding adults. In this vein, a northeast London safeguarding adult's forum was established. This created a space for colleagues within the acute hospitals, community teams and CCG to collaboratively address effective responses to emerging need.

Guidance and service delivery was changed rapidly during the Covid-19 Pandemic. As such the northeast London safeguarding adult's forum enabled support and information sharing between services. It allowed both acute and community providers to identify potential or actual barriers to safeguarding, and / or areas of constraint. Practitioners used this space to identify practice that could be shared due to the commonalities that were challenging services. During this process, agile training solutions were identified and responses to changing legislation and procedures were agreed.

Court of Protection (CoP)

During the reporting year, Waltham Forest commissioners, partners and providers, collaborated to meet local need and, when necessary, escalate matter to the Court of Protection (CoP).

The CoP makes decisions on financial or welfare matters for people who lack mental capacity in regards to making decisions at the time they need to be made.

The Court is responsible for:

- deciding whether someone has the mental capacity to make a particular decision for themselves
- appointing deputies to make ongoing decisions for people who lack mental capacity
- giving people permission to make one-off decisions on behalf of someone else who lacks mental capacity
- handling urgent or emergency applications where a decision must be made on behalf of someone else without delay
- making decisions about a lasting power of attorney or enduring power of attorney and considering any objections to their registration
- considering applications to make statutory wills or gifts
- making decisions about when someone can be deprived of their liberty under the Mental Capacity Act

The work carried out during this period has been twofold, in the first instance the safeguarding adults team supported Continuing Health Care Teams (CHC) and Commissioning teams (CSU) with complex cases that required escalation through the CoP process. This work is ongoing. The plan for 2021/22, is to continue to strengthen and embed the processes in order for the operational teams involved to manage high risk cases and escalate when necessary to ensure legal processes are appropriately utilised and to ensure that the person at the centre of care is appropriately safeguarded. Secondly, the safeguarding adult's team began a scoping exercise to determine requirements of people receiving CHC funding in regards to the introduction of Liberty Protection Safeguards, which will come into force in April 2022. Cases where there is conflict or complexity will require escalation to the CoP.

Liberty Protection Safeguards will replace the current Deprivation of Liberty Safeguards process. The safeguards will provide protection for people who are deprived of their liberty as part of their care or treatment, and don't have mental capacity to consent to their care arrangements.

People in positions of trust (PiPOT)

The Care Act 2014 requires SABs to establish and agree a framework and process to respond to allegations against anyone who works (either paid or unpaid) with adults with care and support needs. Within Waltham Forest there is a PiPOT process in place, however it is recognised that during 2021/22 further work will be required to standardise the approach across the Tower Hamlets, Newham and Waltham Forest (TNW) footprint. The Local Authority are leading on this process locally and TNW designated professionals for safeguarding adults are active members of the NHSE/I PiPOT task and finish group.

In developing this guidance, there will be the provision of a framework for managing cases where allegations have been made against a person in a position of trust (PIPOT).

Work with GPs and acute

A range of work has taken place with both Primary and Secondary care during the reporting year. As an example of this, designates and primary care have collaborated to manage complex cases and escalations to the CoP. Examples of join up have been achieved across all sectors of the health economy, placing local people in the centre of their care.

Homelessness/Exploitation and Modern Slavery

Within the scope of the homeless steering group, it was recognised that whilst there is a significant amount of information available on this topic, it is not always easy to navigate and may result in missed opportunities to support local people within the borough who may be at risk due to issues of homelessness/exploitation and other related factors. As a result, we took a partnership approach and delivered a resource pack for Outreach teams and long term hostel staff to utilise and ensure local operational teams were furnished with the most current, and up to date information to support escalation of concerns and to support people at risk of harm to access the help required.

Outlined within the report is an overview of the safeguarding adult's achievements during 2020-2021.

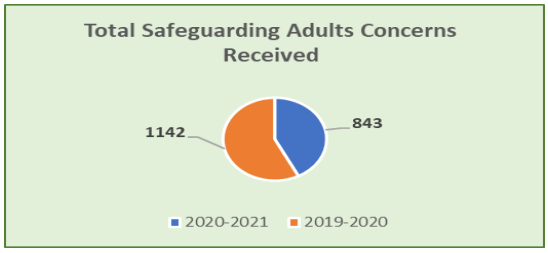
Safeguarding Adult Reviews (SARs)

Whilst there were no new SARs commissioned during the reporting period, work was progressed following the SAR George review. One of the significant actions from this report resulted in the introduction of the Mental Capacity Subgroup, which was convened with a multi-agency partnership approach. The result of this group as has been the development of a Mental Capacity Guidance document that has received incredibly positive feedback and is due for launch later in 2021.

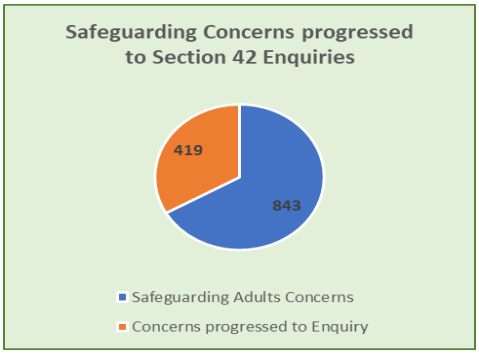
Waltham Forest safeguarding adults highlights

The **Liberty Protection Safeguards** (LPS) Group was relaunched in quarter four.
Scoping Work was undertaken by the CCG designated safeguarding adult professionals to work with provider CHC teams to identify cohorts of people that would be require LPS authorisations under the new legislative changes in April 2022.

April 2020 – March 2021 saw a **26%** decrease in the number of concerns received against the same period in 2019-2020, this suggests the Covid-19 pandemic has impacted on people being able to report their concerns.



Of the 843 concerns received 49.7% progressed to section 42 enquiries.



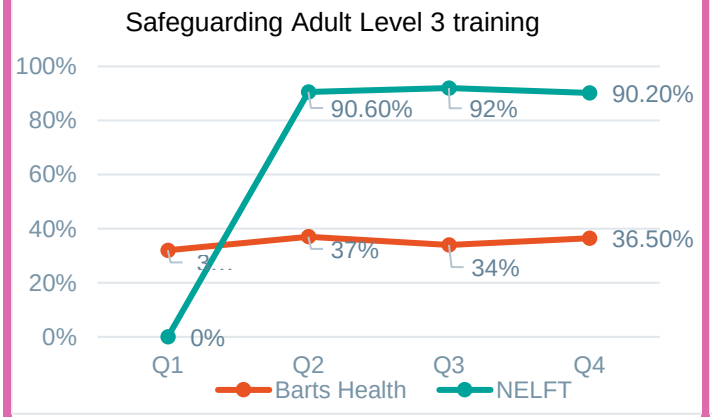
Key achievements

- During Quarter three and four, significant work was undertaken in regards to complex Continuing Health Care (CHC) cases and escalation to the Court of Protection. This involved development of stronger pathways and closer working relationships between key teams within both CCG and Provider organisations to ensure a person centred approach
- The LPS multi-agency implementation steering group is working to ensure that all agencies are prepared for the implementation date and have systems in place to ensure that, when absolutely necessary, people are lawfully deprived of their liberty

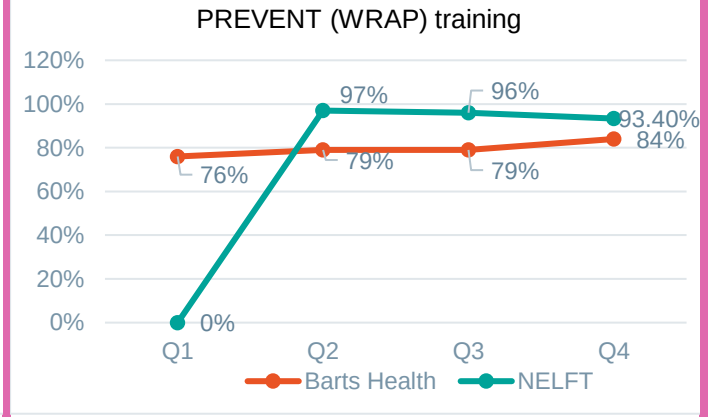
Training and compliance

*Indicates training compliance of identified Cohort of staff in the first phase of delivery

Training Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
WEL CCG				
Level 1	90%	97%	94%	68%
PREVENT Awareness	92%	98%	95%	83%
Barts Health				
Level 2	90%	89%	90%	90.9%
Level 3*	32%	37%	34%	36.5%
PREVENT (WRAP 3)	76%	79%	79%	84%
NELFT				
Level A	*Not recorded due to C19*	97%	96%	94.2%
Level B		90.6%	92%	90.2%
PREVENT (WRAP 3)		97%	96%	93.4%



The minimum bench mark for all the training is 85%



The minimum bench mark for all the training is 85%

How we captured the voice of the person

1. Working with partners to ensure a targeted and tailored approach to safeguarding for individuals, keeping patient's needs central to any concern raised and subsequent action
2. Membership of the SAB and subgroups, engaging in One Panel, SARs and domestic homicide reviews.

In the last year, we have

1. Joined with Newham and Tower Hamlets as a WEL CCG, now called TNW ICP, and begun collectively considering how best to address some of the issues affecting all three boroughs e.g. legal literacy of the Mental Capacity Act 2005

2. Worked with both Continuing Health Care teams and the Clinical Support Unit to continue the strengthening work around CHC assessments and the escalation of complex cases. This enabled the safeguarding team to support the Waltham Forest teams in the recognition and escalation of concerns, which by the end of the financial year had shown positive improvements beginning.
3. Engaged with our Waltham Forest Local Authority colleagues regarding the implementation of Liberty Protection Safeguarding within in a multi-agency approach
4. Improved self–neglect practice by increasing awareness and strengthening support pathways. Joint working with mental health services has been integral to this work
5. Took a partnership approach and delivered a resource pack for outreach teams and long term hostel staff to ensure that providers were furnished with the most current, and up to date information to support escalation of concerns
6. Worked collaboratively with partners in both health and social care to address effective responses to emerging need during the pandemic

This year we will

7. Continue to work towards the implementation of the Liberty Protection Safeguards, which will focus on the operational and strategic priorities required so, when absolutely necessary, that local people are lawfully deprived of their liberty. We will work collaboratively with colleagues to develop a risk stratification tool to identify the high risk cases requiring escalation to the CoP.
8. Continue to work with community partners in regards to continuing health care cases and work towards improving the current processes and embedding in practice.
9. Continue to address the issue of domestic violence in the borough through participation in the Violence Against Women and Girls (VAWG) action group. Within this, we will further support GPs to refer victims and survivors to Multi Agency Risk Assessment Conference (MARAC), and scope domestic violence identification and referral with engagement with IRIS
10. Work with colleagues across the partnership to launch the new Mental Capacity Act Guidance document to support all groups working with people who may lack Mental Capacity to make decisions and ensure the legal framework is followed. This work will also link in to the implementation of the LPS to ensure mental capacity assessments are completed prior to a deprivation of liberty being applied for
11. Strengthen the LeDeR system of reviewing and sharing lessons learned; this will include work at a ICS level to support compliance with NHSE LeDeR targets
12. Implement the Learning and Improvement Forum (LiF) to ensure Learning from SARs/DHRs/LeDeR reviews are shared and learning is proactively shared and embedded across the partnership. The role of the LiF will be to ensure that the relevant agencies involved will be accountable to the group to provide feedback as to the actions identified and will require evidence to feedback into the SAB to provide assurance

Case study

Mr G was a 34 year old gentleman with multiple physical health conditions and reported to be misusing prescription pain medication.

Concerns had been raised to the CCG in regards to Mr G obtaining medication through multiple legitimate channels but also gaining an additional source of medication through other means.

The case was escalated to the medicine optimisation team within the CCG to verify registration with GP services and was actioned through safeguarding routes due to the concerns of self-neglect and substance dependence. It was recognised that during the previous 12 months there had been SARs across the WEL footprint whereby harm had occurred due to service users experiencing substance dependence and self-neglect concerns.

This was highlighted within the safeguarding concern form and the need to consider mental capacity in this complex patient cohort.

Following a review of the patient's record, it was noted that he had moved out of area but contact had been made by the local authority team reviewing the safeguarding concern. Contact was made with both the person identified and his family to feedback that the concerns raised had been actioned and escalated appropriately to ensure patient safety. Feedback from the local authority team indicated that the gentleman was deemed to have mental capacity in regards to the concern raised. However, he was engaging with GP services within the new geographical area.

The CCG's safeguarding adult team recognised the impact and risk associated with complex cases involving self-neglect, substance dependence and homelessness. This case was escalated due to the multi factorial level of concern; not only to the lead statutory agency to ensure the appropriate help was sought but also to ensure that safe practices were in place regarding prescribing and dispensing of medications for people with complex needs who may be misusing prescribed medicines.

Substance misuse is a growing area of concern and SARs have recognised that this is an extremely complex area of safeguarding, which requires a multi-agency response. Professor Michael Preston-Shoot and Suzy Bray et al's research recognises that safeguarding is increasing in complexity. These types of cases requires a skilled approach that does not always mirror historic safeguarding approaches. We, as a wider system, need to recognise the needs of the person, provide a broad offer of support, and remain professionally curious. Case management should be considered in order to determine who is best placed to address specific elements of a person's clinical journey and case coordination is key.

Waltham Forest Safeguarding; Children and young people

This annual report and covers the period of 1 April 2020 – 31 March 2021.This spans a period of the global Covid-19 pandemic which has been a time of unprecedented change, which will have an ongoing impact for many years to come. The report focuses on the Waltham Forest (WF) perspective but makes reference to the TNW ICP collective where relevant. It highlights how we, the NHS WF CCG, have discharged our statutory safeguarding responsibilities to the local population, includes achievements, challenges to business continuity and mitigations.

The Waltham Forest element of TNW ICP is fully engaged in the work of the Waltham Forest Safeguarding Children Partnership (WFSCP). We aim to ensure that safeguarding is visible in all contracts and we work closely with our partners to deliver a consistent safeguarding approach across all services. The commissioned services have safeguarding arrangements in place and are compliant with requirements as outlined by national guidance and legislation (Children Act 2004 and Care Act 2014). This includes clear accessible policies and procedures, safer recruitment practices, robust training and governance systems, all of which are monitored through performance reporting frameworks. This approach is underpinned by the NELCA safeguarding through commissioning policy 2018-22.

Context at place

The overall age profile of the borough, continues to be relatively young compared to London and England average, as the proportion of the population aged 65 years and over in the borough is projected to increase from 11% to 13% by 2030, compared to 15% in London and 22% in England[26]. Waltham Forest is an ethnically diverse borough with the older residents are more likely to be White British and younger residents are more likely to be from other ethnic groups. This means that health promotion and safeguarding messages need to be accessible in the relevant languages in recognition of these demographic differences.

Safeguarding during Covid-19

Covid-19 has transformed both the health and social care landscape, accelerating the pace of digital transformation at a time of increased pressure on the workforce, communities and families. The pandemic has exacerbated pressure on families, led to an increase in the vulnerabilities of children during the period of school closures and lockdown and necessitated redeployment of key staff and adaptations to service delivery to ensure both Covid-19 safety and business continuity. The National Panel Annual Report 2020 has characterised this as a situational risk, accentuating pre-existing risks and also creating new ones. Consequently, during this period both nationally and locally there has been an increase requests for support and protection from MASH in excess of previous years and a surge in the following areas:

- Serious youth violence
- Online and criminal exploitation
- Exposure to domestic violence
- New entrants into care due to family breakdown

From a health perspective some of the unintended consequences of service adaptations to the pandemic which had a varying impact in accordance with the age of the child were as follows:

- 40% reduction in emergency department attendances at the local hospital
- Increased crisis presentations of children in emotional distress requiring Tier 4 CAMHS beds.
- Delayed presentations of acutely sick children

These combined situational risks were attributable to the national messaging encouraging people to stay home to reduce pressure on the NHS. There was also the fear of children being exposed to Covid-19 infection in health settings by the public.

Safeguarding Accountability, Capacity and Governance

The WEL director of quality and safety is the executive lead for safeguarding and children looked after across the three CCGs. In accordance with statutory requirements NHS Waltham Forest Commissioning Group (CCG) has employed a full establishment of designated safeguarding children and named GP for safeguarding in primary professionals on behalf of the health economy and has a governance structure with the clear lines of accountability.

[26] **https://www.walthamforest.gov.uk/sites/default/files/20%20Questions%20Annual%20Public%20Health%20Report%20_FINAL**

Inspection
Inspection preparedness meetings led by the designated nurse for the health economy took place in October 2020 followed by an Ofsted challenge session led by the strategic director for the council. The focussed visit took place in December 2020. There is ongoing preparation in the borough for possible SEND, CQC and Ofsted inspections in 2021/22.

Implementation of Safeguarding Reforms and Multi-agency Safeguarding Arrangements
Under the Children and Social Work Act 2017, three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies to safeguard and protect the welfare of children in the area. The new multiagency safeguarding arrangements at place are established and the CCG continues to contribute to local arrangements through membership and participation in the multiagency safeguarding children partnership boards and sub-groups.

WEL, City and Hackney Child Death Review System Development
The Children and Social Work Act 2017, Working Together (2018) and the subsequent Child Death Review Statutory and Operational Guidance (2019) outline how local authorities and CCGs are required to work together as child death review (CDR) partners. A single CDR system across the Waltham Forest, East London and the City (WELC) footprint has been established, and work to embed this system is ongoing. The overarching CDOP across WEL City & Hackney, which is attended by the designated and named safeguarding professionals provides the opportunity for system learning, improving population health and provide wrap around services for bereaved families.

Local Safeguarding Children Reviews
Designated professionals are core members of the 'One Panel' and the leads for LeDeR. They work together within the partnership and with named professionals/safeguarding leads in provider organisations as well as with named GPs within their own organisation to ensure relevant learning is shared through training, e-journals and team meetings.

Safeguarding Child Rapid Reviews
Three rapid reviews were completed during the year with the dissemination of immediate learning through 7 minute briefings and training to support changes in practice.

Child Safeguarding Practice Reviews (CSPRs
Child S
Child S is a baby who tragically died whilst in the care of her parents. A forensic post-mortem identified that baby who is a twin had multiple injuries including fractures to the skull, rib fractures, a possible fractured wrist and subdural haemorrhage. The cause of death was identified as a head injury. The twins were subject to child protection plans. Two older step-siblings have been removed from mother's care due to concerns of substance misuse and mental health problems. The family were very mobile and had lived in Waltham Forest, Redbridge, Medway, Newham and Barking &Dagenham, but now reside in Essex. Parents were arrested on suspicion of murder but have now been released pending the outcome of investigations. A request was received in March 2021 from Essex safeguarding children partnership Board for participation in the review.

Child Khalsa
Child Khalsa is a 14 year old boy who died unexpectedly in October 2019. He had been reported to be well that day but collapsed suddenly at home and could not be resuscitated. He had a long history of asthma and of previous life-threatening events. There had been historical and recent concerns from health professionals about compliance with treatment. The CSPR and a 7 minute briefing were published in January 2021. Themes identified for learning and service improvement included communication, particularly from the acute to community health, voice of the child, role of the child in their own health care plan, parental health beliefs, professional curiosity and mistaken views of asthma wellness.

Safeguarding Child Review for Child D

Child D's mother experienced domestic abuse prior to her pregnancy and fled from the perpetrator who was his father. Mother lived in east London and was isolated with a limited support network and no extended family in UK. This was a cross-borough review as mother initially resided in Newham during the antenatal period. She moved to Waltham Forest where she lived in a refuge for women experiencing domestic abuse where she lived with Child D. Baby was four months old and at the time of his death, while in mother's care and living in temporarily in a studio accommodation in Hackney, sourced by London Borough of Waltham Forest Housing. The coroner gave the cause of death as "unexplained" noting signs consistent with asphyxiation, and an undiagnosed brain condition. Learning was disseminated to GPs in Waltham Forest. Alcohol and substance misuse services at Whipps Cross Hospital (WXH) are working closely with the named nurse and named midwife for safeguarding to raise awareness of staff working with families.

Embedding Learning from CSPRs

Waltham Forest violence reduction partnership (VRP) is funding a 12 month pilot at WXH to provide a hospital based violence reduction service. An all age safeguarding steering group has been established. St Giles has been commissioned by the VRP to support 17-24 year olds. 'Reachable Moments' (which is a theme from the SCR) has been added to the Barts Level 3 safeguarding training package to raise awareness of staff. The safeguarding transition group has been established to identify children and young people aged 16-18 years within children's services whose vulnerabilities and safeguarding concerns could persist and constitute on-going safeguarding risks at the transition to adult services.

A series of events have been planned across the health economy to secure improvements in clinical and safeguarding practice, they include:

- A desktop mapping exercise in November 2020
- A child death review meeting (CDRM) in March 2021
- An Asthma review which drew on the findings from the CDRM was conducted with clinicians in March 2021
- The designated nurse held meetings with public health colleagues in relation to awareness raising and also with the asthma leads in the Healthy London Partnership and STP Clinical Lead for children to identify relevant learning and benchmark against the national standards and guidelines.
- A multiagency workshop is scheduled for May 2021.

Training and compliance

NELFT (Waltham Forest) mandatory and safeguarding training compliance against a target of 85%.

The workforce remained compliant with safeguarding children training competencies throughout 2020/21, with performance remaining above the commissioned target of 85% in spite of staff being redeployed due to the pandemic.

Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	98.4%	97.7%	97%	94.5%
Level 2	95.76%	93.3%	91.9%	93.1%
Level 3	95.76%	93.3%	91.9%	88.5%

Barts Health (Whipps Cross site) mandatory safeguarding training compliance against a target of 85% for 2020/21 performance in Q3-4 was impacted by winter pressures, sickness and redeployment of the workforce during the Covid-19 pandemic. Improvement measures are in place and performance is now on an upward trajectory for Q1 of 2021/22. The L3 package has been reviewed and consideration has been given to the delivery of a blended offer.

Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	93.4%	94%	94.1%	93.3%
Level 2	91.8%	92.6%	91.6%	90.0%
Level 3	76.1%	73.4%	72%	67.3%

CCG workforce mandatory safeguarding children training compliance against a target of 85% has been exceeded throughout the year . The CCG safeguarding children team has been compliant during 2020/21 with mandatory training at the appropriate competencies in line with guidance.

Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	87.6%	91.3%	90.3%	89.0%
Level 4	100%	100%	100%	100%
Level 5	100%	100%	100%	100%

Prevent channel awareness (CCG) workforce compliance against a target of 85% was achieved in Q1-3. The designated nurse for safeguarding children is the prevent lead for the CCG and the workforce remained compliant during 2020/21. * Compliance for Q4 has been impacted by the national mass vaccination effort, as staff were redeployed to support this effort. All non-compliant staff have received automated reminders from the training system and line managers will be following this up as part of the appraisal process. We are hopeful that compliance will remain above target during 2021/22.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
92%	98.3%	95.0%	83.3%

Managing allegations against professionals

There has been close working with the Local Authority Designated Officer (LADO) during the reporting period.

Safeguarding Supervision

The NELCA safeguarding supervision policy provides strategic direction and options for the supervision models appropriate to staff groups. It promotes critical reflection, professional challenge and the oversight required to maintain the safety of vulnerable children and young people. As such, in accordance with the Intercollegiate Frameworks (2015 & 2019) safeguarding supervision is provided by the designated doctor for safeguarding children to the named doctors for safeguarding children for WXH (Barts Health) and the named GP for safeguarding in primary care. Similarly, the designated nurse provides safeguarding supervision to the named nurses for safeguarding children and named midwife for safeguarding children in both the acute and community providers.

During the pandemic the designated nurse for safeguarding children provided virtual safeguarding supervision to the named safeguarding children professionals at WXH (Barts) and NELFT. Ad-hoc supervision was also provided in response to requests for support and advice from professionals and GPs.

Table 1 - Safeguarding supervision compliance

Quarter 1	Quarter 2	Quarter 3	Quarter 4
100%	100%	100%	100%
81.6%	82.1%	74.9%	77%*
(F)	89.0%	97.3	91
(G)	92.0%	94.3	95.7
Key	CCG	Barts	NELFT

Data sources: CCG Workforce data April 2021, NELFT BI reports April 2021 and Barts Dashboard and Reports February & May 2021. * Recording issues highlighted suggesting compliance may be higher than reported.

F= face to face/virtual G= Group

Priorities for the Local Safeguarding Partnership

The CCG has continued to contribute fully to the work of the multiagency safeguarding partnership and contributed to the bi-annual priority setting session for the boards as set out in figure 1. This includes the chairing of the MASH Strategic Board by the designated nurse as MASH works towards an all age front door.

Multiagency Partnership working in relation to domestic abuse

The CCG participated fully in the VAWG sub-group & community safety net board, the annual safe & well month, 16 days of activism, IRIS steering group, and the launch of the CCG domestic abuse policy for staff. During Covid-19 there was close working with safeguarding partners to ensure that domestic abuse posters developed by the metropolitan police in conjunction with social care were not only displayed in retail outlets but also in pharmacies and GP surgeries. These alerted victims of hidden harm to disclose abuse and seek help during the period of lockdown.

In January 2021 a new scheme – Ask for ANI - was launched to help as many domestic abuse victims as possible, especially at the moment when they could be stuck in lockdown with a perpetrator.
The Ask for ANI scheme is intended to provide an additional tool that can be used to help the most vulnerable victims and survivors of domestic abuse. The scheme has been developed with the help of partners including the domestic abuse sector, pharmacy associations and the police and is being rolled out across the UK.

Ask for ANI (Action Needed Immediately) - has been developed by the Home Office to provide a discreet way for victims and survivors of domestic abuse to signal that they need emergency help from the safety of their local pharmacy. Information regarding local participating pharmacies was circulated and uptake was encouraged in non-participating pharmacies and also highlighted in their safeguarding training.

Figure 1- Waltham Forest Strategic Partnership Priorities for 2019/21

Waltham Forest safeguarding children and young people highlights

IRIS in Primary Care

The Named GP delivered training to practice managers on 10.12.20 to raise awareness of domestic abuse pathways. This led to an increase in referrals to DVA support services and MARAC.

How we captured the voice of the child and young person

1. The lived experience of local children and families using the Haven House Hospice contributed to shaping the delivery of the bereavement support offer for racialised families in Waltham Forest commissioned by the CCG.
2. CAMHS' public engagement has involved safeguarding partners, children and young people who use local services. For instance, the youth mental health ambassadors have:
   - Represent children's voices on the CAMHS board
   - Participate in staff recruitment and co-production of the 'getting help' -Thrive service.
   - Facilitated mental health and emotional well-being workshops in schools
3. The importance of the use of language by professionals has been highlighted in discussions and reports to maintain the focus on the child.

Key Achievements and Highlights of 2020/21

1. The CCG workforce have been supported to remain compliant for the required levels of competency in relation to mandatory safeguarding children training which has contributed to equipping the workforce during an unprecedented period of pandemic and increased safeguarding risk.
2. The CCG contributed to the first national safeguarding fortnight during phase one of the pandemic (June 2020) with the designated nurse presenting to a national audience of over 7,500 professionals key messages and a call for action to address the safeguarding implications of the inequalities experienced by radicalised communities who were most impacted by loss and bereavement.
3. The CCG safeguarding children professionals contributed to the NHSEI safeguarding during Covid-19 After Action Review in July 2020. This identified lessons for the regional team and the five STPs/ICS's in London.
4. The CCG has led the review of the MASH health model on behalf of the safeguarding partnership, this has included a capacity and demand activity which reflected the increased demand on the front-door during Covid-19. As MASH is the safeguarding front door for the partnership, review is to ensure that the model is resilient and that there is sufficient capacity to meet the increasing demands to deliver a safe service for children and families.
5. Relationships with safeguarding colleagues were strengthened leading to participation in national and local programmes to raise awareness of domestic abuse resources for families accessing retail or pharmacy outlets in both Waltham Forest and Newham.

This year we will – Program for 2021/22

Embed learning from statutory reviews and safeguarding incidents	**1.** We will work with safeguarding partners, commissioners, clinicians and children to implement the learning the CSPR for Khalsa a 14 year old who sadly died from an acute episode of asthma. **2.** The system response will involve work at both the ICP and ICS levels to promote awareness of the awareness within schools, children and families. **3.** This includes strengthening communication and safeguarding pathways and working with children in developing key messages and sharing best practice.
Strengthening safeguarding arrangements	**4.** Contribute to the action learning to evaluate the effectiveness of the new CDR arrangements.

Safeguarding within the ICS	**5.** Collaborate with designated colleagues within NEL CCGs to develop the safeguarding frameworks across the footprint and implement the new arrangements required under the Children and Social Work Act 2017 and the statutory guidance, Working Together 2018. **6.** Support awareness raising of the national, NEL and local multiagency safeguarding priorities in the integrated commissioning agenda for children, young people and families through partnership working.
	7. Work with colleagues across the TNW/NEL CCG footprint to achieve the objectives of the NHS Long Term Plan in respect of safeguarding children in relation to improving access to mental health support, safeguarding children in families experiencing domestic abuse, safe transitions for children with complex needs, unaccompanied asylum seeking children, care experienced children and improving the health offer for care leavers by enhancing the current social prescribing model. **8.** Contribute and lead on the relevant work streams within the NEL CCG safeguarding plan and support the implementation of Liberty Protection Safeguards (LPS) for the 16–17 year age groups which come into force in April 2022. **9.** Support the CCG in the full implementation of the child death reforms in NEL and continue to work in partnership to implement learning from child safeguarding practice reviews, child deaths and safeguarding incidents.

Waltham Forest Safeguarding; Children Looked After (Child with Care Experience)

NHS North East London Clinical Commissioning Group (CCG) and Tower Hamlets, Newham and Waltham Forest Integrated Care Partnership and North East London (NEL) Health and Care Partnership has statutory safeguarding responsibilities to the local population and ensures it is discharging its statutory safeguarding responsibilities to the health providers across the CCG.

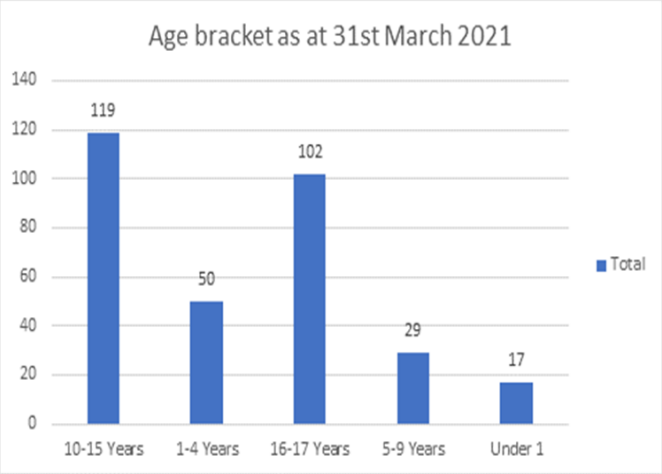
The CCG has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and to protect adults at risk from abuse or neglect in accordance with the Children Act 1989; Children Act 2004; Care Act 2014 and Children and Social Work Act 2017. Within Waltham Forest the CCG is committed to protecting and safeguarding children, young people and adults at risk of abuse and neglect and is fully engaged in the work of the WFSCP.

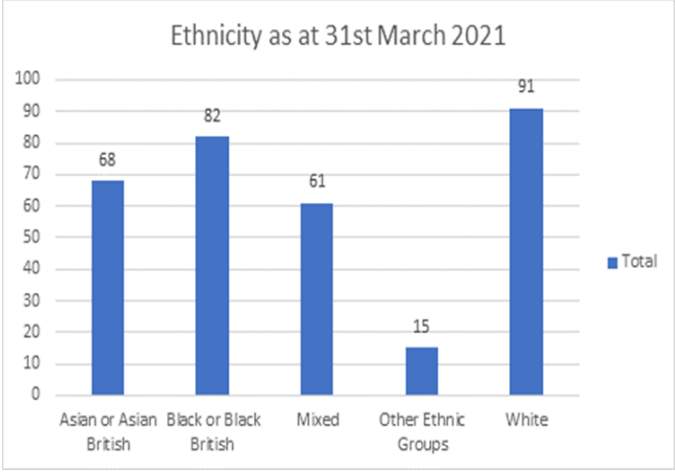
As a commissioner of health services, NEL CCG has statutory obligations to care experienced children and care leavers under section 10 and 11 of the Children Act 2004, Health and Social Care Act 2012 and Children and Social Work Act 2017 for ensuring that health care providers and the CCG are contributing and promoting the health and wellbeing of care experience children and care leavers, ensuring they have access to quality health care and the services are providing a safe and effective service.

Covid-19 and impact on health services:
The past year has been like no other for the NHS, it has seen Covid-19 spread across the country and dramatically affecting the lives of many. The affect this has placed on the health service nationally and locally will be felt for years to come. Ensuring a high quality equitable safe service remains essential for the CCG and provider health services across Waltham Forest. Whilst we are in the process of recovery as the nation attempts to ease restrictions placed on every citizen, this report will reflect the impact Covid-19 has had on our most critical of services and particular focus on the effect it has had on care experienced children and care leavers. Health services remain in the recovery phase and are implementing learning from the initial wave of restrictions to ensure we capture the lived experience of the service users, especially our care experienced children.
The second lockdown, in January 2021, impacted on staffing capacity due to the trainee doctors and designated nurse for children looked after being deployed for a fixed period of time into the acute setting and mass vaccination sites to support the NHS pandemic response. From March 2021, both the trainee's doctor and designated nurse for children looked after resumed their roles in the provider health team and CCG, alongside recruitment to two vacant paediatrician posts, which has enabled any outstanding children requiring an initial health assessment to be offered an appointment. Health providers have created a lead doctor for children looked after role, to provide oversight of operational service delivery. This role has been operational since February 2021 and is already impacting on information sharing with professionals from health & social care to improve care and timely assessment of need.

Data
Waltham Forest has a number of care experienced children being placed into the borough from other local authorities, this number stands at 342 and currently exceeds the total number of Waltham Forest care experienced children at 317. The total number of Waltham Forest care experienced children placed outside the borough is 184 and 49 of these children are placed more than 20 miles away. The rate of care experienced children in Waltham Forest per 10,000 children is 47.5. The total number of unaccompanied asylum seeking children is 85.

Below are graphics on the age and ethnic breakdown of care experienced children in Waltham Forest:





Key achievements

Multi-agency working
The Care Experienced Children Strategic Partnership Board (CECSPB) has continued to meet on an 8 weekly basis and has a strong emphasis on multi-agency partnership working. The board has renamed itself to reflect what local children have chosen to be referred to and is being co-chaired by the designated nurse for children looked after who was newly appointed in May 2020 alongside the associate director for corporate parenting within Waltham Forest local authority.

Increase in foster carers
Waltham Forest benefitted from the initial lockdown period as it saw an increase in foster carer applications, which resulted in 24 new foster carers being recruited from April 20-March 21, taking the total number of Waltham Forest foster carers to 110. Whilst Waltham Forest has seen an increase in the amount of prospective foster carers, there have been difficulties in completing the adult health assessment (AHA) forms that are necessary to complete the recruitment process. Designated professionals have worked closely with local authority colleagues from the fostering team to address the difficulties, contacting GP's, GP surgery managers and consultants within secondary care directly about prioritising completion of adult health assessments due to the delays.

Virtual offer
Following the initial wave of Covid-19 and the arrival of the first national lockdown, community health services moved to a virtual offer, for children looked after and care leavers this meant the local health teams would offer virtual appointments over the telephone or video calling. During this period an interim protocol was developed by designated health professionals in Waltham Forest, in conjunction with the local children looked after health team and local authority colleagues to ensure business continuity. This guidance written in response to the Covid-19 guidance issued to community children's services dated 19 March 2020 (and updated on 2 April 2020).
The provider health team have continued to be operational during Covid-19 with continuity measures in place such as staff working remotely and the offer of virtual contacts for all statutory health assessments during this period. The team have been able to work proactively to risk assess the physical and mental health needs of care experienced children in the borough.
The provider health team will continue to offer a blended approach of face to face and virtual health assessments in collaboration with what children in the borough are telling us.

Strengthened mental health offer
Covid-19 has had a significant impact on children's mental health and emotional wellbeing; and remains an ongoing partnership priority for care experienced children with key themes being:

- Access to timely intervention

- Access to school based intervention
- Prevention of Crisis care
- Improved transition where required

Waltham Forest has benefitted from additional funding being placed in mental health for children, and been placed into strengthening access to mental health service through the primary care team, who have been supporting primary care and mental health in schools.

In January 2021, the newly commissioned Mental Health Support Teams (MHST's) started their initial induction in eight local schools across the borough, prior to undertaking twelve months of training as part of a national programme, before the service goes live in February 2022. The MHSTs will work with the mental health support that already exists in schools to deliver 3 key functions:

1. Delivering evidence-based interventions for children and young people with mild-to-moderate mental health problems.
2. Supporting the senior mental health lead in each education setting to introduce or develop their whole school/college approach. All education settings should aim to identify and train a senior lead for mental health.
3. Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education.

The care experienced children strategic partnership group has also committed to improving the access of mental health for care experienced children. The board created a sub group with key stakeholders and completed two audits looking at the cohort of care experienced children open to the local child and adolescent mental health services. This data fed into the sub group to look at strengthening current pathways and ask if the current service is meeting their needs. Using the data from the audits to push for the integrate model of physical and emotional health model.

Care leaver offer

Designated professionals supported an on-going piece of work lead by Bart's health to look at the NHS as an anchor organisation to offer a range job opportunities and apprenticeships for care leavers.

Creating the future with the children and young people of North East London' was an event that brought together care experienced young people and care leavers across north east London. With speakers including the national champion for care leavers and young people for professionals to hear their voices and experiences of care and their frustrations of seeking employment.

Waltham Forest care leaver's champions were consulted about the proposals for employment through the NHS and what their thoughts/ experiences were about employment in the NHS.

Training

Training Level	Training Type	Audience	Facilitator (s) Training Level
N/A	Covid-19 and the impact of health & wellbeing of children looked after	Foster carers	Designated health professionals
Level 4	Mental capacity update/ Liberty protect safeguards training	CCG	39 Essex Chambers

How we captured the voice of the child and young person

1. The designated nurse for children looked after has developed a video which is part of a series of safeguarding videos for Tower Hamlets Newham and Waltham Forest staff around the lessons learnt from 'language that cares' (TACT 2019) document. This document has been the foundation for a system change across Waltham Forest as we pledged to remove acronyms like LAC (looked after children) from the system. Replacing it with care experienced children (CEC) the preferred choice from the children in care council.
2. The designated nurse for CLA has supported engagement events with the voice in influence service to support care experienced children to set priorities for the health service.

In the last year, we have

1. Established working groups to enhance the mental and physical health offer in Waltham Forest to ensure equitable access for care experienced children, and seen an increase in of care experienced children open to child adolescent mental health service.
2. Developed a robust adult health assessment pathway for prospective foster carers and tuberculosis screening pathway for unaccompanied asylum seeking children and care experienced children.
3. Ensured that care experienced children health has been prioritised during a global pandemic and ensuring access to health services by creating guidance for health services to complete statutory health assessments and prioritise the children most in need and offering flexibility of virtual or face to face health assessments.
4. Enhanced communication between health and social care to allow children looked after health team to have access to mosaic the local authority computer systems, this will allow the children looked after health team to input directly onto mosaic and have direct access to information about the child to aid their health assessment.

This year we will

1. Work with provider health team to capture the voice of care experienced children on an ongoing basis to ensure their needs are being met and their views are taken into consideration in shaping the service. Ensure child friendly language is used when writing reports, combining the lessons from 'language that cares' (TACT 2019).
2. Work with the children in care council and care leavers champions to develop more health promotion activities on their chosen topics and involve the public health and provider health team.
3. Integration of physical and mental health. Work with provider health team to ensure a more robust assessment of the emotional and mental health needs of care experienced children, and ensuring a robust data is captured for care experienced children who are in receipt of health services.
4. Improve performance health indicators and continue partnership working to improve timeliness and quality of statutory health assessments and ensuring the sharing of health information in a timely manner.
5. Following resumption of community health services, work closely with partners to ensure children have access to routine immunisations and dental checks.
6. Work with integrated commissioner to align the health provider team's nursing structure with statutory guidance.

Conclusion

From March 2020 like all of the NHS, the TNW has faced unprecedented challenges and changes to the way we work in response to the Covid-19 pandemic. Working with our members, partners, and fellow London ICSs we have focused our efforts to discharge statutory duties and meet emerging need. This included implementing national guidance and policy, and embedding a local support infrastructure across health services.

Key priorities for the CCG included responding to the pandemic, restarting elective care and rolling out a large scale vaccination programme at pace. As of April 2021, the Covid-19 vaccination programme in north east London had given nearly 700,000 vaccinations. This is an incredible achievement and testament to everyone who worked so hard to get the vaccine programme up and running. We posted over 40 videos featuring local people, faith leaders and NHS staff. The videos are designed for a variety of communities, explaining the vaccine and the importance of having it.

Despite the additional pressures of the pandemic, and a proportion of redeployment to the vaccine programme, the TNW safeguarding team have strengthened safeguarding pathways, led and supported a range of case reviews, and embedding critical learning into practice. As an example of this, the review of Child C brought about significant and systemic change in Waltham Forest. Reachable moments are now stronger, and more highly valued, so that they system can better mitigate the risk of child criminal exploitation.

Safeguarding was a fast changing landscape during the pandemic. Many people became vulnerable to abuse and neglect as others sought to exploit disadvantages due to age, disability, mental or physical impairment or illness[27]. For children and young people, reduced contact with professional and supportive networks have at times mask the true extent of neglect and abuse. In response to this, the TNW safeguarding team has collaborating with partners to strengthen safeguarding pathways. We have worked with providers and partners to positively address significant peaks and troughs in referrals rates linked to hospital hesitancy and hidden harm. The team's work hinged on collaboration and care, with local people at its heart.

The resource pack that the safeguarding team developed for outreach practitioners and long term hostel staff, in response to the high numbers of asylum seekers and people experiencing multiple exclusion homelessness, serves as an example of this. The team went on to produce a report, and attended a learning event in Westminster, regarding adolescent exploitation and serious youth violence. This resulted from a highlight report exposing the top 30 areas for NHS hospital admissions for assault with sharp object in the period of April to September 2020, which included the TNW footprint.

Designated professionals drove key elements of the safeguarding agenda across the partnership and with Trust providers. With meaningful contributions at safeguarding boards, and leadership roles in a range of subgroups; improvements moved at pace. Designates have been considered and creative in providing a blended training and supervision offer during this unparalleled time. Robust process have been established to monitor the delivery of continuing health care in accordance with Mental Capacity Act Code of Practice. For a range of complex cases, designates have represented the CCGs in the Court of Protection, ensuring that the CCGs fulfil their legal responsibilities in line with the Mental Capacity Act.

Work across health, care, community and community groups has enabled us to respond as a united system. More than ever before we have needed to draw on our strength and experience across TNW and NEL to respond to the pandemic, to learn from it and to ensure that despite our challenges, we continue to provide essential healthcare for our population.

[27] https://www.scie.org.uk/care-providers/coronavirus-covid-19/safeguarding

North East London
Clinical Commissioning Group

NEL CCG Governing Body

26 January 2022

Title of report	EPRR update
Item number	7.1
Author	Sophia Beckingham – Senior Governance Manager and EPRR Lead
Presented by	Archna Mathur – Director of Performance and Assurance, Accountable Emergency Officer
Contact for further information	Sophia Beckingham, Sophia.beckingham@nhs.net
Executive summary	**CCG EPRR Update** • Following approval by the Governing Body in Dec 2021, the EPRR Assurance statement of compliance from the CCG's AEO was submitted to NHS England on 23 December. • This EPRR Briefing Paper summarises the CCG's EPRR process in more detail, outlining feedback from NHS England and the steps the CCG needs to take in order to have a fully compliant position • The update also outlines current EPRR discussions taking place and the road map to ensure that the future ICB is fully compliant from an EPRR position at its inception in July 2022.
Action required	Note the EPRR briefing paper, and feedback on items within, particularly regarding potential system arrangements, leadership, EPRR governance and learning from the pandemic and other incidents.
Where else has this paper been discussed?	NHSE Assurance Meeting, Governance Leads Meeting, EPRR ICS Planning Group Meeting, Governing Body Briefing Dec 2021
Next steps/ onward reporting	Feedback from this paper will be incorporated in to the EPRR work plan, with further updates due to come to the Governing Body in future sessions.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	EPRR planning and its associated documents enable the NHS to ensure effective arrangements are in place to deliver appropriate care to patients affected during an emergency (as defined by the CCA 2004) or incident. EPRR planning exists to protect NHS services, its patients, and staff from the burden of incidents and disasters, and therefore

	supports the reduction of health inequalities arising from such a burden.
Conflicts of interest	N/A
Strategic fit	Meets corporate objectives: • Recover from the pandemic and be prepared for future waves • Ensure the best use of resources • Put patient experience at the centre of our delivery • High quality services for patients • Develop our NEL integrated care system
Impact on finance, performance and quality	As outlined in EPRR policy.
Risks	• EPRR risk is governed ultimately by NEL Governing Body, but is supported by the EPRR risk register, the corporate risk register, the GBAF, the Borough Resilience Forum risk registers and the London Community Risk register. • Currently, high scoring risks on the EPRR risk register include supply chain risks, variant risks, environmental related risks and terror related incidents. • Overall, the risk of not having stringent EPRR approaches in place put the CCG and its partner services at jeopardy of failure as a result of an incident.
Equality impact	Promoting equality and addressing health inequalities are at the heart of NHS values. Throughout the development of our EPRR approach we have: • Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it • Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. No associated issues regarding the quality impact assessment and these documents have been raised.

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Emergency, Preparedness, Resilience and Response (EPRR) update

Contents

- CCG EPRR Assurance Process with NHSE
- Trust EPRR Assurance Process with NHSE
- EPRR Workbook regarding ICS/ICB EPRR
- Future milestones and goals

EPRR Assurance Process for the CCG

- The NHSE EPRR Assurance Process is an annual submission to NHSE on the CCG's EPRR and BCP functions.
- The CCG self assesses against the NHSE Core EPRR Standards, of which there are 10 domains (Governance, Duty to risk assess, Duty to maintain plans, Command and control, Training and exercising, Response, Warning and informing, Cooperation, Business continuity, CBRNe (Chemical, Biological, Radiological, Nuclear and Explosives) HAZMAT (hazardous materials)).
- The submission rating contributes to the overall CCG annual assessment rating.
- The submission consists of a spreadsheet where the CCG assesses itself against the domains and give a rating of non-compliant, partially compliant, substantially compliant or fully compliant. This must be supported by evidence such as policies, BCPs and other associated documents.
- **The submission has been audited by NHSE, who met with CCG EPRR leads to discuss the overall submission rating. The CCG was rated as substantially compliant and have agreed an action plan to bring the CCG up to a fully compliant position.**
- All NHS Trusts are required to undertake the same exercise. The CCG attended the trust assurance process meetings. We are pleased with the strides that the trusts have taken in regards to their EPRR approaches, particularly when they have been stretched by Covid-19 and other incidents.

NHSE Feedback from assurance meeting

- NEL CCG EPRR representatives and the CCG AEO (Archna Mathur) met with NHS England EPRR team regarding the assurance submission.
- Feedback from NHSE centred around updating terminology (PHE to UKHSA), adjusting a few areas for clarity and including similar flow charts in place for major incidents for critical incidents.
- The only area where the CCG was rated as Amber was re the Data Protection and Security Toolkit (previously called the IG toolkit). At the time of the submission, the CCG was working towards a fully compliant position on the toolkit but had not achieved this. This affected the EPRR submission, as it required a fully compliant position for the IG toolkit at the time of the assurance meeting in order to achieve full compliance under the IT standard. The IG toolkit submission and rating is governed by the CCG's IT and IG teams.
- NHS England were pleased that the CCG's EPRR documents and evidence referenced the movement towards an ICS and ICB, and showed the CCGs consideration of changes to EPRR under an ICS/ICB banner.
- NHSE felt that the policies and evidence reflected best practice in several areas as well as the system working that took place during Covid-19 that the CCG were keen to embed in the future. Overall, both NHSE and the CCG were pleased with the submission, with the CCG given a statement of substantially compliant.

EPRR Submission Ratings

Red ratings	Amber ratings	Green ratings
0	1	28

Total number of red / amber ratings	1

This means North East London CCG has an assessed level of compliance of **Substantially Complaint.**

- Actions to achieve fully compliant position: N/A by the EPRR team. IT and IG teams must submit a fully compliant IG Toolkit position by 31 December 2021, and have a work plan agreed with NHSE to achieve this. NHSE require this to remain on the EPRR work plan until it is completed.

Trust EPRR Assurance Process with NHSE

The Trusts also went through an assurance process with NHSE, with the following compliance ratings:

- Barts Health: Substantially compliant
- NELFT: Fully Compliant
- BHRUT: Substantially compliant
- ELFT: Fully compliant
- Homerton: Substantially compliant

This means that all NEL trusts and the CCG are substantially compliant or above for their EPRR processes. This is a positive position for NEL, especially given the reliance on the trust's EPRR resource against the back drop of multiple incidents and pressures within the system. In particular, BHRUT have increased their assurance rating from partial to substantially compliant which is a significant advancement. The trusts with amber areas have agreed work plans in place to reach a fully compliant position, but there are currently no concerns to raise in regards to Trust EPRR approach.

The CCG have passed on their thanks and congratulations to the trusts on their assurance ratings and thanked them for their ongoing support and ensuring that North East London healthcare is resilient and responsive to incidents and emergencies.

NHS
North East London
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EPRR – Planning for a ICS/ICB Future

EPRR – Planning for an ICS/ICB future

- With the introduction of the ICBs and ICSs in July 2022, CCGs will cease to exist in their current form. This change requires the current EPRR approach the CCG has to adjust to fit the new requirements of such an organisation and system.

- One key change will be the cessation of CCGs and the new ICB organisation being a category 1 (emergency responder) rather than category 2 responders (co-operating bodies). With this new categorisation comes additional requirements and statutory responsibilities, as well as a changing of roles at ICB level which require consideration.

- This means that the ICB will be considered alongside its provider and LA colleagues as ‘front line’ in terms of emergency planning, and will be required to meet all the category 1 requirements as listed in the Civil Contingencies Act.

- The CCG is in a good position going in to July 2022 regarding this, as the CCG has already been operating with a system view with collaborative, partnership-based responses since Covid-19 and prior. In addition, a number of the requirements of a Cat 1 responder are already in place, such as Director-on-call systems, EPRR policies, emergency plans, data sharing agreements with colleagues and stringent communication support.

EPRR – Planning for an ICS/ICB future

- However, there are several unknowns that require further discussion with local providers and local authority colleagues, including how best to conduct system forums, the resource needed within the EPRR team, system planning and EPRR governance.
- This area of work is currently being developed by the Accountable Emergency Officer, key SMT members and the Governance team, who have taken part in several meetings and NHSE information gathering sessions as part of the initial steps towards a new EPRR system.

EPRR Workbook regarding ICS/ICB EPRR

NHSE have issued an EPRR workbook, which is designed to support the initial consultation phase of NHSEs discussion with the London ICS footprints in the lead up to the establishment of ICSs and ICBs in July 2022.

ICSs are required to share a draft of their thinking to NHSE London via the work book, which will be reviewed by NHS London and the planning team to inform the most appropriate next steps; likely to be either a pan-London workshop or a series of ICS-based workshops in January 2022.

Further work will be required regionally and nationally to define EPRR arrangements and future models. The workbook and the associated workshops will allow NHS London to best represent London systems, at all levels, as this work evolves.

By January 2022, NHSE London and the CCG EPRR team hope to :

- Further understand the possible future landscape, roles and responsibilities in relation to EPRR
- Recognise where opportunities to add value/ reducing burden can be applied
- Ensure NHSE London consider tactical and operational aspects
- Establish a work plan to support future EPRR configuration and planning.

The AEO is currently leading this work and has held discussions with the Director of Corporate Affairs and the CCG Covid-19 SRO as an initial step to support NHSE London in realising the new ICS EPRR Approach.

Future milestones and goals

- Submit work book to NHSE London (Jan 2022)
- Hold workshops with provider, partner and local authority colleagues (Jan 2022)
- Author new EPRR work plan to ensure the ICB will be resilient from its commencement (Jan 2022)
- Update the Governing Body on progress (Ongoing, Q4 2022)
- Adjust policies and procedures for an July 2022 start (July 2022).

Questions

- Accountable Emergency Officer (AEO) – Archna Mathur
- Emergency Planning Officer (EPO) – Sophia Beckingham
- Director of Corporate Affairs – Marie Price

North East London
Clinical Commissioning Group

NEL CCG Governing Body
26 January 2022

Title of report	Audit & Risk Committee Chair's report
Item number	7.2
Author	Anna McDonald, Business Manager, Governance Team
Presented by	Kash Pandya, Lay Member – Governance and Chair of the Audit & Risk Committee
Contact for further information	anna.mcdonald@nhs.net
Executive summary	A short additional meeting of the NEL CCG Audit & Risk Committee was held on 3 December 2021. The key points were: • An update on Integrated Care System developments was noted. • An update on the closedown of NEL CCG in terms of the ledger was noted. • The corporate risk register and board assurance framework were both reviewed and discussed. Draft minutes of the meeting held on 3 December 2021 are attached as an appendix to this report.
Action required	The Governing Body is asked to note the update and the minutes of the meeting held in December 2021.
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	A regular report on key messages from the Audit & risk Committee will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The Committee will ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Governing Body.
Conflicts of interest	There are no conflicts of interest in regard to this report.
Strategic fit	The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that support the achievement of the CCG's objectives.

Impact on finance, performance and quality	The Committee will work closely with other committees established by the Governing Body to ensure there are no assurance gaps.
Risks	The Committee will review the adequacy and effectiveness of the risk register and defined mitigating actions, particularly relating to the most significant risks, to assure that risks are being properly reviewed and effectively managed.
Equality impact	N/A

North East London
Clinical Commissioning Group

Draft minutes - NEL CCG Audit & Risk Committee

3 December 2021 - 9.30am - 10.20am

Via MS Teams

Members	
Kash Pandya (KP) - Chair	Lay Member, Governance
Noah Curthoys (NC) - Chair	Lay Member, Performance
Charlotte Harrison (CH)	Independent Secondary Care Specialist
Sue Evans (SE)	Lay Member, Primary Care
Khalil Ali (KA)	Lay Member, PPI
In attendance	
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Ahmet Koray (AK)	Director of Finance (BHR)
Sunil Thakker (ST)	Director of Finance (TNW)
Marie Price (MP)	Director of Corporate Affairs, NEL CCG
Keeley Chaplin (KLC)	Governance Officer, NEL CCG
Auditors	
Dean Gibbs (DG)	External Auditor, KPMG
Jessica Spencer (JS)	External Auditor, KPMG
Nick Atkinson (NA)	Internal Auditor, RSM
John Elbake (JE)	Internal Auditor, RSM
Anne-Marie Keliris (AMK)	Head of Governance, NEL CCG
Apologies	
Henry Black (HB)	Acting Accountable Officer

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	
1.1	**Declaration of conflicts of interest**	
	The chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NEL CCG. No additional conflicts of interest were declared. The registers of interests held for NEL CCG Governing Body members and staff are available from the Company Secretary .	

1.2	**Minutes of the last meeting**	
	NA noted some minor changes and subject to these the minutes of the meeting held on 29 September 2021 were agreed as a correct record.	
1.3	**Matters arising**	
	The actions log was reviewed and updated accordingly. SC agreed to follow up on the cyber security independent review being sent to KP.	SC
2.0	**Integrated Care System update**	
	MP provided an overview of progress in delivery against the programme milestones. • An ICS Transition Oversight Group are meeting monthly to review programme highlight reports and undertake detailed deep dives with the last meeting focusing on leadership and governance, agreeing the composition of the new ICB board and developing the draft constitution. • The CCG's lawyers for ICS governance are working with each group at place and with the mental health collaboration partners, to ensure consistency. Draft terms of reference have been positively received. • The Health and Care Bill continues to pass through Parliament with several amendments being made, some guidance has not yet been issued and some of final elements are still required to fully progress our governance design. The focus is to plan for the basics to be in place for 1 April 2022 with an understanding that there will be much testing and development over the coming years to fully realise the intentions of the Bill. • Progress is good against the 'readiness to operate' (ROS) checklist from NHSE, aimed at ensuring a smooth transfer to the new ICB. MP clarified that primary care may not come over until April 2023 therefore will continue as it is now, and it is likely the primary care commissioning committee will be retained until clarified by NHSE. KA queried if the primary care team have adequate capacity to deal with pharmacy, dentistry and optometry when they transfer over. MP advised that this is being worked through which will also include primary care complaints and acknowledged there would need to be adequate resource in place when it is transferred in 2023. KA asked if voluntary and community social enterprise organisations will receive financial and upskilling support to provide quality services. MP advised that funding and support has been received from NHSE to help them to become a sustainable sector. A report will be provided at the end of December with recommendations on how voluntary services can bid for funding. There are two red rated risks which relate to Finance and Communications. MP advised the communications risk will be de-escalated and SC will clarify if the Finance risk can be de-escalated at the next meeting following receipt of a robust mitigation plan. NA reported that RSM have completed a system workshop on governance for another system which identified six main themes. NA agreed to circulate the report.	SC NA

	Kash Pandya joined the meeting and took over the chairing from item 3.0. The first meeting of the NEL Executive Committee was held on 2 December 2021. At present the guidance states there should be two Non-Executive Directors on the Board plus the Chair but it is hoped this will be extended to allow three. NC noted staff are transferring to other areas within NEL leaving some teams concerned they are short staffed. MP advised that the senior team are aware of this and are looking at solutions and how to organise teams appropriately. External support has been agreed to support with the design of the new structures until the new CEO is in post. The committee noted the update.	
3.0	**Update on CCG closedown - ledger**	
	SC reported that as part of the CCG closure and the creation of NEL ICB, the CCG is required to shut-down the existing finance system and prepare a new one for the ICB organisation. As part of this process the closing financial balances from the CCG will be cutover as the opening balances of the ICB. Monthly project board meetings have been arranged which include members of the finance team as well as internal audit, NHSE, the CSU and NHS SBS. No concerns have been highlighted as yet and JE and NA agreed to report back if any become apparent. DG reported that guidance is awaited on liability transfers and merger accounting from the CCG to the ICB. NHSE are discussing with the Treasury on what form merger accounting will be in. DG is encouraging all organisations to ensure final payments are made by 31 March 2022. KA queried if the new ledger can be structured to deliver good quality management information at each level of the ICS. SC advised that merger analysis codes will allow reporting at borough level but they will need to follow the operating model. The committee noted the report and that further updates will be provided as the project progresses.	
4.0	**Risk management process**	
	MP presented the risk management process, the corporate risk register and the draft Governing Body Assurance Framework (GBAF). **4.1 Risk management cycle** The risk management cycle describes the process for the review of risks for the NEL Governing Body and the ICP area committees. Each month risk owners review their risks and are taken to relevant groups and sub committees. The governance team review the registers and update the information to be sent to the corporate risk register or the GBAF. **4.2 Corporate risk register** There are a number of red risks. The current key risks relate to: • Underperformance against H2 metrics, specifically elective recovery • Continuing healthcare	

	• Use of resources and finance balance • Vaccine delivery (workforce) • Health inequalities There are a number of risks rated at a high level and these need to be reviewed to ensure they should remain at these levels and they will be reported to the governing body if they are significant for all of NEL. **4.3 Governing body assurance framework** The Governing Body Assurance Framework (GBAF) provides an overview of the current key risks for the CCG. These risks will continue to be monitored and reviewed, with regular updates provided to the Governing Body. SE asked what is needed to move assurance and risk management processes into an ICB risk-based management process. MP advised we will learn from what has or hasn't worked and ensure there is a clear sight on the ICB. The CCG is in the process to move to an electronic reporting system to input and record risks and this is already in use by the Trusts. RSM has been asked to undertake a review of processes for the new ICB and strengthen what is in place. SE queried if there will be a risk pressure following the increased vaccine programme that should be added to the register. An update from the programme director is coming which is being discussed at the SMT level. KA noted concern that risks and mitigations could be defined differently by different teams and that training to define these would be helpful to ensure consistency across NEL. MP agreed this is a development gap and that work on this with DG and JE would be helpful. The committee noted the update.	
5.0	**Any other business**	
	5.1 Key messages to feedback to the Governing Body A short paper will be drafted for the next meeting of the Governing Body.	
	Date of next meeting – 19 January 2022	

North East London
Clinical Commissioning Group

Governing Body meeting

26 January 2022

Title of report	Primary Care Commissioning Committee Chair's report
Item number	7.2
Author	Sue Evans, Deputy CCG Chair and Lay Member - Primary Care
Presented by	Sue Evans, Deputy CCG Chair and Lay Member - Primary Care
Contact for further information	katemcfadden-lewis@nhs.net
Executive summary	The key messages from the NEL CCG Primary Care Commissioning Committee meeting held on 10 November are: • the NEL LIS Equalisation programme has undertaken a reprioritisation process • the Committee approved the recommendation to extend the LIS/ LES income protection until the end of the financial year • the Committee approved the recommendation to release PCN Development Funding for 2021-22 • the Committee approved the Strategic Outline Case for developing Primary Care Services in the Gants Hill Locality • the Committee ratified and approved the decision to continue into the next five years of the APMS contract for the Sandringham Practice and Spring Hill Practice (Hackney) • the Committee ratified and approved the decision to disperse the list of the Southgate Road Medical Centre (Hackney) The approved minutes of the meeting are attached as an appendix to this report.
Action required	The Governing Body is asked to note the update.
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	A regular report on key messages from the Primary Care Commissioning Committee will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	In exercising its functions, the Committee must comply with the statutory duties as set out in the NHS Act, including ensuring quality of primary medical services, reducing inequalities, patient involvement and patient choice, and will provide appropriate independent assurance to the Governing Body.
Conflicts of interest	None.

Strategic fit	The Committee functions as the corporate decision-making body for the management of the primary care delegated functions to NEL CCG.
Impact on finance, performance and quality	The Committee will oversee primary care services, ensuring consistency and value for money across NEL.
Risks	The Committee will review the Primary Care risks and mitigating actions at each meeting.
Equality impact	N/A

North East London
Clinical Commissioning Group

Primary Care Commissioning Committee meeting

2-4pm Wednesday 10 November 2021, Microsoft Teams

Minutes

Present	
Khalil Ali	Lay Member for Patient and Public Involvement, NEL CCG
Sue Evans (Chair)	Lay Member for Primary Care and Deputy CCG Chair, NEL CCG
Charlotte Harrison	Secondary Care Consultant, NEL CCG
Ceri Jacob	Managing Director, BHR ICP, NEL CCG
Kash Pandya	Lay Member for Governance, NEL CCG
Fiona Smith	Registered Nurse, NEL CCG
In attendance	
Rob Adcock	Deputy CFO, BHR ICP, NEL CCG
Richard Bull	Primary Care Director, City & Hackney ICP, NEL CCG
Gohar Choudhury	Assistant Head of Primary Care, NEL CCG
Peter Cox	Peter Cox, Senior Project Manager – Estates, BHR ICP, NEL CCG
William Cunningham-Davis	Primary Care Director, TNW ICP, NEL CCG
Angela Ezimora-West	Primary Care Team, NEL CCG
Mike Fitchett	Independent GP
Alison Goodlad	Deputy Director Primary Care, NEL CCG
Rachel Halksworth	Senior Consultant, NEL CSU Healthcare Consulting
Lorna Hutchinson	Assistant Head Primary Care, NEL CCG
Ahmet Koray (for Steve Collins)	Director of Finance, BHR
Natalie Keefe	Deputy Director Primary Care, BHR ICP, NEL CCG
Jane Lindo	Director of Primary Care, NEL CCG
Kate McFadden-Lewis (minutes)	Board Secretary, NEL CCG
Anil Mehta	Clinical Chair, Redbridge, NEL CCG
Dean Musk	Head of Estates and Capital Programmes, BHR/TNW ICP, NEL CCG
Muhammad Naqvi	Clinical Chair, Newham, NEL CCG
Rob Neave	Principal Healthcare Consultant, NEL CSU Healthcare Consulting
Azeem Nizamuddin	Independent GP
Sarah See	Primary Care Director, BHR ICP, NEL CCG
Mark Spencer (item 3)	Chair, LIS Equalisation Programme
Tina Teotia	Local Medical Committee (Redbridge)
Cathy Turland	HealthWatch - Redbridge
Gladys Xavier	Director of Public Health, London Borough of Redbridge
Apologies	
Steve Collins	Acting Chief Finance Officer, NEL CCG
Anne-Marie Dean	HealthWatch, Havering
Chris Lovitt	Deputy Director of Public Health, City of London & LB of Hackney
Mark Rickets	Clinical Chair, City and Hackney, NEL CCG

Item	
1	**Welcome, introductions, apologies** Sue Evans welcomed attendees to the meeting and apologies were noted as above. The following members of the public were in attendance: • Susan O'meara, Waltham Forest Resident. Mike Fitchett declared an interest in relation to item 5 as his role as a PCN project clinical lead.
2	**Minutes of the last meeting and matters arising** The minutes of the last meeting were accepted as an accurate record.
3	**Equalisation of LISs** Mark Spencer updated on the LIS Equalisation programme progress, reporting that a reprioritisation has been undertaken, with a change in the timeline and priority areas. A detailed roadmap including all of the schemes in the programme will be presented at the next meeting. Key discussion points included: i. the important principle of transparency around how the programme is improving services for the local community ii. the commitment across north east London CCG to ensure funding for this programme, and therefore the importance of ensuring that the finance and strategy teams work closely together on the design of this.
4	**LIS/ LES Income Protection** Alison Goodlad presented on the recommendation to extend the LIS/ LES income protection until the end of the financial year following a review of position across London, with three of the four other CCGs in London continuing income protection, as well as the recent publication of the NHS England and Improvement document, 'Our plan for improving access for patients and supporting general practice', which outlines a range of initiatives to ensure greater access to primary care. The Committee approved the recommendation to extend the LIS/ LES income protection until the end of the financial year.
5	**Primary Care Network Development Funding** Alison Goodlad presented on the Primary Care Network (PCN) Development Funding for 2021-22 reporting that all of the PCNs have now submitted their plans for the funding, based on the national priorities, which have been reviewed and agreed by the local primary care groups. Discussion points included: i. that the the outcomes of these initiatives, including progress on PCN maturity, will be reviewed in summer 2022 ii. the importance of ensuring the learning and good practice is shared across London, as well as north east London iii. assurance that any bids that are in excess of the allocation will be funded within the PCN's budget iv. that the funding and payment is direct to PCNs, and with support from GP federations, where appropriate, to help to avoid any duplication v. the need to ensure good communication with PCNs on the initiatives around tackling inequalities and social prescribing vi. that although the funding is not likely to be enough to fully support PCNs to mature, it is important that it is used in the best possible way to benefit the transformation agenda. The Committee approved the recommendation to release PCN Development Funding for 21/22, following the review of PCN Plans.

6	**NEL Primary Care Contractual update** Lorna Hutchinson presented on the decisions that have been made in regards to contract changes through the ICP primary care groups since the last meeting, and updated the Committee on the progress on action plans for those practices issued with remedial breach notices. In discussion the Committee noted the importance of the support package to practices within the first six months of taking on a new contract.
7	**Primary Care in Gants Hill Community Hub - Strategic Outline Case** Peter Cox presented on the plans to develop a Gants Hill Community Hub, as part of the London Borough of Redbridge's community hub development programme. Key discussion points included: i. the community engagement work and consultation that has taken place around these plans, and the importance of continued comprehensive patient and stakeholder engagement co-ordinated across all agencies and patient groups ii. that it is key that health and social care are working closely on this programme, through the Redbridge borough partnership, so that the non-health indicators of health are considered iii. the need for a workforce plan, as well as the importance of ensuring robust financial modelling and running cost implications to be included in the Outline Business Case. The Committee approved the Strategic Outline Case for developing Primary Care Services in the Gants Hill Locality.
8	**Strategic Reviews:** **a. Sandringham APMS contract expiry Sep 2022** **b. Spring Hill APMS contract expiry Sep 2022** Richard Bull reported that the Sandringham Practice and Spring Hill Practice are both approaching the end of their five year break point in their ten year contract. The City and Hackney primary care group have reviewed and recommend a continuation into the next five years of the APMS contract, with the aim to negotiate the terms of the contract closer to GMS over the next five years. **c. Southgate Road Medical Centre** Richard Bull then presented on the recommendation, following scrutiny by the City and Hackney primary care group, to disperse the list of the Southgate Road Medical Centre following the partners handing back the contract. The Committee approved the recommendations of these three strategic reviews.
9	**Chair's Actions** The Committee noted the Chair's approval between meetings, due to the urgency, on the appointment of a Caretaker Provider for Forest Surgery and the Aberfeldy Village Health Centre Full Business Case.
10	**Subsystem updates** System leads gave a brief update on their ICP area. It was agreed that for future meetings subsystems will update by exception and the PCCC papers pack will include all minutes from each Primary Care Sub-Group.
11	**Primary Care Budgets update** Ahmet Koray updated the Committee on the primary care budgets across NEL, outlining that H2 planning has recently been completed and is very similar to H1. Key discussion points included: i. the current overspend on the prescribing budget and additional arrangements for managing the Covid-19 pandemic, which will be managed within CCG resources. The overspend on prescribing will likely continue due to continuing medications to treat patients on the waiting list, as well as the increasing cost of drugs

	ii. the need to recruit to the additional roles as soon as possible to ensure the CCG received the maximum funding available, as well as to support important programmes across north east London, such as social prescribing.
12	**Questions from the public**: None.
13	**AOB** Jane Lindo briefly updated the Committee on the submission to NHS England and Improvement for winter access funding to support increasing same day access to primary care from November 2021 to March 2022. The deadline was 28 October, and there was a very tight turnaround time. Each ICS was asked to focus on unwarranted variation and identify a list of up to 20% of practices that had the lowest level of access, in particular face to face. The plan focussed on supporting programmes of work which are already in place, and the 20% of practices needing the most support were anonymised. From the 20% of practices, a group were identified to become accelerator sites, to receive focussed support and to share any learning from the programme. Other schemes include supporting enhanced capacity and the duty doctor scheme, as well as a robust communications campaign for primary care. All of the proposed schemes are in line with the programme of work already in place to support primary care for winter, and this funding will support accelerating these plans. These plans will be discussed in more detail at the next meeting.

North East London
Clinical Commissioning Group

NEL CCG Governing Body meeting
26 January 2022

Title of report	Finance & Performance Chair's report
Item number	7.2
Author	Muna Ahmed
Presented by	Noah Curthoys – Lay Member for Performance
Contact for further information	Muna.ahmed2@nhs.net
Executive summary	Since the last Governing Body, two Finance & Performance Committees have been held on 28 October and 24 November respectively. Items discussed and reviewed at the October Finance & Performance Committee are as follows: • The Committee noted the Performance Report and the challenges in diagnostics and mental health. • The Committee received comprehensive Winter Plan which is a response to the 10 point plan by the national team. The plan has been more combined this year and included work on demand and capacity to support elective recovery. A key test of the winter plan was the ability to be resilient to support the continuation of elective recovery. • The Committee noted in the finance report that month 6 was stable and it has been a 'soft' close for the end of H1. NEL is reporting a breakeven position. Claims are due back on the hospital discharge programme (HDP) and working through the criteria for the elective recovery fund for H2. • The Committee noted the H2 Update. A final submission will be submitted around 16 November. As focus was around activity. The plan includes activity trajectories for elective care and maintaining non-elective and out of hospital targets. It also incorporates the targeted investment fund (TIF). Maintaining focus on core infrastructure and have included additional revenue funding to support A&G, equipment upgrades and digital input. • The Committee noted the Phlebotomy and Advice & Guidance updates.

	• The Committee endorsed the outline business case for St George's. 24 November 2021: The H2 planning submission was submitted on 18 November. A summary of the trajectories and activity in the H2 plan was presented. There were discussions around trajectories and the ability of Trusts realistically achieve them. Concerns remains around diagnostics. A balanced financial plan was submitted. The Committee noted the update on the H2 planning submission. • The Committee noted the Performance Report. IAPT, SMI physical health checks and Dementia performance are a concern with workforce cited as a contributing factor. • The Committee noted the month 7 finance report. A break-even position on the core budgets was reported. However, delivery of the break-even position has been reliant on the use of non-recurrent mitigations and contingency funds (Covid related) to offset identified budgetary pressures. • The Committee endorsed the Advice & Guidance and Referrals scheme. • The Committee noted the Phlebotomy update. The minutes for the 28 October and 24 November are attached as an appendix to this report.
Action required	The Governing Body is asked to note the update.
Where else has this paper been discussed?	Finance and Performance Committee.
Next steps/ onward reporting	A regular report on key messages from the Finance & Performance Committee will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The Committee: • provides assurance to the public and the Governing Body on the robustness of the in-year financial strategy and financial management for the CCG and spend of public funds • gains assurance on the longer term financial strategy and planning to ensure stability of the health services for the people of NEL • scrutinises the performance of providers and of the CCG against established contractual, statutory and KPI metrics, and act based on these findings • Agrees and recommends business cases and contract awards.

Conflicts of interest	There are no conflicts of interest in regard to this report.
Strategic fit	The Committee reviews and monitors the financial strategy and operational financial plans of the CCG and the current and forecast financial position of the overall CCG budget. In addition, it approves business cases that are beneficial to the public and fit within the CCG financial plans that are within delegation limits.
Impact on finance, performance and quality	The Committee will manage the key areas of finance and performance as outlined in this report.
Risks	The Committee will review and monitor system wide operational performance in accordance with national operational planning guidance and advise on risks and mitigations. The Committee will Manage system risks to the CCG's financial performance and of plans to mitigate their impact. A risk based report shall be sent to the CCG Governing Body every two months; along with any necessary progress reports, recommendations and formal requests for approval in relation to contracting activity.
Equality impact	N/A

NHS
North East London
Clinical Commissioning Group

NEL CCG Finance and Performance Committee Meeting
27 October 2021 from 10:00 to 12:00, Microsoft Teams

Minutes

In attendance

Name	Role	Committee Role	Organisation
Noah Curthoys	Lay Member for Performance	Chair	NEL CCG
Steve Collins	Acting Chief Finance Officer	Member	NEL CCG
Archna Mathur	Director of Performance & Assurance	Member	NEL CCG
Fiona Smith	Independent Clinical Representative – Registered Nurse	Member	NEL CCG
Kash Pandya	Audit Chair	Member	NEL CCG
Ken Aswani	Clinical Chair Waltham Forest	Member	NEL CCG
Sam Everington	Clinical Chair Tower Hamlets	Member	NEL CCG
Sunil Thakker	Director of Finance	Attendee	NEL CCG (C&H and TNW Area)
Ahmet Koray	Director of Finance	Attendee	NEL CCG (BHR ICP)
Muna Ahmed	Governance Lead	Attendee	NEL CCG

Apologies:

Name	Role	Committee Role	Organisation
Henry Black	Accountable Officer	Member	NEL CCG
Rob Adcock	Deputy Director of Finance	Attendee	NEL CCG (BHR Area)

No.	
1.	Noah Curthoys (NC, Committee Chair and NEL CCG Lay Member for Performance) welcomed the group, noted apologies and confirmed that the meeting was quorate. There was a discussion about Mark Ricketts, who has stepped down from the Committee. A replacement will be sought. Minutes of the meeting held on 22 September 2021 were agreed as an accurate record.
2.	**Performance Report** Archna Mathur (Director of Performance and Assurance, NEL CCG) presented the performance report. AM provided the following highlights from the report:

Elective Recovery

- NEL has the fourth largest PTL in London. The PTL size in NEL is 179,489. The largest PTL is in NCL, followed by SEL, NWL, NEL and SWL has the smallest PTL. The growth is mainly in Barts and BHRUT.
- Regarding over 52ww, NEL is delivering against trajectories. The total across NEL is 10,415. However, the rate of decrease is starting to slow down, consistent with the pattern across London.
- There has been an increase in 78ww, driven by Barts and BHRUT. BHRUT has a strong trajectory and are confident that they will not have any 78ww after October.
- The area of concern is patients waiting over 104 weeks. Our performance is 704, against a trajectory of 595 and we have the biggest volume in London. This is all driven by Barts Health and the specialties affected are paediatric dentistry and ENT. There is a new service in paediatric dentistry called "Project Tooth Fairy", started on 15th Oct. The service is being delivered in Barts Health and is pan London. The bulk of the capacity is for Barts Health patients to clear the backlog by March 2022, which will be a challenge.
- ENT – issue is around admitted patients. Work is in progress, mainly in Whipps Cross to ensure there is sufficient capacity and resource. Anaesthetics resource is an issue.
- Elective outpatients - the delivery is 90%, against a trajectory of 104%. This puts NEL fourth in London. The activity trend for outpatients is on a downwards trajectory resulting in increased growth in the non-admitted PTL which is also consistent with the rest of London. The growth in the PTL is all in non-admitted PTL.
- AM flagged the introduction of a new metric in H2 for the number of completed pathways. This is where the clock stops. This will provide a clear view of the volume of activity that results in a patient being removed from the PTL and will be compared with 2019/20 performance.
- In 2019/20, at the same time, NEL was at 73.9% of clock stops. The aim is to stop more clocks than are started, in order to reduce the PTL and long waiters.
- Total elective activity (inpatient and day case) - is at 79% of business as usual (as in 2019/20), this is behind trajectory of 93% which is largely consistent with London, driving an overall flattening in the admitted PTL across London.

Advice & Guidance

As requested by the Committee, AM provided the actual figures for A&G. The July published position for A&G was:

- Barts - 2470 against a trajectory of 3520.
- BHRUT - 840, against a trajectory of 708.
- Homerton (HUH) - 858 against a trajectory of 700.

NEL ICS continues to have the highest volume of A&G requests in London.

The H2 A&G request has changed from the number of requests and trajectories in H1, to specifying that there needs to be a minimum of 12 (12%) A&G requests for every 100 first outpatient appointments and is across NEL. AM noted that we will still recieve borough and provider level trajectories but will report it as one figure. Currently, our performance is 28%, driven by Barts Health. AM also noted that the definition of A&G has changed to include Referral Assessment Services (RAS) and all other triage mechanisms.

KA queried whether we are achieving our ambition of transformation. KA felt we should have achieved our pre-Covid level in outpatients. Regarding A&G, KA stated that we need to do what will make a difference to patients. Demand is increasing. Most of the referrals will be managed in primary care. KA commented that we should continue to make progress on A&G and make it meaningful for patients and wider transformation.

FS queried how we will know A&G is working. AM explained it will be mainly through PTL size. FS felt it would be helpful to know what the growth in the PTL would be without A&G. AM stated that it is difficult to identify unmet need and requires resource. Unmet need can be measured through non-elective attendances presenting at ED/A&E.

	AM added that A&G and patient initiated follow up (PIFU) are examples of outpatient transformation. A&G can be tracked numerically. We have follow up pathways for breast, colorectal and prostate cancers where patients initiate follow up, rather than waiting on the PTL to be recalled. Regarding the non-admitted and outpatients, it is mainly operational. H1 and H2 have the same target of 25% of first outpatient appointments being virtual. HUH is delivering at 27%. FS suggested that another measure could be discharges after first appointment. AM explained that the new clock stop metric on how many patients have been discharged in H2, will address this and be compared to the same time last year. <u>Diagnostics</u> There is concern around MRI and non-obstetric ultrasounds, as we have a significant volume of backlog. The metric is patients waiting over 6 weeks and 13 weeks. More work is needed on how much longer than 13 weeks patients have been waiting. AM stated that there is a corelation between patients waiting for diagnostics and are also on the non-admitted PTL. Work is ongoing. AM confirmed the Mile End diagnostics centre is now open and will mainly support endoscopy and there is a bid to support MRI. <u>Cancer</u> The area of concern is the number of patients waiting over 63 days and the volume of 2 week wait referrals, as well as late presentations. The faster diagnosis standard is the most challenged in NEL compared to London with performance at 66.2% against a target of 75%. It is a new standard to diagnose and provide a first treatment within 28 days. Plans are in place to address these issues. <u>Mental Health</u> AM highlighted dementia and SMI physical health checks and stated that they have received 2 deep dives on mental health in the ICS focus calls. The last deep dive was on SMI physical health checks. Currently, they only have data for the quarter 1 position. There are capacity issues in primary care. Dementia services have been stood up and there is a backlog. Regarding mental health services, SC stated that there is not a financial constraint but behavioural and workforce constraints. We need to consider how we can do things differently to address the issues. Some of it is related to the pandemic and the recovery. FS added that there are funding inequalities at borough level, e.g. in Waltham Forest within TNW. FS felt it would be helpful to review how we are going to address this at a system and place level where risks will be held. Need to consider how we will do governance reporting differently. **Action: The Committee to consider how funding inequalities will be addressed at system and place level.** The Committee noted the Performance Report.
3.	**Winter Planning Update** AM presented the winter planning update and stated that the plan has been submitted to the region and has been well received. The plan has been more combined this year and included work on demand and capacity to support elective recovery. A key test of the winter plan was the ability to be resilient to support the continuation of elective recovery. The national team has developed a 10 point plan and the winter plan is a response to the 10 point plan. 1. Supporting 111/999 services 2. Supporting Primary Care & community services to manage UEC demand 3. Supporting greater use of UTCs

4. Increasing support for Children and young people
5. Using communications to support the public to choose services wisely
6. Improving in-hospital flow and discharge
7. Supporting Adult and children's mental health
8. Reviewing IPC measures
9. Reviewing Covid isolation rules
10. Ensuring a sustainable workforce

There is also a key element within the plan around the process for escalation and operational oversight, to enable our system to be used flexibly and strategically.

AM highlighted from the plan:

- Resilience for 111/999 – workforce (call handlers) particularly at weekends due to general sickness. There are 2 support services in Derby and Herts. The London Ambulance Service (LAS) is managing the contracts and working on the resilience of the services.
- Ambulance handover delays and times – the least resilient sites are Queens, King George's and Whipps Cross. The delays are tracked on a daily basis and measured in 15, 30, 60 minutes and over 120 minutes and over 180 minutes. The LAS has put LAS led cohorting in place which involves some paramedics to stay behind to look after patients, in order to release ambulances.
- There are also transformational schemes in place for the use of alternative care pathways, such as Rapid Response, which enables LAS to refer into the community Rapid Response service which is supposed to respond in 2 hours. Currently working on standardising.
- Access to primary care and appointments.
- Communications – national and local.
- Focus on discharges and the reasons for delayed discharges.

KA stated that there are differences this year and felt that focus is required on daytime primary care which has an impact on the system. KA added that the community pharmacist service can be utilised to manage low severity patients. KA mentioned consultant leadership and specifically the frailty service which is helpful and positive and overlaps with care homes. KA also stated that receiving urgent advice from consultants has made a big difference and overlaps with urgent advice and guidance. The more backlog in the system, the more impact there is on urgent care.

KP congratulated the team on a good plan and shared concerns around workforce and exhaustion.

AK confirmed that a request has been made by BHRUT for one additional ward to support winter plans and in the long term, to open another 2 wards, if funding is available.

NC queried whether there is a bigger risk for LAS this year, compared to previous years. AM stated that LAS has highlighted where the biggest risks are within London. For NEL, that is Queens, King George's and Whipps Cross. The difference is our ability to make our decisions rapidly and locally. It is difficult on weekends and we need LAS to work with us. As part of the winter plan, Queens has the ambulance receiving unit (ARC) which is a pre-planned handover space and there is funding for HALO – a paramedic at the site who advises on conveyances.

There is also work on how 111 and 999 can work together. A review of intelligence conveyance is also in use where LAS review what is happening on each site and move ambulances accordingly. More pan London work with LAS is required.

The Committee noted the Winter Plan Update.

4.	**Month 6 Finance Report** Steve Collins (Chief Finance Officer (Acting) NEL CCG) presented the Month 6 Finance Report. SC reported that month 6 was stable and it has been a 'soft' close for the end of H1. NEL is reporting a breakeven position. Claims are due back on the hospital discharge programme (HDP) and working through the criteria for the elective recovery fund for H2. A breakdown for each ICP is provided in the report. SC stated that they are continuing to commit the non-recurrent resources to support recovery, some of which is planned. Working through pressures in prescribing to identify whether they are due to volume pressures from increased numbers of discharges and price pressures. Also reconciling areas where there are continued reserves against sustainability and transformation funds. Focus is also on planning the exit of 2021/22. Areas of concern is scrutiny around overspends and bringing forward historic reserves. Emerging pressures are around ensuring we are committed to, planning and spending the System Development Fund (SDF) and ensuring transformation. There is increased pressure with local authorities on discharges under the HDP and to maintain support via CHC. KP raised concerned about the use of reserves in H1 and felt H2 will be more challenging. KP was also concerned about underspending in mental health and the reputational and financial repercussions. KP would like to see a deep dive on ICS funding and how it supports transformation. SC stated that they are managing the run rate and spending. SC felt they can do more to manage the demand in mental health. Regarding the SDF and ICS transformation funding, they are having discussions about mobilising quickly and in the right way. Workforce is still a constraint. KP suggested utilising the voluntary sector. Regarding workforce, FS acknowledged that there are some areas of workforce that do not exist and highlighted that non-recurrent funding is not conducive to recruiting and retaining staff, as it produces uncertainty and insecurity. It also limits the providers' ability to plan and think creatively about their workforce and are unable to carry out any transformational work. FS emphasised the importance of understanding the issues with workforce. NC agreed and added that any long term plans need to address workforce. ST noted that we are not sighted on financial planning arrangements for 2022/23. This has been discussed at the TNW F&P, along with the consumption of H1 and H2 allocation, reserves in the system across the provider portfolio and the deployment of non-recurrent reserves and making them sustainable. We need to plan and prepare in Q4. ST noted pressures in TNW driven by 1.3% H1 growth at higher cost pressures than growth in CHC and prescribing, historic funding arrangements and gaps and inequalities that need to be addressed as part of a reset in the new financial year. SE asked what we are investing in primary care. SC will provide a list of investment into primary care and stated that the funding includes SDF, IT capital and enhancing access funding. **Action: SC to provide a breakdown of investment primary care.** The Committee noted the month 6 finance report.
5.	**H2 Update** SC presented the item and informed the Committee that a draft plan was submitted a few weeks ago, followed by a narrative update last week and the plan for additional funding for primary care will be submitted by 28 October. There has been work on the transformation investment

	funding. A final submission will be submitted around 16 November. As focus was around activity, the plan includes activity trajectories for elective care and maintaining non-elective and out of hospital targets. It also incorporates the targeted investment fund (TIF). SC clarified that the TIF in the paper is £150m but has now reduced to £109m. The headline number is just under £30m. Maintaining focus on core infrastructure and have included additional revenue funding to support A&G, equipment upgrades and digital input. Financial overview for H2 – there will be block arrangements for core providers, an efficiency target in NEL of 1.5% and £90m Covid fund in H2, which is £6m less than in H1. The HDP will continue and has changed from 6 weeks to 4 weeks for assessments and the funding will be £17m in H2, whereas it was £20m in H1. Working through bids for primary care. The elective recovery fund (ERF) criteria has shifted and is set at 89%. The Committee noted the H2 Update.
6. and 7.	**Phlebotomy and Advice and Guidance** ST has discussed phlebotomy with William Cunningham-Davis (TNW Director of Primary Care) who confirmed that the primary care team is working on this and awaiting a response. SE is concerned that it is taking a long time and would like to see a timetable for this. Commissioners should be asking what is good for patients. The decision needs to be clinically driven and needs passion and leadership. SE added that if we are going to do A&G, a key enabler is phlebotomy in every practice. In Tower Hamlets, they have successfully moved type 2 diabetes and CKD management into the community. SE emphasised that it is important to think strategically. SE would like to know the timescale for phlebotomy and when it will be offered to every practice. SE informed the Committee that we are at 28% on A&G, the national target is 12%. However, SE stated that we have the potential to achieve 60%. The next step would be A&G to all diagnostics in Trusts with metro diagnostic hubs in every practice. SE felt strongly that we need the same speed on this, as during the pandemic. There was a discussion about how to take this forward. AM stated that we have the structure and processes in place and that elective recovery sits in the Provider Alliance and Claire Hogg leads the elective programme. It was agreed that we would want the assurance on the approach. SE would like to see the programme come back to the Committee with timescales and financial implications. **Action: AM, NC, SC, SE to discuss how to progress with A&G and to include ST and AK.** The Committee noted the Phlebotomy and Advice & Guidance updates.
8.	**AOB** 1. SC informed the Committee that NEL has been offered £2m to support local discharge initiatives, as long as we match it, so it will be £4m. SC will share plans once developed. NELFT, ELFT and HUH will provide plans and the finance team will scrutinise. NC queried whether we know when we will be able to return to long term strategy, that will take place outside of H2. SC explained that they have started to look at sustainability and long term financial recovery and there is a lot of work to do on sustainability. 2. St George's outline business case (BHR) – SC stated that he is looking for endorsement by the Committee to proceed with the business case and that the business case will be taken to the NEL GB for approval, as part of the system. SC provided some context and added that it is system wide approach, as it includes primary care, low acuity services, NELFT and

	BHRUT. KA commented that out of hospital services need to be robustly in place and ensure the transformation and quality improvement benefits patients and improves productivity. The Committee endorsed the outline business case for St George's.
9.	**Date of next meeting –** 24 November 2021, 10-12, via Microsoft Teams

NHS
North East London
Clinical Commissioning Group

NEL CCG Finance and Performance Committee Meeting
Wednesday 24 November 2021 from 10:00 to 12:00,
Microsoft Teams

Minutes

In attendance

Name	Role	Committee Role	Organisation
Noah Curthoys (NC)	Lay Member for Performance	Chair	NEL CCG
Steve Collins (SC)	Acting Chief Finance Officer	Member	NEL CCG
Archna Mathur (AM)	Director of Performance & Assurance	Member	NEL CCG
Fiona Smith (FS)	Independent Clinical Representative – Registered Nurse	Member	NEL CCG
Kash Pandya (KP)	Audit Chair	Member	NEL CCG
Ken Aswani (KA)	Clinical Chair Waltham Forest	Member	NEL CCG
Sam Everington (SE)	Clinical Chair Tower Hamlets	Member	NEL CCG
Rob Adcock (RA)	Deputy Director of Finance, BHR	Attendee	NEL CCG (BHR)
William Cunningham-Davis (WC-D)	Director of Primary Care and Transition, TNW	Attendee	NEL CCG (TNW)
Meena Kaur (MK)	Business Manager	Attendee	NEL CCG
Muna Ahmed (MA)	Governance Lead	Attendee	NEL CCG

Apologies:

Name	Role	Committee Role	Organisation
Henry Black	Accountable Officer	Member	NEL CCG
Ahmet Koray	Director of Finance	Attendee	NEL CCG (BHR ICP)
Sunil Thakker	Director of Finance	Attendee	NEL CCG (C&H and TNW Area)

No.	
1.	Noah Curthoys (NC, Committee Chair and NEL CCG Lay Member for Performance) welcomed the group, noted apologies and confirmed that the meeting was quorate. FS informed the Committee that she will not be attending the next Committee in December. Steve Collins introduced Meena Kaur who is the new Business Manager in his team and will be observing the meeting.

2.	**Minutes and Action Log** The minutes of the meeting held on 27th October 2021 were agreed as an accurate record. <u>Action Log</u> NELFP-2 Performance Report - The Committee to consider how funding inequalities will be addressed at system and place level. Open NELFP-3 A&G - AM, NC, SC, SE to discuss how to progress with A&G and to include ST and AK – on agenda. Close
3.	**H2 Update** Archna Mathur and Steve Collins presented the item, jointly. AM stated that the H2 planning submission was submitted on 18th November. No feedback has been received as yet. <u>Activity and Performance</u> AM provided a summary of the trajectories and activity in the H2 plan: - Clock stops – the number of pathways stopped, compared to the same time in 2019/20. - Elective activity – the requirement is to achieve above the 2019/20 level and above 89%. NEL is achieving this with BHRUT at 94% and Barts is at 83% and will achieve 92% by March. Homerton University Hospital (HUH) is lower but this is due to a baseline issue which has been corrected. - The overall business as usual on elective is 76.6%. Barts is at 70%. - Retaining the size of the PTL to the level in September 2021, or lower. NEL is not compliant and is 205 pathways away from the baseline. This is due to Barts. The impact of winter and non-elective activity may reduce elective capacity and then lead to an increase in PTL. - The PTL in NEL is currently at 182,211. - Elective long waiters – the requirement for 52week waits is to keep it the same as it is now, or lower and to eliminate 104ww by end of March 2022. A compliant trajectory has been submitted for both. However, the trajectory is challenging. Barts is a concern and is being monitored closely. - Cancer – the requirement is to manage the backlog by reducing the number of people waiting over 63 days and achieve the same level as in February 2020. Barts and BHRUT are forecasting above the target. - Diagnostics – requirement is to achieve 2019/20 levels. There is variation between the submissions by the Trusts and areas of concern are ultrasound and flexi sigmoidoscopy. More work is required with HUH. HUH does not have enough activity for endoscopy and currently reviewing options for mutual aid. The MRI and CT backlogs in Barts are also a concern. - Outpatients – patient initiated follow-up (PIFU) trajectories for increasing the volume of patients discharged or moved to PIFU to 1.5% of first outpatients by December and 2% by March are non-compliant for BHRUT and HUH. Barts submitted compliance, however, there is a lot of work for them to do and is a risk. - Outpatients – the advice and guidance (A&G) target is 12 out of every 100 first outpatient appointment to be delivered by A&G. NEL is already meeting this target and has submitted a compliant trajectory. EROC is a national data submission and is how the data is captured and the trajectory has been developed. Significantly above 12%. Barts is at nearly 29%. - Non-elective – monthly activity figures have been submitted and covers A&E attendances, non-elective spells and non-elective admissions. For non-elective admissions, Barts is forecasting less than 2019/20 levels and could be due to a number initiatives implemented during winter. We have asked Barts to review their figures. - Workforce – a lot of work has been carried out on this as it is a significant risk to trajectories being delivered. - Out of hospital – activity numbers have been submitted for inpatients with learning disabilities (LD) and autism, LD health checks, GP appointments and 111 referrals. The significant risk is in LD health checks and relates to the ability of primary care delivering this. - Availability of GP appointments – the total for October 2021 to March 2022 exceeds the H1 submission and will continue to be tracked.

	KA commented that overall, it looks like a challenge and would like to understand how realistic the trajectories and targets are. AM stated that these are forecast projections. There is a concern, mainly with Barts. The Barts PTL is stable. NEL is an outlier for long waits. There was a discussion about the sign off of the plan and the process for managing the planning round by setting principles and checklists for inter Trust sign off. Areas of concern are 104ww and diagnostics. SE felt there is not enough data on primary care. AM noted there is a request on GP appointments. It was noted that the submission and targets are requested by NHS England. Primary care performance data can be presented at this Committee. There was a discussion about the HUH submission, as there is a variation between HUH and the other Trusts. It was noted that HUH has submitted a realistic position and that they are not as large as the other Trusts, in terms of numbers. More work is required around diagnostics. <u>Finance</u> SC stated that a balanced financial plan has been submitted and highlighted that there is risk within the system which is due to uncertainty around the elective recovery fund (ERF) and the targeted investment fund (TIF). The plan included continuation of the deficit funding and slightly reduced Covid funding. The level of financial support is unprecedented outside of the Covid period and points to potentially significant cost pressures as financial support starts to normalise from 2022/23. The plan also includes the continuation of investments within the CCG and mostly relates to out of hospital initiatives. Continuing to work through the hospital discharge programme (HDP). NEL has been successful in securing additional funding. SC noted emerging financial pressures in local authorities. Work on 2022/23 needs to be undertaken in advance of the planning round starting in January, to look at how the system manages the anticipated tighter financial regime. The Committee noted the update on the H2 planning submission.
4.	**Performance Report** Archna Mathur (Director of Performance and Assurance, NEL CCG) presented the performance report. AM presented an update on mental health, as the other performance data was covered in the H2 update. AM highlighted IAPT waiting times between the first and second appointment, dementia and SMI physical health checks which are all underperforming. AM noted that we are in recovery. All boroughs are not meeting the SMI physical health checks target. Tower Hamlets and Newham are the only boroughs delivering the dementia target. Work is ongoing with NELFT which provides services for the boroughs not meeting the target. The issues are related to workforce and services have been impacted by the pandemic and compounded by winter. The Committee noted the Performance Report. [AM left the meeting]

5.	**Month 7 Finance Report** Steve Collins (Chief Finance Officer (Acting) NEL CCG) presented the Month 7 Finance Report. SC reported that NEL CCG has achieved a break-even position on the core budgets. However, delivery of the break-even position has been reliant on the use of non-recurrent mitigations and contingency funds (Covid related) to offset identified budgetary pressures. The CCG is expecting to receive funding of £9.5m relating to HDP/Covid and ERF expenditure (for month 7, with £22.3m forecast) in line with the NHSE retrospective allocation process. As with previous reporting periods, this is shown as an overspend against the CCG position. There are continuing pressures in activity driven areas, such as acute, primary care and prescribing, that have been managed with the use of non-recurrent measures. SC also highlighted pressure in CHC which remains a concern. A breakdown by system for H1 and H2 is provided in the papers and shows that we are a £3.9b system. SC commended the Finance Team for their hard work. The Committee noted the month 7 finance report.
6.	**Advice and Guidance** William Cunningham-Davis (TNW Director of Primary Care and Transition) presented the item. WC-D noted that in addition to A&G, they are also reviewing the referral pathway. Therefore, it is now called A&G and Referral. The scheme for Barts means services will use A&G and referral. They have reviewed the 13 specialties and bringing it into the whole system, for City & Hackney and BHR. An audit was carried out in Tower Hamlets to identify the capacity required in primary care based on the work that was returned from acute Trusts. The financials and timescales were produced and included administration. The audit enabled an understanding of the uptake until the end of March 2022. SE added that this will mean that there is only one route from primary care to a specialist. SE stated that we also need to look at A&G and R for diagnostics which accounts for 50% of referrals. SE queried what other enablers are required to make this happen and to set an end date of the end of July. SE noted that it will need a cultural change. NC added that BHRUT will also need to implement it. NC raised whether this work needs a strategic objective. It was noted that a culture change is difficult during a governance change. FS queried how we are preparing primary care to implement this safely, i.e. capacity, workforce, technology, processes and keep patients at the centre. WC-D noted that primary care is already doing some of this work. We will need to work with the LMC and PCNs and set up how we will carry out quality data reviews with the acutes and practices. SE suggested a dashboard to show variability between practices. SC stated that we need to be clear on what success looks like for primary care, acute Trusts and improvements in patient experience. KA felt that making A&G and R a strategic objective is meaningful. KP supports the proposal and stated that we need to engage patients. The Committee endorsed the Advice & Guidance and Referrals scheme. SC and WC-D to take

	forward the work on the strategic objective to the Board.
7.	**Phlebotomy** WC-D stated that the NEL equalisation process includes Phlebotomy and Barts is also conducting work on Phlebotomy. Working on bringing together and options for patients. A business case will come to the Committee in the future. SE added that we have a model in Tower Hamlets and Hackney. SE felt Phlebotomy should be a core service in practices and that blood tests are vital for screening. The next step will be a business case to this Committee. **Action: MA to add a deep dive on diagnostics to the agenda for the December meeting.** The Committee noted the Phlebotomy update.
8.	**Forward Planner** The forward planner will be reviewed outside of the meeting.
9.	**AOB** None raised.
10.	**Date of next meeting –** 22 December 2021 at 10:00-12:00, via Microsoft Teams

North East London
Clinical Commissioning Group

NEL CCG Governing Body

26 January 2022

Title of report	Quality, Safety and Improvement Committee (QS&I) Chair's report
Item number	7.2
Author	Muna Ahmed, Governance Manager, NEL CCG
Presented by	Fiona Smith, Chair of QS&I Committee, and Independent Clinical Member – Registered Nurse
Contact for further information	Muna Ahmed, Governance Manager, NEL CCG, Muna.Ahmed2@nhs.net
Executive summary	The last NEL CCG Quality, Safety and Improvement Committee was held on 10th November 2021. The committee was chaired by Fiona Smith, Independent Board Nurse. The Governing Body are advised that the main items discussed and reviewed were as follows: • The Committee approved the proposal for detailed updates on the NEL ICS/ICB Quality Governance Framework to be provided to this Committee. • The Committee approved the proposal to bring regular updates on quality functions across NEL to the Committee, as the develop. • The Committee noted a deep dive on Quality in Primary Care presented by Ceri Jacob. • The Committee approved the IFR policy. • The Committee approved the 3 variations to the EBI programme. • The Committee noted the amendments to the terms of reference. • The Committee approved the NEL Safeguarding reports which had been approved at the ICP Quality sub-Committees. • The Committee noted the Quality Report. • The Quality and Safety risk register will be reviewed outside of the meeting. The minutes of the meeting are attached as an appendix to this report.

Action required	The Governing Body is asked to note the update.
Where else has this paper been discussed?	NEL Quality, Safety and Improvement Committee.
Next steps/ onward reporting	A regular report on key messages from the QS&I Committee will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The Committee: • provides assurance of internal governance and quality standards where the CCG has responsibility for regulatory standards and statutory requirements • Has an oversight of quality across the NEL system and works to the benefit of NEL patients • Will oversee areas of assurance relating to patient experience.
Conflicts of interest	There are no conflicts of interest in regard to this report.
Strategic fit	The Committee is responsible for system assurance regarding quality and safety and patient experience and has a collective view of risks to quality through sharing relevant information, data and intelligence to understand emerging concerns and risks across providers and the system. It identifies themes and trends across the system and utilises its reports and data to scrutinise and assure the system that quality objectives are met and issues reviewed accordingly.
Impact on finance, performance and quality	The Committee will manage the key areas of risk to quality and safety as outlined in the QS&I TOR.
Risks	The Committee will review and monitor system wide quality issues in accordance with and advise on risks and mitigations.The committee is responsible for Quality and safety risks on the Board Assurance Framework and agree any action for improvement.
Equality impact	N/A

NHS
North East London
Clinical Commissioning Group

NEL Quality, Safety and Improvement Committee
Wednesday 10 November 2021, 12:00-14:00, via MS Teams

Minutes

Present	
Members:	
Fiona Smith	Independent Registered Nurse – Chair of the Quality, Safety and Improvement Committee, NEL CCG
Khalil Ali (KA)	Lay Member – Patient and Public Involvement, NEL CCG
Mark Gilbey-Cross	Deputy Nurse Director, BHR ICP, NEL CCG
Charlotte Harrison (CH)	Independent Clinical Member - Secondary Care Clinician, NEL CCG
Archna Mathur (AM)	Director of Performance and Assurance, NEL CCG
Ceri Jacobs	Managing Director, BHR ICP
Jenny Singleton (JS)	Head of Quality, C&H ICP
Chetan Vyas (CV)	Director of Quality and Safety, TNW ICP, NEL CCG
Justin Roper (JR)	Deputy Director (Acting) of Quality and Safety
Jagan John (JJ)	Chair, NEL CCG
Alison Goodlad (AG)	Deputy Director of Primary Care, NEL CCG
Mark Ricketts (MR)	GP Clinical Borough Chair, C&H ICP, NEL CCG
Attendees:	
Alison de Metz	Head of IFR & HPSU, NELCSU
Hilary Shanahan	Head of Quality and Clinical Governance, BHR ICP
Sue Evans	Lay Member Primary Care Commissioning Committee, NEL CCG

Funmi Hedman	Assistant Director of Acute Contract Management, NEL CCG
Alison Glynn (AG)	Head of Contracts, NEL CSU
Natalee Lewis-McLeod	NEL CCG
Jack Squire (JS)	Designated Nurse for Children Looked After in Waltham Forest, NEL CCG
Muna Ahmed (MA)	NEL Governance Manager, NEL CCG
Apologies:	
Diane Jones (DJ)	Chief Nurse, NEL CCG
Sandra Moore (SM)	Deputy Director of Continuing Healthcare (Interim), NEL CCG
Fiona Erne (FE)	NEL CCG
Mary O'Reardon (MoR)	Designated Safeguarding Adults Manager, C&H ICP, NEL CCG
Cindy Fischer	Commissioning Programme Manager, C&H ICP
Dawn Newman-Cooper (DNC)	Assistant Director of NEL LMS Maternity Programmes
Amy Wilkinson	LB Hackney/NEL CCG
Sam Spillane	Designated professional for Safeguarding, NEL CCG

No.	Agenda item
1.	The Chair welcomed members to the meeting and introductions were made. Sue Evans joined the meeting and introduced herself. The meeting was quorate. No further conflicts of interest were declared.
2.	**Minutes of the meeting on 8 September 2021** The committee approved the minutes from the 8th September 2021 meeting, as an accurate record. AM felt that there were no follow up actions on the Continuing Healthcare (CHC) item within the minutes recorded in the minutes although some next steps had been discussed. FS suggested we pick this up in the CHC section of the Quality Report.

	Action log QS2021#7 Quality Report – Complaints - CV stated that complaints will be included within the Quality Report, as a standing item and that a deep dive on complaints is on the forward planner for January. Close QS2021#11 Medicines optimisation – Jason Clarke sent a paper for comments. Some members reported that they had not received the paper. It was agreed that the paper will be re-circulated to members. Action will remain open.
3.	**National Update** CV presented an update on national guidance, highlighting references to quality and an update on the development work on the North East London (NEL) Integrated Care System (ICS). The update provides a level of assurance on how the guide is being utilised. The proposal is to bring a paper to the Committee, with a level of detail on proposed implementation. Regarding learning disabilities (LD) and autism, KA queried where the existing LD Partnership Boards will report to and how the quality, safety and improvement system will interact and work with these Boards. CV stated that we are nearing completion on a staff consultation on quality and safety functions across NEL. The proposal is to bring the learning from deaths of people with a learning disability (LeDeR) team into the structure to embed in NEL. KA would like to see the link with primary care strengthened, and this was supported by the committee. FS queried where due diligence on the transition of quality functions and risks into the ICP is being reviewed. CV explained that it is an officer led exercise and will feed into the wider transition programme. There is also a range of workstreams relating to core business that need to be closed down for NEL CCG and transition into an ICS. There is lay member representation on the overarching ICS Transition Group. CV reported that a lot of the quality work on the due diligence checklist has not happened due to the close down on complaints, serious incidents (SIs) and Individual Funding Request (IFRs) which will take place early next year. The due diligence checklist and assurance on the quality aspects of the close down programme will come to this Committee. SE is on the ICS Transition Group and is assured that there is a framework in place and there is a quality workstream. They will capture legacy issues in quality and other areas. FS would also like this Committee to have oversight of the legacy issues that are proposed for transitioning to the ICP. SE agreed that this Committee needs to have oversight. FS proposed that we will need due diligence oversight for quality in quarter 4 added to the forward planner. FS queried whether the ICS Clinician Professional Leadership guidance includes clinicians other than GPs and the borough chairs, such as nurses and allied health professions (AHPs). CV confirmed they are. JJ added that they are looking at a

	multi-disciplinary clinical leadership and will have issues around the legacy leadership, i.e. the knowledge base. A leadership group is looking at Trusts and CCG and the implementation of a new clinical leadership structure is in progress. **Action: MG-C to add due diligence oversight for quality, to the forward planner, for Q4.** The Committee approved the proposal for detailed updates on the NEL ICS/ICB Quality Governance Framework to be provided to this Committee. **Post meeting update – it was agreed outside of the meeting that the oversight of due diligence checklist, close down and legacy issues will be included within the National Update provided by CV.**
4.	**Quality Function** CV presented the item and stated that it links to the previous item. The paper is in draft form and describes the likely ICS responsibilities and who the lead officer may be. The functions will be shared between the ICS Chief Nurse and ICS Medical Director. The paper also provides a local NEL update, regarding what is planned, proposed and is related to the specific function. CV also advised that there is a workplan around the role of the service, governance, raising the profile of the Freedom to Speak Up role, function and training. Since the paper, an updated quality functions table has been published which provides further details on the role of the provider, the role of the ICS, role of the ICB and provides greater clarity which enables us to put in place frameworks, processes and mechanisms. CV added that it also provides more details on the patient safety functions and JS will be bringing a paper on patient safety to the January meeting. Guidance on system quality groups has also been published and is being reviewed for how it will be implemented. CV commented that although there is a lot of work, there will be a framework in place and a one-year plan. KA highlighted that we will need to align quality with local authorities and the system. CV stated that the distinction is the way of working across the ICS, and the ICB which is where the statutory functions and assurance needs to continue. FS queried whether there is an intention to work in shadow form. CV stated that there is, however we have only just received guidance on quality and still negotiating with health partners. There was a discussion about whether there will be a draft framework in January and a final proposal in March. CV noted that the system meetings have been increased from monthly to fortnightly and have created smaller working groups to accelerate progress. The Committee approved the proposal to bring regular updates on quality functions across NEL, to this Committee.

5.	**Deep Dive - Primary Care** Ceri Jacob presented the slides in the papers and highlighted: - Strategy – a primary care strategy was agreed in May 2019 and the delivery plan is reviewed every year. The 2 main themes are the delivery of core high quality general practice and delivery of integrated care. The 3 main programmes driving primary care ambitions are quality, new model and workforce. - Quality – after the first wave of Covid, a full primary care recovery plan was put in place. For quality, 13 priorities were identified and included multi-disciplinary team (MDT) working in every practice and Primary Care Networks (PCNs), management of people with complex needs and workforce. - Governance – there is a Primary Care Steering Group attended by all the GP borough chairs and a Primary Care Commissioning Committee (PCCC) which is a sub-committee of the NEL Governing Body which meets in common. From April, NEL will be directly responsible for contracting primary medical services and there will not be a formal need for a primary care sub-committee of the Board. - A primary care dashboard is under development and will measure local incentive schemes (LISs), local enhanced services (LESs) and identify variation. This will enable the development of a business intelligence (BI) tool that is useable by PCNs. The data can be broken down by CCG, PCN and practice level. CJ highlighted that there are data issues in capturing access data. - New models of care – the aims are accessible planned/unplanned care, continuity of care and proactive in managing inequality. Digital, workforce and estates are key enablers to this workstream. - Equalisation – the aim is financial equality across the boroughs. Bring up the level of investments and standardise the LISs to improve care in PC. - CQC ratings – the aspiration is to have 95% of practices in NEL with 'Good/Outstanding' ratings. We are currently at 94%. Close working between the NEL Contracting Team and local primary care teams. - GP satisfaction/survey – key finding was that a third of people did not do anything when they did not get an appointment. Actions taken to improve patient experience and access includes utilising the enhanced winter fund for system work to improve urgent same day access to primary care; increase capacity and appointments; improve data; support for extra costs during winter and identify the 20% of practices with lowest access. Also completed work on websites. - Access and appointments - face 2 face appoints is at 58%. Focus will be on addressing high volume of telephone calls. - GP referral rates reduced at the start of the pandemic and for 2020/21 it is at 76% of 2019/20 levels. - Patient to GP ratios have an impact on the quality of care. Waltham Forest, Redbridge, Barking & Dagenham and Havering have the least favourable ratios. City & Hackney has a good ratio. KA felt that with the support given by the CCG, he would like to see more practices aiming for an 'outstanding' CQC rating. KA commented that we need to consider clinical governance around minor surgery. KA also mentioned the pressure on district and community nurses supporting primary care.

	CJ addressed the points raised by KA. The focus is moving practices out of 'inadequate' and 'requires improvement' CQC ratings. PCNs and federations could consider other routes for minor surgery. There is an opportunity for district nurses and practice nurses to work together and learn from each other. FS queried where the Board level oversight is for quality in primary care and what is the primary care quality governance framework. CJ stated that the PCCC mainly covers contracting. The Steering Group will have the oversight and will drive the dashboard and includes the 7 borough chairs who are also Board members. Also, quality is managed at a local level and the local directors of primary care have a good understanding and are members of the Steering Group. CJ also suggested that the quality of pathways also needs to be considered. FS questioned where the steering group feeds in to and whether there was sufficient primary care quality oversight at Board level. She advised that primary care quality oversight has been suggested for this Committee and this Committee will report back to the Board. SE supports the approach and stated that going forward, it may be challenging for the voice of primary care to be heard and to include it. KA commented that we will need a better understanding on the metrics for quality in primary care. KA felt too much focus was on access and would like more focus on other areas of primary care quality. CJ suggested bringing more detail on the dashboard which will address all the areas of primary care. MG-C relayed that he and DJ have discussed wider nursing leadership support in primary care which will be developed further as we move towards becoming an ICS. **Action: Responsibility for primary care quality assurance to be strengthened in the TOR of this committee** **Action: CJ and CV to work on what the quality primary care report will provide to this Committee.** The Committee thanked CJ for the very helpful deep dive on Quality in Primary Care.
6.	**Local Maternity System update** Deferred to the next meeting as a Deep Dive.
7.	**Individual Funding Requests (IFR) Sign off** Alison de Metz presented the item. The IFR policy was updated to reflect current organisations and governance arrangements and align the IFR policy and process, following improvements made in previous years. The paper came to the Committee on 8th September and one comment was received but no amendment to the policy was required. The policy has been updated slightly, since the last meeting.

	The Committee approved the IFR policy.
8.	**Evidence based interventions programme** FH presented the item and stated that she is seeking approval for the variation to 3 of the national recommendations, out of the 31 interventions recommended. AG added that the work was carried out with a clinical review group with clinicians and support from specialists. The clinicians were asked to review the quality and equality impacts for the 31 interventions. The 3 areas of variation from national guidance are: 1. **Knee MRI should not be routinely used to initially investigate suspected meniscal tears in primary care.** The NEL variation from this guidance is because an intermediate service cannot yet provide this service, a project meeting has been scheduled to address this and it is planned that this change will be implemented in the future. Therefore, GPs will continue to make this diagnosis and intermediate care services should educate GPs as part of the pathway. This will mean a continuation of the current referral pathway and no change at this point. As such there is no Equality or Quality impact, future plans to implement this are covered in the national impact assessment. 2. **Imaging for shoulder pain should be offered under the guidance of shoulder specialists where possible.** Ultrasound is a good imaging modality for rotator cuff pathology especially in primary care, however primary care currently sees a lot of shoulder pathology and have been able to manage mostly without imaging and the level of imaging has not been an identified issue in NEL. Therefore, there are no plans to change the current pathway. There will be continued monitoring to ensure that there is the appropriate use of Ultrasounds and any outliers to this are identified. The monitoring of this is being built into the monitoring system for the implementation of the EBI requirements. 3. **Adenoids in children with Glue Ear.** The variation is in relation to adenoids in children with Glue ear, the Clinical Review Group decided not to adopt the recommendation while it seeks more information from the national programme. Local ENT consultants did not agree with the guideline and felt the evidence presented by AOMRC was out of date. This has been escalated for national review. Therefore, there will be no change in services at this point in this area until best practice is agreed. AM queried whether the variations can be applied retrospectively to reduce the waiting list for diagnostics. AG stated that the clinicians are applying the guidance already. AM and AG to work on waiting list. JR stated that the panel undertaking the equality and quality impact assessment process is in the process of being set up and finalised. JR added that they are looking to have a patient representative on the panel The committee felt assured the interventions have been through a review clinical process.

	The committee discussed whether there should be a retrospective application of the changes. **Action: AM and AG to review the waiting list for diagnostics, in light of the variations to Knee MRIs and imaging for shoulder pain and apply as appropriately retrospectively.** The Committee approved the variations to the EBI programme.
9.	**Terms of reference** CV presented the item and informed the Committee that amendments have been made, as per feedback from the previous Committee. KA stated that the ToR should include reducing health inequalities. CV acknowledged the previous discussion that primary care aspect also needs to be strengthened. It was agreed that further amendments will be made to the ToR and that the ToR will be sent to Committee members for approval, outside of the meeting. **Action: MG-C and CV to finalise the terms of reference and send to Committee members for approval.** The Committee noted the amendments to the terms of reference.
10.	**Safeguarding Annual reports** FS congratulated the safeguarding teams for the work they have carried out, during a difficult year. <u>BHR</u> MG-C presented the BHR annual safeguarding reports for adults, children, children looked after and the child deaths overview process. The reports outline the work carried out, the pandemic and priorities for the coming year. The reports have been approved at the BHR Quality and Performance Oversight Group. <u>C&H</u> JS presented the C&H reports. JS highlighted the impact of the pandemic and that a cyber-attack in Hackney resulted in the switch off of the child protection information sharing system and a lack of historical data for adult safeguarding. JS also highlighted the focus on the neighbourhood programme to link primary care and schools. A focus on children with complex and chronic health needs and support for adults with complex needs and behaviours. There is a C&H integrated childhood adversity programme and the adult information sharing programme which provides a whole system approach. JS flagged an increase of suicides in Hackney and the setting up of the Public Health Suicide Prevention Group. There has been work to capture the voice of the child and young people. Next year, the focus will be on how children and adults safeguarding is considered, as we move to an ICP including: developing and facilitating training programmes for PCNs; continuing to work collaboratively with all safeguarding leads across NEL; supporting the safeguarding partnerships and

	Boards to manage and understand the impact of Covid, particularly to our workforce; and managing the implementation of the Liberty Protection Safeguards. <u>TNW</u> CV advised that this is the second combined TNW children and adults report. CV highlighted the work carried out on bringing the voice of the children and adults to the fore and is apparent within the report. CV thanked Jessica Juon and team for their hard work and the reports. The reports have been approved at the TNW QSI sub-Committee. KA raised concern about the same issues arising, whenever there is an incident and queried whether we can implement preventative mechanisms to avoid these outcomes. JR advised that there are monthly NEL designate meetings where themes and trends are identified and there is more collaborative working. MGC stated that there is a quality and safety risk register and that more focus is needed on preventative measures. FS flagged that in the C&H report, CAMHS input is rated as a red risk. FS queried whether there are common themes across all 3 ICPs and what we are doing about the common themes on a population basis. CV stated that next year, it will be a NEL report. CV added that he has also raised concern about the same issues re-occurring, at the children and adults safeguarding Boards. Learning still needs to be implemented in ICPs and NEL level. JR added that there has been shift in quality of care for LD, in the LeDeR report and that there is learning for the wider population groups. FS felt it would be helpful for the Committee to have the safeguarding common themes at NEL level and what is being done on an outcome basis, for the next safeguarding report. **Action: The next safeguarding report to include the common themes around safeguarding at NEL level and what is being done on an outcome basis.** The Committee approved the NEL Safeguarding reports.
11.	**Quality Report** MG-C presented the BHR report and highlighted that assurance has been provided on BHRUT maternity concerns. There have been discussions with CQC inspectors, the regional Chief Midwife for London and BHRUT has been invited to the maternity services improvement programme and is also linked into the local maternity system. A lot of support and oversight going into BHRUT. For NEL, JR noted the vaccine mandate in care homes and NHS staff going into care homes. For C&H, JS reported a positive patient survey for Homerton University Hospital (HUH). However, in the IPC report, HUH is an outlier for MRSA. There is concern around the increase of complaints and implementing lessons learned. JS also

	noted concern about 111/LAS and the handover times for ambulances, as NEL is an outlier. Schemes are in place to address the handover delays. AM clarified that the ambulance handovers issues are for 60 mins and 120 mins and is related to flow, demand and capacity. There are daily calls and is a challenge. <u>CHC</u> AM is concerned that there is no information on the risks in winter for CHC and where they sit within the boroughs. AM chairs escalation calls across the emergency care system and provided the example of where there is no flow especially at Whipps Cross, it is unknown whether this is because of issues in CHC. AM suggested a winter plan for CHC. AM added that on the risk register, the CHC risk does not address what is happening operationally. AM felt the Committee is also unaware of where we are with trajectories for the core CHC metrics. AM suggested a deep dive would be helpful. There was a discussion about who is the lead for CHC. It was agreed that CV will discuss with DJ and identify the best way to address the issues raised and share a strategy and plan to address AM's concerns and how the information is presented. AM noted that serious incidents are not raised in the report. It was noted that there will be a deep dive on SIs at the January meeting. **Action: MA to ensure report authors are invited to present their sections of the quality report.** **Action: CV to discuss the CHC report with DJ and bring back an update to the next meeting. In the meantime, CV will also get back to AM with an update on CHC winter plan, issues and risks in CHC and progress against CHC trajectories.** The Committee noted the Quality Report.
12.	**NEL CCG quality and safety risk register** Due to time contraints, it was agreed that FS and KA will review the risk register and feedback to MG-C. **Action: FS and KA to review the Quality and Safety Risk Register and feedback to MG-C.**
13.	**Forward Planner** Noted and will be reviewed in light of today's discussions.
14.	**AOB** None raised.
Date of the next meeting: Wednesday 12 January 2021, 11:30- 13:30, MS Teams	

North East London
Clinical Commissioning Group

NEL CCG Governing Body
26 January 2022

Title of report	BHR Integrated Care Partnership Board (incorporating BHR CCG Area Committee) - update
Item number	7.2
Author	Anna McDonald, Business Manager, BHR ICP
Presented by	Kash Pandya, BHR ICP Area Committee Chair
Contact for further information	anna.mcdonald@nhs.net
Executive summary	The key messages from the BHR Integrated Care Partnership Board meeting held on 25 November 2021 are: • Current risks to the BHR ICP and the key risks to the NEL CCG Governing Body were discussed and noted • Next steps in the development of an engagement structure to support the local partnership were approved • A proposal for ongoing collaboration in BHR was approved and members noted the further work to be undertaken to define how the areas of multi-borough collaboration will be overseen • Progress of the BHR Transformation Boards in relation to the delivery of transformation schemes in 21/22 and the achievements made to date in terms of reducing activity in secondary care through the provision of alternative services through transformation were noted • An update on the BHR community phlebotomy pilot was noted • Progress made in regard to BHR ICP priority actions was noted • An update on the winter plan was noted • Latest finance position was discussed and key messages noted • Items that have received BHR Area Committee approval were noted.
Action required	The Governing Body is asked to note the update and the minutes of the meeting held on 25 November 2021.
Where else has this paper been discussed?	N/A

Next steps/ onward reporting	A regular report on key messages from the BHR ICPB will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The ICPB will seek to act in the best interest of residents in the BHR health and care system as a whole, rather than representing the individual interests of any of its members.
Conflicts of interest	There are no conflicts of interest in regard to this report.
Strategic fit	The ICPB provides strategic leadership for, and delivery of, the overarching strategy and outcomes framework for the BHR ICP.
Impact on finance, performance and quality	The ICPB will: • ensure the delivery of high-quality outcomes, putting patient safety and quality first • have lead responsibility for population modelling and analysis within the ICP area, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality • Approve proposed health needs prioritisation policies ensuring that this enables the CCG to meet its statutory duties in relation to outcomes, equality and inequalities • Receive recommendations from the ICP Finance and Performance Sub-Committee and make decisions on matters referred to it by that sub-Committee.
Risks	The ICPB has developed a risk register that covers the most critical risks to the BHR ICP and will form part of the overall NEL CCG risk management process.
Equality impact	N/A

BHR Integrated Care Partnership
Better care, better lives, together for all

Draft minutes – BHR Integrated Care Partnership Board

25 November 2021

1.00pm – 3.00pm

Via MS Teams

Members:

Cllr Maureen Worby (MW)	ICPB Chair (LBBD)
Kash Pandya (KP)	Lay Member, Governance & Area Committee Chair, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Jacqui Smith (JS)	Joint Chair, BHRUT & Barts Health
Matthew Trainer (MT)	Chief Executive, BHRUT
Joe Fielder (JFi)	Chair, NELFT
Jacqui Van Rossum (JVR)	Executive Integrated Care Director (London), NELFT (representing Oliver Shanley)
Andrew Blake-Herbert (ABH)	Chief Executive, LBH
Adrian Loades (ALo)	Corporate Director of People, LB Redbridge
Cllr Mark Santos (MS)	LB Redbridge
Dr Jagan John (JJ)	NEL CCG Chair and B&D Clinical Chair
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Dr Anil Mehta (AMe)	Redbridge Clinical Chair
Dr Narendra Teotia (NT)	PCN Clinical Director, B&D
Dr Shabnam Ali (SA)	PCN Clinical Director, Redbridge (Representing Dr Pazhanisami)

Attendees:

Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Kirsty Boettcher (KB)	Deputy Director, Transformation, BHR ICP
Anna McDonald (AMcD)	Business Manager, BHR ICP
Anne-Marie Keliris (AMK)	Head of Governance, NEL CCG
Caron Bluestone (CB)	Associate Lay Member, BHR ICP
Jayam Dalal (JD)	Associate Lay Member, BHR ICP
Emily Plane (EP)	Programme Lead, BHR ICP
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Dr Rami Hara (RH)	Deputy B&D Clinical Chair
Dr Caroline Allum (CA)	Executive Medical Director, NELFT
Melissa Hoskins (MH)	Head of Communications and Engagement, BHR
Ross Arnold (RA)	CEO Redbridge GP Federation
Hanh Xuan-Tang	Deputy Director of Recovery Planning, BHR ICP
Jeremy Kidd (JK)	Deputy Director of Transformation - Planned Care, BHR
Mark Dumbrill (MD)	Redbridge CAMHS, NELFT
Dr Jwala Gupta (JG)	Havering PCN, Clinical Director
Dr Narinderjit Kullar (NK)	Havering PCN, Clinical Director

Apologies:

Oliver Shanley (OS)	Chief Executive, NELFT
Cllr Jason Frost (JFr)	LB, Havering
Ahmet Koray (AK)	Director of Finance, BHR ICP (rep SC)
Dr Sangeetha Pazhanisami (SP)	PCN Clinical Director, Redbridge
Henry Black (HB)	Acting Accountable Officer, NEL CCG
Dr Gurmeet Singh (GS)	PCN Clinical Director, Havering
Chris Naylor (CN)	CEO, LBBD
Magda Smith (MSm)	Chief Medical Officer, BHRUT

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies received were noted.	
1.1	**Declarations of conflicts of interest**	
	The chair reminded everyone of their obligation to declare any interest they may have on any issues arising at the meeting. No additional conflicts of interest were declared. The register of interests was noted.	
1.2	**Minutes of the last meeting**	
	The notes of the meeting held on 30 September 2021 were agreed as an accurate record.	
1.3	**Actions/matters arising**	
	ICPB members noted the action taken since the last meeting.	
2.0	**Managing director's report**	
	CJ presented the update report which covered the following areas: • BHR Process to articulate our local vision for collaboration at a multiborough level • Anchor Organisations – procurement workshop • Contracting discussion • Organisational Development • St George's health and well-being hub outline business case • Enhancing population awareness project for cancer • New conflicts of interest management system In addition, CJ recapped on the recent appointment of Zina Everidge to the position of Chief Executive Officer Designate for the NEL ICS and BHR ICPB members welcomed the appointment. The Chair commented on the positive news regarding the St George's health and wellbeing hub and added that she will be keen to hear more about how it links in with tri-borough plans going forward. The Chair also commented on the update in regard to 'Community Links' noting that the group is	

	Newham based and stressed the need to ensure they are provided with the most appropriate contacts across BHR including GPs to ensure they liaise with the sectors already in place in BHR. CJ to follow-up with SR and TR on this outside of the meeting. Members of the ICPB: • Noted the update.	CJ/SR/ TR
3.0	**BHR Integrated Care Partnership Risk Management**	
	SR presented the risk update and advised that the current key NEL CCG level risks relate to: • Underperformance against H1 metrics, specifically elective recovery • Continuing Healthcare • Use of resources and financial balance. A further risk is being developed in relation to health inequalities. The risk relating to vaccine delivery has been added and specifically relates to workforce challenges. The degree of change regarding the nature of the risk will continue to be a feature given the fast-changing pace of the programme and guidance. The current key risks within BHR ICP relate to: • Meeting the needs of children with learning difficulties and mental health needs, and access to services and discharge from inpatient beds • Appropriate digital infrastructure • Financial balance across the BHR system, including the Local Authorities position • Workforce, including adult social care provider workforce • Risk of the impact of future waves of COVID-19 • Backlog of elective activity KP emphasised that the risk relating to financial balance and resources/workforce is significant across the NEL system. The Chair agreed and asked for the narrative in regard to this to be more explicit so that it fully reflects the financial pressures and workforce pressures in Local Authorities as well as health. JFi asked what the contingency plans are in regard to the impact of the decision to make the Covid-19 vaccination mandatory for staff. AL responded from a Local Authority perspective and advised they are working very closely with social care providers and the concern is mainly the impact on the 'home care' sector from 1 April 2022. MT updated ICPB members in regard to BHRUT staff and confirmed that currently 84% of staff have been double vaccinated and work is continuing to provide as much information as possible to staff in order to increase the up-take. Workforce is also a significant issue at BHRUT and discussions with Barts Health and PELC are being held. ICPB members supported the view that it is the responsibility of each organisation to progress the vaccine agenda. CJ advised that £6.3m of funding has been received in NEL to support hospital discharge and is being shared with Local Authorities and Providers.	SR

	Some of the money is being used for roles such as therapists and social workers and members were briefed on work being undertaken by the BHR Academy looking at medium to longer terms solutions. Further possible solutions that can be undertaken collectively in the short term are also being considered. Other areas that have an impact on workforce such as the differences in pay rates across the NEL boroughs were discussed. Concerns were expressed about funding discrepancies between the inner NEL boroughs and the outer NEL boroughs and reference was made to a recent report on primary care presented to ICS leads. ICPB members agreed the differences need to be addressed as a priority in order to achieve the planned improvements in health inequalities. Members were assured that there is firm commitment going forward to level up the funding across the NEL boroughs and the Chair asked for the primary care report to be shared with ICPB members after the meeting. Members of the ICPB: • Noted the current risks to the BHR ICP and the key risks to the NEL CCG Governing Body. • Agreed that the narrative relating to financial balance and resources/workforce needs to be more explicit so that the risk register fully reflects the financial pressures and workforce pressures in Local Authorities as well as health.	CJ SR
4.0	**Patient and Public engagement update**	
	JD provided an update on the development of a BHR system-wide approach to patient and public engagement. New guidance from NHSE/I on the expectations on how integrated care partners should work with people and communities has led to a refocus on the original proposals discussed earlier in the year. System partners have committed to co-designing the structure with local patient representatives and the voluntary and community sector and an overview of all the work that is continuing at a borough level and a NEL level was given. JD proposed that the CCG hosts a workshop that will help to involve local patient representatives, voluntary and community sector organisation and individual residents in the shaping of the engagement structure. The workshop will enable each borough to share their plans and attendees will help co-design the approaches. The workshop will also consider how to involve or seek the views of those less digitally-able to ensure the future approaches support equitable inclusion of feedback and views from across our diverse communities. The importance of having the voice of residents in every provider area was noted together with the need to provide as much information as possible to the wider communities so they have a greater understanding of the ICS. Members of the ICPB: • Noted the update. • Approved the proposals for the next steps	
5.0	**Integrated Care System Development**	
	5.1 Developing our Barking and Dagenham, Havering and Redbridge Partnership within the North East London Integrated Care System context	

	CJ presented the proposal which has been developed in partnership across health and care. The output from all the discussions that have taken place have been shared with partners and Place Based Partnerships and have been collated together into a proposal for ongoing multi borough collaboration. It was noted that BHR has a strong and successful history of working collaboratively and CJ fed back that system partners are keen to continue to collaborate on areas such as the Integrated Sustainability Plan (ISP) and the associated Transformation Board work, the BHR Health and Care Academy and the BHR Health & Care Cabinet. CJ suggested the need to formally review the areas of collaboration every six months going forward. It was noted that multi-borough collaboration means wider than BHR, including for example, Waltham Forest and Redbridge working together in regard to Whips Cross Hospital. ICPB members were assured that the BHR Integrated Care Executive Group (ICEG) endorsed the proposal as its meeting on 18 November 2021 and CJ outlined what the next steps will need to be in terms of governance. A final proposal will be presented to the ICPB at the next meeting. It was acknowledged that the BHR system has successfully worked collaboratively for some time. Members of the ICPB: • Approved the proposal for ongoing collaboration in BHR. • Noted the further work to be undertaken to define how the areas of multi-borough collaboration will be overseen	
6.0	**Transformation**	
	6.1 BHR Transformation Boards 21/22 – key progress and achievements to date HX presented the report which provided an update against the key milestones of each of the Transformation Boards and the current 21/22 forecasted impact against targets set out in the ISP for each Transformation Board. The key messages in the report were given and attention was drawn to the key impacts of the transformation schemes that sit within each Transformation Board. Overall, the impact of the Transformation Boards is positive and they are delivering the expected shift in activity and it is expected that the activity levels will be sustained as we move forward. The Chair commented on the positive and informative report and suggested it would be helpful to present it at the Overview & Scrutiny Committees. It was noted that as we move forward, the Place Based Partnership Boards will need to understand the transformation journey and help to drive it to ensure delivery. Members of the ICPB: • Noted the current progress of the Transformation Boards in relation to the delivery of transformation schemes in 21/22 • Noted the achievements made to date in terms of reducing activity in secondary care through the provision of alternative services through transformation. **6.2 BHR community phlebotomy update** The new pilot model for community phlebotomy provision started on 1 July 2021 and JK advised that it is progressing well with high levels of patient	TR

	satisfaction being reported. The patient satisfaction survey results were included in the report and an overview of the key messages particularly in regard to the positive feedback on travel time was given to ICPB members. JK to follow up on a request made by RH for the survey results to be broken down by age groups and provider groups. Members of the ICPB: • Noted the update.	JK
7.0	**BHR ICP Performance**	
	7.1 BHR priority actions progress update SR presented the update on the agreed four key priorities for the BHR ICP; recovering well; addressing inequalities and prevention; Anchor Organisations; Leadership, Culture, and Leading Change. The report included a 'plan on a page' for each of these areas and the progress made was noted. It was also noted that a deep dive on 'addressing inequalities and prevention' had been undertaken at the BHR ICEG meeting on 18 November 2021. Members of the ICPB • Noted the progress update. **7.2 Winter Plan** The update provided a summary of the actions being taken in line with NHSE's ten-point plan for urgent care including the additional services and capacity being put in place to mitigate the identified risks. Additional investment has been agreed for winter 21/22 and the additional capacity was outlined in the report. KB advised that the winter plan will be updated to reflect additional primary care funding and additional discharge funding recently been received. BHRUT is developing a more detailed winter plan and KB confirmed she is liaising with all the leads to ensure the BHR system developments and the impacts are captured. It was reiterated that one of the biggest risks system-wide is staffing and that the demand in urgent care has significantly increased. A substantial winter communications campaign will begin week commencing 29 November 2021 which is across all partners in health and social care. The follow-up session to the recovery summit held in July was referenced and CA commented how useful it was and explained that all the actions to support the pressures within urgent care were reviewed and work is being progressed at pace. Capacity issues in primary care were flagged and it was suggested that a more holistic approach is needed to improve capacity and address demand. ICPB members agreed that communicating the right messages to the public is key to ensuring they are supported to access the most appropriate setting for treatment, first time. The additional monies for Local Government in regard to hospital discharge were referenced and ABH commented that consistency is needed in regard to how the money is distributed as some ICS's are following a different process to NEL. CJ clarified that the recent £6.3m referred to earlier in the meeting is new additional money targeted to Trusts and Local Authorities	

	and that the funding that ABH referenced is the hospital discharge fund which is different money. CJ added that not all areas of London have followed the same approach used in South East London. Members of the ICPB • Noted the update. **7.3 Finance report** NEL CCG and the ICPs have submitted a break even plan for the second half of the financial year (H2) and it is expected that a break-even position will be achieved. At Month 7 NEL CCG has reported a break-even position on the core budgets, with a reported variance. The break-even position in BHR ICP has been achieved using non-recurrent mitigations (forecast £8.7m) and this relates to the overspend reported in H1. BHR are expecting to manage the H2 position within budget. NHS contracts continue to be paid on a block basis. The key risks relate to the independent sector, prescribing, NEL corporate costs and in-envelope Covid spend in primary care. The change to the Elective Recovery Fund (ERF) was outlined and SC gave an overview of areas where investment funding has been secured for NEL. Members were advised that the System Development Fund will continue into 2022. Further discussion took place in regard to the emerging risks relating to workforce and Local Authority funding and SC reiterated the message that we will work together as a system to address the risks. Concern was expressed about the reported projected underspend in health for Continuing Health Care (CHC) in contrast with the situation being experienced in Local Authorities. Concern was also raised as to whether the discussions on how the hospital discharge pathway funding would be distributed were held system-wide, noting that the pathway is a significant cost for Local Authorities. SC confirmed that the hospital discharge pathway plan was drawn up in partnership with Local Authority finance colleagues and clarified that it is a claims process and encouraged Local Authority colleagues to ensure that claims that are eligible and meet the criteria are submitted. The Chair asked SC to discuss the reported underspend in CHC with the BHR Local Authorities finance leads out side of the meeting. Members of the ICPB • Noted the BHR ICP H2 and full year budgets in line with the planned system submission.	SC
8.0	**Any other business**	
	No additional items were raised.	
9.0	**Items for information**	
	9.1 BHR Area Committee approvals ICPB members were advised that the following items received Area Committee approval at the start of November 2021: • Individual Placement Support business case • COPD Community Redesign Project • Heart Failure with reduced Ejection Fraction • Proposal to extend BHR's community ophthalmology service (Evolutio)	

	• Single Tender Waiver request to extend existing provision by North West Ostomy Services (NWOS) dressings provision services to BHR patients. **10.1 Minutes of relevant fora:** The minutes of the following meetings were noted: • Integrated Care Executive Group – September and October 2021 • Health & Care Cabinet – September and October 2021 • Finance sub-committee – September and October 2021 • Quality & Performance Oversight Group – September and October 2021 • Integrated Safeguarding assurance Board – October 2021	
11.0	**Any other business**	
	There was no other business.	
12.0	**Questions from the public**	
	Question asked by Mark Dumbrill in advance of the meeting: Are the ICPB members aware that young people in Redbridge aged sixteen and seventeen are currently unlikely to receive any specialist CAMHS treatment due to the long waiting times for both assessment and any subsequent recommended treatment, and that adult mental health services in Redbridge are refusing to accept referrals for these young people until they turn 18, meaning they then must join new waiting lists for assessment and any subsequent treatment? **Response:** The ICPB is aware that there are pressures on service within CAMHS currently, due to high numbers of children and young people being referred to the service. NELFT is increasing the service capacity above the usual establishment level by contracting with additional staff, who will be onstream shortly. Review clinics have been introduced that are run by psychologists and assistant psychologists to identify C&YP who would benefit from group intervention - 350 C&YP have been reviewed through this process so far. Adult mental health services are not refusing to accept referrals for young people until they turn 18. If the young person is open to CAMHS, a discussion can take place in the NELFT transitions meeting for a referral to adult mental health services after they reach the age of 17 ½. If the young person is suitable for a referral, they will get their first appointment before their 18th birthday to ensure a smooth transition between services. Not all CYP are suitable for transfer to adult mental health services and adult mental health services are not able to accept referrals for young people who are not already under CAMHS prior to their 18th birthday. There is a workstream under the Mental Health Transformation programme that is reviewing the transitional processes and how they can be improved over the course of this year. The CCG has a set of actions in place with NELFT to address this issue and we will be tracking this through our quality committees.	
	Date of next meeting – 27 January 2021	

North East London
Clinical Commissioning Group

NEL Governing Body
26 January 2022

Title of report	City and Hackney Area Committee update, meeting as part of the Integrated Care Partnership Board (ICPB)
Item number	7.2
Author	Dr Mark Rickets, City and Hackney Chair, NEL CCG
Presented by	Dr Mark Rickets, City and Hackney Chair, NEL CCG
Contact for further information	matthew.knell@nhs.net
Executive summary	The City and Hackney (C&H) Integrated Care Partnership Board (ICPB) met on Thursday 11 November 2021 for a shorter than normal session and discussed: • A proposal for funding the Neighbourhoods programme of work in 2022/23, along with the first of a series of sustainability proposals; • The ICPB discussed the work of the Neighbourhood programme to date, noting the need to pivot work in this area to ensure future sustainability and embedding of the programme in business as usual and mainstream services; • Further business cases would be presented to the ICPB in the coming months for further aspects of the work contained in the programme and the ICPB explored the linkages between this work, anticipatory care and wider work underway in the area to address inequalities and community involvement; • The need to measure performance and cross system impacts from work underway in the Neighbourhood programme was discussed, with an evaluation report on aspects of the programme due to become available in the next few months; • The ICPB received a recommendation from the City and Hackney Finance and Performance Sub-Committee and approved the proposal for funding for the Neighbourhoods programme in 2022/23 through drawing down £738,496 from the Better Care Fund. As part of this funding, the ICPB approved the Sustainability proposal for the Neighbourhood model for community pharmacy for £55,200 plus VAT as recurrent funding and noted that further Sustainability proposals will be presented to the December 2021 ICPB meeting for the

	Neighbourhood model for resident involvement and community and voluntary sector engagement.
Action required	The NEL Governing Body is asked to: 1. Note this update from the ICPB; 2. Receive and note the ICPB minutes agreed at the Thursday 9 December 2021 meeting.
Where else has this paper been discussed?	N/A
Next steps / onward reporting	A regular report on key messages from the C&H Integrated Care Partnership Board (ICPB) will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The City and Hackney Area Committee meets together with partners in a Committee in Common arrangement, in public to take local decisions on decisions on the functions delegated to it as the ICPB. Meeting in public promotes transparency and allows discussion and challenge in real time with members of the public. The Committee holds specific functions related to population health management, including lead responsibility for population modelling and analysis within the ICP area, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality as well as for stakeholder engagement and management, including the discharge of NEL CCGs statutory duty in relation to public involvement and consultation.
Conflicts of interest	There are no conflicts of interest in regard to this report.
Strategic fit	The Committee exercises a variety of delegated functions granted to it by the NEL GB and as such, has relevance to all of NEL CCGs Corporate Objectives.
Impact on finance, performance and quality	The Committee will report to the NEL CCG Governing Body on a bi-monthly basis and a copy of its minutes are presented to the NEL CCG Governing Body, for information and assurance purposes.
Risks	The Committee will hold and review an ICP risk register and monitor progress against defined mitigating actions, particularly relating to the most significant risks, to assure that risks are being properly reviewed and effectively managed.
Equality impact	N/A

City & Hackney Integrated Care Partnership Board

This is also a meeting of the **Integrated Commissioning Board** which is a Committee in-Common meeting of the:

- The London Borough of Hackney Integrated Commissioning Sub-Committee ('The LBH Committee)
- The City of London Corporation Integrated Commissioning Sub-Committee ('The COLC Committee')
- North East London CCG Governing Body City and Hackney ICP Area Committee (The 'CCG Area Committee')

Minutes of meeting held in public on 11 November 2021 by Microsoft Teams

Members:

Hackney Integrated Commissioning Board		
Hackney Integrated Commissioning Committee		
Cllr Chris Kennedy	Cabinet Member for Health, Adult Social Care & Leisure	London Borough of Hackney
Cllr Rob Chapman	Cabinet Member for Finance	London Borough of Hackney

City Integrated Commissioning Board		
City Integrated Commissioning Committee		
Marianne Fredericks	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Randall Anderson QC	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Helen Fentimen	Member, Community & Childrens' Services Sub-Committee	City of London Corporation

North East London CCG City & Hackney Area Committee		
Dr Mark Rickets	City & Hackney Clinical Chair	NE London CCG / City & Hackney Integrated Care Partnership
Sue Evans	Lay Member	NE London CCG / City & Hackney Integrated Care Partnership
Sunil Thakker	Executive Director of Finance	NE London CCG / City & Hackney Integrated Care Partnership

Integrated Care Partnership Board Members		
Caroline Millar	Acting Chair	City & Hackney GP Confederation
John Gieve	Chair	Homerton University Hospital NHS Foundation Trust

Tracey Fletcher	ICP Chief Officer and Homerton University Hospital NHS Foundation Trust Chief Executive	Homerton University Hospital NHS Foundation Trust
Ian Williams	Acting Chief Executive	London Borough of Hackney
Laura Sharpe	CEO	City & Hackney GP Confederation
Haren Patel	Clinical Director	Primary Care Network
Jenny Darkwah	Clinical Director	Primary Care Network
Honor Rhodes	Associate Lay Member	NE London CCG
Ann Sanders	Lay member	NE London CCG
Jon Williams	Executive Director	Healthwatch Hackney
Dr Sandra Husbands	Director of Public Health	London Borough of Hackney
Dr Stephanie Coughlin	Neighbourhoods & Covid-19 Clinical Lead	NE London CCG / City & Hackney Integrated Care Partnership
Helen Woodland	Group Director – Adults, Health & Integration	London Borough of Hackney
Eileen Taylor	Vice Chair	East London NHS Foundation Trust

Attendees

Jessica Lubin	Health Transformation Director	Hackney Council for Voluntary Services
Jonathan McShane	Integrated Care Convenor	NE London CCG / City & Hackney Integrated Care Partnership
Matthew Knell	Head of Governance & Assurance	NE London CCG / City & Hackney Integrated Care Partnership
Nina Griffith	Workstream Director: Unplanned Care	NE London CCG / City & Hackney Integrated Care Partnership
Stella Okonkwo	Integrated Commissioning Programme Manager	NE London CCG / City & Hackney Integrated Care Partnership

Apologies:

Deputy Mayor Anntoinette Bramble	Deputy Mayor & Cabinet Member for Education, Young People & Childrens' Social Care	London Borough of Hackney
Henry Black	Acting Accountable Officer	NE London CCG
Steve Collins	Director of Finance	NE London CCG

Ruby Sayed	Member, Community & Childrens' Services Sub-Committee	City of London Corporation
Paul Calaminus	Chief Executive	East London NHS Foundation Trust
Tony Wong	Chief Executive	Hackney Council for Voluntary Services
Susan Masters	Co-Director: Health Transformation, Policy and Neighbourhoods	Hackney Council for Voluntary Services
Paul Coles	General Manager	Healthwatch City of London
Andrew Carter	Director: Community & Childrens' Services Sub-Committee	City of London Corporation

No.	Agenda item and minute
1.	**Welcome, Introductions and Apologies for Absence** The Chair of the Integrated Care Partnership Board (ICPB), Randall Anderson (RA), opened the meeting, welcoming those present and noting apologies as listed above.
2.	**Declarations of Interests** The City Integrated Commissioning Board **NOTED** the Register of Interests. The Hackney Integrated Commissioning Board **NOTED** the Register of Interests. RA briefed the ICPB that a new declarations of interest system was still in the process of being implemented, which would allow members to self-manage their declarations. This was now planned to become available later in November, but had not been ready in time for this meeting of the ICPB.
3.	**Questions from the Public** Two members of the public were present at the meeting and no questions from the public were raised at the ICPB meeting.
4.	**Minutes of the Previous Meeting & Action Log** Ann Sanders (AS) noted that on page 14 of the circulated papers, Catherine Macadam (CM) had been indicated as being in attendance at the October 2021 meeting, while she was a member of the ICPB and asked for this to be corrected in the minutes of the meeting. **ACTION:** Catherine Macadam's membership of the ICPB to be reflected in the minutes of the October 2021 ICPB. The City Integrated Care Partnership Board otherwise **APPROVED** the minutes of the previous meeting and **NOTED** the action log.

	The Hackney Integrated Care Partnership Board otherwise **APPROVED** the minutes of the previous meeting and **NOTED** the action log.
5.	**Report from the ICP Chief Officer** Tracey Fletcher (TF) briefed the ICPB that Siobhan Harper (SH) had moved from the City and Hackney (C&H) system to Tower Hamlets, Newham and Waltham Forest (TNW) and that she would be taking on more of a leadership role across the place based team. Attendance at the North East London Clinical Commissioning Group (NEL CCG) would be taken up by either Nina Griffith (NG) or Amy Wilkinson (AW) to ensure messages and feedback flow between the central team and C&H colleagues. Discussions were underway with NEL CCG colleagues around the future leadership structure, including the creation of a Director of Delivery and Development role that would be advertised shortly. TF continued to outline that debate was underway across the whole of NEL on the strategy and development of the future Integrated Care System (ICS), with discussions taking place across a number of forums and involving many colleagues present in the ICPB.
6.	**Neighbourhoods - Progress in 2021/22 and Future Plans:** NG joined the ICPB and directed members' attention to the circulated papers, noting that the ICPB had discussed the outline proposals for approval of the continuation of the Neighbourhoods programme in the coming years at its previous meeting in October 2021. This proposal was also accompanied by a series of sustainability proposals, to support the movement of an existing programme from non-recurrent standing to a business as usual approach. Further proposals to support sustainability proposals for resident, community and voluntary sector engagement in the coming months. NG briefed the ICPB members on the progress made within the core Neighbourhoods programme, with multi-disciplinary teams working to deliver services at a neighbourhood level and new models of care being developed and delivered by the team. Work was now pivoting to look to the future of the programme to ensure its sustainability and that the teams work and services become embedded in the local health and care system as 'business as usual'. This new phase of work will involve the reduction of programme non-recurrent funding, and the mainstreaming of the model to be included in standard funding streams, without extra investment wherever possible. Some elements of the programme however were novel and new funding streams would need to be established, for instance to support the community pharmacy driven work and to support the resident, community and voluntary sector engagement. Business cases to cover recurrent funding for the engagement work will come to a future ICPB meeting and will be cast in light of the overall funding envelope and the Better Care Fund (BCF), while a proposal for the community pharmacy work was before the ICPB today. NG briefed the ICPB members on the proposal for funding for the Neighbourhoods programme in 2022/23 and the sustainability proposal for the Neighbourhood model for community pharmacy going forward. NG confirmed

	that the overall requested amount from the BCF in 2022/23 was £738,496, which would be drawn from the BCF as in prior years to cover core Neighbourhoods programme costs. NG flagged that this ask was a reduction on the sum requested for 2021/22 and that this number should be expected to decrease year on year in the future. NG added that the circulated papers both covered a look back at what the programme had achieved so far, but also a look forward at what changes would be required in the upcoming years to ensure that the work of the programme is mainstreamed into day to day working practices. NG presented the Community Pharmacy Neighbourhood leads programme, noting that these leads supported the involvement and collaboration with Primary Care Networks (PCNs). These leads (funded based on allocation of days) have a role in acting as Neighbourhood Pharmacy champions and communicating with community pharmacies in their Neighbourhood and taking a leadership role, working closely with wider system partners including PCNs and PCN Clinical Directors. A series of objectives had been put in place for the team, and their roles aligned with the BCF metrics. A total sum of £55,200 plus VAT was being requested for approval on a recurrent basis. Haren Patel (HP) thanked NG for the circulated material, noting that experience working with Neighbourhood teams had been positive. HP asked if similar structures, or an approach like Neighbourhoods was in place in other areas across NEL. HP flagged that there may be a risk of overlap with the Community Pharmacists work to support PCNs, for which there is an existing contract in place and asked if this was being mitigated. Sunil Thakker (ST) stated that these two initial proposals had been discussed and recommended by the City and Hackney Finance and Performance Sub Committee (FPSC) at its October 2021 meeting. ST flagged that the only point of contention had been that the CCG had not received formal notification of allocation for 2022/23 and therefore was unable to commit spend at this point, although was supportive of both proposals. ST continued that careful consideration of the evaluation and performance monitoring needs of this work needed to be undertaken, to ensure that benefits can be measured and articulated. NG thanked HP and ST for their questions, noting that the C&H team was working with colleagues across NEL, with the PCN structure in place across the whole of NEL, as it was nationally mandated, with much discussion underway on how to embed community services at a similar service level to support the work of PCNs. Ideas, learning and possible proposals were regularly shared between NEL colleagues, however the C&H approach was taking a broader look at addressing health inequalities and involved a wider range of partners in this work. NG recognised the risk in an overlap between the Community Pharmacists work to support PCNs and the work set out in the proposal before the ICPB, but informed the ICPB that the teams worked closely with the Medicines Management Team (MMT) to ensure that this didn't happen and that the contract was clear that this work was in addition to that undertaken elsewhere. NG flagged that each service line delivered through the Neighbourhoods programme was managed as an individual contract, with attached performance monitoring and metrics with the provider partner. Contract payment was also

	based on actual spend, supporting analysis of costs and performance. Cordis Bright were engaged to look at the broader programme driven outcomes, measures and performance and this would be updated on soon. Chris Kennedy (CK) asked whether the long term picture for this work involved the programme generating savings, which could be drawn down as Neighbourhood specific funding from NEL CCG, as funding through the BCF may not be sustainable in the long term. NG responded that there were a few elements to this, and that many aspects of the work covered by the Neighbourhoods programme were included in normal contracting arrangements with partner providers, and that there wouldn't be financial implications if this was the case. NG continued that some aspects of the new models of care were accompanied with new national funding, for instance that in place around anticipatory care, while other aspects would require local partners to take a view on possible investment, like the community pharmacy proposal under discussion at the meeting. A discussion with finance colleagues would be needed to investigate what the future may look like without the BCF, but in the meantime, the BCF was a recurrent funding stream option available to local partners. NG noted that despite the work underway to mainstream much of the Neighbourhood funding and services, it remained likely that a small, central fund to co-ordinate and drive improvement on an ongoing basis would be needed, but that discussions were needed with system partners on how to best meet this need, aligned with the PCN programme. ST agreed that the work within the Neighbourhood programme needed to be considered in upcoming funding and allocation related work for 2022/23 and form part of local planning requirements. Honor Rhodes (HR) thanked NG for the proposals, noting that care needed to be taken to ensure that local people and communities are bought into – and along with this work and that Neighbourhoods don't become a healthcare dominated programme of work, but consider the wider needs of local people. HR raised that the engagement proposals were vital to the success of the programme, and that without them, true co-production and co-design would not be possible. Metrics would be vital to ensure that this work remained a success, but not in terms of numbers, but instead to look at impacts, outcomes and what successes local people took away from the Neighbourhoods programme. AS noted that the circulated papers indicated that an evaluation framework would be in place by January 2022 and asked if resource had been set aside for further external review to support the programme. NG responded that further material on the engagement model would be coming to a future meeting of the ICPB for approval, work on which was being supported by HealthWatch partners. NG stated that work continued with Cordis Bright to develop an evaluation framework, and that once this work became available, a discussion on whether to continue with external support or internalise this work would take place, led by the framework that emerges. Helen Fentimen (HF) asked whether the impact of the anticipatory care work could be measured, particularly on whether individuals can identify changes in services and support available to them. Additionally, HF asked whether the financial impact of this work would be measurable, noting that this was key to indicate whether the services could be successfully mainstreamed and self-

	sustain in to the future. NG responded that Cordis Bright had supported the creation of an anticipatory care evaluation framework, which was being actively monitored in the currently running pilot, with early patient level outcomes being reported on. Work was also underway with the national NHS England and Improvement (NHSEI) team to make sure that the outcomes being realised locally align with those expected from the central funding allocated to this work. NG continued that community pharmacy proposal aimed to bring and engage local pharmacies, as trusted local health professionals, in working closely with their communities to help relieve pressure on other parts of the health system and engage with the health and care system as a whole as key partners and local leaders. Other work was underway within the PCN system to support prescribing best practice and to enable individual or cohort reviews of medication to ensure local patients are best supported. John Gieve (JG) thanked NG for the positive paper and indicated his support of the proposals. JG noted that it should be expected that, if the interventions under discussion were successful, that there would be a knock on effect on core funding flows across the system – for instance, increased social care support may result in less medical interventions being required. JG asked how these cross partner impacts, costs and outcomes could be explored and discussed as a group from a system point of view. NG responded that some elements of this discussion will become apparent on a service by service basis, and that the anticipatory care pilot that was currently underway was being closely monitored for exactly these kind of impacts, and that it was hoped work in this area would become clearer by March 2022. NG noted that a proposal for the use of central funding to support anticipatory care would be coming to a future meeting of the ICPB in the near future for approval, along with further information on this work. NG noted that services still probably needed to be assessed and considered under within their own specifications and stand on their own and justified to partners in the short to medium term. Mark Rickets (MR) confirmed that he had supported the proposals at the FPSC and continued to do so, noting that the Health and Wellbeing Board was in the process of reviewing its strategy and that elements of this work may impact on that project. MR continued to flag that the results of the evaluation work that Cordis Bright are producing could benefit from ICPB discussion when available and used to inform the future of the usage of metrics, outcomes and outputs across the local health and care system. **ACTION:** NG to ensure that Cordis Bright's work on Neighbourhoods evaluation and stock take is presented to the ICPB when available for discussion. HP raised that there were significant differences across the many community pharmacies in the local area in terms of readiness to support and engage with the work under discussion and that this needed to be kept in mind. Jessica Lubin (JL) flagged that it may be important to consider and measure the cost effectiveness of the anticipatory care pilots' impacts, potentially through benchmarking against similar costs across providers. RA supported this approach, noting this approach was likely to become more vital as local partners needed to prioritise funding and spend in the future. JL highlighted that much of the voluntary and community sector's (VCS) work tended to be financed through short term, non-recurrent funding and that there were further benefits to be

	gained by moving towards longer, more stable arrangements between local partners. **DECISION:** The ICPB approved the proposal for funding for the Neighbourhoods programme in 2022/23 through drawing down £738,496 from the Better Care Fund. As part of this funding, the ICPB approved the Sustainability proposal for the Neighbourhood model for community pharmacy for £55,200 plus VAT as recurrent funding and noted that further Sustainability proposals will be presented to the December 2021 ICPB meeting for the Neighbourhood model for resident involvement and community and voluntary sector engagement.
7.	**Any Other Business and Reflections** No further business was discussed.
	Next meeting: Thursday 9 December 2021

North East London
Clinical Commissioning Group

NEL CCG Governing Body
26 January 2022

Title of report	TNW Area Committee Chair's report
Item number	7.2
Author	Sophia Beckingham
Presented by	Fiona Smith – CCG Independent Registered Nurse
Contact for further information	sophia.beckingham@nhs.net
Executive summary	Since the last Governing Body, the TNW Area Committee met on 2 December and discussed the following: • The committee APPROVED the Single Tender Waiver for the Supplementary Network Service (SNS) scheme specification for Newham. • The committee received an update from the Director of Transition. Key highlights included a vaccination programme update, the specialised GP hub which received a commendation from the HSJ awards, the approval for Whipps Cross redevelopment planning and movement towards an ICS/ICB. • The committee received an update from the TNW Finance and Performance sub-group, noting the TNW run rate gap, which is driven by independent sector spend to delivery additional surgical capacity in managing waiting lists, acute sector activity and prescribing activity. Additional funding has also been needed to address system priorities and risks such as backlog reduction. • The committee received an update from the Quality, Safety and Improvement sub-committee, noting the TNW initiatives in relation to operation Hopgrove, the continuation of IPC support to care homes and the development of the NEL Quality Governance Framework. The draft minutes of 2 December meeting are attached as an appendix to this report.
Action required	The Governing Body is asked to note the update.

Where else has this paper been discussed?	TNW Area Committee.
Next steps/ onward reporting	A regular report on key messages from the TNW Area Committee will be presented at each meeting of the Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The Committee: • provides assurance to the Governing Body on the robustness of the in-year financial strategy and financial management for the TNW area of the CCG and spend of public funds • gains assurance on the longer term financial strategy and planning to ensure stability of the health services for the people of NEL and TNW • scrutinises the performance of providers and of the CCG against established contractual, statutory and KPI metrics, and act based on these findings. • Agrees and recommends business cases and contract awards • Supports and develops the TNW area's strategic priorities and approach • Engages with local system partners.
Conflicts of interest	There are no conflicts of interest in regard to this report.
Strategic fit	The Committee reviews and monitors the TNW strategy, financial, quality and operational plans of the TNW are of the CCG. In addition, it approves business cases that are beneficial to the public and fit within the CCG financial plans that are within delegation limits.
Impact on finance, performance and quality	The Committee will manage the TNW area as outlined in this report.
Risks	The committee will Manage TNW system risks as part of the overall CCG risk management programme. A risk based report shall be sent to the CCG Governing Body every 2 months; along with any necessary progress reports, recommendations and formal requests for approval in relation to contracting activity. Current key risks within TNW include the financial run rate gap, diagnostics backlog, CHC and winter pressures.
Equality impact	N/A

North East London
Clinical Commissioning Group

Tower Hamlets, Newham and Waltham Forest (TNW)
Area Committee
Thursday 2 December 2021, 13:45 – 14:30, Microsoft Teams

DRAFT Minutes

Present:	
Members	
Fiona Smith (FS) **(Chair)**	NEL CCG Board Independent Nurse
Sunil Thakker (ST)	TNW Executive Director of Finance (Acting), NEL CCG
Ken Aswani (KA)	Clinical Chair, Waltham Forest
Muhammad Naqvi (MN)	Clinical Chair, Newham
Siobhan Harper	Director of Transition, TNW
Henry Black (HB)	NEL CCG Accountable Officer (Acting)
Sam Everington (SE)	Clinical Chair, Tower Hamlets
Chetan Vyas (CV)	TNW Director of Quality and Safety, NEL CCG
Attendees	
Anna Carratt (AC)	TNW Director of Strategy and System Transformation, NEL CCG
William Cunningham-Davis	TNW Director of Primary Care NEL CCG
Chetan Vyas (CV)	TNW Director of Quality and Safety, NEL CCG
Sophia Beckingham	Senior Governance Manager, TNW NEL CCG
Members of the TNW Delivery Group	
Apologies	
Steve Collins (SC)	NEL CCG Chief Finance Officer (Acting)

No.	Agenda item and minute
3 General business	
4.0	**Welcome, introductions and apologies** FS welcomed all members and attendees from the TNW Delivery Group to the Area Committee meeting Apologies were noted, as above.
	Conflicts of interest FS noted that MN was conflicted against agenda 5.1, as he is a practicing GP in Newham and works within a PCN.
	Quoracy The meeting was declared quorate.
4.1a	**Minutes from the previous meeting** The Committee agreed the minutes from 14 July, as an accurate record of the meeting.
4.1b	**Action log** FS confirmed that the Advice and Guidance item had been sufficiently covered in the Delivery Group, and asked that ST and SH bring the action regarding Long Term Conditions to the next meeting.
4.1c	**Matters Arising** No additional matters were raised.
Items for approval	
5.1	Single Tender Waiver Approval - Supplementary Network Service (SNS) scheme specification for Newham. William Cunningham-Davis (WCD, Director of Primary Care TNW) presented the waiver, explaining that the TNW Area Committee were required to approve Single Tender Waivers (STWs) which are above the delegated sign off amounts of singular Directors and other governance forums. WCD explained that the waiver is for the Supplementary Network Service (SNS) scheme specification for Newham, which incorporates many clinical areas such as Cancer care, demand management, LTC reviews and Mental Health services. These are enhanced services for patients registered on a GP Practice patient list, and can only be delivered by the PCNs for patients registered via the GP practice within the PCNs. Due to this, the contract could not be delivered by any alternative provider and therefore required a single tender waiver. WCD outlined the background of SNSs, noting they had been developed for Primary Care Networks (PCN's) through their constituent practices in order to deliver enhanced primary care services to their registered patients and aligns with the CCG's strategic priorities for effective management of Long Term Conditions and other priority clinical areas. WCD explained that this waiver covers all SNS services with all Newham PCNs, whereby an NHS standard contract will be issued to each PCN (and its Practices). ST noted that this proposal had been via the procurement group, as well as had been reviewed by the Director of Finance for TNW. FS queried the line "contract includes incorporated SNSs which were formally known as outcome measures". WCD explained that historically, NHSE conducted a piece of equalization work for PMS, GMS and APMS. PMS had additional premium KPIs, and these were shifted in the enhanced service contract. WCD confirmed that the CCG were not paying double on any of these areas.

	SE queried the rationale for retendering services during a time of pressure for the NHS, where it is key to maintain continuity of good services which are delivering for patients. SE asked that the CCG remain mindful of keeping patients at the heart of decision making and maintain fairness in contract management, regardless of size of the organisation. HB agreed with SE's statement and noted that the CCG continues to have to meet procurement legislation impacts how the CCG procures services, even within the current pressured climate. HB assured the committee that the finance and procurement teams continue to issue advice which meets legislative requirements but also results in the most straight forward and patient orientated procurement approach. The TNW Area Committee APPROVED the Single Tender Waiver for Supplementary Network Service (SNS) scheme specification for Newham.
6 General Business	
6.1.a	**Transition Director update** SH (Siobhan Harper, TNW Director of Transition) updated the Area Committee on key headlines within the report, noting that the vaccination programme had scaled up rapidly due to recent government announcements regarding boosters and target numbers. SH explained that the target for the NEL additional vaccination and booster regime was extremely large and the plan to meet these requirements was developing at pace, with key details in the paper. SH informed the committee that a specialised GP hub in Tower Hamlets was shortlisted and highly commended for "Innovation project of the Year" HSJ award. SH explained that the hub focuses on tailored health and wellbeing support for children and young people and was positive for TNW given the struggles that young people can have to effectively access primary care. SH noted that agreement for planning permission for Whipps Cross redevelopment had taken place and had moved on to the next stage of workshops and establishment of work streams to support its development. SH highlighted the ICS delegation information within the paper pack, stating that the TNW team were working on how the TNW area will support and transition in to an ICB, as well as supporting work at borough level. SH noted that a number of committee members were already engaged in this work as governing body members and committed to returning with a paper which gives further detail in the next committee. The committee NOTED the update.
6.1b	**Summary: TNW finance and performance sub-committee update** ST outlined that the TNW Finance and Performance Sub-committee reviewed a number of areas, including: - Deep dive elective care - Winter pressures update - Finance report for month 7 TNW Subsystem - Paper regarding mental health - Update on H2 Planning Cycle ST expanded on the financial position of TNW, explaining that there is a run rate gap relative to the assigned budgets for TNW of circa £48M. ST explained that this amount

	had been driven by in year cost pressures in the Independent Sector, Acute Sector and Prescribing. ST explained that in addition, prior year investments were contributing to financial gap, which were initially funded from non-recurrent monies but required continuation of funding in order to address system needs or strategic NEL system priorities, such as clearing backlogs. ST explained that there will be a recalculation of these budgets in Q4 and finance are looking at a run rate of spend in year, with a view to erode the gap. ST informed the committee that TNW and NEL CCG were operating at risk in order to address key system priorities. ST updated the committee on expected financial plan assumptions, noting that there will likely be flat growth with a reduction of Covid funding but with an ERF funding increase. ST explained that the view from NHSE is that there will be a revising down of funding that systems such as NEL will receive, with a repurposing back to BAU funding over a 3 year time frame. FS asked if there is a plan to do star chamber process in terms of efficiency scheme oversight. ST explained that the finance team are doing an exercise to review investments and respective run rates and determine if there is head room within the investments to spend in other areas. ST committed to bringing back an update on this area. The Committee NOTED the Summary of the TNW Finance and Performance Committee.
6.1c	**Quality, Safety and Improvement update sub-committee update** FS advised the committee that Chetan Vyas (CV) had provided a written update for the committee, which she shared in detail as follows: It was noted that the CCG had initiated a response to operation Hopgrove, which is a complex abuse investigation taking place in Waltham Forest and has been in local press. TNW have been asked to stand up health offers to those affected, including young people and their families and this is developing at pace. The contract for this is until end of March 2022 with a further review planned to be undertaken at end of February. FS noted that the QSI Sub-committee discussed the children's and young people's risks and supported the business case which went to the NEL finance and performance committee. FS also noted that TNW set up a service at the start of the pandemic to support care homes and residential settings across TNW with their IPC needs. The service and the team have received fantastic feedback and TNW have secured additional resource through the Discharge funds to enable the ICP to continue the service until the end of March, with a NEL approach to hopefully take its place after this time. FS noted that a NEL Quality Governance Framework is being developed with partners with the ambition of creating a Quality Management System across NEL. As part of this work, the TNW Quality team have also started conversations with the Borough Directors to gauge what they see as important as a Quality function at place. The Committee NOTED the update.
6.2	**Any other business** No other business noted.
6.3	**Next meeting**: Wednesday 2 Feb, via teams