Public Document Pack

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

4.00 pm	Tuesday 28 January 2020	Redbridge Town Hall, 128-142, High Road, Ilford, IG1 1DD

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Eileen Keller
Councillor Paul Robinson
Councillor Mohammed Khan

LONDON BOROUGH OF WALTHAM FOREST

Councillor Umar Alli

LONDON BOROUGH OF HAVERING

Councillor Nic Dodin
Councillor Nisha Patel
Councillor Ciaran White

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Beverley Brewer
Councillor Neil Zammett (Chairman)

EPPING FOREST DISTRICT COUNCIL

Councillor Alan Lion (Observer Member)

CO-OPTED MEMBERS:

Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Richard Vann, Healthwatch Barking & Dagenham

For information about the meeting please contact:
Anthony Clements
anthony.clements@oneSource.co.uk 01708 433065

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Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

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Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

Essex County Council

Waltham Forest

Havering LONDON BOROUGH

London Borough of Redbridge

London Borough of Barking & Dagenham lbbd.gov.uk

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS (Pages 1 - 2)

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

Directions to the venue are attached.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies for absence have been received from Ian Buckmaster, Healthwatch Havering.

3 DISCLOSURE OF INTERESTS

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 3 - 14)

To agree as a correct record the minutes of the meetings held on 15 October 2019 and 6 November 2019 (attached).

5 ALIGNING COMMISSIONING PRIORITIES - EVIDENCE BASED INTERVENTIONS POLICY (Pages 15 - 56)

Report attached.

6 HEALTWATCH REDBRIDGE - BHRUT RESPONSES TO CHEMOTHERAPY ISSUES (Pages 57 - 70)

Previous correspondence from Healthwatch Redbridge to BHRUT attached. Healthwatch Redbridge officers will update on the latest position if possible.

7 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT) - PERFORMANCE REPORT (Pages 71 - 90)

Report attached.

8 JOINT COMMITTEE'S WORK PLAN

The Joint Committee is asked to suggest any items for scrutiny at future meetings.

Anthony Clements
Clerk to the Joint Committee

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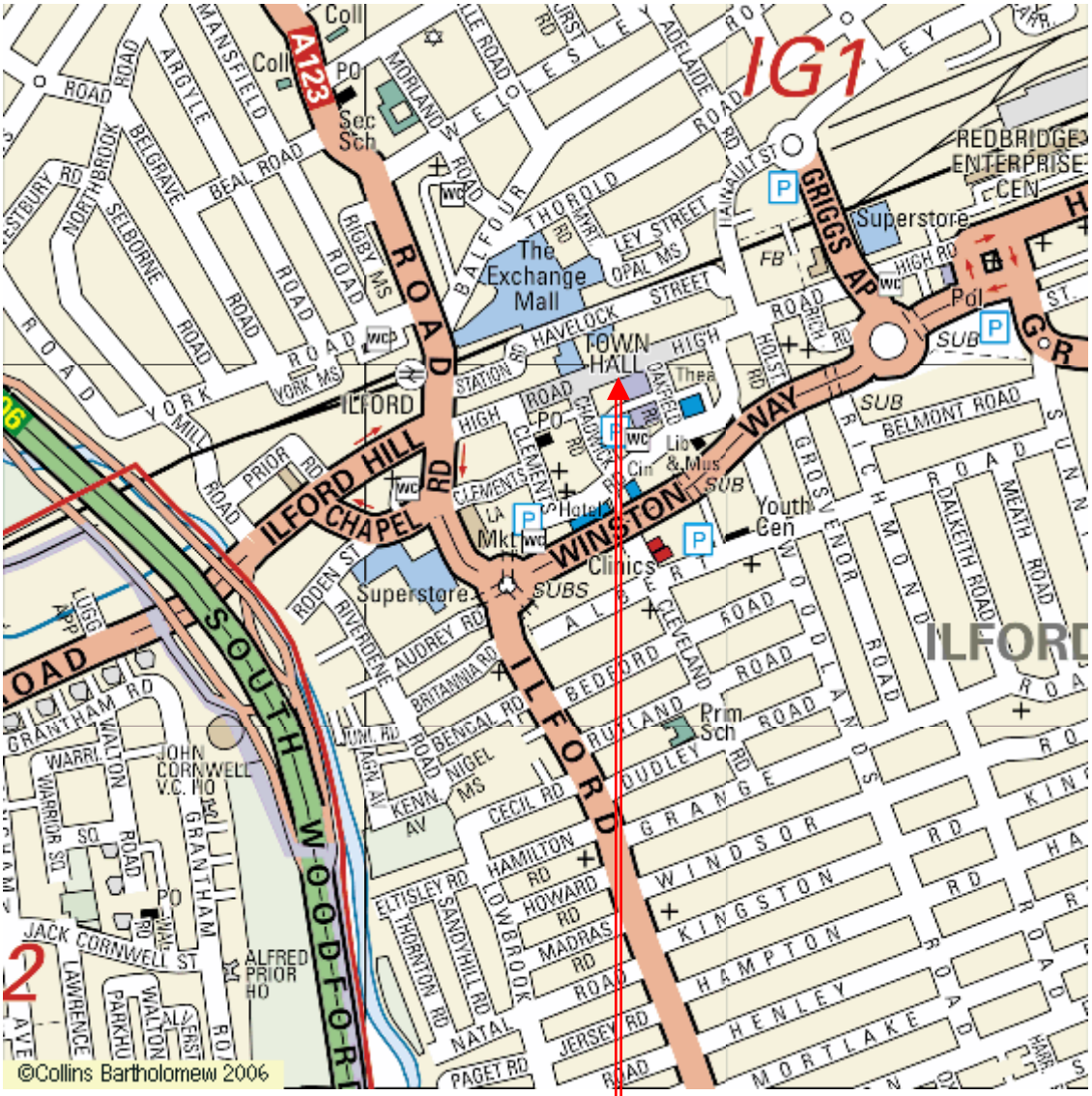
Map of LB Redbridge Town Hall
128-142 High Road , Ilford, Essex 1G1 2DD



Meeting rooms

Council Chamber, Committee Room 1 & Committee Room 2 are on the 1st Floor
Rooms 42, 43 and 49 are on the 2nd Floor

Travel directions

The Town Hall is 5 minutes walk from Ilford Station, which is in zone 4. Trains run every 10 minutes from Liverpool Street and you can also join the train at Stratford. Journey time is 15 mins by train from Liverpool Street and 7 mins from Stratford. When you come out at Ilford station turn right and cross at the lights. Walk through the Town Centre (passing an Iceland Supermarket on your right and The Exchange Mall on your left) until you come to the Town Hall on your right.

If you are driving, were near the nearest motorways are the A406 or the A12.

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**MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE**

15 October 2019 (4.00 - 6.35 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Eileen Keller, Mohammed Khan and Paul Robinson
London Borough of Havering	Nic Dodin, Nisha Patel and Ciaran White
London Borough of Redbridge	Beverley Brewer and Neil Zammett
London Borough of Waltham Forest	Richard Sweden (substituting for Councillor Umar Alli)
Essex County Council	Chris Pond
Epping Forest District Councillor	Alan Lion
Co-opted Members	Ian Buckmaster (Healthwatch Havering), Cathy Turland (Healthwatch Redbridge) and Richard Vann (Healthwatch Barking & Dagenham)

Apologies were received for the absence of Councillor Umar Alli (Richard Sweden substituting) Mike New, Healthwatch Redbridge (Cathy Turland substituting).

Councillor Aniket Patel (Epping Forest) was also present.

Also present:
Sarah See and Emily Plane, Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs)
Dr Amit Sharma and Daniel Monie, BHR CCGs
Tim Burdsey, NEL Early Diagnosis Programme Manager
Archna Mathur, Director of performance and Assurance, NEL Commissioning Alliance
Dr Angela Wong, Clinical Chair, NEL STP Cancer Commissioning Board
Natasha Dafesh and Peter Hunt, Communications, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Jeff Middleditch, Cancer and Clinical Services Divisional Manager, BHRUT

Anthony Clements, Principal Democratic Services Officer, London Borough of Havering
Jilly Szymanski, Scrutiny Co-Ordinator, London Borough of Havering

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

9 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

10 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Joint Committee held on 9 July 2019 were agreed as a correct record and signed by the Chairman.

11 PRIMARY CARE TRANSFORMATION UPDATE

Officers representing the BHR CCGs that a primary care strategy had been introduced for North East London that sought to establish more integration between health providers and between the health and social care sectors. It was accepted that recruiting and retaining the GP workforce remained important to the success of the strategy.

Governance of primary care transformation included the establishment of a BHR primary care transformation programme board, chaired by a Cabinet Member from Essex. The most significant area of work was the development of Primary Care Networks and 40% of GP practice income would in future be derived via collaborative working.

There would be six Primary Care Networks in Barking & Dagenham, five in Redbridge and four in Havering. Each Network had a local GP who acted as clinical director. Paid roles in the Networks could include a social prescriber (for which 100% of the cost would be reimbursed this year) and a local pharmacist (for which 75% pf the cost would be reimbursed. From April 2020, a workforce budget would be allocated to each Primary Care Networks for the Network to spend as it preferred on roles such as physician associates or paramedics. A total of £1.6m would be invested in Primary Care Networks in Redbridge alone.

Work was in progress to increase the availability of GP appointments that could be booked on line. On line consultations could be accessed by 60% of Redbridge residents, 42% in Barking & Dagenham but only 23% in Havering. It was also noted that the new GP contract would require practices to open from 8 am to 6.30 pm. There remained significant numbers of patients who booked appointments but did not attend or cancel

these. A new text messaging reminder service had been introduced in order to address this.

There were 46 vacant GP posts across the BHR area. This was better than the London average but slightly worse than the national average. A scheme had been introduced to match GPs to potential vacancies and efforts were also being made to address workload issues by establishing more part time GP posts. Only four GPs had this far been recruited via the international recruitment programme.

There were a total of 122 GP practices in the BHR area and the CCGs aimed to have GP practices care in a more collaborative way. It was accepted that satisfaction rates for GP services were too low (with Redbridge recording the lowest figures locally) but it was difficult to increase these ratings in the short term.

It was clarified that a capacity plan for all three boroughs was being developed and the CCGs were working with Councils on this. Consideration was being given to the level of health facilities that would be needed for new developments such as those at Rainham and the former Victoria Hospital site in Havering and Barking Town Centre and Baking Riverside in Barking & Dagenham. Efforts were being made to find a different model of health facilities for these new developments and work with Council officers was ongoing on this.

Officers accepted that it was sometimes difficult to persuade GPs top move from converted houses into more modern premises. It was agreed that work undertaken in Redbridge on how the location of GPs is decided should be shared with the Joint Committee for information.

It was an overall priority of the CCGs to move more care out of the hospital environment. This depended however on workforce issues being sufficiently resolved. Good work undertaken by local GPs in areas such as diabetes and atrial fibrillation had already reduced pressure on hospitals in these areas.

The Joint Committee noted the update.

12 CONTINUING HEALTHCARE UPDATE

Following a referral from the Barking & Dagenham Health Scrutiny Committee, Continuing Healthcare was defined as NHS care for patients assessed with a primary health need. Eligibility of patients for this type of care was reviewed annually and this was current received by 149 patients in Barking & Dagenham, 181 in Havering and 175 in Redbridge.

The CCGs intended to introduce a placements policy in order to help them make decisions about the location of Continuing Healthcare Packages (e.g. at home or in a care/nursing home). This would apply to all new patients eligible for Continuing Healthcare and a small number of existing patients whose care needs had changed considerably since their last review. The number of patients expected to be affected in the local BHR boroughs was estimated to be 20-25 per year. The overall eligibility to receive Continuing Healthcare would not change.

The policy to be introduced would mean that a home care package would not be funded if this cost was in excess of 10% more expensive than the cost of the equivalent package in a care or nursing home. An appeals process would be available against any such decisions. A consultation on the policy had run from 8 July to 30 September 2019 and the main themes of responses had covered signposting of support, the impact of the potential separation of family members and the maintenance of personalised care. A final decision on implementing the new policy would be taken by the CCGs on 28 November.

Members felt that the consultation documents had been difficult to follow and that patient choice was being disregarded by the new policy. It was that people may be forced to go into care even though many elderly people fared better in their own homes. Other points raised by the Committee were that Local Authorities should be represented on the appeals panel and that the 28 day window for an appeal was too short given CCG rates of response to correspondence. It was also felt that the 10% threshold should not apply for people approaching the end of their life.

In response, officers confirmed that all feedback would be considered and that the make-up of the appeal panel would be reviewed. It was possible that the final policy would have a threshold larger than 10% and it was confirmed that this would not apply to people at the end of their life who wished to die in their own home.

Members also raised concerns at the impact on people having to enter care homes. It was questioned what quality assurance systems would be used for care homes and how many homes used for Continuing Healthcare were rated as inadequate or requires improvement. Other issues raised included that care should be provided at home where possible and that it was unclear patients would be allowed to attend any appeal and if the decision making meeting on 28 November would be held in public.

It was agreed that the clerk would draft a letter giving the Committee's views as outlined during the meeting and including recommendations for changes to the proposed policy.

13 NORTH EAST LONDON CANCER EARLY DIAGNOSIS CENTRE

The proposed North East London Cancer Early Diagnosis Centre was aimed at patients who required repeated cancer screening procedures. The centre, which was due to open in May 2020, would support a personalised care approach whilst supporting best practice.

A construction company had been commissioned and building work was about to start. The location of the site had to be within budget and a non-acute site was also required and it was therefore felt that Mile End was the only location that met all the criteria.

Members were concerned however that too many resources were being put into the Tower Hamlets area at the expense of Outer North East London boroughs. Officers responded that early diagnosis rates were higher in Outer London than e.g. Tower Hamlets and that the new facility would allow the sharing of good practice. This would allow hospitals in North East London to support each other to deliver capacity. It was also hoped to establish a similar centre in Outer North East London. An officer from the Barking, Havering and Redbridge University Hospitals NHS Trust added that the Trust had been involved in the development of the facility and the new Centre may allow BHRIT to perform more endoscopies or similar procedures in its own unit.

The Joint Committee noted the position.

14 FORECAST DEMAND FOR CHEMOTHERAPY

The cancer and clinical support divisional manager stated that the view of clinicians was that demand for chemotherapy would fall over the next 10 years as advances in technology and medical options would mean that surgery or radiotherapy would be the more common options for the first line of cancer treatment.

There was a very good radiotherapy service at BHRUT with two new machines having been recently introduced. It was felt that any growth in demand for chemotherapy services up to 4-6% per year could be accommodated in the existing chemotherapy unit and also by increasing the proportion of chemotherapy delivered at home.

Members remained unclear however how the Trust would meet the increase in demand for chemotherapy which it had previously stated would be some 80% over the next 10 years. The Committee was not convinced that this could be done using the existing Sunflowers Suite at Queens Hospital nor that the fall in demand for chemotherapy predicted by the Trust would happen in reality. It was also felt that the responses by the Trust were too vague with no clear statement of the methodology used to forecast chemotherapy demand.

It was agree that a separate meeting be arranged for a representative group of the Joint Committee to discuss these matters in ore detail with appropriate BHRUT officers.

15 CANCER SERVICES - HEALTHWATCH RESPONSES

The Chief Executive of Healthwatch Redbridge explained that the organisation retained a number of concerns around the changes to chemotherapy services. These covered a lack of information around the demographics of patients using the service, the lack of knowledge among patients of the Cedar Centre cancer support hub, and that care may not be delivered close to home as seen with the planned Early Diagnosis Centre in Mile End. Disappointment was also expressed that BHRUT had not as yet taken the option of using the group of cancer patients Healthwatch had engaged with, as a reference group.

It had not proven possible for a meeting between Healthwatch and BHRUT to discuss these issues to be arranged prior to the Joint Committee meeting but the Healthwatch representative would bring a further update to a future meeting of the Joint Committee.

16 HEALTHWATH HAVERING - STP WHAT WOULD YOU DO? SURVEY

Whilst separate versions of the report had been produced by each borough Healthwatch, it was noted that a number of the general findings applied to all three boroughs. All Healthwatch organisations in England had been commissioned by NHS England to undertake a survey of local residents on how they would like to see the NHS develop during the period of NHS England's long term plan.

Key concerns raised by respondents included the time taken to obtain a GP appointment and improvements needed at A & E. NHS terminology was often confusing and, in Havering, there had been a low take-up of digital services with face to face consultations being preferred. Recommendations by the Healthwatch organisations covered the increased use of social prescribing, cancer care, phlebotomy services and signposting patients to available support.

The report on the equivalent survey compiled by Healthwatch Redbridge would also be forwarded to the Committee for information. Social prescribing was used more extensively in Redbridge and work was also in progress with the CCG to improve refugee and migrant access to healthcare. The main theme of findings in Barking & Dagenham related to primary care and in particular the lack of out of hours appointments. Some 89% of respondents in Barking & Dagenham wanted better access to GP appointments with 60% wanting to see a GP within one week.

The Healthwatch Havering officer would check if it was correct that 90% of respondents in that borough had been aged over 65. The survey would feed into development of the 10 year NHS plan and the findings, although not

raising any new issues did reinforce what the concerns of local residents were. The relevant CCG had agreed an action plan following the Healthwatch Barking & Dagenham survey and were happy to do the same for Havering and Redbridge.

The Committee noted the survey work undertaken by the Local Healthwatch organiations.

17 COMMUNITY URGENT CARE UPDATE

The Joint Committee noted a written update on the implementation of a new model for Community Urgent Care and that it was not possible to scrutinise this issue in detail due to an ongoing procurement process.

18 JOINT COMMITTEE'S WORK PLAN

Future issues suggested for the Joint Committee's work programme included the digital transformation of NHS services and performance information including A & E waiting times and friends & family test scores

Chairman

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**MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
East Ham Town Hall
6 November 2019 (7.15 - 8.30 pm)
(Meeting held simultaneously with meeting of the Inner North East London Joint Health Overview and Scrutiny Committee)**

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Eileen Keller and Mohammed Khan
London Borough of Havering	Nisha Patel (Chairman)
London Borough of Redbridge	Beverley Brewer
London Borough of Waltham Forest	Richard Sweden (substituting for Councillor Umar Alli)
Epping Forest District	Alan Lion (observer member)

Apologies were received for the absence of Councillors Paul Robinson (Barking & Dagenham) Nic Dodin & Ciaran White (Havering) Stuart Bellwood & Neil Zammett (Redbridge) Umar Alli (Waltham Forest) and Chris Pond (Essex). Apologies were also received from Ian Buckmaster (Healthwatch Havering co-opted member).

Also present:
Councillor Winston Vaughan, London Borough of Newham

Dr Dee Hora, Portfolio GP, Camden Named GP Adult Safeguarding and Planned Care Clinical Lead, North Central London Planned Care Clinical Lead, London Clinical Senate Council Member
Jo Moss, Director of Strategy, Moorfields Eye Hospital NHS Foundation Trust
Denise Tyrell, Consultation Programme Director, North Central London CCGs

Masuma Ahmed, Democratic Services Officer, London Borough of Barking & Dagenham
Anthony Clements, Principal Democratic Services Officer, London Borough of Havering (minutes)
Roger Raymond, Senior Scrutiny Policy Officer, London Borough of Newham
Jilly Szymanski, Scrutiny Co-Ordinator, London Borough of Redbridge

Approximately eight members of the public were also present.

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

19 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

20 DEVELOPING A RESPONSE TO THE NHS LONG TERM PLAN

The Joint Committee noted with regret and frustration that NHS officers had not attended the meeting due to legal advice that they could not discuss this item during the pre-election purdah period. Members disagreed strongly that this non-appearance was justified. It was felt that the draft long term plan should not be submitted to NHS England without its having been subject to appropriate scrutiny first and that NHS England should be asked to defer any decision on this matter until such scrutiny had first taken place.

It was agreed that the clerk would draw up letters on behalf of the Joint Committee to the Accountable Officer for the North East London Commissioning Alliance and to NHS England expressing the Committee's frustration and displeasure at the refusal of NHS officers to attend the meeting. It was also agreed that a further joint meeting should be arranged in order to scrutinise the Long Term Plan.

21 MOORFIELDS HOSPITAL PLANNED RELOCATION

Moorfields officers explained that it was proposed to move Moorfields Eye Hospital from its current site in City Road to a new location in St Pancras in 2026. The current site was felt to be too small and restrictive and could lead to appointments taking the best part of a day to complete. The Institute of Ocular Ophthalmology would move with the hospital to combine with Moorfields on the purpose-built St Pancras site.

A lot of engagement work had taken place during the consultation to date which had included how visually impaired people could navigate the new site itself as well as the distance from the nearest transport hubs to the site. Seventy-three per cent of respondents to the consultation had agreed or strongly agreed that the move should take place although this was slightly lower in the North East London area, principally due to concerns over travel times. Travel analysis had however shown only a three minutes increase in journey times overall compared to the current site.

The St Pancras site was located close to partner organisation such as the Royal National Institute for the Blind, the Crick Institute and UCL Partners.

The proposals would go to joint scrutiny for the North-Central London area on 29 November and a final decision was expected on 19 December.

The private theatres at the Moorfields site were part of a private business owned by the NHS. All profits from the private business were reinvested into the Moorfields NHS Trust. Investments made in private theatres would be recouped by the time of the move.

It was accepted that the children's department was in a newer building compared to the rest of the hospital but it was not feasible to leave this on the current site. Many hospital staff worked across both the adults and children's departments.

The valuation of the City Road site was based on current value and officers accepted that this may change due to the effects of Brexit. This would be reflected in the full business case which would be submitted in 2021. Moorfields operated a networked model of care covering 30 sites which would not be affected by any move of services based at the main hospital site.

Some 71% of respondents to the consultation survey were current users of the hospital services. Quality assurance for the consultation had been undertaken by the Consultation Institute and the proposals would also be scrutinised by the Mayor of London.

The nearest station to the current site (Old Street) was not step free whilst this would be available from Kings Cross station for the new hospital location. A group of visually impaired patients had already tested the walking route from Kings Cross station to the site and work on the route had also been undertaken with the Royal National Institute for the Blind.

Officers wished to have more bus routes serving the new site and to encourage better signposting to the new hospital both from the station and at street level. Engagement work with Transport for London and London Borough of Camden was already underway on these issues.

A number of alternative sites had been considered but only the St Pancras location had met all critical success factors. The existing City Road site would be put on the market once the full business case had been approved which was expected to be confirmed in late 2020. The new building would be formally completed in spring 2026 though a transition of period of around six months was likely as services moved over to the new site. It was planned to transfer and reuse existing equipment where possible but detailed work on this had not been undertaken as yet.

The bed capacity of six would remain the same at the new site as nearly all current Moorfields treatment was undertaken on a day patient basis. Improvements in technology were also likely to man less overnight stays would be needed. Capacity for outpatients would be increased by the design of the new hospital.

Officers were aware of the risks of overspends in the project or of rises in inflation but the business case would include contingencies for this and this would be challenged as part of the business case process.

It was agreed that a visit to the current hospital site should be arranged for Members in order to scrutinise further the issues faced by the hospital. The Committee thanked the officers for their attendance and noted the overall position.

Chairman

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 28 JANUARY 2020

Subject Heading:	Aligning Commissioning Priorities – Evidence Based Interventions Policy
Report Author:	Anthony Clements, Principal Democratic Services Officer, London Borough of Havering
Policy context:	The information presented gives an update on changes to commissioning policies for a number of local health services.
Financial summary:	No financial implications of the covering report itself.

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

Details are given in the attached papers of progress with changes to local commissioning policies for a number of health services.

RECOMMENDATIONS

1. That the Committee considers the information presented and takes any action it considers appropriate.

REPORT DETAIL

The North East London Commissioning Alliance has asked to update the Joint Committee at this point on progress with changes to its commissioning policy on a number of local health services. Further details including a summary of changes to the policy are shown in the attached papers.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

North East London Evidence Based Interventions Policy

North East London Commissioning Alliance

Update for BHR JHOSC

1.0 Introduction

This paper provides an update on the Evidence Based Interventions Policy, it includes a 'You said, We did' section which has been cascaded to stakeholders and participants in the engagement. Embedded in the document is the new policy which has been named the North East London Evidence Based Interventions Policy.

2.0 Background and Context

In May 2019, we asked local people to tell us what they thought about plans to change our commissioning policies in Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. These list specific treatments, procedures and interventions that the NHS funds, and who is eligible to have them.

During the six weeks of engagement we spoke to around 600 individuals by hosting or attending approx. 30 events and received 230 responses from individuals and organisations including:

- Patient Engagement Forums
- Older Peoples Reference Group meetings
- Age UK meetings
- Local Medical Councils
- GP Protected Learning Time Events
- Council for voluntary services
- Patient Participation Groups
- Patient Workshops
- Patient Events
- Health scrutiny committees

Information was published on the Clinical Commissioning Group (CCG) websites, which included an easy read format, a patient friendly version of the engagement document, a clinical version of the engagement document, an equality impact assessment and a quality impact assessment along with a questionnaire to collect responses.

CCG communications teams distributed communications to local GPs, CCG staff, MPs, Health Watch, patient reference groups, hospitals, councils and the north east London Citizen's Panel and tweets regarding the programme were sent from CCG corporate accounts. Information on the proposals was also included in staff newsletters, practice bulletins and GP practice portals and sent to local optical committees.

Chief Medical Officers from Barts, BHRUT, Homerton, ELFT, NELFT and Moorfields were contacted and asked to disseminate information via their networks to ensure feedback from consultants on the proposals could be captured.

Feedback given at events, via email and in questionnaires have been analysed and this feedback was presented to the Clinical Reference Group who discussed potential changes to the overall policy and to specific treatments.

Appendix B sets out a summary of the procedure level decisions made at the Clinical Reference Group which formed the basis of the recommendations we will be making to CCG Governing Bodies.

We are grateful to all those who have contributed and helped us refine and strengthen our proposals. We have benefitted from a rich array of suggestions and insights which have helped shape the proposed north east London Evidence Based Interventions policy **(embedded in Appendix A (i)).**

3.0 You said, we did

The following is a summary of recurring themes received either in questionnaires or at events and the actions the Alliance is taking as a result. This summary will be published on CCG websites and distributed to clinicians, patients and the public who took part in the engagement exercise.

1. **Concerns about the criteria for hip and knee replacements and whether it unfairly targeted older people and could undermine clinical judgement**

We have conducted an audit which showed that clinicians were following the proposed pathway and there would be no real impact on clinical practice from making this change, so GPs agreed to remove hip and knee replacements from the policy.

2. **Suggestions were made for patients to be involved throughout the process in the future.**

We are keen to learn from this engagement which is the first we've done as the North East London Commissioning Alliance and we will look at how we can involve patients more in the design and implementation of services.

3. **"The proposed policy does not state any exclusions for mental health patients"**

Mental health is often a factor in patients seeking treatment or surgery. There are no universally accepted and objective measures of psychological distress, so it is difficult to include such factors when setting clinical thresholds for agreeing when a particular treatment is effective or needed.

We believe it is generally better to provide support, such as therapy, to treat the mental health need, but if a clinician thought there were exceptional mental health reasons why a patient needed treatment, they could apply through the individual funding request process explaining why this is an exceptional case.

Our GPs considered the feedback received and felt it was important the policy was altered to make clear that if mental health affects people's ability to function then it should be considered for funding, provided there is evidence of the patient having received psychological treatment prior to the procedure. The policy has been updated to reflect this.

4. **Cancer - "It is unclear whether all (or just selective policies) are not applicable to patients who have or have survived cancer."**

We have always been clear that this does not apply to patients with confirmed or suspected cancer. GPs have updated the policy to include a statement to clarify that that cancer patients will be excluded where the treatment sought is in relation to their cancer care.

5. **"The documentation is too clinical and not clear"**

The nature of a document like this is that it is clinical, as it was developed in line with the latest national clinical guidance. Recognising this, we produced an easy read version but will consider how we might involve patients in ensuring documents are easy to understand in future work.

6. **"NICE guidance says you can't use visual acuity to determine whether cataract removal should be carried out"**

We have sought advice from clinicians at our local hospitals including Moorfields, a specialist eye hospital, and they all support the policy. This means that all patients in London will get the same access to cataract surgery.

7. "The questionnaire needs to be improved, hard for people to reference back to main document constantly to answer"

The complexity of what we were proposing meant that the questionnaire was complicated and we will test future questionnaires with local people before they are finalised.

8. If patient are unable to access these treatment, what are the alternatives?

We will make sure all clinicians know how to apply the policy asking them to consider the overall health and wellbeing of the patient and to ensure that, where appropriate, referrals are made to talking therapies and support services available through social prescribing link workers.

9. Clinicians fed back that they were concerned that this might add an additional administrative burden to their already busy workloads

Further to this feedback, work has commenced to simplify and automate the process using special software to reduce the administrative burden for clinicians.

5.0 Implementation Update

The NEL CCGs informed all acute and independent Sector providers on 1st October 2019 in accordance with service condition 29.24, via their Coordinating Commissioner. The policy came into effect from 1st November 2019.

Blue Teq System Implementation

There are three main NHS Acute Providers within the NEL CCG system; these are BHRUT, Barts and Homerton. As part of the implementation phase, a new process that requires the Trust to get prior approval for specific procedures is being put in place. These procedures are outlined in category 2 of the NEL EBI policy. Out of the three, BHRUT is the only Trust that had an existing prior approval process in place.

We have met with each of the providers to help support the change in process and system along with the CSU Prior Approval Team. The preferred software system used by the team is BlueTeq.

5.1 Policy Review

The Clinical Review Group (CRG) agreed to review the policy six months from the date the policy went live (1 November 2019), therefore a review CRG will be established in May 2020 to look through any feedback received since the policy has been published.

APPENDIX A

(i) Final Policy

NEL EBI
2019-2020_CRG_DRA

APPENDIX B

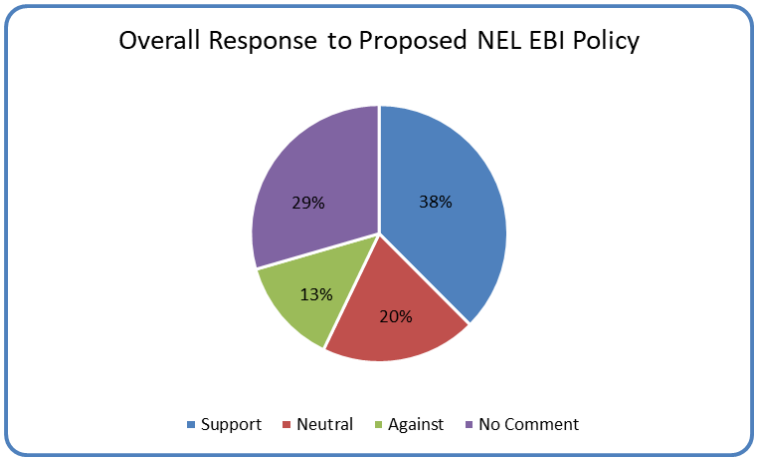
Procedure	Decision made
The following Injections for <u>non-specific</u> low back pain :	
Facet joint injections	Adopt NHS England policy to ensure consistency of approach for patients and clinicians.
Therapeutic medial branch blocks	Adopt NHS England policy but provide clarity that diagnostic medial branch blocks continue to be funded as per NICE guidance
Intradiscal therapy	Adopt NHS England policy to ensure consistency of approach for patients and clinicians.
Prolotherapy	Adopt NHS England policy to ensure consistency of approach for patients and clinicians.
Trigger point injections with any agent, including botulinum toxin	Adopt NHS England policy to ensure consistency of approach for patients and clinicians.
Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis	Adopt NHS England policy to ensure that consistency of approach for patients and clinicians.
Any other spinal injections not specifically covered above	Adopt NHS England policy to ensure that consistency of approach for patients and clinicians.
Surgical interventions for snoring in the absence of obstructive sleep apnoea	Adopt NHS England policy to ensure that consistency of approach for patients and clinicians.
Chalazia removal	Adopt NHS England policy to ensure consistency of approach for patients and clinicians.
Haemorrhoidectomy	Adopt NHS England policy to ensure consistency of approach for patients and clinicians.
Shoulder Decompression	Adopt NHS England policy but with a review in March 2020 if anticipated guidance has an impact.
Interventional treatments for back pain : Epidurals, Spinal Decompression, Discectomy, Epidurolysis, spinal fusion surgery	Adopt London policy to ensure consistency of approach for patients and clinicians.
Lumbar disc replacement surgery	Adopt London policy to ensure consistency of approach for patients and clinicians.
Acupuncture	Clarify that acupuncture is not routinely funded as an isolated intervention

Ozone discectomy	Adopt London policy to ensure consistency of approach for patients and clinicians.
Cataract Surgery	Adopt London policy to ensure that consistency of approach for patients and clinicians.
Hip arthroplasty	Remove from policy following feedback and audit results showing compliance with good practice
Knee arthroplasty	Remove from policy following feedback and audit results showing compliance with good practice
Laser surgery for short sightedness	Adopt proposed local policy following support from local clinicians
Functional electrical stimulation (FES) for foot drop	Adopt proposed local policy
Abdominal wall hernia management and repair	Adopt proposed local policy
Bariatric Surgery	Adopt proposed policy in line with NICE guidance
Pinnaplasty/Otoplasty	Adopt proposed policy following feedback from local clinicians
Rhinoplasty/Septoplasty/Rhinoseptoplasty	Adopt proposed policy following feedback from local clinicians
Dupuytren's contracture release	Adopt NHS England policy to ensure that consistency of approach for patients and clinicians.
Female breast reduction	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Grommets for glue ear in children	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Trigger Finger	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Dilation & Curettage (D&C) for heavy menstrual bleeding in women	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Surgical treatment of carpal tunnel syndrome	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Repair of split ear lobes	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Herbal medicines	Adopt NHS England policy to ensure consistency of approach for patients and clinicians
Treatment for scarring and skin hyper- or hypo-pigmentation	Adopt proposed local policy
Sympathectomy for severe hyperhidrosis	Adopt proposed local policy

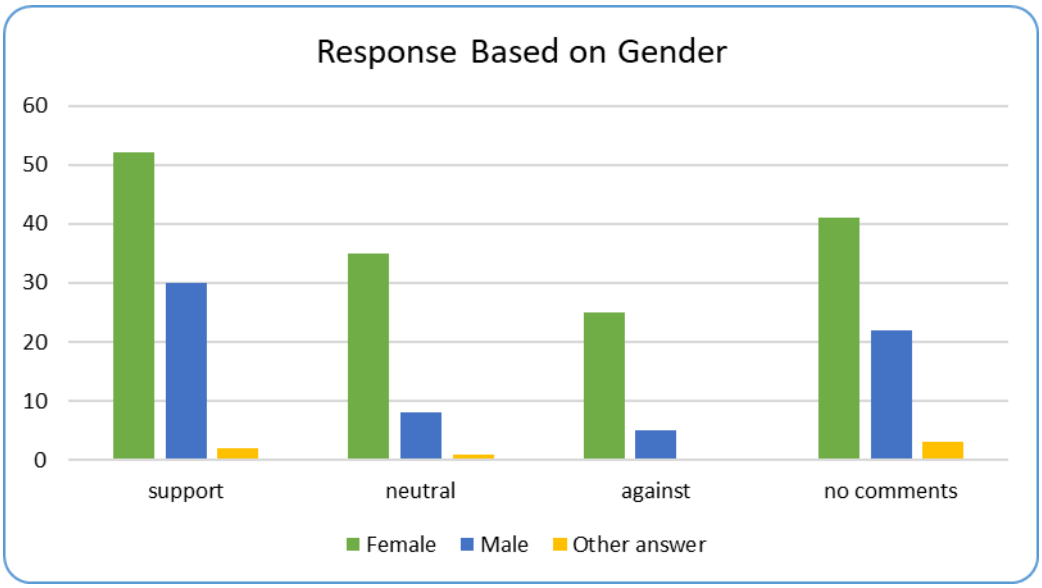
APPENDIX C

The following is an analysis of the questionnaires that were received either electronically or on paper. These graphs demonstrate the reach that the engagement exercise achieved and the level of support for the proposed changes.

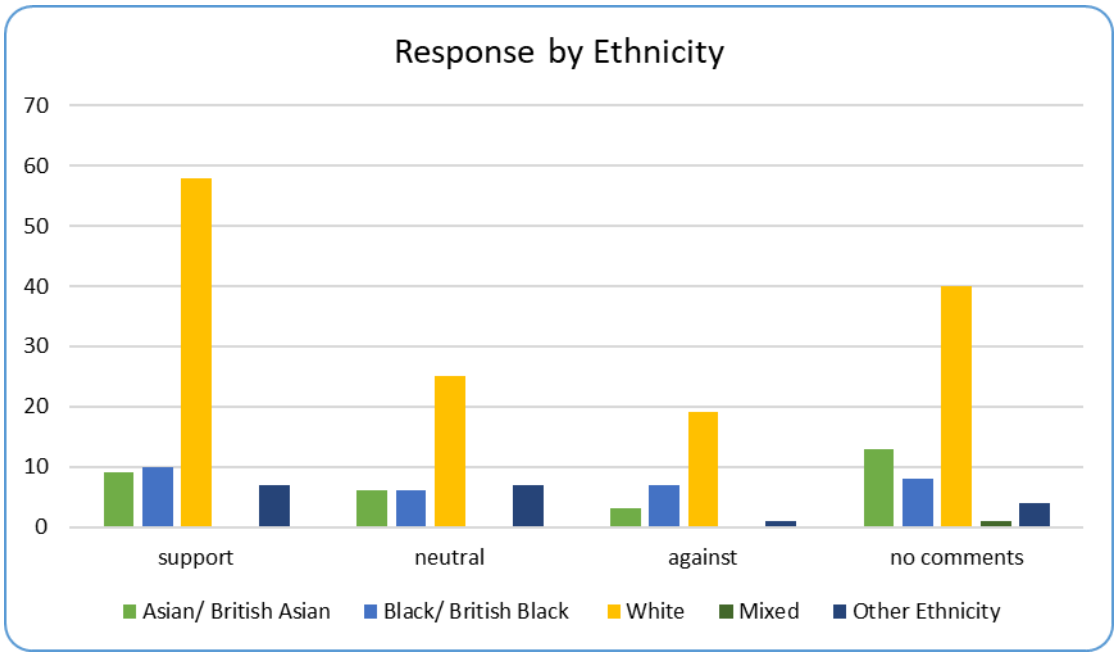
1. Overall response to proposed NEL EBI Policy



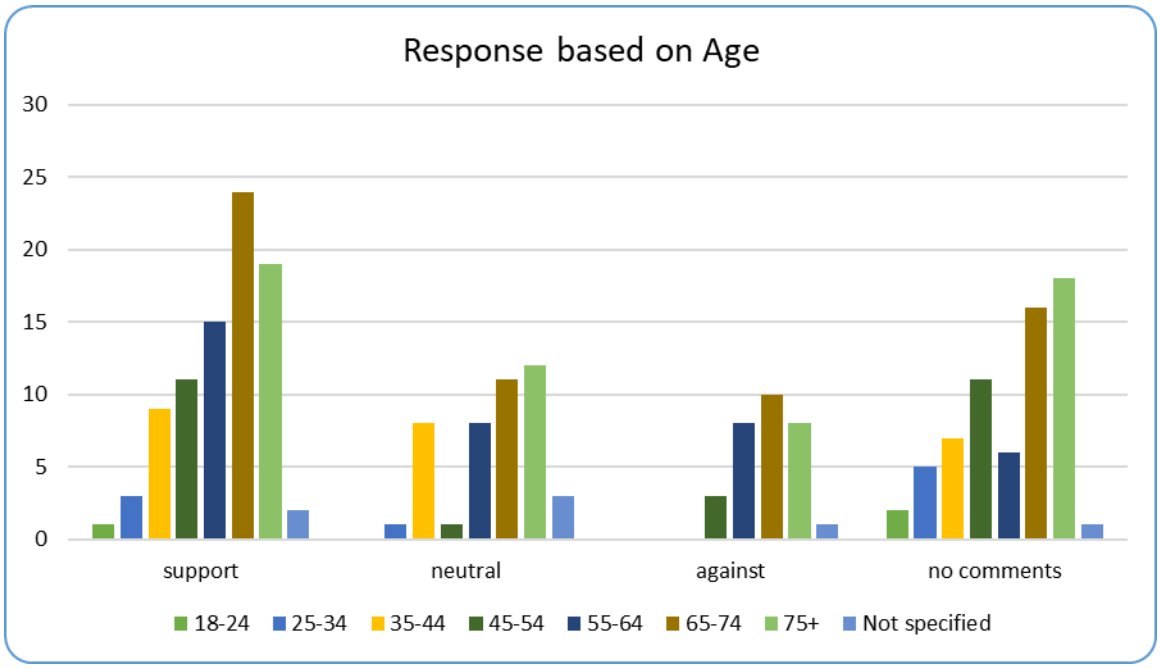
2. Response based on Gender



3. Response based on Ethnicity



4. Response based on Age



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North East London Commissioning Alliance

North East London

Evidence Based Interventions Policy

Procedures not routinely funded (Individual Funding Requests (IFR)) or requiring prior approval

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

Version: 1.0

Date of publication: October 2019

Document details

Document reference	NEL Evidence Based Interventions Policy Version 1.0
Document category	Clinical Policy
Date of publication	October 2019
Approved By	North East London Clinical Commissioning Groups

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.

NEL EBI Policy is a clinically led and evidence based programme. In developing the NEL EBI, we have taken into account clinical advice from local clinicians, national clinical evidence and guidelines i.e. NICE. A network of clinicians from all seven North East London CCGs have been involved in the development of this policy and in reviewing and updating specific sections.

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 stricter 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 the seven North East London Clinical Commissioning Groups (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. **Obtaining funding approval and due process.**

There are two main routes by which funding can be sought and obtained as outlined below:

Funding for any of the procedures or interventions contained in this policy will be subject to (a) if an exceptional case is made through an individual funding request (IFR) OR (b) prior approval. Further details are described below:

Prior Approval - This means the CCG will fund treatment if the patient meets the stated clinical threshold for care. Before the procedure is undertaken Prior Approval must be sought and obtained. A GP or Consultant must seek approval for an individual before treatment is carried out. In the majority of cases this will be requested by the treating clinician with the exception of the following procedures where the GP will have more information regarding the patient's clinical condition.

- Tonsillectomy (page 12)
- Chalazia removal (page 9)
- Abdominal wall hernia management and repair (page 25)

IFR (Not routinely funded) - The statement "NEL CCGs 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 contacting the following:

For City and Hackney, Newham, Tower Hamlets and Waltham Forest**:**

Email: nelcsuwelc-ifr@nhs.net or Tel. 020 3688 1290

For Barking and Dagenham, Havering and Redbridge:

Email: nelcsubhr-ifr@nhs.net or Tel. 020 3688 1290

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:

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

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. If a patient's clinical condition matches the 'accepted threshold indicators' for a treatment that is not funded, their circumstances are not, by definition, exceptional.

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.

Performance monitoring arrangements

Performance measures and audits will be used to monitor provider activity. These will be carried out as instructed by individual CCGs. Any procedures carried out that are not in line with this policy will be investigated and, where appropriate, challenged for non-payment.

Prior Approval and IFR – 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

Retrospective audits - The frequency, scope and depth for the said 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.

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

Equality statement

NEL CCGs have 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 CCGs have 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 CCGs 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 CCGs have completed an Equality Impact Assessment (EIA) and Full Quality Impact Assessment (fQIA) for this policy update.

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 their cancer pathway eg. breast reconstruction following breast cancer.
- If Mental Health affects functionality then it should be considered for funding. Although in such cases there should be evidence of the patient having received psychological treatment prior to the procedure.
- 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 as part of the payment verification process.

Implementation time scales

This policy will be used to assess all patients being referred for assessment or treatment from 01 November 2019. The NEL EBI will be reviewed one year from the date of implementation. A formal Clinical Review Group (CRG) will be reinstated and the Nationally mandated policies will be adopted without further consultation.

Category 1 Procedures: Individual funding request (IFR)

This list includes procedures that are not routinely commissioned by NEL CCGs, 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.

Acupuncture	Alternative therapy	27
Herbal medicines	Alternative therapy	27
Homeopathy	Alternative therapy	27

* Appendix A provides more clinical guidance for category 1 – IFR procedures.

** See breast reduction and correction of breast symmetry

Category 2 Procedures: Prior Approval (PA)

Procedures	Speciality	Page No.
Excision of skin and subcutaneous lesions	Dermatology & Skin	6
Hair epilation	Dermatology & Skin	7
Keloid and other scar revision	Dermatology & Skin	8
Cataract surgery	Ophthalmology	8
Chalazia removal	Ophthalmology	9
Surgery on the upper or lower eyelid (blepharoplasty)	Ophthalmology	10
Grommets for glue ear in children	ENT	10
Pinnaplasty/otoplasty (correction of prominent or bat ears)	ENT	11
Rhinoplasty/Septoplasty/Rhinoseptoplasty (surgery to reshape the nose)	ENT	11
Surgical treatment of chronic sinusitis	ENT	12
Tonsillectomy	ENT	12
Breast reduction and correction of breast symmetry	Breast	14
Nipple inversion	Breast	15
Removal / revision of breast augmentation	Breast	15
Bunion surgery (Hallux Valgus)	Orthopaedics	16
Dupuytren's contracture release	Orthopaedics	16
EXOGEN bone healing	Orthopaedics	17
Functional electrical stimulation (FES) for foot drop	Orthopaedics	17
Ganglion excision	Orthopaedics	17
Interventional treatments for back pain	Orthopaedics	18
Shoulder decompression	Orthopaedics	20
Surgical treatment of carpal tunnel syndrome	Orthopaedics	20
Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary)	Orthopaedics	21
Trigger finger	Orthopaedics	21
Bariatric Surgery	Bariatric surgery	23
Bartholin's cysts	Gynaecology/Urology	23
Circumcision	Gynaecology/Urology	23
Hysterectomy for menorrhagia (heavy menstrual bleeding)	Gynaecology/Urology	24
Abdominal wall hernia management and repair	General surgery	25
Abdominoplasty	General surgery	26
Haemorrhoidectomy	General surgery	26
Varicose veins	General surgery	27
Botulinum toxin (not cosmetic)	Other	28
Open MRI	Other	29

Detailed Procedure Criteria Guidance

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 hair loss (alopecia)
Treatment for scarring and skin hyper- or hypo- pigmentation

Category 2 Procedures: Prior Approval (PA)

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 **With prior approval, NEL CCGs 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

With prior approval, NEL CCGs 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 CCGs do not fund maintenance treatment for hirsuitism, 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 hirsuitism due to an endocrine disorder may be referred to an endocrinology department but this is not an indication for NHS funding of epilation. NEL CCGs will fund radiosurgery for the treatment of symptomatic trichiasis.

Keloid and other scar revision

Criteria

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

With prior approval, NEL CCGs 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.

Ophthalmology

Category 1 Procedures: Individual funding request (IFR)

Laser surgery for short sightedness

Category 2 Procedures: Prior Approval (PA)

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

With prior approval, NEL CCGs 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

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).

*List of 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

Chalazia removal

Criteria

With prior approval, NEL CCGs 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

With prior approval, NEL CCGs 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 CCGs 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.

Ears, Nose & Throat (ENT)

Category 2 Procedures: Prior Approval (PA)

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.

With prior approval, NEL CCGs 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 prominent or bat ears)

Criteria

With prior approval, NEL CCGs 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 significant prominent or bat 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

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

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.

Surgical treatment of chronic sinusitis

Criteria

ENT referral is appropriate for suspected:

Complications, e.g. periorbital infection or suspected sinonasal tumour.

Surgical treatment of chronic sinusitis is not routinely funded by NEL CCGs and will only be considered for funding, with prior approval, where all of the following criteria are met:

1. Recurrent or chronic sinusitis of uncertain cause

AND

2. Unremitting or progressive facial pain

AND

3. A trial of intranasal corticosteroids of three months in duration has been ineffective

AND

4. A significant anatomical abnormality

Additional Information

Evidence Base: NHS Clinical Knowledge Summaries advise a trial of intranasal corticosteroids for three months for treatment in the first instance.

Sinus puncture and irrigation has a poor diagnostic yield, and carries the risk of secondary contamination.

Only short-term benefit seen in patient refractory to medical management treated with balloon catheter dilation of sinus ostia.

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.

With prior approval, NEL CCGs 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

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 CCGs will fund surgery when one of the following criteria are be met:**

Section 2

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.

Respiratory

Category 1 Procedures: Individual funding request (IFR)

Surgical interventions for snoring in the absence of obstructive sleep apnoea

Haematology

Category 1 Procedures: Individual funding request (IFR)

White cell apheresis

Breast

Category 1 Procedures: Individual funding request (IFR)

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

Category 2 Procedures: Prior Approval (PA)

Breast reduction and correction of breast symmetry
Criteria
Section 1: Bilateral breast reduction **With prior approval, NEL CCGs 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. **With prior approval, NEL CCGs 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.

With prior approval, NEL CCGs 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 **With prior approval, NEL CCGs 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 **Revision** **With prior approval, NEL CCGs will fund reinsertion of new breast implants when criteria 1 and one of criteria 2(a) or 2(b) are met:** 1. The original implant insertion was funded by the NHS **AND** 2(a). The patient would still be eligible for breast implant under NEL CCGs commissioning policies breast augmentation **OR** 2(b). The patient would still be eligible for breast implant under NEL CCGs commission policy for correction of asymmetry NEL CCGs will not contribute funding to procedures funded privately, irrespective of whether part of that procedure involves removal of breast implants.

Orthopaedics

Category 1 Procedures: Individual funding request (IFR)

Autologous chondrocyte (cartilage) implantation
Injections for non-specific low back pain
Knee arthroscopy for patients with osteoarthritis
Lumbar disc replacement
Ozone discectomy
Spinal fusion for non-radicular back pain

Category 2 Procedures: Prior Approval (PA)

Bunion surgery (Hallux Valgus)

Criteria

With prior approval, NEL CCGs 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

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.

With prior approval, NEL CCGs 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

With prior approval, NEL CCGs 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

EXOGEN bone healing

Criteria

With prior approval, NEL CCGs will fund EXOGEN ultrasound bone healing system when the following criteria are met:

1. Long bone fractures that have failed to heal after nine months (non-union)

NICE Guidance MTG12

Functional electrical stimulation (FES) for foot drop

Criteria

With prior approval, NEL CCGs 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

Ganglion excision

Criteria

Section 1: Wrist ganglia

With prior approval, NEL CCGs 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

With prior approval, NEL CCGs 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

With prior approval, NEL CCGs 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

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

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.

Section 1: Epidurals

With prior approval, NEL CCGs 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.

Medial branch blocks, sacroiliac joint injections and subsequent medial branch radiofrequency lesioning (facet joint denervation) or sacroiliac joint radiofrequency denervation are only funded if performed in a Pain Service with a multidisciplinary team approach, only to be performed by doctors trained in Biopsychosocial Assessment.

Section 2: Spinal decompression

With prior approval, NEL CCGs 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

Section 3: Discectomy

With prior approval, NEL CCGs will fund interventions for discectomy when both of the following criteria are met:

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

AND

2. The patient has shown no sign of improvement despite conventional therapy for 12 weeks

Section 4: Epidurolysis (See also NICE IPG 333)

With prior approval, NEL CCGs 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.

Spinal Fusion

Spinal fusion surgery is not routinely funded for non-radicular back pain

Lumbar Disc Replacement

Lumbar disc replacement surgery is not routinely funded

Acupuncture

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

Ozone Discectomy

Ozone discectomy is not routinely funded

Shoulder decompression

Criteria

With prior approval, NEL CCGs 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.

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)

With prior approval, NEL CCGs 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.

Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary)

Criteria

With prior approval, NEL CCGs 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.

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) **With prior approval, NEL CCGs 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%).

Abdominal Surgery

Category 1 Procedures: Individual funding request (IFR)

Cholecystectomy for asymptomatic gall stones

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: Prior Approval (PA)

Bariatric Surgery
Criteria
With prior approval, NEL CCGs 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

Gastroenterology

Category 1 Procedures: Individual funding request (IFR)

Double balloon enteroscopy for diagnostic purpose

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
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

Category 2 Procedures: Prior Approval (PA)

Bartholin's cysts
Criteria
With prior approval, NEL CCGs 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
With prior approval, NEL CCGs 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. Paraphimosis

OR

3. Suspected cancer or balanitis obliterans

OR

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

OR

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

OR

6. 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.

With prior approval, NEL CCGs 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.

With prior approval, NEL CCGs 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.

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

General Surgery

Category 1 Procedures: Individual funding request (IFR)

All treatments for vascular lesions

Category 2 Procedures: Prior Approval (PA)

Abdominal wall hernia management and repair
Criteria
With prior approval, NEL CCGs will fund abdominal wall hernia management and repair when one of the following hernias are diagnosed: 1. Symptomatic hernias (i.e. hernias causing pain) **OR** 2. Irreducible hernias **OR** 3. All femoral hernias **OR** 4. Spigelian hernias **OR** 5. Inguinal hernias extending to scrotum **OR** 6. Incisional hernias with small defects **OR** 7. Hernias at risk of strangulation - small neck **OR** 8. Symptomatic umbilical hernias

Abdominoplasty
Criteria
With prior approval, NEL CCGs 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 **With prior approval, NEL CCGs 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.

With prior approval, NEL CCGs 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.

With prior approval, NEL CCGs 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.

Physiotherapy

Category 1 Procedures: Individual funding request (IFR)

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

Medicine

Category 1 Procedures: Individual funding request (IFR)

Ketogenic diet for epilepsy

Alternative therapy

Category 1 Procedures: Individual funding request (IFR)

Acupuncture
Herbal medicines
Homeopathy

Other

Category 2 Procedures: Prior Approval (PA)

Botulinum toxin (not cosmetic)
Criteria
NEL CCGs will not fund the use of Botulinum Toxin for cosmetic treatments. **<u>Botulinum Toxin applications in oculoplastics</u>** **With prior approval, NEL CCGs will fund the use Botulinum A by an oculoplastics specialist when one of the following criteria are met:** **<u>Section 1: Entropion</u>** **Botox will be commissioned by NEL CCGs 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 **<u>Section 2: Corneal Ulcer/lagophthalmos</u>** **With prior approval, NEL CCGs will fund corneal ulcer/lagophthalmos by an oculoplastics specialist when one of the following criteria are met:** Botox will be commissioned by NEL CCGs 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 lagopthalmos 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. **With prior approval, NEL CCGs 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.

Appendix A

This appendix provides more clinical guidance for treatments for category 1 procedures (IFR) through either the work of London Choosing Wisely or the National Evidence Based Interventions.

Category 1 Procedures: Individual funding request (IFR)

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. Alternative options are suggested in line with the National Back Pain Pathway. For further information, please see: https://www.nice.org.uk/guidance/ng59

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. UIltrasound 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.

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.

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.

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Mr Joe Fielder, Chair
Mr Chris Bown, Interim Chief Executive Officer
Barking, Havering and Redbridge University Trust
Queen's Hospital
Rom Valley Way
Romford, Essex RM7 0AG

6 September 2019

Dear Mr Fielder and Mr Bown

BHRUT Response to the Healthwatch Report to JHOSC 9 July 2019

At the Joint Health Overview and Scrutiny Committee (JHOSC) meeting in April 2019, the Healthwatch organisations from Barking & Dagenham, Havering and Redbridge published their joint report regarding the impact of the recent changes to chemotherapy services at BHRUT. At the meeting, officers from BHRUT accepted the recommendations within the report and were asked to provide further responses at the JHOSC meeting on 9 July 2019.

Colleagues from all three Healthwatch have now had the opportunity to meet and review your response and we would like to make some additional comments based on our original recommendations.

We feel it might be helpful if we were also to arrange a meeting to discuss our response in order to identify where additional concerns were raised and to ensure patients and carers are provided the best care and support possible at Queens and King George's Hospitals.

It would be helpful if the meeting could be arranged before the next JHOSC meeting (15 October 2019) as we will be sending a copy of our response to the committee for information and comments. We will also be raising our additional comments at the committee meeting.

To ensure clarity, we have updated your responses to each of the original Healthwatch recommendations.

Yours Sincerely

Cathy Turland

For and on behalf of Barking & Dagenham, Havering and Redbridge Healthwatch

Healthwatch Redbridge
Cathy Turland - Chief Executive Officer

Healthwatch Barking & Dagenham
Richard Vann – Healthwatch Officer

Healthwatch Havering
Ian Buckmaster – Executive Director

Cc: Anthony Clements, JHOSC

HEALTHWATCH RECOMMENDATION RESPONSES

Accident and Emergency

HW Recommendation

The main concern to emerge from the event was the apparent lack of familiarity of staff in both Urgent Treatment Centre and the mainstream Emergency Departments, with the specific healthcare needs of patients undergoing treatment for cancer.

We recommend as a matter of urgency, clinical leads from urgent and emergency care meet their counterparts in oncology to agree protocols for dealing with cancer patients who hold red cards and require urgent or emergency treatment to ensure that their cancer treatment is not compromised in any way.

BHRUT Response

Since the Healthwatch report was published we have taken the following actions:

1. Trust colleagues have met with the Partnership of East London Cooperatives (PELC) who provide the Urgent Treatment Centre service. They are now displaying clear notices in waiting areas to ensure our cancer patients know to identify themselves.
2. Staff who carry out the streaming of walk-in patients to our Emergency Departments (EDs), have been briefed to flag to the appropriate department that the patient has a red card when directed there.
3. Signs have been placed in clinical areas to remind staff to prioritise these patients.
4. We have refreshed our system and have clear protocols in place and flags on our patient record system.

It is worth noting that whilst our ED staff are highly skilled and trained, there may be a need to refer to a specialist on call for cancer patients, in order that the best possible care and treatment is provided.

Red cards (chemotherapy alert card)

When they first present in our EDs, patients with a red card are fast-tracked to find out what is wrong, and to assess their risk for infection (alerting staff to the increased risk of neutropenic sepsis).

However, it does not necessarily mean they will be fast-tracked to immediate treatment. Once the assessment has been made they will then be prioritised based on their medical need.

We will review how the red cards are explained to patients as the report has highlighted the potential for miscommunication or misunderstanding.

HW Additional Response

- *Healthwatch Havering recently carried out a visit to the Urgent Treatment Centre at Queen's Hospital and were pleased to observe a number of notices for patients and staff.*
- *We would however, request a copy of the protocol be forwarded to us.*
- *We will continue to monitor UTC's and Emergency Departments across the region to ensure this remains consistent.*
- *Healthwatch Redbridge have recently been made aware that a patient at another*

hospital has raised concerns as they were not triaged appropriately. This will be followed up in due course.

- *We understand that a patient's treatment is prioritised on their need however, we would question how a patients' needs are affected (such as their possible low immune systems) by other patients presenting with possible contagious conditions.*

Sunflower Suite (Queen's Hospital)

HW Recommendation

The lack of privacy, cramped space and lack of natural light needs to be addressed by the Trust. Patients are undergoing treatments which can be quite traumatic. Having conducive surroundings has a huge impact on the wellbeing of patients undergoing lengthy treatments.

BHRUT Response

There has been no increase in beds or chairs on the Sunflower Suite to accommodate extra patients. The move from Cedar Ward at King George Hospital has resulted in treating an additional 10 patients per week on Sunflower Suite and there has been no impact or increase of the number of patients being treated at any one time.

With 24 to 27 days available each month to spread the activity, the growth on any given day is minimal, and this current increase in demand has been comfortably accommodated by extended hours and Saturday opening.

Should further capacity be needed, the option to extend the service to seven-day working is possible, opening on a Sunday should demand require it.

It is worth noting that due to the increase in the number of patients presenting with more complex cases, the number of patients being treated at Cedar Ward was naturally reducing over time and correspondingly the number was increasing at Sunflower Suite; see following table.

Number of chemotherapy treatments

2018	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
KGH	225	195	202	155	147	72	49	52	28	35	7	0	1167
QH	524	498	504	548	591	659	717	708	696	754	777	705	7681

Sunflower Suite does have three skylights, however, we appreciate there are no windows letting in natural light. At the current time there are no other available options.

HW Additional Response

- *At the focus group, patients and carers at all tables stated they felt the suite was cramped. We would ask why there is this perception.*
- *In what way were the hours extended? What are they now?*
- *It also appears from the figures presented that there was a reduction in patients attending since June 2018, a long time before the consultation took place. Could this be explained please?*

Patient Transport & Parking Facilities

HW Recommendation

Patients and carers should have access to parking when they need it. If the car park is required for other purposes, we would recommend the Trust identify how they could ensure patients can access other parking facilities free of charge.

BHRUT Response

Parking

We do provide free parking for cancer patients whilst receiving treatment at Queen's. However, we acknowledge the dedicated oncology parking was reduced at the time as a result of two temporary units (a mobile decontamination unit (EMS) following a fire in our endoscopy suite and an MRI scanner) being placed in the car park.

However, the decontamination unit was removed on 16 April and has improved the availability of parking spaces considerably.

As part of our ongoing review of services, should parking for chemotherapy patients become a significant problem at any point in the future due to an increase in demand we will reassess the current arrangements, and consider other options.

HW Additional Response

- *The decontamination unit was in place for over a year. The endoscopy unit is still taking up car parking spaces.*
- *At what point are patients and carers made aware they can park for free in the multi-story car park or other bays? Is there a leaflet within the ward or outpatients department?*
- *We found little evidence that patients (attending the focus group) were asked or indeed knew that they could get free parking or transport.*

HW Recommendation

All patients should be assessed for patient transport.

BHRUT Response

Patient transport

Consultants assess all our patients prior to their first treatment, and authorise transport if the criteria are met.

If, over the course of a patient's treatment, nurses notice changes in their condition and their ability to attend our hospitals, they are reassessed and transport is booked where appropriate.

HW Additional Response

- *We found little evidence that patients (attending the focus group) were asked, or indeed knew that they could get free parking or transport.*
- *How is patient transport actually assessed? Does the consultant make an assessment without asking the patient or carer?*
- *Is the reassessment assumed by nursing staff or are patients provided with this information when they attend future appointments?*

Oncology Appointments

HW Recommendation

We recommend the system for booking patient appointments is reviewed. Patients should be able to confirm their next appointment before leaving the department.

BHRUT Response

The direct booking at reception for oncology appointments was stopped due to the large number of appointments requiring overbooking into clinics which cannot be done by the reception team.

There were also issues with long queues for patients waiting to book their appointments.

We are currently considering what options are available to help improve the current process.

HW Additional Response

- *Regarding your comment on overbooking - could you clarify what you mean?*
- *Where you say you are considering options, could you explain how, and with whom you are consulting*

Chemotherapy Appointments

HW Recommendation

We recommend the system for booking chemotherapy appointments is reviewed to ensure patients are booked in appropriately and not made to wait unnecessarily. Patients should not have to wait for long periods of time when they could be booked in later in the day.

If appointments are being offered before 9.30am, medication should be ready to be administered.

BHRUT Response

This is a very complex issue that we constantly strive to improve, and is a topic frequently discussed at our Chemotherapy Working Group.

Changes to the scheduling of the system have been made over the last few months, and templates have been provided to assist both the nursing and booking teams.

However, chemotherapy being dispensed on time is dependent on a number of factors, including the prescription being completed, the health of the patient, and bloods being within set parameters. Anything that requires further review or escalation to consultants will naturally slow the process down to ensure the continued safe treatment of our patients.

We try to accommodate requests for specific times as much as possible. Appointments at 9.30am are offered to patients who require at least 30 minutes pre-medication to try and prevent delays if the pharmacy has been unable to dispense the medication the night before.

HW Additional Response

- *Who are the members of you chemotherapy working group?*
- *Are any recent users of your chemotherapy services on it?*
- *If the suite is open from 8am, could you perhaps explain why the first appointments are not scheduled until 9.30am?*

Questionnaire

HW Recommendation

Information and issues identified through surveys and questionnaires should be addressed. Patients should feel listened to and valued for their opinion

BHRUT Response

Feedback from our patients is invaluable as it helps us to make improvements to our services. For example following patient comments regarding staffing levels in oncology, we held a recruitment drive and have increased our staffing numbers. We also extended our hours to include Saturdays.

There are a number of ways patients can give feedback, share their suggestions, and raise issues or concerns. This includes our Friends and Family Test, which every patient is encouraged to complete, and is where we ask them 'how likely are you to recommend our ward/service to friends and family if they needed similar care or treatment?'

As well as patients raising things locally with staff on the wards, our corporate teams such as our Patient Experience team, support, listen and respond to patient feedback aiming to improve the overall experience.

Our Patient Advice and Liaison Service (PALS) is also available to help patients and their relatives or carers with any advice or concerns.

Reviewing our services and continuously improving is a priority for us, and looking at new ways to incorporate the views and feedback from patients and visitors is vital to this.

HW Additional Response

- In regards to your comment about staffing levels; when were these comments received?
- Recruitment was already required before the move took place. Was this for additional resources?
- Could you also confirm whether student nursing placements are counted within your establishment figures, or super-numery?
- Are you now at full complement for chemotherapy nurses?

Phlebotomy

HW Recommendation

We would recommend that phlebotomy services are reviewed to understand where a better service could be initiated.

BHRUT Response

We recognise the opportunity for improvements in our Phlebotomy service (blood tests), and this has been a focus for the Trust over the past 12 months.

Based on feedback and data we are currently rolling out new initiatives such as an electronic appointment booking system, and a pilot of Saturday working at Queen's Hospital with a view to migrate to a seven day Phlebotomy service in the future.

Our patient partners are working closely with the division.

In addition, we are working closely with our system partners (NELFT and the CCGs) to improve services.

We are also looking into the possibility of a dedicated service for cancer patients.

HW Additional Response

- *Thank you for your response. We have no further comments.*

Clinic services

HW Recommendation

Patients should be able to ask for additional clinical support when they are attending clinics and not be sent to Accident and Emergency or Urgent Treatment Centre.

As previously stated, patients have raised concerns that Emergency Department clinicians do not always have the right level of experience to respond to the specific healthcare needs of patients undergoing treatment for cancer.

BHRUT Response

The most important thing is that our patients get the right advice and the right treatment from the right clinician. Whilst this may feel like an inconvenience by patients who are directed to another department, ultimately our key concern is their health and ensuring their needs are being met by the most appropriate person and service.

If required, patients from the clinic can be considered for direct admission to the ward but the safety and comfort of the individual patient dictates the option chosen.

HW Additional Response

- *Thank you for your response. We have no further comments.*

Cedar Centre

HW Recommendation

Patients who have used the new 'Living with Cancer and Beyond Hub' have rightly praised it, however we recommend that more patients need to be made aware of the opportunities. More publicity and information should be made available to patients attending Queens Hospital.

BHRUT Response

Health and wellbeing services are part of a major programme of work, formerly known as the 'recovery package' for cancer patients, and now referred to as 'personalised care.'

We have been working on the delivery of health and wellbeing groups for the past five years. There is national guidance on the core content of health and wellbeing information that should be available for cancer patients; we ensure we always follow this guidance when planning any groups.

The first stage of delivering personalised care is about ensuring our patients have had a Holistic Needs Assessment (HNA) which enables them to identify their main concerns at various points throughout the pathway of diagnosis and treatment.

Our clinical nurse specialists have been conducting HNAs with our patients for approximately two years. From these we have been able to run reports to evidence the top four concerns of our patients which in turn helps us to plan services to meet their needs. Finance and worry, and fear and anxiety, are consistently rated in the top four concerns; we have therefore increased our complementary therapy service to help address anxiety and are in the process of increasing our welfare benefits service.

Our group sessions are designed to meet people's information and support needs both pre

and post treatment.

The first session was initiated over five years ago, which is a one day post treatment health and wellbeing event. This is evaluated from written feedback from patients and carers who attend, and a patient partner also contributes.

Patient feedback from this event highlighted they would have found the information more useful before they started treatment, so in direct response we devised the EMPOWER session (a highly-commended service) which is a two-hour weekly workshop open to all patients recently diagnosed with any cancer.

Patients and carers complete feedback forms at every session. Weekly huddles are also held to review the attendance and comments of groups from the previous week, the information from which is used to build on and improve services.

In terms of signposting patients to the Cedar Centre service, our main form of communication about the range of activities on offer is via our newsletter, which is shared in the following ways:

- Oncology outpatient reception
- Receptions and waiting rooms in both Radiotherapy and Chemotherapy
- Macmillan information room
- Copies inserted in every new patient pack
- Promoted by all clinical nurse specialists (the keyworker for each patient) who signpost direct to services

We plan to expand this, by offering patients the option to sign up to this electronically to receive the newsletter by email – something already offered to those attending EMPOWER.

All the services available at the Cedar Centre (including complementary therapies and psychological support) are listed on our website, including contact details and how to book, plus a video to help people feel at ease for their first visit, and we hope to produce more videos about the services available in the coming months – more information can be found at www.bhrhospitals.nhs.uk/cancer-services

We have also begun issuing letters to all newly diagnosed patients inviting them to attend EMPOWER. It is expected that once people access this session they will take up more of the other services we offer.

For those who prefer social media, we have a cancer Twitter account (@BHR_cancerinfo) that regularly publicises activities taking place, so we have a range of ways for patients to hear about our services and engage with us.

All services are available to all patients having chemotherapy or radiotherapy treatment – however it's worth noting that accessing these additional services is optional.

HW Additional Response

- *Many patients and carers (at the focus group) said they were not made aware of the services available at the Cedar Centre.*
- *How do you make patients and carers aware of the services?*
- *Is the information available in other formats (other languages, easy read, large print etc).*

Demographics

HW Recommendation

We were however, concerned that the diversity figures presented by the Trust are not representative of the local populations particularly in Redbridge and Barking & Dagenham. Although we are aware a patient has the choice to use these services, we would recommend the Trust review the types of services being offered to identify why they are not being used by particular community groups.

BHRUT Response

The important point to note in regards to demographics is that the diversity of patients accessing our health and wellbeing services is largely reflective of our patients receiving treatment. We believe this to be a more appropriate measure than local populations.

We will continue to monitor and analyse the uptake of services.

See Appendix 1 for tables and charts showing a breakdown of ethnicity data between 1 December 2018 and 31 March 2019 for both the number of patients receiving treatment and those attending health and wellbeing services.

HW Additional Response

- *We remain concerned that the tables provided are not representative of the population served by the hospitals.*
- *National figures for cancers[1] do reflect some indications that demographics play a part in cancer diagnoses, however we remain concerned that the figures suggest that most patients receiving treatment at Queens (75%), and those accessing the Cedar Centre (81%) are not from BME populations, which is very different to the overall balance of the population across BHR.*

Pharmacy

HW Recommendation

Patients should be given better information and support to access pharmacy services. No patient should be asked to wait for a prescription if it will take over four hours to prepare. Better systems should be in place to allow patients to return to collect their prescription at a suitable time.

If patients are required to contact the pharmacy, the Trust must ensure contact details are continually reviewed and updated.

BHRUT Response

Some cancer patients are required to pick up prescriptions following appointments in Oncology outpatient clinics and due to the complexities of their conditions, these can take longer to prepare than standard medication, and need a number of checks completed.

However patients are provided with an approximate timeframe so they can leave and return to the Pharmacy later to pick up the drugs.

It is rare for a patient to have to wait four hours to have chemotherapy prepared, however chemotherapy for many patients cannot be pre-prepared as it has to be confirmed on the day after consideration of their physical condition; time then needs to be allowed for the preparation and administration to occur. Unfortunately this can cause

[1] https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/ethnicity

a delay however it is necessary to safeguard our patients.

For outpatient prescriptions it would be very rare that preparation would take four hours, unless there was an issue that had to be checked with the prescriber. In this case Pharmacy would advise the patient and ask them to come back later.

Pharmacy details have not changed and we accept on this occasion we may have given out the wrong number.

The provision of the chemotherapy medication for patients at the Cedar Centre was not ideal in that medication often could not be prepared until patients arrived at Cedar on the day of treatment and the distance between the hospitals inevitably caused some delays for the patients while they waited for the drugs to be delivered from Queen's Hospital.

This delay has been removed and although we cannot eliminate delay from the system completely, the movement to Sunflower Suite has made the system more efficient for patients.

HW Additional Response

- *Other hospitals such as Whipps Cross Hospital for example, still use this system of a 'satellite service' whereby chemotherapy medication is transported from a central hub.*
- *We are concerned that, as there was no proper consultation, the impact of this change has not been reviewed appropriately. When services are moved, there is a possibility that the cost burden is externalised and sits with the patient (in terms of additional travel costs for example).*

Patient Engagement

HW Recommendation

We recommend the Trust review the way patients and carers are involved in the development of the service. The Trust told us they had engaged with some patients who were previously using cancer services but we were not able to confirm whether they were recent users of current services.

Most patients and carers we spoke with told us they were not actively engaged with during the service change and would welcome the opportunity to have an input into the proposals.

BHRUT Response

We acknowledge that on this specific occasion we were unable to engage with patients as we had planned due to unforeseen circumstances which meant the service had to be moved much quicker than had been expected.

Whilst we regret patients and their families or carers were not able to input into the changes on this occasion, we strongly believe the move was in the best interests of patients and are pleased the Healthwatch findings did not highlight anything to the contrary.

As is standard practise, we will continue to review the service, and engage with all relevant stakeholders as appropriate.

We have very good engagement with our Patient Partner for the service, whose views and opinions are routinely taken on board, whether on general opportunities to improve or develop, or on specific proposals.

We also listen to views and suggestions, and ensure ideas are followed through, from the Cancer Patient Public Advisory Group (CPPAG).

HW Additional Response

- *We do feel the report highlighted a number of areas of concern. Your response seems to suggest the opposite.*
- *Many people were really positive about being engaged with in the future but are not Patient Partners (either by choice or because they do not know about the group).*
- *We remain concerned that not enough cancer patients and carers currently receiving treatment are involved in the service changes.*
- *We previously suggested that patients and carers who attended this focus group might be formed into a current patient user group to support the Trust to develop the service. Indeed, this was fully supported by BHRUT's Professional Lead for AHP's & Nursing | Cancer and Clinical Support.*

APPENDIX 1

Table 1 and Chart 1 – Ethnicity of patients receiving treatment, 1 December 2018 to 31 March 2019

Table 2 and Chart 2 – Ethnicity of patients attending health and wellbeing services, 1 December 2018 to 31 March 2019

Table 1

Ethnicity of patients receiving treatment 1 December 2018 to 31 March 2019	
Ethnicity	**Count**
White British	541
Any other White background	53
Indian or British Indian	45
Black African or Black British African	37
Asian – other	23
Black Caribbean or Black British Caribbean	17
Any other ethnic group	16
Pakistani or British Pakistani	16
Bangladeshi or British Bangladeshi	10
Not stated / refused	10
Any other Black background	9
White Irish	6
Chinese	5
Any other mixed background	3
Mixed White and Black African	3
Mixed White and Black Caribbean	3
Unknown	3
Mixed White and Asian	1
TOTAL	**801**

Table 2

Ethnicity of patients attending health and wellbeing services - 1 December 2018 to 31 March 2019	
Ethnicity	**Count**
White British	181
Any other White background	8
Indian or British Indian	10
Black African or Black British African	11
Asian – other	4
Black Caribbean or Black British Caribbean	4
Any other ethnic group	1
Pakistani or British Pakistani	1
Bangladeshi or British Bangladeshi	2
Not stated / refused	4
Any other Black background	3
White Irish	2
Chinese	1
Any other mixed background	0
Mixed White and Black African	1
Mixed White and Black Caribbean	1
Unknown	1
Mixed White and Asian	0
TOTAL	**235**

Chart 1

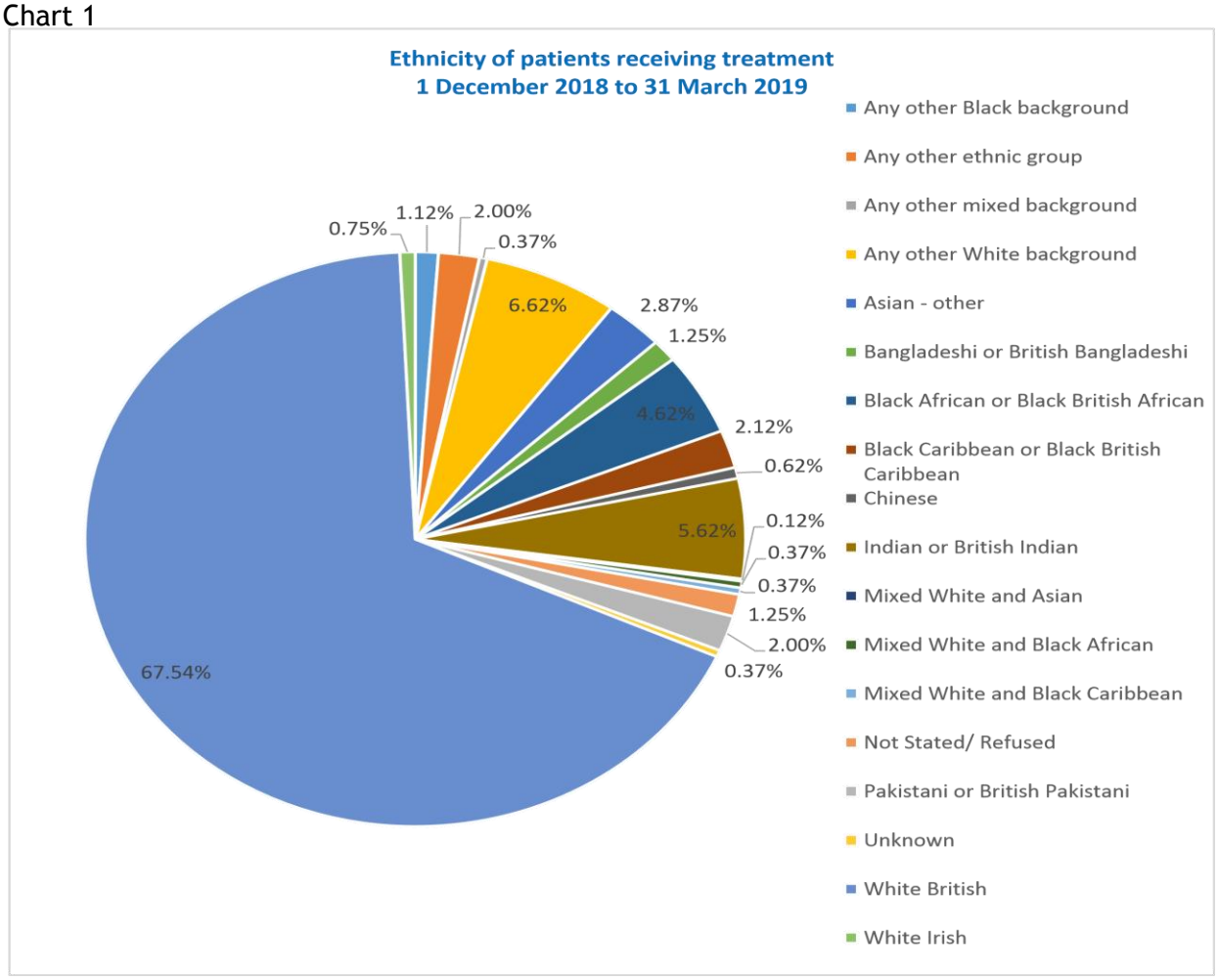
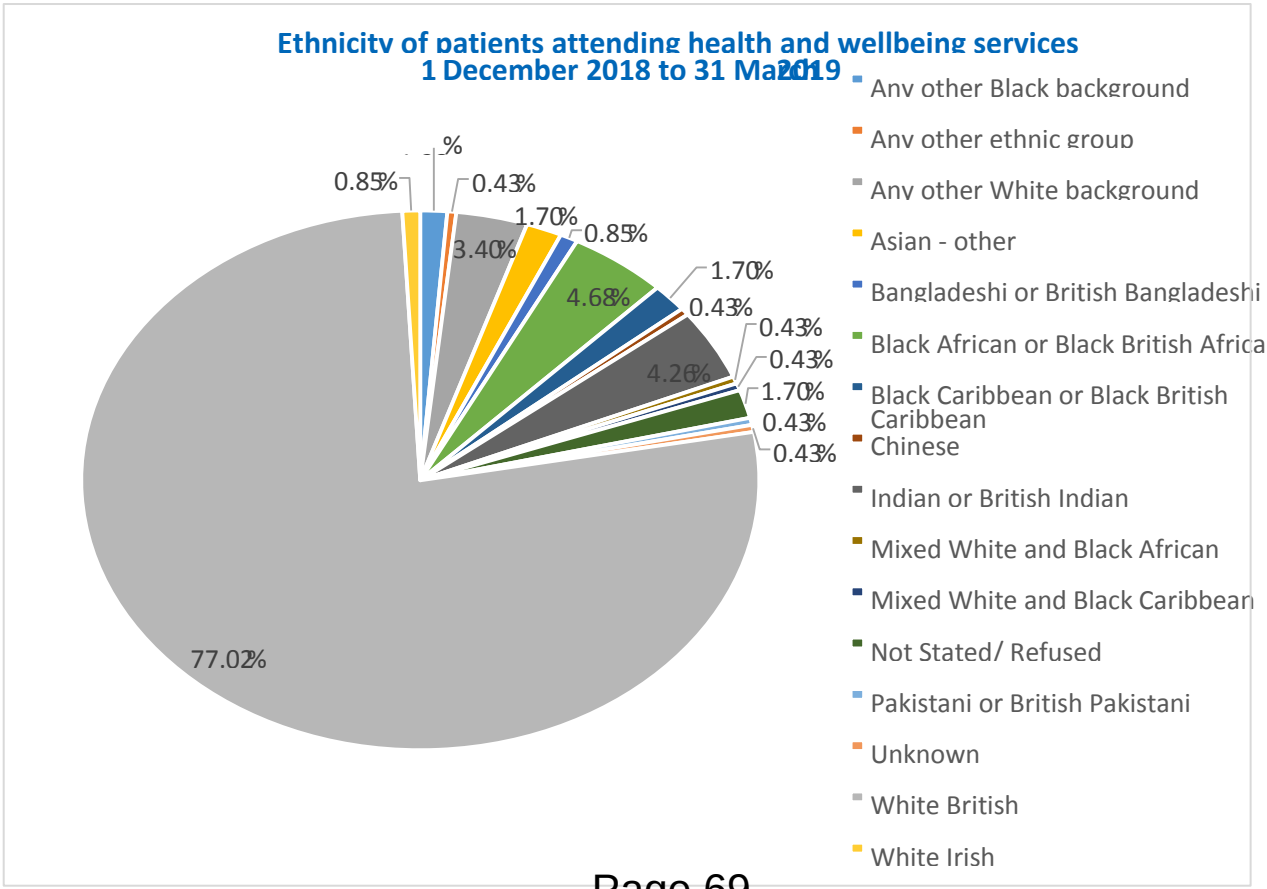


Chart 2



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Havering
LONDON BOROUGH

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 28 JANUARY 2020

Subject Heading:	Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) – Performance Report
Report Author:	Anthony Clements, Principal Democratic Services Officer, London Borough of Havering
Policy context:	The information presented gives details of BHRUT performance.
Financial summary:	No financial implications of the covering report itself.

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached presentation covers details of BHRUT performance in a number of areas.

RECOMMENDATIONS

1. That the Committee considers the information presented and takes any action it considers appropriate, including agreeing the format and frequency of any further performance reports.

REPORT DETAIL

The attached presentation gives details of BHRUT performance in a number of areas that was requested by the Joint Committee. This includes information on the Trust's financial performance, the meeting of service targets, staffing and patient feedback.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

PERFORMANCE REPORT

Shelagh Smith
Chief Operating Officer

Nick Swift
Chief Financial Officer

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

OUR PERFORMANCE

As requested, our report covers the following items:

- Finances
- Performance against constitutional standards
  - four hour emergency access standard
  - referral to treatment
  - cancer
  - diagnostics
- Staffing
- Patient feedback (iWantgreatcare)

FINANCE

Performance to date (October) for financial 2019/20

- Annual target: -£50.8m (deficit)
- Year to October planned: -£26.2
- Year to October actual: -£31m
- So we are £4.8m adverse to plan YTD
- Annual gross quality and cost improvement programmes identified £28.4m
- £6.2m delivered
- This is £9.4m behind plan

In addition, capital funding remains a national problem

NARRATIVE

- Delivery of the planned £50.8m deficit will trigger payment of £27.7m through the Financial Recovery and Provider Sustainability Funds
- Integral to our plan are a number of key transformational programmes of work:

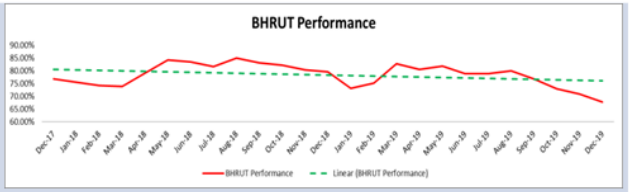
    1. Elective flow – reducing waste will improve efficiency and performance with savings materialising through more effective use of theatre capacity
    2. Reduction in outpatient activity – reducing the number of unwarranted outpatient appointments. The ambition is to reduce by 10% per year
    3. Reduction in spend on premium staffing costs

- We have high levels of confidence in our diagnosis of the deficit drivers

- However implementing the necessary changes is taking longer than planned

- Additional short term cost control initiatives are being put in place to close the current gap to plan, for example, pay and non-pay control panels

FOUR HOUR EMERGENCY ACCESS STANDARD

Key metrics	This month	Trend	Local Target/Threshold	National Target/Threshold
4 Hour Access Performance	Trust 67.65% KGH 69.21% QH 66.58%		System 4 hour target: 82.71%	95%

December 2019	King George	Queen's	Trust overall
Type 1	56.06%	37.67%	44.56%
Type 3	94.47%	97.02%	96.06%

- Average daily attendances increased by 10.25% compared to December 2018 (from 26,111 to 28,935 patients)
- Average number of patients seen within 4 hours decreased by 5.68%
- If attendances were same as Dec'18, given the number of patients seen within 4 hours, overall performance would have been 74.96% - a 7.81% improvement on actual performance of 67.65% against the 82.71% trajectory

KEY CHALLENGES

- Along with the rest of the NHS, we are currently under extreme pressure
- We often see up to 1,100 patients attending on a daily basis through the Urgent Care Centre and Emergency Departments (ED)
- We also know many people arriving at our EDs could be better treated in a more appropriate setting. For example on average, 9 out of 10 patients arriving by ambulance at King George are discharged that day
- We're one of the London trusts which receive the highest number of ambulances – up to 200 ambulances per day from both London and East of England ambulance services
- Heavy reliance on agency staff due to recruitment challenges – reflects the national picture
- Space constraints – would require a great deal of capital to reconfigure
- Flow remains difficult through our hospitals – affects performance against the 95% target
- Bed occupancy often at 99% at Queen's

IMPROVEMENTS AND MITIGATIONS

- Innovative new roles, for example, advanced care practitioners
- Implemented Red2Green - national initiative to highlight delays in patient care
- Recently launched ‘Red2Green Live’ - enables data on delays to be reviewed daily following afternoon rounds to help unlock delays for patients
- Held three ‘perfect week’ events throughout 2019 - help to highlight the importance of patient flow and learn from each campaign; success in reducing length of stay as a result
- Established a weekly rhythm to target high demand days; built in weekly long length of stay reviews to improve our 7 and 21 length of stay patients
- To support winter pressures:
  - frailty unit at King George - specialist teams in one place
  - additional care of the elderly beds in Foxglove
- Close working with system partners
- Patients in ED kept safe and comfortable – recognised and widely acknowledged by Sir David Sloman, NHS Regional Director for London
- ED receives consistently high iWantgreatcare scores

REFERRAL TO TREATMENT

Performance November 2019

- We reported 9 patients over 52 weeks in November
- This is in line with the trajectory agreed with our commissioners
- Our waiting list has increased by 58 patients since September, - total 41,395
- However performance has improved slightly – 77.16% (against September 76.4%)

Key challenges

- Receive more referrals in comparison to previous years - due to repatriation of patient activity from other hospitals
- Pension issues are limiting ability to provide additional capacity in some areas
- Challenges in specific specialties, for example, pain and urology

IMPROVEMENTS AND MITIGATIONS

- Huge programme of outpatient transformation work to support:

  - improvement in appropriateness of referrals
  - better demand and capacity management
  - ensuring patients are seen by the right clinician in the right setting
  - effective use of resources
  - ensuring GP referrals have all appropriate information before being sent to Trust

- Improved governance and oversight through changes to key meetings such as specialty waiting list review meetings

- Twice weekly huddles for ‘long waiters’

- Close partnership working

CANCER

Performance September 2019

- 62 day performance for September was 85.5%, exceeding 83% target
- We missed the two week standard in September - 83.3% against a target of 93%
- We do not expect to achieve either standard for October or November
- Recovery plan in place to be compliant by end March 2020

Key challenges

- Outpatient capacity in gynaecology and lower GI (gastrointestinal)
- Continued high volumes of referrals for lower GI and for urology
- Pathology and pre-assessment capacity

MANAGEMENT

- Continue to provide extra diagnostic and treatment capacity for cancer patients
- Increasing clinic capacity, particularly for lower GI
- Exploring template biopsy capacity in the independent sector to improve prostate pathway
- Extending triage (for gynaecology and lower GI) and straight-to-test (for lower GI).
- Extending capacity for pathology through outsourcing
- Develop plans for the new 28-day faster diagnosis standard
- Insourcing for pre-assessment

DIAGNOSTICS

- Delivered against the national diagnostic performance target for October
- Reported 0.80% breaches, (below a national standard of 1%)
- This was improved compared to September - reported 1.62%
- Reported fewer than half the number of breaches in October (82) compared to September (171)
- Improved performance for endoscopy – 2.9% in October compared to 7.48% in September
- MRI and ultrasound were below the 1% threshold and improved against September

VACANCIES (% OF FTE)

Staff group	October 2019	October 2018
Medical and dental	11.6%	14.9%
Registered nurse and midwifery	15.3%	15.5%
Clinical other	13.2%	8.4%
Non-clinical	12.1%	15.1%
Overall vacancy	13.4%	13.2%

Moving in right direction

- Seeing continued improvement in turnover and stability rates
- Staff turnover 13.35% in month against a 12% trajectory; in October 2018 it was 22.3%
- Continued decrease in stability rates to 17.4%; below 18% target
- 115 wte (whole time equivalent) new starters in month; including student nurses and overseas doctors
- Staff survey 56.9% response rate - c.800 more staff than last year

KEY CHALLENGES AND IMPROVEMENTS

Challenges

- Location of our hospitals (geography; outer London waiting)
- National shortages including ED doctors and paediatric nurses
- High number of bank and agency staff

Improvements

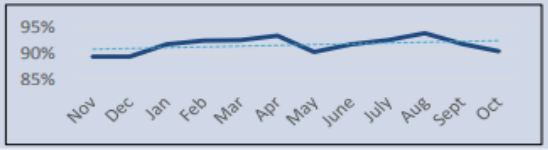
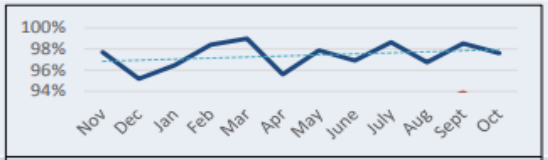
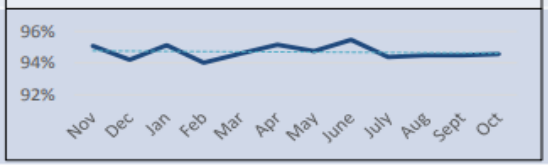
Medical recruitment

- Academy of surgery (innovative way to attract new doctors globally – recruited from more than 20 countries)
- Acute division 33 Clinical Fellow posts in pipeline
- Time to hire has reduced from 150 days to 71 days in last 12 months

Nursing recruitment

- Senior intern programme (first of its kind in the country)
- Improved retention rates – from 25% leaving within first year to 9%
- Nurse Associate programme – 57 qualified
- Nurse apprenticeships
- Over next 6 months circa 138 international nurses due to be appointed

PATIENT EXPERIENCE

Key metrics	This month	Trend	Local Target/Threshold	National Target/Threshold
% likely to recommend A&E	90.39%		85%	None
% likely to recommend Maternity (labour)	97.62%		98.5%	None
% likely to recommend Inpatient	94.57%		94%	None

- Number of surveys (9061) received in September has increased by over 1000
- Almost 7,000 comments received - 94.12% were positive. This is a consistent score
- Most areas achieved the target for positive recommendation
- Exceptions were:
  - Maternity labour, postnatal and maternity community postnatal
  - Outpatients

NARRATIVE

- Refreshed membership of our Patient Partnership Council including new Chair
- The 15 steps programme continued in October with a further nine ward visits taking place during the month supported by Patient Partners to ensure focus kept on the patient experience.
- This also provides a baseline to support the ward accreditation programme due to launch in Spring
- New volunteer uniforms to improve visibility
- Programme of work around improving accessibility, for example, for our deaf and blind patients including re-establishing our patient working groups and introduction of a braille menu. Also commissioned Healthwatch Redbridge to support a review of accessible information and accessibility at Queen's Hospital - awaiting report
- Expanding volunteering roles to support winter pressures across the hospitals – particularly ED, assessment units. Flexible roles to support where required – bleep/response volunteers
- Development of accessible changing facilities at Queen's Hospital – plan to be accredited as part of Changing Places in early 2020 and then undertaken at King George

CQC HIGHLIGHTS

Inspection between September and November 2019 – positive findings

- Three of the five domains rated 'Good' - 'Well led'; 'Caring'; 'Effective'
- Use of resources rating improved from 'inadequate', to 'requires improvement'
- Overall rating remains 'Requires Improvement'

What we do well

- Inspectors saw several examples of outstanding practice such as:
  - end of life care at Queen's Hospital, including mortuary visits for staff to help them understand the importance of care after death

  - our award winning Senior Intern scheme, the first of its kind in the country

- Other highlights include:
  - demonstrable evidence of The PRIDE Way methodology for making improvements having a positive impact

  - doctors, nurses and other healthcare professionals working well together to benefit patients and support each other to provide good quality care

  - staff treating patients with compassion and kindness, respecting their privacy and dignity and taking into account their individual needs

CQC HIGHLIGHTS

Areas to improve

Inspectors also highlighted areas to improve; in most cases this is already underway

Focus for improvements include:

- "Paediatric Emergency Department at Queen's Hospital should have sufficient staff at all times"

  Usually two registered children's nurses are in the department. When a second children's nurse is unavailable, it is covered by a nurse, who is not a specific children's nurse, however does have additional paediatric experience to allow them to care for children

- "Inspectors also noted there could be a shortage of middle-grade doctors"

  Doctor recruitment is a challenge for NHS trusts across the country, and we have already brought in innovative ways to tackle this, including introducing our own Academy of Surgery, to recruit doctors from abroad

Delighted England's Chief Inspector of Hospitals, Professor Ted Baker, stated

"our Trust is definitely moving in the right direction"