BHR Integrated Care Partnership

Better care, better lives, together for all

BHR Integrated Care Partnership Board

1.00pm – 3.00pm

via Microsoft Teams

Agenda

MS Teams etiquette: could people keep their cameras off and sound on mute when they are not speaking. The Chair will keep her camera and sound on all the time along with the person presenting or commenting. People can indicate to the Chair when they would like to speak using the 'hand' function or 'chat' function and the chair will invite them into the conversation.

	Item	Time	Lead Director	Attached, Verbal or to follow
1.0 1.1 1.2	**Welcome, introductions and apologies** Declaration of conflicts of interest Minutes of the meeting held on 1 March 2021	**1.00**	**Chair**	 **Attached** **Attached**
2.0 2.1 2.2	**Terms of reference** Integrated Care Partnership Board Area Committee	**1.05**	**AB**	**Attached**
3.0	**Confirmation of Integrated Care Partnership Board chair and deputy chair**	**1.10**	**CJ**	**Verbal**
4.0	**Managing director's report**	**1.15**	**CJ**	**Attached**
5.0 5.1	**ICPB assurance** BHR ICP risk management approach	 **1.25**	 **CJ**	 **Attached**
6.0 6.1 6.2 6.3	**Transformation** BHR transformation board achievements to date and 20/21 year-end position BHR transformation board key priorities BHR integrated sustainability plan	 **1.30** **1.40** **1.50**	 **TW** **TW** **SR**	 **Attached** **Attached** **Attached**
7.0 7.1 7.2 7.3	**Quality and performance** Quality and safeguarding report Performance report Finance report	 **1.55** **2.05** **2.10**	 **MGC** **SR** **AK**	 **Attached** **Attached** **Attached**
8.0 8.1 8.2	**Development/governance** Terms of reference – finance sub-group, quality & performance group Framework for patient and public engagement	 **2.20** **2.25**	 **AB** **MH**	 **Attached** **Attached**

	Item	Time	Lead Director	Attached, Verbal or to follow
8.3 8.4	Borough partnership development update Proposed primary care governance	**2.35** **2.40**	**AB** **SS**	**Attached** **Attached**
9.0 9.1	**Any other business** Barts Health/BHRUT collaboration	**2.45**	 **Chair**	 **Verbal**
10.0	**Questions from the public**	**2.50**		
Due to conflicts of interest the next part of the meeting is for NEL CCG and Local Authority members only. **All other members will be excluded from the meeting.**				
11.0	**Phlebotomy – case for change**	**2.55**	**TW**	**Attached**
	Date of next meeting – 29 July 2021	**3.00**		

Glossary of terms and abbreviations

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

CIL	Community Infrastructure Levies
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQRM	Clinical Quality Review Meeting
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
CTT	Community Treatment Team
CVS	Council of Voluntary Services
CYPP	Children and Young Person Plan
DES	Direct Enhanced Service
DoH	Department of Health
DSPG	Data Security & Protection Group
DToC	Delayed Transfer of Care
EBI	Evidence Based Interventions
ECG	Electrocardiogram
ED	Emergency Department
EOL/ EOLC	End of Life/ End of Life Care
EPR	Electronic Patient Record
FOI	Freedom of Information
FSPPDM	Financial Sustainability Plan Procurement Delivery and Monitoring
FYE	Full Year Effect
GBAF	Governing Body Assurance Framework
GLA	Greater London Authority
GMC	General Medical Council
GMS	General Medical Services
HCAIs	Healthcare Associated Infections
HCC	Health and Care Cabinet
HEE	Health Education England
HLP	Healthy London Partnership
HSC	Health Scrutiny Committee
HWBB	Health & Wellbeing Board

IAPT	Improving Access to Psychological Therapies
ICEG	Integrated Care Executive Group
ICP	Integrated Care Partnership
ICPB	Integrated Care Partnership Board
ICS	Integrated Care System
ICM	Integrated Case Management
ICSG	Integrated Care Joint Health and Social Care Steering Group
IG	Information Governance
IFR	Individual Funding Request
IRS	Intensive Rehabilitation Service
IST	Intensive Support Team
ITU	Intensive Therapy Unit
JAD	Joint Assessment and Discharge Service
JCC	Joint Commissioning Committee
JHWS	Joint Health & Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
KGH	King George Hospital
KPIs	Key Performance Indicators
LAC	Looked After Children
LAS	London Ambulance Service
LAs	Local Authorities
LCFS	Local Counter Fraud Specialist
LD	Learning Disability
LES	Local Enhanced Service
LETB	Local Education and Training Boards
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LSCB	Local Safeguarding Children’s Board
LTC	Long Term Conditions
MASH	Multiagency Safeguarding Assessment Hub
MD	Managing Director

MLU	Mid-wife Led Unit
MOU	Memorandum of Understanding
MPIG	Minimum Practice Income Guarantee
MSK	Musculoskeletal
MSRB	Maternity Systems Readiness Board
NEL	North East London
NELCA	North East London Commissioning Alliance
NELFT	North East London Foundation Trust
NELHCP	North East London Health and Care Partnership
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
OD	Organisation Development
ONEL	Outer North East London
OOH	Out of hours
OPD	Outpatient department
PALS	Patient Advice and Liaison Service
PCCC	Primary Care Commissioning Committee
PEF	Patient Engagement Forum
PELC	Partnership of East London Cooperatives
PHE	Public Health England
PMCF	Prime Minister’s Challenge Fund
PMO	Project Management Office
PMS	Personal Medical Services
POD	Point of Delivery
PPGs	Patient Participation Groups
PPI	Patient and Public Involvement
PSED	Public Sector Equality Duty
PTL	Patient Tracking List
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality Outcome Framework
RAG	Red, Amber, Green

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

NHS
North East London
Clinical Commissioning Group

Barking & Dagenham, Havering and Redbridge Integrated Care Partnership's Conflicts of Interest Register
Date - 20 May 2021
Conflicts of interest will remain on the register for a minimum of 6 months following expiry

First Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk	Member of
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To		
Atul	Aggarwal	Havering Clinical Chair; NEL CCG	Maylands Healthcare	X			Direct	GP Partner	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Maylands Healthcare Ltd	X			Direct	Director and shareholder in on-site pharmacy	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Parkview Dental Practice			X	Indirect	Sister is an NHS dentist within Havering	1996	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Essex Medicare LLP	X			Direct	Part-owner (which owns Westland Clinic, Hornchurch. Space leased to: •Inhealth (Diagnostics) •Nuffield Health (Brentwood)	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Havering Health Ltd	X			Direct	Shareholder. GP partner at Maylands Surgery (Dr Kendall) is a Director	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Barking, Dagenham and Havering LMC		X		Direct	Co-opted Member	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Westlands Clinic (Langton Dental) who has an outsourced contract with BHRUT for oral surgery)			X	Indirect	Spouse is a dentist	2018	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			New Medical Centre (Havering Practice)			X	Direct	Family GP practice	1990	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Havering and Wellbeing Board		X		Direct	Member	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Anglia Ruskin University Medical School		X		Direct	Lecturer	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Caroline	Allum	Executive Medical Director; NELFT	None									BHR ICPB
Michael	Bell	Chair; BHRUT	BHRUT	X			Direct	Chairman	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Croydon Health Services NHS Trust	X			Direct	Chairman	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			MBARC Ltd (service commissioning)	X			Direct	Director	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Strasys Management Consulting	X			Direct	Senior Associate Consultant	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			ZPB Consulting Ltd	X			Direct	Senior Advisor	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			DAC Beachcroft LLP	X			Direct	Senior Leadership and Governance Advisor	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Henry	Black	Acting Accountable Officer; NEL CCG	BHRUT			X	Indirect	Wife is employed as Assistant Director of Finance	Jul-05	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Tower Hamlets GP Care Group			X	Indirect	Daughter is a Social Prescriber	Jul-05	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NHS Clinical Commissioners		X		Direct	Board Member	Jul-05	Jul-21	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Andrew	Blake-Herbert	Chief Executive; London Borough of Havering	London Borough of Havering	X			Direct	Employed as Chief Executive	May-16	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Tony	Chambers	Chieft Executive; BHRUT	None									BHR ICPB
Steve	Collins	Acting Chief Finance Officer; NEL CCG	Trisett Limited (business support service)		X		Direct	Director	2003	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Sevenoaks Primary School		X		Direct	Chair of Governors	2002	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Hope Church Sevenoaks		X		Direct	Chair of Trustees	2020	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Fegans (charity)			X	Indirect	Wife is Chair of Trustees	2017	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			PwC			X	Indirect	Daughter is employed as a Senior Associate	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Joe	Fielder	Chair; NELFT	Form yet to be submitted - TBA									BHR ICPB
Jason	Frost	Councillor; London Borough of Havering; Cabinet Member for Health & Adult Care Services; Chair of Havering Health & Wellbeing Board	Local care provider which receives CHC patients			X	Indirect	Mother is employed as a registered nurse	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Ceri	Jacob	Managing Director; BHR ICP; NEL CCG	None									BHR ICPB

Jagan	John	Chair; NEL CCG	Parkstone Holdings Ltd	X			Direct	Director	Feb-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Aurora Medcare	X			Direct	GP Partner	Jan-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Parkview Medical Centre	X			Direct	GP Partner	Mar-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Together First Limited (GP Federation)	X			Direct	Practice is a shareholder	May-14	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Harley Fitzrovia Health Limited	X			Direct	Director and shareholder	Jan-18	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Aurora Medcare			X	Indirect	Other employed GPs are family members	Jan-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			New West Primary Care Network			X	Indirect	Brother/ GP Partner is the Clinical Director	Nov-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Personalised Care - Healthy London Partnerships and NHS England Region		X		Direct	Clinical Lead	Mar-17	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NELFT - Barking & Dagenham Community Cardiology Service		X		Direct	GP with Special Interest (GPwSI) in Cardiology	Aug-11	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Barking & Dagenham Health and Wellbeing Board		X		Direct	Deputy Chair	2018	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Monifieth Limited **Historic**	X			Direct	Director and shareholder	Mar-18	Oct-20	Historic	BHR ICPB
			Diagnostics 4u (previously Monifieth Ltd)	X			Direct	Director and shareholder	Oct-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Adrian	Loades	Corporate Director of People; London Borough of Redbridge	None									BHR ICPB
Anil	Mehta	Redbridge Clinical Chair; NEL CCG	Fullwell Cross Medical Centre	X			Direct	GP Partner	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Metropolitan Police	X			Direct	Forensic Medical Examiner	2015	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			The Cleaning Company			X	Indirect	Sister-in-law is the owner	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NHSE	X			Direct	GP Appraiser	2015	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Healthbridge Direct (GP Federation)	X			Direct	Shareholder	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Fouress Enterprise Ltd	X			Direct	Director	2015	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Prescon	X			Direct	Ad-hoc screening work	2018	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			London Healthwise Ltd (non-trading)		X		Direct	Director	2009	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			GMC		X		Direct	Associate	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Ilford Lane Surgery (Redbridge practice)			X	Direct	Registered patient (family)	2000	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Redbridge Health and Wellbeing Board		X		Direct	Vice Chair	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Anglia Ruskin University Medical School		X		Direct	Lecturer	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Queen Mary University of London		X		Direct	GP Tutor	2021	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Chris	Naylor	Chief Execuive; London Borough of Barking & Dagenham	None									BHR ICPB
Kash	Pandya	Lay Member; NEL CCG	Southend-on-Sea Borough Council	X			Direct	Independent Audit Committee Member	2016	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Essex Police, Fire and Crime Commissioner's Audit Committee	X			Direct	Independent Audit Committee Member	2021	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			University of Essex		X		Direct	Independent Audit Committee Member	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Brentwood Citizen's Advice Bureau			X	Direct	General Advisor	2009	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Metro Bank			X	Indirect	Son is employed as Procurement Manager	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Accenture			X	Indirect	Son is employed as Senior Legal Counsel	2017	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Sangeetha	Pazhanisami	PCN Clinical Director; Redbridge	Form yet to be submitted - TBA									BHR ICPB
Mark	Santos	Councillor; London Borough of Redbridge	Form yet to be submitted - TBA									BHR ICPB
Oliver	Shanley	Chief Executive; NELFT	None									BHR ICPB
Gurmeet	Singh	PCN Clinical Director; Havering	Form yet to be submitted - TBA									BHR ICPB
Sarita	Symon	PCN Clinical Director; Havering	Form yet to be submitted - TBA									BHR ICPB

Narendra	Teotia	Clinical Director; Barking & Dagenham North Primary Care Network	Together First CIC (B&D GP Federation)	X			Direct	Shareholder	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Maureen	Worby	Chair of the ICPB; Councillor, London Borough of Barking & Dagenham	Form yet to be submitted - TBA									BHR ICPB

DRAFT ACTION NOTES

Meeting:	**Integrated Care Partnership Board**
Date:	Monday 1 March 2021

Attendees:	Maureen Worby (Chair)	**MW**	London Borough of Barking and Dagenham
	Ceri Jacob	**CJ**	BHR CCGs
	Henry Black	**HB**	NELCA
	Andrew Blake-Herbert	**ABH**	London Borough of Havering
	Barbara Nicholls	**BN**	London Borough of Havering
	Cllr Jason Frost	**JFr**	London Borough of Havering
	Oliver Shanley	**OS**	NELFT
	Dr Caroline Allum	**CA**	NELFT
	Joe Fielder	**JFi**	NELFT
	Kash Pandya	**KP**	BHR CCGs
	Richard Coleman	**RC**	Havering CCG
	Elaine Allegretti	**EA**	London Borough of Barking and Dagenham
	Matthew Cole	**MC**	London Borough of Barking and Dagenham
	Dr Jagan John	**JJ**	Barking and Dagenham CCG
	Dr Arun Sharma	**AS**	Barking and Dagenham GP Federation
	Cllr Mark Santos	**MSa**	London Borough of Redbridge
	Tony Chambers	**TC**	BHRUT
	Michael Bell	**MB**	BHRUT
	Dr Magda Smith	**MSm**	BHRUT
	Dr Dan Weaver	**DWe**	Havering GP Federation

In attendance:	Alison Blair (AB), Anna McDonald (AMc), Lesley Seary (LS), Anne-Marie Keliris (AMK), Emily Plane (EP), Tracy Welsh (TW), Hanh Xuan-Tang (HX), Alison Crewe (AC)

Apologies:	Adrian Loades, Dr Mehta, Dr Aggarwal, Fiona Peskett

Agenda item	Summary	Action
1. Welcome and Introductions	Introductions and apologies noted as above.	
2. Action notes and log from previous meeting	The action notes/log were noted as accurate for the last formal meeting in November 2020.	
3.Covid-19 Response & recovery – report from SOCG	OS gave an overview of the Strategic System Operational Command Group (SOCG*):* The Group were established at the onset of the Covid-19 pandemic; membership is comprised of BHR system leaders working collaboratively on behalf of residents to address and resolve key challenges across the system. Examples of the key areas of focus were provided. This has proved to be a successful group and has provided a firm foundation in terms of working together moving forward. • MC commented that SOCG has worked very well and asked if the group could be used as the vehicle to address the waiting lists challenge. CJ responded that SOCG has built on the relationships that were in place pre-Covid-19 and one of its roles is to oversee recovery which will happen at different levels. In terms of waiting lists, SOCG will have oversight but a good deal of the work will happen within the Acute Alliance. • The importance of clinical leadership was highlighted in regard to prioritising the work needed over the coming months particularly around transformation. • A discussion was held about the scale of the recovery after the first peak of Covid-19. There was oversight of the scale of the elective challenge at a NEL level. • KP asked what the future plans are for SOCG. OS responded that the group was originally established to manage the BHR partnership response to the pandemic. • JJ stressed the need to be clear who does what and where to avoid duplication. This is an opportunity at a local level to create something better than what we have had previously. • CJ advised that a mapping exercise is being undertaken by the Recovery & Restoration Planning Group via SOCG which can be shared. • AS agreed with the points made by JJ and expressed his view that direct conversations with operational level systems that currently exist is the way forward. He gave the vaccination response as a good example where key players are working together in partnership.	

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	• A number of solutions to address elective appointments are going to be about partnership working between clinicians in primary care, secondary care and community care to make delivery more effective. • JFi referred to the role of non-executives and that they should play a stronger role in borough partnerships as they develop. • CJ summarised that the message being conveyed is to use what we already have in place such as the Transformation Board for Planned Care which joins up primary care and acute care. SOCG's role is to join everything up and address anything that is missing. The role of SOCG will continue to be reviewed. • ABH added that SOCG is a perfect example of how health & social care colleagues have worked together and it has been a huge success. The Chair drew the discussion to a close by summing up:- • Our governance needs to ensure that no meetings create duplication • Use the Transformation Boards to feed into the borough partnerships • Greater use of non-executives The ICPB: • Noted the work of all members of SOCG who have come together as a multidisciplinary leadership team to support the system • Commented on the work programme overseen by SOCG and next steps for recovery • Noted the report and agreed to receive a further update on recovery in April 2021	**Action:** Outcome of the SOCG recovery and restoration mapping exercise to be shared at the next meeting. **CJ** **Action:** further update from SOCG on steps towards recovery to be given in April
4. Transformation Boards and the planning process for 2021/22	TW gave an overview of the key actions for transformation and confirmed that the leadership and ownership of each Transformation Board is now aligned to Chief Executives across the system. The Boards will begin to meet again from this month and will follow and implement the model agreed in December 2020. • CA welcomed the strong link into the Health & Care Cabinet and reiterated the need to make sure we have significant clinical leadership with the right transformational support. • RC welcomed the clearer focus and reinforced the need to ensure that the voice of local people is clear fed through into the work of the Transformation Boards. TW responded that a resident engagement plan is being developed that is driven by local people. OS agreed that we must work with 'experts by experience' to ensure that services are meeting local needs. We need to agree what the priorities are that we want to deliver on rather than trying to do everything at the same time, and linked to that we need sufficient capacity and resource to deliver.	

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	• The Chair suggested that each Transformation Board should have three main priorities to deliver on and asked for the term 'resident' to be used rather than 'patient'. • CJ said she would like to have resident and patient involvement as a key priority. The main priorities need to reflect the response to recovery and key challenges. • MS commented that the Transformation Boards are currently very 'professional heavy' and emphasised the importance of having a strong resident voice to drive service change. Localising things at a borough level is critical but there are some things we can do better at a BHR level and NEL level. CJ gave an example of the Paediatrics work that is currently being undertaken which will provide a real opportunity to test how complex work such as CYP will be taken forwards across the three levels. • KP suggested the role of Barts Health needs to be emphasised and also that it would be helpful as part of this review work, to reflect on the obstacles that the Transformation Boards have faced. TW agreed and confirmed that she has a direct link to the new Director of Planned Care for WEL CCGs. • JFi signalled the importance of getting clear and concise reporting to the ICPB in order for its members to be able to determine whether the system is delivering the outcomes and priorities expected and ensure good progress is being made for the local population. • The Chair added that a clear outcomes matrix is needed. • JFr referred to 'organisational champions' and suggested that patient participation groups and Healthwatch representatives could be the voice of the 'end user' in the discussions on planned care and emergency care. • MC expressed his view that unless we look at how services are commissioned this will not work as the 'one size fits all' model does not allow the borough partnerships to make the changes that are relevant for the needs of their residents. CJ responded that there should be nothing to stop things being flexed to meet the needs of the residents in the boroughs by working in partnership. CJ and MC to discuss this further outside of the meeting. • The Chair commented on slide 5 (Governance) and requested a more streamlined, simplified decision route. The ICPB: • Noted and commented on the report.	**Action:** Discuss flexing the model to meet the needs of local residents. **CJ/MC.** **Action: AMK/AB** to map out the formal decision-making routes within the partnership governance
5.BHR Health and Social Care Academy Business Plan	AC provided an update on the Academy, the strategic plan and the baseline system-wide process. A general discussion took place and the main outcome points were: • The opportunity to run 'virtual learning' needs to be reflected in the plan • Look at data from the Nightingale – what made people want to work there and how we can connect them into our	

	services going forward • A join approach to workforce challenges and ensuring that our workforce have everything they need is more important than the location of the Academy Hub. This will be a hub and spoke model. • Look at the co-location of services using the Local Authority estate • Need to make sure the workforce priorities are aligned with the post-Covid-19 recovery plans, in particular those of Local Authority partners • Ensure that the work of the academy is aligned with existing borough-based training academies such as the Social Care Academy in Havering to avoid duplication AC to bring back an update to a future meeting. The ICPB: • Considered and commented on the report and next steps.	**Action:** update to be brought to a future meeting. **AC**
6. White paper- Integration & Innovation, working together to improve H&SC for all – implications for BHR	The paper was taken as read. AB confirmed that the White Paper supports our direction of travel, in particular borough partnerships and the need to develop placed based care. A general discussion took place and the main points raised were: - • MB commented that the white paper doesn't fully reflect the challenge within BHR to develop the borough partnerships at pace in order for them to be fit to receive future delegated funding. A more structure programme of work is needed to address health in-equalities. • CJ clarified that the sub-committee of NEL CCG will be the ICPB and funding will flow through to the ICPB to managed collectively across BHR. The role of Borough Partnerships will increase as they become established. • HB confirmed that the calculation of the delegated budget is at a borough level. Things will be done at a NEL level, BHR level and borough level where appropriate. • BN said this is an opportunity to refocus – promoting good health rather than treating ill-health. Borough partnerships are not just about health and adult social care, the wider public health agenda cannot be understated. • JJ commented that the White Paper refers to clinical leadership very loosely and we need to make sure that whatever we design, it must have clinical leadership interweaved in everything and clarified that clinical leadership includes AHPs and social workers. • The Chair commented that the Health & Wellbeing strategies for each borough should be the drivers of everything that we do. The ICPB: • Consider and commented on the report and next steps.	

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7. BHR Integrated Care Partnership – Borough partnerships	Due to time constraints, the Chair took the paper as read and tasked each of the borough partnerships to focus on development of their roadmaps as a priority, with a view to sharing them by May 2021. The ICPB: • Noted progress to date and the current position • Reviewed and commented on the approach to developing Borough Partnerships • Each partner organisation to reiterated commitment to supporting this approach and development of Borough Partnerships	**Action:** BN/AL/EA/MC to lead development of borough partnership roadmaps by May 2021.
8. BHR Integrated Care Partnership - structures	• AB confirmed that the revised terms of reference have been approved by the respective Boards and Governing Bodies across the system. • A meeting with Healthwatch is scheduled following their comments which will link to the point raised earlier about co-design and ensuring strong resident involvement is included in everything we do. • A new date is being considered for the next ICPB development session which is currently scheduled for 29 March 2021. • A schedule of regular dates for the ICPB is being set up with meetings likely to be held on a Thursday and AB reminded everyone that the meetings will be held in public. • The Chair referred to the request she made earlier in the meeting under agenda Item 4 about the need for a more streamlined decision-making route adding that the H&W Boards will also needs to align their decision-making processes. AB clarified that scenarios on how decisions will be made will be looked at the workshop. The ICPB: • noted and commented on the update • noted approval of the ICPB terms of reference by all partner boards • noted approval of the Integrated Care Executive Group and Health and Care Cabinet terms of reference • noted the development of the ICPB sub groups – finance and quality & performance terms of reference and the framework for public and patient engagement/co-production will be presented at the meeting in May 2021 • noted the proposals for managing conflicts of interest of the ICPB • approved the proposal that BHR ICP meetings will take place on Thursdays during 2021/22	
9. AOB	No additional items were raised.	

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	Integrated Care Partnership Board- action log	Responsible	Due date	status
ICPB – 4 December 2019				
110.	MA to produce a dashboard to measure the difference the JSNA is making	MA	November	Update at May meeting
115.	JSNA paper to come back to a future meeting	MA	November	Update at May meeting
ICPB 11 November 2020				
137	Revised governance arrangements will continue to be developed for partnership sign off in January	AMK/AB	Jan	Complete
139.	AK to include a macro picture into the BHR Financial Plan for the next ICPB meeting **Update 16th February 2021:** *NHSE financial guidance for 21/22 remains to be confirmed, but the expectation is that the current system of nationally set block contracts to cover the cost of NHS services will remain in place for the three months of the new financial year. All other costs will be determined by the levels of historical expenditure with no additional funds made available for investments. Planning guidance is expected to be announced during this period, which will allow the BHR system to establish a locally set plan for the remainder of the year. There has been no indication of allocations at this stage. Establishing a draft financial plan in advance of the new financial year has therefore not been possible. However, work has commenced to quantify the impact of services returning to normal including early analysis of activity demand and the capacity available to meet this going forward. The expectation is that this will be the basis on which contracts will be agreed and depending on the allocation BHR ICP receives, will determine the level of investment available or saving required. This will be confirmed by no later than the end of June 2021 and will also capture the position across all partners within the ICP so a complete plan is available.*	AK	Jan	Closed - this is now the Integrated Sustainability Plan. The plan is on the agenda for May meeting.
140.	To receive a report on the inequalities' work at the next meeting with clear outputs	MC/CJ	Jan	July meeting as ICP priorities confirmed
ICPB 1 March 2021				
141.	Outcome of the SOCG recovery and restoration mapping exercise to be shared at the next meeting	CJ/OS	April	Closed – shared with ICEG
142.	Further update from SOCG on steps towards recovery to be given in April	OS	April	Closed – shared with ICEG
143.	CJ/MC to meet outside of the meeting to discuss borough partnerships can work as a partnership to achieve integrated ways of working and better outcomes for local residents within the current structures that we have largely	CJ/MC	April	BP workshop on 19th May – update at May meeting

144.	**AMK/AB** to map out the formal decision-making routes within the partnership governance	AMK/AB	April	Completed
145.	**Alison Crewe** to bring an update on the BHR Health and Care Academy to a future ICPB meeting	Alison Crewe	May	June meeting
146.	BN/AL/EA/MC to lead development of borough partnership roadmaps by May 2021	BN/AL/EA/MC	May	Update at May meeting and roadmaps at June meeting

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Integrated Care Partnership Board

Date: 27 May 2021

Title of report	BHR ICPB Terms of Reference
Item number	2.0
Author	Anne-Marie Keliris, ICP Governance Programme Lead
Presented by	Alison Blair, Director of Transition, BHR System
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	The ICPB terms of reference are presented for approval by the ICPB. The ICP area committee terms of reference are presented for approval by CCG members – a small amendment to the quoracy is proposed to support management of conflicts of interest. The quoracy has been changed to any three members of the area committee.
Action required	Approval
Where else has this paper been discussed?	The ICPB terms of reference have been developed with all integrated care partners over the last year and have been approved by all partnership boards and the North East London CCG governing body.
Next steps/ onward reporting	The ICPB terms of reference will be kept under regular review to ensure they are fit for purpose.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The terms of reference will support the ICPB to make sound decisions with a focus on tacking health inequalities and delivery of high quality, integrated health and care services for people living in BHR.
Conflicts of interest	There are no conflicts of interest (COI) to note, however the terms of reference and protocol for managing terms of reference will be used for managing COIs.

Strategic fit	The development of the ICP is in line with the national strategy around the development of integrated care systems and our governance is designed to support integration, in anticipation of the recent White Paper proposals and forthcoming Bill on ICSs.
Impact on finance, performance and quality	Terms of reference for the system quality and performance group and finance sub committee are presented later on the agenda.
Risks	There are no significant risks identified.
Equality impact	There are no direct impacts.

Barking & Dagenham, Havering and Redbridge Integrated Care Partnership Board Terms of Reference

North East London Clinical Commissioning Group Governing Body BHR ICP Area Committee

Introduction	1. The Health and Care Partner Organisations listed below as Members of the Barking & Dagenham, Havering and Redbridge Integrated Care Partnership Board ("ICPB") have come together to enable the delivery of integrated population health and care services, as set out in more detail below. 2. The ICPB will be responsible for making decisions on policy matters relevant to the Barking & Dagenham, Havering and Redbridge Integrated Care Partnership ("ICP") and, where applicable, on matters that it has been asked to manage on behalf of the CCG and/or other constituent partner members of the ICP. 3. As far as possible, Members will exercise their statutory functions within the ICP governance structure, including within the ICPB. This will be enabled through delegations to specific individuals or through specific committees or other structures established by Members meeting in parallel with the ICPB. However, where a Reserved CCG statutory decision needs to be taken by one or more statutory organisation only, the structures used in Part 2 of these Terms of Reference will apply. 4. Part 1 of these Terms of Reference applies to the ICPB generally, whilst Part 2 contains those arrangements that will apply where a decision needs to be taken by one of the Partner Organisations, acting in their statutory capacity. Initially, Part 2 will be focussed on the CCG arrangements but over time it will be added to. Where a CCG decision is required on a matter (a CCG Reserved Function, the arrangements in Part 2 will apply. This means that on these occasions' decisions will be reserved to either the CCG Governing Body BHR ICP Area Committee or to individual members of that Committee, acting within the scope of any delegated authority given to them by the CCG Governing Body. Members of the ICPB will be present at such times subject to the management of any conflicts of interest. 5. Whether decisions are taken under Part 1 or Part 2 of these Terms of Reference, decisions taken by the ICPB and Partner Organisations will reflect national and local priority objectives and strategies. 6. The ICPB is established and constituted in accordance with the Codes of Conduct: code of accountability in the NHS (July 2004) and the UK Corporate Governance Code (June 2010). 7. The BHR ICP will operate within the NEL ICS/CCG reporting to the NEL ICS/CCG in relation to the exercise of its functions. These terms

	of reference will be reviewed in 2021/22 in line with developing national guidance and legislative framework.
Part 1: Terms of Reference for the ICPB	
Status	8. The ICPB is a non-statutory partnership body, that brings together representatives from across the ICP area to make decisions on policy matters relating to the ICP and on matters that the Member organisations have asked it to manage on its behalf. 9. It also incorporates Partner Organisation-specific structures that have been established in order to enable statutory decisions to be taken within the ICPB structure, to the extent permitted by law. These are set out in Part 2. 10. The ICPB is founded on the basis of a strong partnership with representation from across the BHR health and care system, including from the CCG, local provider trusts, local authorities and primary care providers. 11. The ICPB will be supported by the ICP Executive Group, which will lead on the delivery of the ICP strategy and vision agreed by the ICPB, and by the Health and Care Cabinet, which will have responsibility for the development and review of pathways, as well as being the primary forum for the provision of health and care expertise and advice to the other parts of the ICP governance. Both the ICP Executive Group and the Health and Care Cabinet are non-statutory partnership bodies, like the ICPB. 12. The ICPB will formally commence its operation on 1 April 2021.
Principles	13. The ICPB and its Members agree to abide by the following principles: 13.1. Encourage cooperative behaviour between ourselves and engender a culture of "Best for Service" including no fault, no blame and no disputes where practically possible. 13.2. Ensure that sufficient resources are available, including appropriately qualified staff who are authorised to fulfil the responsibilities as allocated. 13.3. Assume joint responsibility for the achievement of outcomes. 13.4. Commit to the principle of collective responsibility and to share the risks and rewards (in the manner to be determined as part of the agreed transition arrangements) associated with the performance of the ICP Objectives. 13.5. Adhere to statutory requirements and best practice by complying with applicable laws and standards including relevant EU procurement rules, EU and UK competition rules, data protection and freedom of information legislation.

	13.6. Agree to work together on a transparent basis (for example, open book accounting where possible) subject to compliance with all applicable laws, particularly competition law, and agreed information sharing protocols and ethical walls.
Role	14. The ICPB will seek to act in the best interest of residents in the BHR health and care system as a whole, rather than representing the individual interests of any of its members. 15. The role of the ICPB is as follows: 15.1. to oversee delivery on the expectations of population and patients for their health and care services; 15.2. to provide strategic leadership for, and delivery of, the overarching strategy and outcomes framework for the ICP; 15.3. to provide oversight and facilitation of the transformation and design of the health and care in Barking & Dagenham, Havering and Redbridge, in particular facilitating the establishment Borough Partnerships and the Primary Care Networks (PCNs); 15.4. to provide collective accountability for delivery to the partner organisations, through its membership and reporting arrangements; 15.5. take collective decisions on matters that it has been asked to manage on behalf of one or more partner organisation; 15.6. along with the ICP Executive Group, to be the forum within which, to the extent permitted by law, Members take reserved statutory decisions; 15.7. take collective decisions on the use of any ICS funding allocated to the ICP; 15.8. promote and model partnership working within the ICP; 15.9. negotiate and robustly manage any actual or potential conflicts of interest, in accordance with applicable guidance and legal requirements. 16. Where a Member organisation has asked the ICPB to manage functions on its behalf, these are set out in Part 2 to these ToR. The ICPB may in turn ask that these management functions are devolved to another part of the ICP governance structure, provided that it ensures appropriate oversight and reporting arrangements are in place so as to meet its own obligations, as set out in Part 2 to these ToR.
Duties	17. The ICPB's duties shall include:

	17.1. producing and championing a coherent vision and strategy for health and care for the ICP; 17.2. developing and describing the high-level strategic objectives for the system that are related to health and wellbeing; 17.3. producing an outcomes framework for the whole of the ICP to deliver increasing healthy life expectancy, address local variation and seeking to reduce health inequalities; 17.4. undertaking stakeholder engagement which will include engaging with staff, patients and the population; 17.5. developing a coherent approach to measuring outcomes and strategic objectives within the framework; 17.6. ensuring the delivery of high-quality outcomes, putting patient safety and quality first; 17.7. having oversight and management of the ICP financial resources, reporting to the ICS and to Member organisations as appropriate; 17.8. having responsibility for the collective delivery of those responsibilities that the ICPB is asked to manage on behalf of one of its Members.
Geographical Coverage	18. The ICPB shall cover the Barking & Dagenham, Havering and Redbridge area.
Membership	19. ICPB members are selected so as to be representative of the constituent organisations, but attend to promote the greater collective endeavour. 20. ICPB members are expected to make good two-way connections between the ICPB and their constituent organisations, modelling a partnership approach to working as well as listening to the voices of patients and the general public. 21. The membership of the ICPB shall include those individuals listed below:— **North East London CCG** Accountable Officer Chief Finance Officer Lay member **Barking & Dagenham, Havering and Redbridge Integrated Care Partnership** BHR Managing Director

	Barking, Havering & Redbridge University Trust/North East London Foundation Trust Chair/s CE, North East London Foundation Trust CE, Barking, Havering & Redbridge University Trust **Local Authorities** 3 x Elected members CEO/representative – London Borough of Barking & Dagenham CEO/representative – London Borough of Havering CEO/representative – London Borough of Redbridge **Primary Care providers** 3 representatives (one from each borough) **Clinical Leadership** Chair - Health & Care Cabinet 3 x Clinical Directors (NEL CCG governing body members, one from each borough) **Attendees:** Healthwatch representative 22. The ICP Board may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. 23. The arrangements regarding decision making; administrative support for the ICPB and management of conflicts of interest are set out below.
Chairing Arrangements	24. The Chair of the Board will be selected from among the members of the Board 25. The Chair of the Board will have the following specific roles and responsibilities: 25.1. be a visible, engaged and active leader; 25.2. have sufficient time, experience and the right skills to carry the full responsibilities of the role; 25.3. ensure that the Board supports the operation of the CCG; 25.4. promote the governance design principles in the Board's operation, as follows: 25.4.1. 80:20 local:NEL; 25.4.2. clinically led; 25.4.3. resident driven;

	25.4.4. size balanced with appropriate representation; 25.4.5. strengthen democratic accountability; 25.4.6. recognises sovereignty; 25.5. create an open, honest and positive culture, encouraging partnership working and consensus decision-making; 25.6. comply with the CCG's governance requirements in terms of procedures for decision-making, including in relation to managing actual and potential conflicts of interest; 25.7. ensure reporting requirements are complied with. 26. At its first meeting, the Board will appoint a Deputy Chair drawn from its membership.
Meetings and Decision Making	27. The Board will operate in accordance with the ICS governance framework, as set out in the ICS Governance Handbook , except as otherwise provided below. 28. The quoracy for the Board will be nine, including a representative from each of the partner organisations. Each representative must have appropriate delegated responsibility from the partner organisation they represent to make decisions on matters within the ICPB's remit. 29. The Chair will consider requests for substitute arrangements from members on an individual basis. 30. There will no less than six meetings per year. 31. Meetings shall be held in public and members of the public will have an opportunity to ask questions. The ICPB may resolve into private session as provided in the ICS's Standing Orders. 32. Other senior representatives of the Members may be invited for specific items where necessary. 33. Meeting dates are set by the governance team for each financial year in advance. Changes to meeting dates or calling of additional meetings should be provided to members and attendees within five days of the meeting. 34. A minimum of five working days' notice and dispatch of meeting papers is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed and supporting papers. 35. The Chair may agree that members of the ICPB may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting.

	36. The Chair may determine that the ICPB needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair. Urgent meetings may be held virtually. 37. The aim will be for decisions of the ICPB to be achieved by consensus decision making. Voting will not be used, except as a tool to measure support or otherwise for a proposal. In such a case, a vote in favour would be non-binding. The Chair will work to establish unanimity as the basis for all decisions. 38. In situations where any decision(s) require the exercise of Member organisation reserved statutory functions, then these should be made solely by the organisation in question, pursuant to the Member-specific arrangements set out in Part 2 of these Terms of Reference. To the extent permitted by law, discussion and decision-making in relation to reserved statutory functions will take place within the ICPB structure. 39. Conflicts of interest will be managed in accordance with the policies and procedures of the ICS and shall be consistent with the statutory duties contained in the 2006 Act and the statutory guidance issued by NHS England to the NHS ((Managing conflicts of interest: revised statutory guidance for CCGs 2017 https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/) 40. A member of the CCG Governance team shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.
Accountability and Reporting	41. The ICPB will report to the NEL ICS in relation to the exercise of its functions. 42. The ICPB ensure that it complies with any Member-specific reporting requirements that apply in relation to statutory functions that it is asked to exercise on behalf of a Member. 43. The Integrated Care Executive Group and Health and Care Cabinet will report directly to the ICPB. 44. The ICPB will receive reports from the Health and Wellbeing Boards/borough partnerships and make recommendations to them on matters concerning delivery of the ICP priorities and delivery of the ICP outcomes framework. Health and Wellbeing Boards will continue to have statutory responsibility for the Joint Strategic Needs Assessments.

Working Groups	45. In order to assist it with performing its role and responsibilities, the ICPB is authorised to establish working groups and to determine the membership, role and remit for each working group. Any working group established by the ICPB will report directly to it. 46. The terms of reference for any working group established by the ICPB will be incorporated within the ICS Governance Handbook. Where any working group is established to support ICPB in performing functions the Committee has asked it to manage, the terms of reference for such group will also be incorporated within the CCG Governance Handbook.
Monitoring Effectiveness and Compliance with Terms of Reference	47. The Board will carry out an annual review of its functioning and provide an annual report to the NEL ICS and to constituent Member organisations, where it has been asked to manage functions on their behalf. This report will set out the ICPB's work in discharging its responsibilities, delivering its objectives and complying with its terms of reference.
Review of Terms of Reference	48. The ICPB shall, at least annually, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to Member organisations for approval.

Part 2

This Part sets out the Member-specific arrangements that have been established, both in terms of setting out any statutory functions that the ICPB has been asked to exercise on behalf of a Member organisation and the associated Member-specific governance arrangements that have been established in order to enable decision-making on reserved statutory functions.

BHR ICP Area Committee of the NEL CCG North East London CCG Governing Body	
Status of the Committee	49. The Committee is a committee of the North East London CCG Governing Body ("NEL CCG Governing Body"), established in accordance with Schedule 1A of the 2006 Act and with the specific provisions contained within the CCG's Constitution and in the NHS Act 2006. 50. The Committee will commence its operation on 1 April 2021.
Role of the Committee	51. The Committee has been established in order to enable the CCG to take decisions on the Delegated Functions within the ICPB structure, as permitted by law, and to enable, where necessary, commissioner only decision-making on the Reserved Functions in a simple and efficient way. The Delegated and Reserved Functions are summarised below and are also set out in the CCG's SoRD. 52. In each case, where the Committee has been asked to oversee the development of a policy, framework or other equivalent, this includes the function of providing assurance to the NEL CCG Governing Body on the appropriateness of the policy, framework or other equivalent in question.
Authority	53. The Committee is authorised by the NEL CCG Governing Body to investigate any activity within these Terms of Reference. It is authorised to seek any information it requires in this regard from any employee within the CCG and all employees are directed to cooperate with any request made by the Committee. 54. The Committee is also authorised by the NEL CCG Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. 55. The Committee will be responsible for determining any additional or reconfigured sub-structural arrangements to support fulfilment of the Committee's remit.
Delegated Functions	56. The Delegated Functions that the Committee will exercise include the following. In general, and subject to the Reserved Functions, the

	intention is that the Delegated Functions will be exercised within the ICPB structure. *Commissioning Strategy: the Committee will have lead responsibility for the CCG's commissioning strategy in the ICP area. This includes exercising the following specific functions in this context:* 56.1. overseeing the health and care needs assessment process within the ICP area and supporting the CCG in the overall health and care needs assessment process in the ICP; 56.2. overseeing the development of the commissioning vision and outcomes setting, and supporting the CCG in the development of the overall commissioning vision and outcomes setting, within the ICP area; 56.3. overseeing the development and implementation of service specification and standards within the ICP area, ensuring that these are consistent with the overarching principles agreed by the CCG; 56.4. overseeing the development and implementation of a decommissioning policy within the ICP area, ensuring consistency with the overall policy agreed by the CCG. *Population health management: the Committee will have lead responsibility for population modelling and analysis within the ICP area, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality. This includes exercising the following specific functions in this context:* 56.5. ensuring appropriate arrangements are in place to support the ICP to carry-out predicative modelling and trend analysis; 56.6. overseeing and implementing information governance arrangements within the ICP area; 56.7. overseeing the development and implementation of system incentives and re-alignment in order to deliver a response population health driven system. *Market management: the Committee will work the ICPB, asking it to manage aspects of market management as appropriate, as part of its overall role in relation to this function, as follows:* 56.8. working with the ICPB to evaluate health and care services in the ICP area; 56.9. working with the ICPB to design and develop health and care services; 56.10. agreeing the strategic market shape for the ICP area, ensuring consistency with the overall objectives and principles agreed by the CCG for the ICP;

	56.11. leading on horizon scanning within the ICP area. *Financial and contract management: the Committee will support the CCG in discharging its statutory financial duties, including through managing the budget delegated to it by the NEL CCG Governing Body and exercising the following functions:* 56.12. managing the budget for the ICP area, ensuring that it operates within the agreed CCG financial accountability and reporting framework; 56.13. managing the allocation of budgets to any sub-committee established by the Committee and ensure that accountability and reporting arrangements are in-place, consistent with the overall financial accountability and reporting framework agreed by the CCG; 56.14. overseeing the development of a financial plan for the ICP area and, once approved by the NEL CCG Governing Body, manage the plan, ensuring that all NEL CCG Governing Body reporting requirements are met; 56.15. leading on tendering and procurement within the ICP area; 56.16. leading on contract design for health services commissioned within the ICP area; 56.17. working with the ICP Board to manage supply chain for health and care services within the ICP area; *Monitoring performance: the Committee will support the CCG in discharging its statutory reporting requirements and in discharging its duties in relation to quality and the improvement of services, as follows:* 56.18. working with the ICPB to manage and monitor contracts for health and care services in the ICP area; 56.19. working with the ICPB to ensure continuous quality improvement in health and care services within the ICP area; 56.20. complying with statutory reporting requirements in relation to services being commissioned in the ICP area; 56.21. working with the ICPB in relation to safeguarding, ensuring that all CCG policies and procedures are appropriately implemented within the ICP area; 56.22. overseeing safeguarding interventions, working with the ICPB; 56.23. leading on performance review and management for the ICP area; *Stakeholder engagement and management: the Committee's overall role is to support the CCG in discharging its statutory duty under*

	section 14Z2 in relation to public involvement and consultation. This includes, but is not limited to the following responsibilities: 56.24. overseeing the development of the ICP engagement strategy and implementation plan; 56.25. overseeing the development and delivery of patient and public involvement activities, as part of any service change process in the ICP area; 56.26. facilitating and promote clinical and professional engagement within the ICP area. 57. In exercising the Delegated Functions, the Committee's role is to support the CCG in discharging its statutory duties. 58. When exercising any Delegated Functions, the Committee will ensure that it has regard to the statutory obligations that the CCG is subject to including, but not limited to, the following statutory duties set out in the 2006 Act: • Section 14P – Duty to promote the NHS Constitution • Section 14Q – Duty to exercise functions effectively, efficiently and economically • Section 14R – Duty as to improvement in quality of services • Section 14T – Duty as to reducing inequalities (and the separate legal duty under section 149 of the Equality Act 2010, the Public Sector Equality Duty) • Section 14U – Duty to promote involvement of each patient • Section 14V – Duty as to patient choice • Section 14W – Duty to obtain appropriate advice • Section 14X – Duty to promote innovation • Section 14Z – Duty as to promoting education and training • Section 14Z1 – Duty as to promoting integration • Section 14Z2 – Public involvement and consultation (and the related duty under section 244 and the associated Regulations to consult relevant local authorities) • Section 14O – Registers of interests and management of conflicts of interest • Section 14S – Duty in relation to quality of primary medical services

	• Section 223G – Means of meeting expenditure of CCGs out of public funds • Section 223H – Financial duties of CCGs: expenditure • Section 223I: Financial duties of CCGs: use of resources • Section 223J: Financial duties of CCGs: additional controls on resource use 59. Annex 2 sets out which of the above Delegated Functions are Reserved Functions, to be exercised by the Committee or by an individual with appropriate delegated authority only. 60. In performing its role, the Committee will exercise its functions in accordance with its Terms of Reference; the terms of the delegations made to it by the NEL CCG Governing Body and the financial limit on its delegated authority, which shall be the total budgeted resource allocated to the Committee. 61. Where there is any uncertainty about whether a matter relates to the Committee in its capacity as a decision-making body within the CCG governance structure or whether it relates to its wider local system role as part of the ICPB, the flowchart included in Annex [3 to these Terms of Reference will be followed to guide the Chair's consideration of the issue.
Geographical Coverage	62. The geographical area covered will be the same as the ICPB.
Membership	63. There will be a total of eight members, as follows: **NEL CCG** • Accountable Officer or nominated deputy • Chief Finance Officer or nominated deputy • Governing Body Lay Member (**Chair**) • Borough Clinical Chairs (x3) for Barking & Dagenham, Havering and Redbridge • BHR ICP Managing Director • Director of Finance 64. Any member of the ICPB will have a standing invite to attend all meetings of the Committee. 65. Although attendees will not have a formal decision-making role in relation to the Delegated Functions and will not be entitled to vote on such matters, they will be encouraged to participate in discussions and to contribute to the decision-making process, subject always to the Committee operating within the CCG's governance framework, including in relation to managing actual and potential conflicts of interest.

Chairing Arrangements	66. The role of Chair of the Committee will be performed by the Governing Body Lay Member who is also a member of the Committee. 67. At its first meeting, the Committee will appoint a Deputy Chair drawn from its membership.
Secretariat	68. Secretariat support will be provided to the Committee by the governance team.
Meetings and Decision Making	69. The Committee will operate in accordance with the CCG's governance framework, as set out in its Constitution and CCG Governance Handbook, except as otherwise provided below. 70. The quoracy for the Committee will be three. 71. The Chair may agree that members of the Committee may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. 72. The Chair may determine that the Committee needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair. Urgent meetings may be held virtually. 73. Each member of the Committee shall have one vote. Attendees do not have voting rights. 74. The aim will be for decisions of the Committee to be achieved by consensus decision-making, with voting reserved as a decision-making step of last resort and/or where it is helpful to measure the level of support for a proposal. 75. Decision making will be by a simple majority of those present and voting at the relevant meeting. In the event that a vote is tied, the Chair will have the casting vote. 76. Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership. 77. Conflicts of interest will be managed in accordance with the policies and procedures of the CCG and shall be consistent with the statutory duties contained in the 2006 Act and the statutory guidance issued by NHS England to CCGs ((Managing conflicts of interest: revised statutory guidance for CCGs 2017 https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/) 78. Members of the Committee have a collective responsibility for its operation. They will participate in discussion, review evidence and

	provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view. 79. Where confidential information is presented to the Committee, all members will ensure that they comply with any confidentiality requirements. 80. The Committee will meet bi-monthly. The frequency of meetings may be varied to meet operational need, with the Chair determining this as necessary and in accordance with the provisions for meetings set out above.
Accountability and Reporting	81. The Committee shall be directly accountable to the NEL CCG Governing Body. 82. The Committee will ensure that it reports to the NEL CCG Governing Body on a bi-monthly basis and that a copy of its minutes is presented to the NEL CCG Governing Body, for information. 83. In the event that the NEL CCG Governing Body requests information from the Committee, the Committee will ensure that it responds promptly to such a request.
Sub-committees	84. In order to assist it with performing its role and responsibilities, the Committee is authorised to establish sub-committees and to determine the membership, role and remit for each sub-committee. Any sub-committee established by the Committee will report directly to it. 85. The terms of reference for any sub-committee established by the Committee will be incorporated within the CCG Governance Handbook. 86. The Committee may decide to delegate decision-making to any of its sub-committees duly established but, unless this is explicitly stated within the terms of reference for the relevant sub-committee, the default will be that no decision-making has been delegated. Where decision-making responsibilities are delegated to a sub-committee, these will be clearly recorded in the Committee's SoRD, which shall be maintained by the Secretariat to the Committee and incorporated within the CCG Governance Handbook. 87. The Committee may delegate funds from its overall budget to a sub-committee, provided that appropriate accountability and reporting arrangements are agreed and that these reflect the Committee's own financial reporting requirements. 88. The ICP Finance and Performance Sub-Committee will report into the Committee on matters relating to ICP finance and performance and make recommendations on matters within its remit for the Committee to consider.
Monitoring Effectiveness	89. The Committee will carry out an annual review of its functioning and provide an annual report to the NEL CCG Governing Body on its work

and Compliance with Terms of Reference	in discharging its responsibilities, delivering its objectives and complying with its terms of reference.
Review of Terms of Reference	90. The terms of reference of the Committee shall be reviewed by the NEL CCG Governing Body at least annually.

1.1. Annex 1: Functions that the ICP Board will manage on behalf of the Committee

The Committee, operating in accordance with its terms of reference, hereby asks the ICPB to manage the following functions on its behalf:

1 Developing, agreeing and implementing the ICP vision and outcomes, ensuring that this reflects the agreed CCG-specific vision and outcomes;

2 Supporting the CCG Committee in relation to market management, including through managing the following:

2.1 service evaluation; and

2.2 service design and development.

3 Supporting the CCG Committee in relation to financial and contract management, specifically through supply chain management.

4 Leading on planning and delivery within the ICP, ensuring that in doing so the outcomes are consistent with the ICP commissioning strategy agreed by the Committee, as follows:

4.1 community-based assets identification and integration;

4.2 integrated pathway-design;

4.3 service and care coordination;

4.4 place-based planning;

4.5 evidence-based protocols and pathways;

4.6 cost-reduction and demand management;

4.7 workforce strategy.

5 Support the CCG Committee in relation to monitoring performance, including through managing the following:

5.1 contract management and monitoring;

5.2 promoting continuous quality improvement;

5.3 safeguarding interventions and learnings;

5.4 regulatory liaison and relationship;

5.5 regular public outcome reporting.

6 Support the CCG Committee in relation to stakeholder engagement and management, including through the following:

6.1 political engagement;

6.2 clinical and professional engagement;

6.3 public and community engagement;

6.4 provider relationship management;

6.5 strategic partnership management.

7 When managing functions on behalf of the Committee, the ICPB will ensure that it has regard to the statutory duties that the Committee is subject to, including but not limited to the following:

- Section 14P – Duty to promote the NHS Constitution
- Section 14Q – Duty to exercise functions effectively, efficiently and economically
- Section 14R – Duty as to improvement in quality of services
- Section 14T – Duty as to reducing inequalities (and the separate legal duty under section 149 of the Equality Act 2010, the Public Sector Equality Duty)
- Section 14U – Duty to promote involvement of each patient
- Section 14V – Duty as to patient choice
- Section 14W – Duty to obtain appropriate advice
- Section 14X – Duty to promote innovation
- Section 14Z – Duty as to promoting education and training
- Section 14Z1 – Duty as to promoting integration
- Section 14Z2 – Public involvement and consultation (and the related duty under section 244 and the associated Regulations to consult relevant local authorities)
- Section 14O – Registers of interests and management of conflicts of interest
- Section 14S – Duty in relation to quality of primary medical services
- Section 223G – Means of meeting expenditure of CCGs out of public funds
- Section 223H – Financial duties of CCGs: expenditure
- Section 223I: Financial duties of CCGs: use of resources
- Section 223J: Financial duties of CCGs: additional controls on resource use

8 The ICPB will report to the Committee on a bi-monthly basis.

9 The Committee may revise the scope of the functions that it has asked the ICPB to manage on its behalf.

1.2. Annex 2: Reserved Functions to be exercised by the Committee only

CCG Reserved Functions

This list sets out the key CCG functions that will be the exercised at the ICP level and where a formal, legal decision may be required by the CCG. The list is not an exhaustive list of the CCG's functions and should be read alongside the CCG Constitution and the CCG Handbook.

The functions set out below may be exercised in the following ways:

(a) by each of the three CCG Governing Body Area Committees established by the NEL CCG Governing Body; and/or

(b) by individuals with delegated authority to act on behalf of the CCG and within the scope of such delegated authority.

Subject to ensuring that conflicts of interest are appropriately managed, the CCG Reserved Functions may be exercised by (a) or (b) at a meeting of the ICP Board.

- Approving commissioning plans (and subsequent revisions to such plans) developed in order to meet the agreed ICP population health needs assessment and strategy;
- Approving demographic, service use and workforce modelling and planning, where these relate to the CCG's commissioning functions;
- Approving proposed health needs prioritisation policies and ensuring that this enables the CCG to meet its statutory duties in relation to outcomes, equality and inequalities;
- Approving the CCG's financial plan for the ICP area;
- Approving financial commitments where these relate to delegated CCG budgets;
- Receiving recommendations from the ICP Finance and Performance Sub-Committee and making decisions on matters referred to it by that Sub-Committee;
- Approving procurement decisions, where these relate to health services commissioned by the CCG;
- Approving contract design, where these are developed specifically to reflect health needs and priorities within the ICP area;
- Approving health service change decisions (whether these involve commissioning or de-commissioning);
- Overseeing and approving any stakeholder involvement exercises proposed, consistent with the CCG's statutory duties in this context;
- Approving ICP-specific policies and procedures relating to the above, where these are different to any NEL CCG policies and procedures;
- Approving a proposal to enter into formal partnership arrangements with one or more local authority, including arrangements under section 75 of the NHS Act 2006;
- Other matters at the discretion of the CCG Governing Body BHR ICP Area Committee or individuals with delegated authority acting on behalf of the CCG, where it is considered that the matter is one that should be considered and determined by the CCG alone (including where this is necessary in order to ensure appropriate management of conflicts of interest).

[ALSO: agree how specific treatment decisions, safeguarding, CHC etc. are dealt with revise this list accordingly once this has been discussed.]

1.3. Annex 3: Decision-Making Flow Chart

1. Does any legislation expressly place a function or duty on a statutory body or bodies which means that it and only it should determine the issue in question?

   [If it does that statutory body or group of bodies should make the decision.]

2. Should no statutory body or bodies hold such a function or duty then is the issue an ICS matter?

   [If it is then the matter should go to the proper part of the ICS governance for determination.]

3. If the issue is an ICS matter, is it one that is within the ICPB's scope of responsibility?

   [If it is, then the matter should go to the ICPB for determination]

4. Does the issue in question cover decisions that may fall for determination in both statutory forums and the ICPB?

   [If the split in decision making is apparent then that should be followed, otherwise the matter should be referred to the ICP Executive Group for agreement on the approach to be followed].

BHR Integrated Care Partnership

Better care, better lives, together for all

Integrated Care Partnership Board

27 May 2021

Title of report	Managing Director's Report – BHR Integrated Care Partnership Update
Item number	4.0
Author	Emily Plane, Programme Lead, BHR System Development
Presented by	Ceri Jacob, Managing Director, Barking and Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP)
Contact for further information	e.plane@nhs.net
Executive Summary	2021/22 is a key year for the development of the BHR Integrated Care Partnership within the context of the wider North East London Integrated Care System. BHR Partners are ensuring that we make best use of this 2021/22 'transitional year' to embed learning from the pandemic as we recover and restore services, identify and articulate our key priority areas, and fully establish and embed the key elements of our BHR Integrated Care Partnership, including development of our Borough Partnerships, ahead of April 2022. Progress against each of the key foundation blocks of our BHR Partnership which are in development, is set out in more detail in the body of this report.
Action Required	Members are asked to note the progress to develop the key elements of our BHR Integrated Care Partnership detailed within this report. Members are asked to receive at their next meeting in July for approval; - Borough Partnership Roadmaps - BHR ICP priority area detailed work plans

Where else has this paper been discussed?	This is a recurring report from the BHR ICP Managing Director to members of the BHR Integrated Care Partnership Board
Next steps/ onward reporting	N/A; this report is intended to update members of the BHR Integrated Care Partnership Board on progress of our partnership work
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Every element of work referenced in this report has the aim of embedding more integrated working with a view to making best use of resources and improving outcomes for local people. Reducing inequalities is a key priority for the BHR Partnership as described within the body of this report
Conflicts of Interest	There are no conflicts of interest arising from this report
Strategic Fit	All areas of progress noted in this report align with national, North East London Integrated Care System, and BHR Integrated Care Partnership strategy
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage
Risks	One of the key overall risks for 2021/22 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the 'integration and innovation' White Paper from April 2022
Equality Impact	Not applicable at this stage

1. Introduction

1.1 2021/22 is an important year for the development of our Barking and Dagenham Havering and Redbridge Integrated Care Partnership. As the impact of the latest lockdown measures and vaccination programme is felt and the latest wave of the pandemic eases, as a Partnership we are taking stock of the innovation and partnership work that took place during the pandemic and embedding all of the elements that worked well as we develop and operationalise our recovery and restoration plans for health and care services.

1.2 Alongside this, publication of the White paper, 'next steps to building strong and effective integrated care systems across England' set out plans to move to more formal partnership working as Integrated Care Systems from 2022, which will likely replace the CCG statutory bodies. This proposal is in line with, and builds on our plans and journey towards greater integration, with the ultimate aim of improving health and care outcomes for local people. It also places even greater emphasis on the importance of supporting the development and maturity of Borough Partnerships throughout 2021/22.

1.3 BHR Partners are ensuring that we make best use of this 2021/22 'transitional year' to embed learning from the pandemic as we recover and restore services, identify and articulate our key priority areas for this year and beyond, and fully establish and embed the key elements of our BHR Integrated Care Partnership, including development of our Borough Partnerships, ahead of April 2022.

2. Progress update

<table>
<tr><th colspan="2">As a BHR Partnership at the beginning of this key 'transitional' year, we are focusing our efforts on:</th></tr>
<tr><td>Recovery and restoration of services</td><td>Guided by the following key principles:
We recognise that ensuring that services recover their position and address backlogs is a key area of focus, however, recovery and restoration in BHR will also consider recovery through the lens of Public health and the need to address the wider determinants of health
The BHR Partnership will, through their recovery and restoration plan and activities, aim to support recovery of our communities, not just recovery of services.
We will ensure that staff are supported as much as possible, particularly in relation to those who have lost friends, relatives, work colleagues and loved ones due to Covid, and also take into account through the recovery and restoration process the intense pressure that staff have been over during the course of the pandemic
We will review and embed best practice where new ways of working (e.g. virtual) or new models of care have worked well during the pandemic
We will ensure that any changes that are made permanent, meet the needs of all of our residents, e.g. if virtual working is embedded as the preferred model in some areas, we will ensure that there is an option for face to face consultations for those for whom virtual appointments are more challenging</td></tr>
<tr><td>Ongoing development of our BHR Partnership</td><td>The programme of Organisational Development for the BHR Integrated Care Executive Group and BHR Integrated Care Partnership Board continues to progress, with the most recent meetings at the end of April 2021 focusing on our key priority areas as a Partnership.</td></tr>
<tr><td>Identification of our key priorities</td><td>The BHR Integrated Care Partnership want to develop a shared sense of purpose focussing our work on a few critical areas that will make a difference to our residents. We are currently reviewing our priorities for 2021/22 and beyond. This will take into account and align to the existing priorities across the system at a North East London level, alongside those that exist across our Transformation Boards, are being developed by our Borough Partnerships, and those that exist at an organisational level.

We are:
Reviewing the previous long list of priorities to ensure that we have captured our most key and pressing priorities
Identifying a small number of key areas that we can focus on addressing as a partnership over the next 9 months
Identifying leads and developing action plans for each of these key areas ensuring measurable outcomes.</td></tr>
</table>

	The following emerging priorities for the BHR ICP in 2021/22 are being organised under the four key headings of: o Recovering well o Addressing inequalities and prevention o Anchor Organisations o Leadership culture and leading change Emerging priorities for the BHR ICP over the next 9 months which sit beneath the above headings: ▪ Develop a joined-up approach to **recovery** in BHR. ▪ Developing an **approach to Population Health Management** in BHR; strong emphasis on the prevention, self-care, **addressing inequalities** and using all community assets. ▪ Supporting key priorities from each of **our Borough Partnership**s including Children and Young People ▪ Launching the **BHR Health and Care Academy** ▪ Support and develop the communities we serve as '**anchor organisations'** ▪ **Supporting primary care networks** along with BHR **Borough Partnership development** ▪ Development of the BHR system **Integrated Sustainability Plan** ▪ **Continued development of the BHR Integrated Care Partnership** within the wider north east London Integrated Care System ▪ Develop a clear, streamlined and strong **framework for decision making and mutual accountabilities** Leads and action plans for these priorities are in development and these more detailed plans will be brought to the next ICPB meeting. A more detailed update on the emerging priorities is found in **appendix 1** to this paper.
Getting our Partnership governance right	BHR Partners have established a strengthened governance structure which includes evolution of the BHR ICPB as a formal Board of the North East London Clinical Commissioning Group governance. This is a key step ahead of planned legislative changes from April 2022 that will see Integrated Care Systems placed on a statutory footing, and the dissolution of Clinical Commissioning Groups. Partners are also strengthening our local Partnership governance by developing a proposal to establish a people and public board and ongoing programme of engagement with local people to ensure that they have a strong voice and are able to genuinely and effectively shape service transformation. A more detailed discussion on the emerging framework for this will take place under agenda item 8.
Supporting development of our Borough Partnerships	The three BHR Borough Partnerships are in the process of producing their development roadmaps ahead of submission to the BHR Partnership at the end of May 2021. Leads from the three boroughs came together at a workshop on Wednesday 19th May to share their draft roadmaps and emerging key priorities. Borough Partnerships will submit their Roadmaps (one for each Borough) by the end of May 2021.

	Following submission of the completed roadmaps by the end of May 2021, the ICPB and Health and Wellbeing Boards will be asked to review and endorse the roadmaps in June 2021. On the basis of an agreed roadmap (subject to approval and steps set out above), the CCG is looking to provide an additional non recurrent allocation of monies for borough partnership development in 2021/22 to support Borough Partnerships to deliver their roadmaps and key priorities. A more detailed report on this will be discussed under agenda item 8.
Development of a BHR System Integrated Sustainability Plan	Building on the 2018/19 Integrated Financial Recovery Plan (FRP) and taking into account the disruption caused by COVID, there is now the need to 'reset the system' and refocus the Transformation Boards on addressing the main challenges faced across BHR. A BHR Integrated Sustainability plan is in development which will help to focus the BHR System on the right priorities as we slowly recover from the COVID Pandemic and will include a focus on mental health and children and young people investments. A full report on the BHR Integrated Sustainability Plan will be discussed later on the agenda at this meeting.
BHR Transformation Board priorities	Our BHR Transformation Boards have mapped their achievements to date and later on the agenda we will discuss their 2020/21 year-end position as well as their emerging priorities for 2021/22 which are being articulated in a refreshed 'plan on a page' for each Transformation Board.
Establishing our BHR Health and Care Academy	As both a BHR Integrated Care System, and individual organisations, we face a number of workforce challenges. As a system we have established an innovative BHR Health and Social Care Academy to seek to address these. We have appointed a programme manager who is progressing the programme plan for 2021/22 with the key ambition of embedding the Academy, led by the SRO, Kathryn Halford, Chief Nurse at BHRUT. As a priority for 2021/22, the Academy is focussing on the challenges that we face around Allied Health Professional recruitment and retention, with an initial workshop on 20th May 2021 to review the key challenges and identify ways in which we can come together as a Partnership to address these.
Primary Care Network development	A programme of development has been commissioned for Primary Care Network Clinical Directors (PCN CDs) to support ongoing development of their leadership skills. NHS Elect have been commissioned to undertake interviews from which tailored Personal Development Plans will be developed. A programme of development will then be commissioned based on the needs identified within these. The programme of training will be a mix of different approaches (e.g. mentoring / online webinars), and will include an Action Learning Set approach so that PCN CDs are able to apply their learning into real transformation through their respective Borough Partnerships.

3. Risks and mitigations

3.1 A full risk register for our BHR Integrated Care Partnership is in development, this will record risks that are specific to our BHR Partnership, and will feed up into the North East London Integrated Care System Risk Register. As a Partnership we have developed a comprehensive risk register which has captured the evolving risks associated with the Coronavirus Pandemic and service recovery, which has been reviewed on a weekly basis for the past 12 months by our BHR System Oversight and Command Group (SOCG). The key risks from this are also being captured within the BHR Integrated Care Partnership Risk Register that is in development.

3.2 One of the key overall risks for 2021/22 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the 'integration and innovation' White Paper from April 2022.

4. Recommendations

4.1 Members of the BHR Integrated Care Partnership Board are asked to note the progress to develop the key elements of our BHR Integrated Care Partnership detailed within this report

4.2 Members are asked to receive at their next meeting in July for approval;

- Borough Partnership Roadmaps
- BHR ICP priority area detailed work plans

Appendices:
Appendix 1 – Emerging priorities for the BHR Integrated Care Partnership

Emily Plane
Programme Lead, BHR System Development
May 2021

APPENDIX

BHR Integrated Care Partnership

Better care, better lives, together for all

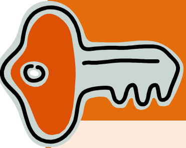
BHR Integrated Care Partnership

Key Priority Areas – SUMMARY OF CURRENT POSITION

May 2021

Reviewing Priorities for 2021/22

There are a large number of priorities that are being progressed by various elements of the NEL/BHR System. It is right that each organisation, Borough Partnership and Transformation Board is working to progress priorities matched to their own localised challenges.



Key next steps

BHR Integrated Care Partnership want to develop a shared sense of purpose focussing our work on a few critical areas that will make a difference to our residents. We recognise that these need to address some of our biggest areas of challenge. We are currently reviewing our priorities for 2021/22 and beyond. We are:

- Reviewing the previous long list of priorities and ensure that we have captured our most key and pressing priorities
- **Identifying a small number of key areas** that we can focus on addressing as a partnership over the **next 9 months**
- Identifying leads and develop action plans for each of these key areas ensuring measurable outcomes.

Previous long list of BHR priorities (July 2020)

- Workforce Development
- Developing Borough Partnerships
- Children's and Adults Safeguarding
- Developing the BHR ICP:
- Framework decision making and accountability
- Transformation Board Development
- Addressing inequalities and embedding prevention
- Winter Planning
- Organisational Development
- Children and Young People's services, particularly CAMHS and SEND
- Supporting people with long COVID

These are alongside the specific priorities of each Transformation Board (being developed via their plans on a page), Borough partnership and individual organisation priorities.

Emerging BHR ICP priorities within the NEL ICS

NEL Integrated Care System

Some key elements of an ICS include:

Improve outcomes in population health and healthcare

Tackle inequalities in outcomes, experience and access

Enhance productivity and value for money

Help the NHS to support broader social and economic development

Key priorities for the **NEL ICS (May 2021) are:**

ICS Development programme Co-ordination of the various workstreams into a coherent whole, agreeing objectives & tracking delivery

Governance Overall governance framework for the ICS during the transition year and in readiness for the new statutory NHS body for April 2022

Vaccinations Ensure the vaccination of NEL residents delivers a timely and accessible response

Acute Alliance Developing the acute alliance with appropriate governance and outcomes including elective programme

Mental Health Collaborative Developing the Collaborative including LTP targets and impact of Covid

Reducing Health Inequalities Use system-wide opportunities to tackle some of the enduring inequalities across NEL, establishing anchor principles, equalities impact frameworks

Business Intelligence and Population Health Management Build a strong BI and PHM function for the ICS and embed into the planning, delivery and performance management of the ICS.

Input from BHR

Impact on BHR

The following emerging priorities for the BHR ICP in 2021/22 are set out in more detail in the following slides which organise these under the four key headings of:

- Recovering well
- Addressing inequalities and prevention
- Anchor Organisations
- Leadership culture and leading change

Emerging priorities for the BHR ICP over the next 9 months which sit beneath the above headings:

- Develop a joined-up approach to **recovery** in BHR.
- Developing an **approach to Population Health Management** in BHR; strong emphasis on the prevention, self-care, **addressing inequalities** and using all community assets.
- Supporting key priorities from each of **our Borough Partnerships** including Children and Young People
- Launching the **BHR Health and Care Academy**
- Support and develop the communities we serve as **'anchor organisations'**
- **Supporting primary care networks** along with BHR **Borough Partnership development**
- Development of the BHR system **Integrated Sustainability Plan**
- **Continued development of the BHR Integrated Care Partnership** within the wider north east London Integrated Care System
- Develop a clear, streamlined and strong **framework for decision making and mutual accountabilities**

BHR ICEG Development Session – 30th April – summary of key priorities

Key area	Initial Scoping	Suggested Leadership
Recovering well	Develop a **joined-up approach to recovery in BHR**. Building on borough based work on recovering communities, this element will focus on supporting better health and well-being providing a joined up, system approach to recovery. To summarise, as well as managing the impact of the pandemic and the on-going vaccination programme, this work will also consider: • The health and well-being implications of Covid for longer term planning including addressing inequalities • Immediate operational pressures of demand and unmet need • Staff health and wellbeing, recognising the long term impact of dealing with the pandemic on individuals, teams and services. • Managing the backlog safely • Reviewing service changes to embed those which have had a positive impact.	Oliver Shanley (Sponsor) Steve Rubery (SRO) with SOCG
Addressing inequalities and prevention	1. Developing an approach to **Population Health Management in BHR**; strong emphasis on the **prevention, self-care, addressing inequalities** and **using all community assets.** Building on work undertaken by Care City on development of approaches and pathways to identify and support the vulnerable, participation in the NEL pilot and joining up the work of Borough Partnerships and the Transformation Boards. 2. Supporting key priorities from each of **our Borough Partnerships**.	TBC With Health and Care Cabinet and BHR Prevention Group in support
Anchor Organisations	1. Launching the **BHR Health and Care Academy**, to improve recruitment and retention and increase employment opportunities for local population. 2. Support and develop the communities we serve as '**anchor organisations**', through community development and spending money locally to promote local economic development and sustainability	Oliver Shanley (sponsor) and Kathryn Halford (SRO) with WA Steering Group Other – TBC
Leadership culture and leading change	▪ Development and delivery of the BHR ICP **Integrated Sustainability Plan** ▪ Supporting **primary care networks**, along with developing **Borough Partnerships,** and **multidisciplinary leadership** ▪ **Continued development of the BHR Integrated Care Partnership** within the wider north east London Integrated Care System ▪ Develop a clear, streamlined and strong framework for **decision making and mutual accountability**	Ceri Jacob

Integrated Care Partnership Board

Date: 27 May 2021

Title of report	BHR ICP Risk Management approach
Item number	5.1
Author	Anne-Marie Keliris, ICP Governance Programme Lead
Presented by	Ceri Jacob, Managing Director, Barking and Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP)
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	This report sets out a summary of the proposed approach to manage risk across North East London CCG and the BHR ICP
Action required	• Note the proposed approach to manage risk and support further development of a risk register that covers the most critical risks to the BHR ICP.
Where else has this paper been discussed?	Risks will be reviewed and managed at all levels and flow as follows: Group/Committee – Quality & Performance, Finance Clinical oversight – Health and Care Cabinet Executive oversight – Integrated Care Executive Group Assurance – Integrated Care Partnership Board/Area Committee and NEL CCG governing body.
Next steps/ onward reporting	Regular updates will be presented to the ICEG and ICPB.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	That the CCG and local integrated care partnerships are actively managing and mitigating the key risks to our system and in meeting our

	corporate objectives which include a focus on high quality and safe services and tacking inequalities.
Conflicts of interest	There are no conflicts of interest associated with this report.
Strategic fit	Draft corporate objectives: 1. High quality services for patients 2. Put patient experience at the centre of our delivery 3. Ensure the best use of resources 4. Support our people to thrive 5. Develop our NEL integrated care system 6. Recover from the pandemic and be prepared for future waves
Impact on finance, performance and quality	Risks to delivery of financial balance, performance standards and high-quality care are addressed.
Risks	This report is about how we manage risks.
Equality impact	N/A

1. Introduction

The North East London (NEL) CCG have recently introduced a risk management strategy and policy which is due to be presented to its governing body on 30 June 2021.

This sets out how the CCG will manage risk at across the CCG and the three Integrated Care Partnerships (ICP).

Each ICP shall have an ICP Risk Register, which contains all of the key risks, any of these risks assessed to require escalation to the corporate level will be included in the NEL CCG Corporate Risk Register.

The NEL CCG Corporate Risk Register (CRR) will contain all of the CCG's key risks assessed at the corporate level against the CCG's strategic objectives. There will be occasions where a risk is escalated for continued oversight on a case by case basis, particularly for risks that are subject to scrutiny from regulators and/ or are of public interest.

The ICPB are asked to note the proposed approach to manage risk and approve the BHR ICP risk register.

2. Approach to managing risk

In February 2020, BHR Partnership members developed an initial list of key risks and issues. Since then, a comprehensive risks and issues log for the BHR Partnership has been developed and is reviewed weekly by the BHR Recovery and

Restoration Planning Group which reports into the System Operational Command Group (SOCG).

This reflects key partnership risks, particularly those that have arisen in relation to the pandemic. The register has risk owners from across health and care corresponding with the nature of the risk.

Alongside this, BHR CCGs held a corporate risk register of key issues which sat within the CCG governance structure.

From April 2021, the seven CCGs in North East London merged into a single North East London (NEL) CCG. This will eventually transition into the North East London Integrated Care System, on a statutory footing, from April 2022 (subject to approval of the legislative changes set out in the February 2021 White Paper; 'Integration and Innovation: Working together to improve health and social care for all'). There are a number of multi borough/place Integrated Care Partnerships within the wider NEL footprint.

As a result of these changes, a corporate CCG risk register is now held at a NEL level, the BHR Integrated Care Partnership Board includes a CCG committee and is a formal sub group of NEL CCG. There is a need to ensure that we have a BHR Integrated Care Partnership Risk Register which captures our collective risks at a partnership level, owned and reviewed by the ICPB.

The draft ICPB risk register attached is one element of the risks held by the integrated care partnership and further work is beginning to ensure that CCG legacy risk and those of the partnership are captured in further iterations.

3. Risks and mitigations

The proposed process will ensure that risks are reviewed and mitigated at all levels of the ICP and CCG to give assurance to the ICPB and NEL CCG governing body.

4. Conclusion / Recommendations

The ICPB are asked:

- to note the approach to risk across the North East London CCG and Integrated Care Partnerships.
- To support further development of a risk register that covers the most critical risks to the BHR ICP.

Anne-Marie Keliris
Head of Governance
24 May 2021

DRAFT sample risk register
(to be further developed)

ID no.	Date raised	Raised by (individual/ committee/ programme)	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating: Likelihood	Current rating: Impact	Current rating: Risk Score (1-25)	Target rating	Target completion date	Mitigating actions: Completed	Mitigating actions: Uncompleted	Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Updates/ comments	Close Down Status
BHR ICP 001_21	04/05/2021	TBA	8	Develop our NEL integrated care system	If the different accountability structures across health and social care (planning regimes and funding frameworks) are not reconciled with the new governance structures, system working may be compromised which could impact the effectiveness of the ICS from April 2022.	NEW	2	4	8	6	Mar-22	Creation of a strong BHR Integrated Care Partnership governance structure, with the ICPB as a formal group of the NEL CCG. BHR Joint Commissioning Board established.	Development of a BHR Integrated Sustainability Plan which will bring together a whole system view of the scale of the financial and activity challenge, including social care - in development	Ceri Jacob	Alison Blair/ Anne-Marie Keliris	ICPB	Y	Score of 8 or above - to be escalated to NEL CCG corporate risk register		Open
BHR ICP 002_21	04/05/2021	TBA	8	Develop our NEL integrated care system	If there are significant changes to senior and clinical leadership in the BHR system, this could affect the pace of progressing the ICS therefore strategy development and delivery could be compromised.	NEW	2	4	8	6	Mar-22	Reiteration of commitment to the BHR Integrated Care Partnership Review of the BHR Health and Care Cabinet membership / ways of working complete, alongside cementing the role of the Health and Care Cabinet at a BHR level to ensure that our work is clinically and professionally led Review of BHR Partnership membership complete to ensure that there is strong clinical and professional leadership at each level of the partnership	Review of Clinical Leadership across the BHR system underway, identifying gaps and addressing these / ensuring that there is a clinical lead for each key area / stream of work Review of the Transformation Boards underway to ensure that all of the right leads are around the table The CCG is providing resource to support development of the BHR PCN Clinical Directors, this is starting with 1-1 interviews to develop PDPs and a tailored development programme	Ceri Jacob/ Caroline Allum	Alison Blair/ Emily Plane	ICPB	Y	Score of 8 or above - to be escalated to NEL CCG corporate risk register		Open
BHR ICP 003_21	04/05/2021	TBA	8	Support our people to thrive/ Develop our NEL integrated care system	If Primary Care Networks and GP Federations do not reach sufficient stages of maturity, it will impact on the system's ability to improve quality and implement new models which could affect service delivery and patient experience/ outcomes.	NEW	2	4	8	6	Mar-22		Ongoing evening PCN / Federation Development Sessions Agreement that Federations will work to support PCNs to deliver their key priorities, piece of mapping work underway to set out the key 2021/22 priorities for PCNs to support this Strong focus on supporting the establishment of Borough Partnerships	Ceri Jacob	Sarah See	ICEG	Y	Score of 8 or above - to be escalated to NEL CCG corporate risk register		Open
BHR ICP 004_21	04/05/2021	TBA	16	Develop our NEL integrated care system	If historic cultures and behaviours across partner organisations do not evolve (i.e. provider/ commissioner divide), this would make system working less effective which could compromise the progression of the ICS.	NEW	4	4	16	6	Mar-22		Organisational Development programme underway for the BHR ICP Governance structure and members. Partners codeveloping and signing up to the BHR System Sustainability Plan	Maureen Worby/ Ceri Jacob	Alison Blair/ Emily Plane	ICPB	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF		Open
BHR ICP 005_21	04/05/2021	TBA	20	Support our people to thrive/ Develop our NEL integrated care system	If the current workforce is unavailable to deliver the new system models of care whilst maintaining current services, then delivery will be severely compromised now and in the long-term future which could impact on patient outcomes and staff wellbeing.	NEW	4	5	20	12	Mar-22		BHR Health and Social Care Academy being established to support the BHR workforce to adapt to new ways of working and deliver more integrated Care	Ceri Jacob	Kathryn Halford	ICEG	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF		Open
BHR ICP 006_21	04/05/2021	TBA	20	Ensure the best use of resources	If the appropriate digital infrastructure is not implemented, the BHR system will be unable to create accurate population health models or be able to share information at resident and population levels. This could result in duplication of work and innaccuracies.	NEW	4	5	20	6	Mar-22		BHR IT system lead and role to be identified / agreed, alongside key priorities	Ahmet Koray/ Umesh Gadhvi	Ahmet Koray/ Umesh Gadhvi	ICPB/ ICEG	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF		Open
BHR ICP 007_21	04/05/2021	BHR System Operation Command Group	20	Ensure the best use of resources	If the BHR system cannot sustainably reach financial balance, this could create a financial gap across partners which may require cost savings to be made that could impact on services and outcomes for local people; potentially increasing inequalities. This may also have implications for the investment of transformation schemes.	NEW	4	5	20	12	Mar-22	A sub-group of the BHR ICP finance group has been established to start the process of developing a BHR ICP financial sustainability plan using the outputs of the Transformation Boards to inform the position across the system. This work will continue to allow a medium-term financial picture across the BHR and NEL system to be developed.	Allocations for the first half of the new financial year have been received and the process of developing plans has begun. Development of a BHR Integrated Sustainability Plan which will bring together a whole system view of the scale of the financial and activity challenge, including social care - in development	Ceri Jacob/ Ahmet Koray	Ahmet Koray	BHR ICP Finance Sub-committee	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF	Escalate for discussion at a NEL level as this will have implications for all NEL boroughs.	Open
BHR ICP 008_21	04/05/2021	BHR System Operation Command Group	20	Recover from the pandemic and be prepared for future waves	If provider estates are unable to deliver business as usual activity alongside Covid activity (including the vaccination programme), this could further impact on treatment waiting times and affect patient outcomes.	NEW	5	4	20	12	Dec-21	Provider estate has been segregated to support cohorting of COVID, and non-COVID pathways		TBC	Steve Rubery	SOCG	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF		Open
BHR ICP 009_21	04/05/2021	BHR System Operation Command Group	20	High quality services for patients	If the number of children with LD and Mental Health needs cannot access or move on from inpatient beds, this could result in poor patient outcomes which would further impact the health and care system as the patients transition into adult services.	NEW	4	5	20	12	Dec-21		A meeting has been convened linking in with the CAMHS Task and Finish group to ascertain what plans they have developed to meet future potential surges. The required meeting has been expanded from the initial attendees to include representatives from the 3 boroughs to address issues relating to social care and delayed discharge. The suitable attendees have been confirmed by the 3 relevant LA Directors. NELFT are confirming attendees from both community and Interact/CYPHTT provision. Safeguarding and provider collaborative representation will be in place. A full BHR approach is being taken with Whipps Cross being requested to attend to agree common approaches. The meeting will be organised to take place as soon as possible and will deliver a full TOR, actions and required outcomes for subsequent distribution and assurance.	Oliver Shanley	Sharon Morrow	SOCG	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF	There are an increasing number of children with LD and Mental Health needs accessing or unable to move on from inpatient beds. Children are presenting from around 14 and often with complex histories including being in care of Child Protection services. This has been exacerbated by Covid and appears that this trend is set to increase. There is an urgent need to review the services that we have in place for this cohort, and what this means for developments of community services and including system reconfigurations to enable a holistic 18-25 pathway, especially with many more young people transferring to adults.	Open
BHR ICP 010_21	04/05/2021	BHR System Operation Command Group	16	Support our people to thrive/ Recover from the pandemic and be prepared for future waves	If the adult social care provider workforce continues to face significant pressures relating to the pandemic response (key pressures listed under "updates/ comments"), this could result in an increase in staff absences and affect staff members' wellbeing. This could then impact on the delivery of services and quality of care.	NEW	4	4	16	10	Dec-21	Business continuity plans reviewed. Asymptomatic NHS staff testing is being rolled out across the sector	Mutual aid across providers being negotiated, including e.g. extra care, home care staff supporting in extremis Mental health & wellbeing package for frontline provider staff, and currently reviewing a package that can be introduced to managers. Ongoing recruitment campaign (London's Proud to Care) to bring people back into or into for the first time the social care workforce, including apprenticeships and career pathways. working. Care home staff currently being vaccinated. Will extend to other care staff in next few weeks	Oliver Shanley	DASSs	SOCG	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF	Specific issues/ concerns include: •Staff shortages due to increased spread within a care home or supported living setting, with mass numbers of staff having to self isolate at once following asymptomatic testing. •Staff shortages in home care agencies emerge over time. There is no routine testing available for home care agency staff or vulnerable adults they care for, which is of concern as most councils support more people at home than in care home settings. • Staff and manager burnout • Shortage of nursing staff, exacerbated by requirement to make plans to remove staff movement, through e.g. paying staff their full usual weekly wage across all settings they work in, but restricting them to a single setting (ICF funding insufficient to cover all this additional expenditure). • Concerns that other clinical/professional visitors to care homes are not tested weekly, therefore risk of further introduction of COVID-19 from asymptomatic staff.	Open
BHR ICP 011_21	04/05/2021	TBA	16	Develop our NEL integrated care system	If the Borough Partnerships are not sufficiently developed by April 2022 in line with the legislative changes regarding the statutory ICS, the Partnerships will not be prepared to effectively manage the additional funding and responsibilities associated with them. This could then impact on the delivery of services to patients and residents.	NEW	4	4	16	6	Mar-22		The CCG has identified funding to support Borough Partnership development in 2021/22, with the first stage being the development of Roadmaps for the rest of the year, with funding following to support the operationalisation of these Strong BHR ICP focus on ensuring that Borough Partnerships are established	Ceri Jacob	Alison Blair/ DASSs	ICPB	Y	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF		Open

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Risk grading matrix

Severity

Rating	Description	A Objectives/ projects	B Harm/injury to patients, staff visitors & others	C Actual/potential complaints & claims	D Service disruption	E Staffing & competence	F Financial	G Inspection/ Audit	H Adverse media
1	Insignificant	Insignificant cost increase/time slippage. Barely noticeable reduction in scope or quality	Incident was prevented or incident occurred and there was no harm	Locally resolved complaint	Loss/ interruption more than 1 hour	Short term low staffing leading to reduction in quality (less than 1 day)	Small loss <£1000	Minor recommendation s	Rumours
2	Minor	Less than 5% cost or time increase. Minor reduction in quality or scope	Individual(s) required first aid. Staff needed <3 days off work or normal duties	Justified complaint peripheral to clinical care	Loss of one whole working day	On-going low staffing levels reducing service quality	Loss of 0.1% budget. <£10,000	Recommendatio ns given. Non-compliance with standards	Local media column
3	Moderate	5-10% cost or time increase. Moderate reduction in scope or quality	Individual(s) require moderate increase in care. Staff needed >3 days off work or normal duties	Below excess claim. Justified complaint involving inappropriate care	Loss of more than one working day	Late delivery of key objectives/servic e due to lack of staff. On-going unsafe staff levels. Small error owing to insufficient training	Loss of more than 0.25% of budget. <£100,000	Reduced rating. Challenging recommendation s. Non-compliance with standards	Local media front page story
4	Major	10-25% cost or time increase. Failure to meet secondary objectives	Individual(s) appear to have suffered permanent harm. Staff have sustained a "major injury" as defined by the HSE	Claim above excess level. Multiple justified complaints	Loss of more than one working week	Uncertain delivery of services due to lack of staff. Large error owing to insufficient training	Loss of more than 0.5% of budget. <£500,000	Enforcement action. Low rating. Critical report. Major non-compliance with core standards	Local media short term
5	Severe	>25% cost or time increase. Failure to meet primary objective	Individual(s) died as a result of the incident	Multiple claims or single major claims	Permanent loss of premises or facility	No delivery of service. Critical error owing to insufficient training	Loss of more than 1% of budget. >£500,000	Prosecution. Zero rating. Severely critical report.	National media more than 3 days. MP concern

Likelihood

Rating	1	2	3	4	5
Description	Rare	Unlikely	Possible	Likely	Certain
Probability	<10%	10% - 24%	25% to 45%	50% - 74%	>75%
Severity 1	1	2	3	4	5
Severity 2	2	4	6	8	10
Severity 3	3	6	9	12	15
Severity 4	4	8	12	16	20
Severity 5	5	10	15	20	25

Risk category	
Severe	
High	
Medium	
Low	

Integrated Care Partnership Board

27 May 2021

Title of report	BHR Transformation Board Achievements to Date and 2020/21 Year End Position
Item number	6.1
Author	Hanh Xuan-Tang, Deputy Director of Recovery Planning, NEL CCG (BHR ICP)
Presented by	Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Contact for further information	Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Executive summary	• This paper sets out the key achievements of the BHR Transformation Boards since their inception to date. • It also sets out the schemes that have been delivered over the course of 2020/21 despite and often in support, of the covid pandemic pressures
Action required	Note/Discussion
Where else has this paper been discussed?	Integrated Care Executive Group
Next steps/ onward reporting	A version of this paper will be shared with the Health and Care Cabinet and BHR ICP Clinical Leaders Group
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The successes delivered by the Transformation Boards will have resulted in improved experience, pathways and treatment for BHR residents and patients. Collaborative working across the BHR ICP has also been improved as a result of these fora which will also result in more “joined up” services for the populations that we serve.

	The Transformation Boards were established to drive system change and through that change, ensure that BHR becomes a financially sustainable system.
Conflicts of interest	None
Strategic fit	Transformation of services – resulting in delivery of the BHR Financial Recovery Plan
Impact on finance, performance and quality	The successes of the Transformation Boards will have contributed to improvements in the quality of services provided, improved performance and delivered financial benefits.
Risks	N/A
Equality impact	N/A – EIAs will have been completed at a scheme level

North East London
Clinical Commissioning Group

BHR Transformation Board Achievements to Date – May 2021

Meeting name: Integrated Care Partnership Board
Presenter: Tracy Welsh, Director of Transformation
Date: 27th May 2021

Barking and Dagenham, Havering and Redbridge

BHR TRANSFORMATION BOARDS - KEY ACHIEVEMENTS SUMMARY

OLDER PEOPLE

- The Acute Frailty Service (AFS) continues to exceed its target throughout 20/21 despite Covid. The service continues to support c250 patients a month with at least c80% (200) frail patients being discharged from ED and being managed in the community or their own homes and therefore avoiding an admission.
- Since June 2019 there continues to be a reduction in conveyances from Care Homes (average 30 conveyances per month) when compared to the previous year. This downward trend of conveyances from Care Homes continued throughout the the Covid pandemic. The reduction is part contributed to by the Care Home DES (formally Integrated Nursing), however, it is difficult to ascertain whether the reduction is wholly driven by the scheme or also due to Covid.
- The creation of Co-ordinate my Care (CMC) records continue to exceed the planned targets for 20/21. In 19/20, 832 CMC records were created against a target of 318. As at the end of March 2021, 3,776 plans were uploaded and live on the system. This supports the sharing of records across organisations to support End Of Life (EOL) care patients in their care, but also to die in their preferred place of death
- Due to Covid, the 20/21 activity levels had been skewed and therefore achievement is based on 19/20 data. Overall Non-elective admissions (NEA) reductions in 2019/20 across a range of schemes for Older People were reduced by 3%.

LONG TERM CONDITIONS

- Since the roll out of the Asthma COPD LIS – Phase 1 in 20/21, 55% (3,389) of high risk asthma patients and 46% (1,692) of high risk COPD patients received their high risk reviews. 54% (3241) of the high risk asthma patients and 41% (1,423) of the high risk COPD patients received a personalised action plan. Both above the target of 40%. This is thought to have contributed to the overall reduction seen in asthma and COPD emergency admissions.
- The implementation of the Acute COVID-19 remote monitoring (Oximetry @ Home and Covid Virtual Ward) has resulted in 86 patients have been discharged earlier from hospital via the covid virtual ward since February 2021. Circa 100 patients a week have been monitored at home via the oximetry @ home service, saving circa 1200 GP appointments to date.
- Due to Covid, the 20/21 activity levels had been skewed, and therefore achievement is based on 19/20 data. Overall, there was a 3% reduction in 19/20 Non-elective admissions (NEA) for patients with a LTC.

BHR TRANSFORMATION BOARDS - KEY ACHIEVEMENTS SUMMARY

URGENT AND EMERGENCY CARE

- The procurement of 4 urgent treatment centres has been completed which increased the number of UTC sites in BHR from 2 to 4 further supporting the right care at the right place agenda.

- Implementation of a Virtual Minor Injury Pilot between 111 and PELC (UTCs) allowing 111 to seek advice from UTC Minor Injury consultants prior to referral. 38.3% of cases were able to be treated and closed over the phone.

- The LAS Alternative Care Pathway (extension from pilot) (ACP) Pilot to provide alternative care pathways for LAS crews to utilise as alternatives to ED has contributed to the 26% reduction in LAS conveyances to BHRUT (c10,500 less conveyances compared to 19/20)

- Direct booking from 111 implemented at Queen's, KGH, UTCs and Primary Care to support the current IPC requirements. From 12-25 April, 43% of all KGH ED cases and 37% at Queen's were given a time to arrive. UTC activity shows a 13% increase in bookings (average 1,453 bookings per month) compared to Q4 last year. Primary Care increased by 4,458 from January to April (w/e 7/1 9,375: w/e 8/4 13,833).

PLANNED CARE

- Roll out of Advice and Guidance to top 7 specialties to reduce unnecessary hospital attendances and enable greater management of patients within primary care, including a pilot for Cardiology of an "A&G only referral service". Advice & Guidance requests have increased by c30% (c200 requests) over the past 6 months.

- The roll out of virtual appointments (telephone or video) continues as well as the re-opening of face to face consultations since the last Covid wave. c40% (c13,000 appointments) of all outpatients consultations at BHRUT were done virtually in 20/21 meeting the 28% national target in this year's Operating Guidance.

CHILDREN & YOUNG PEOPLE

- The Sustainable Asthmas LIS, which was implemented in response to the Regulation 28 review has resulted in an increase in the number of Care Management Plans and reviews being in place for children with Asthma. In August 20, 1,574 were issued. By the end of March 21, this had increased to 4,790.

- Due to Covid, the 20/21 activity levels had been skewed and therefore achievement is based on 19/20 data. Overall, the number of Paediatrics attending ED has reduced by 23% between 18/19 and 19/20 with a reduction of 3% in admissions over the same period.

BHR TRANSFORMATION BOARDS - KEY ACHIEVEMENTS SUMMARY

MENTAL HEALTH

- IAPT: Accelerated move to virtual platforms of provision with live webinars on Covid-19 specific areas; created a dedicated area on website for NELFT staff and IAPT staff have also been supporting NELFT Borough based Hubs

- Single Point of Entry (Access, Community Recovery Teams): Access, Community recovery teams have concentrated resources in a Hub model with other mental health specialists deployed into the Hub allowing for a more integrated offer at point of triage e.g. direct support from IAPT staff in the Hub

- Inpatient service: An intense effort has been made to reduce occupancy on the inpatient wards via a Covid-19 admission pathway in order to reduce the risk of outbreak on MH inpatient wards

- Community SMI transformation: Work to develop the future mental health community model of care and support is underway, supported by system development funding. The programme governance and infrastructure have been put in place to oversee planning and delivery with borough level steering groups established to oversee borough planning and implementation of the model and to mobilise early implementer projects with PCNs

PRIMARY CARE

- The success of the Covid Vaccination programme has resulted in 53% of the BHR adult population receiving at least 1 dose of vaccine with over 80% of cohorts 1-9 vaccinated. Primary Care and PCNs delivered c60% of all vaccines administered and BHR has achieved the highest rate of vaccination across NEL.

- The acceleration of digitalisation in Primary care has increased the number of telephone and virtual appointments from c20,000 per month in 19/20, to over 120,000 appointments being delivered virtually each month throughout 20/21. This efficiency of virtual appointments has resulted in c33,000 additional appointments being made available throughout 20/21 compared to the previous year.

CANCER

- The Cancer LIS has resulted in a significant increase in the number of Care Reviews completed and the number of Care plans discussed. The number of Care reviews completed increased from 157 in Q1 (20/21) to 2,954 by the end of March-21. Care Plan discussions had increased from 90 to 1,798 during the same period.

LD & AUTISM

- NEL has had significant success in reducing the number of adults inpatient beds; adult admission rates have reduced by 33% since the beginning of the programme in 2016 and the total number of adult inpatients has reduced by 35%.

- In line with Building the Right Support, the programme has implemented a number of improvements to community infrastructure including: Imbedded the Dynamic Support Register and C(E)TR processes for both adults and CYP, including two C(E)TR co-ordinator posts, established a Positive Behaviour Support offer across all seven boroughs, introduced a robust discharge planning process for adults and children across health, social care and education, developed a specialist autism service in Outer NEL.

- BHR CCGs have performed exceptionally well in maintaining annual health checks over the COVID pandemic, with B&D and Redbridge forecast to have exceeded the national target in 202/21 and Havering close to it

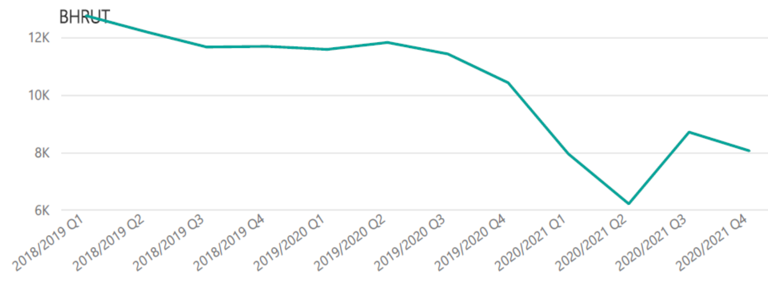
Older People

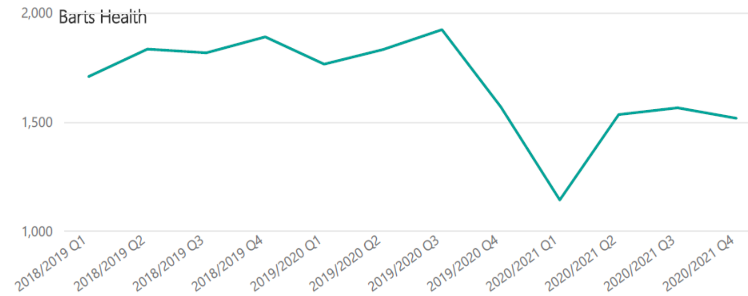
Objectives: To help people live healthier lives. For all older people to have a good experience of their care; living well for longer and supported to remain independent for longer.. Embed integrated care interventions that minimised frailty and avoid unnecessary long-term health and care needs.

To acknowledge a person's wishes and support their end-of-life needs in their preferred place of care.

Patients aged 65+: Type 1 A&E attendances

FRP p 3



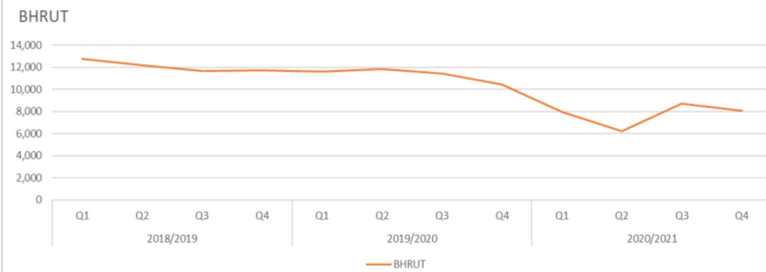


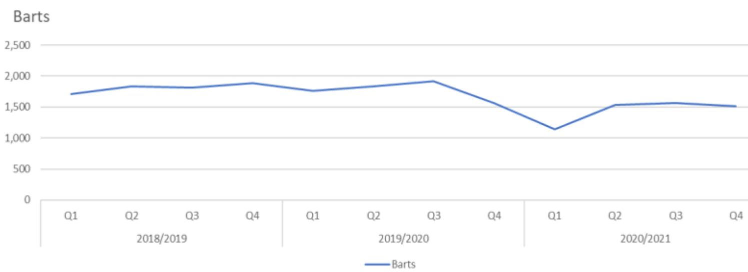
F.Year	2018/2019				2019/2020				2020/2021			
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	12,753	12,190	11,662	11,686	11,580	11,821	11,421	10,419	7,940	6,203	8,699	8,049
Barts	1,706	1,832	1,815	1,888	1,763	1,830	1,921	1,567	1,141	1,532	1,563	1,515
Total	**14,459**	**14,022**	**13,477**	**13,574**	**13,343**	**13,651**	**13,342**	**11,986**	**9,081**	**7,735**	**10,262**	**9,564**

Quarterly activity

Data Source: SUS

Patients aged 65+: Emergency Admissions





F.Year	2018/2019				2019/2020				2020/2021			
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	6,276	6,241	6,029	5,883	6,007	5,964	6,176	6,054	4,857	5,863	5,844	5,571
Barts	1,218	1,246	1,273	1,255	1,211	1,225	1,260	1,199	923	1,199	1,162	1,240
Total	**7,494**	**7,487**	**7,302**	**7,138**	**7,218**	**7,189**	**7,436**	**7,253**	**5,780**	**7,062**	**7,006**	**6,811**

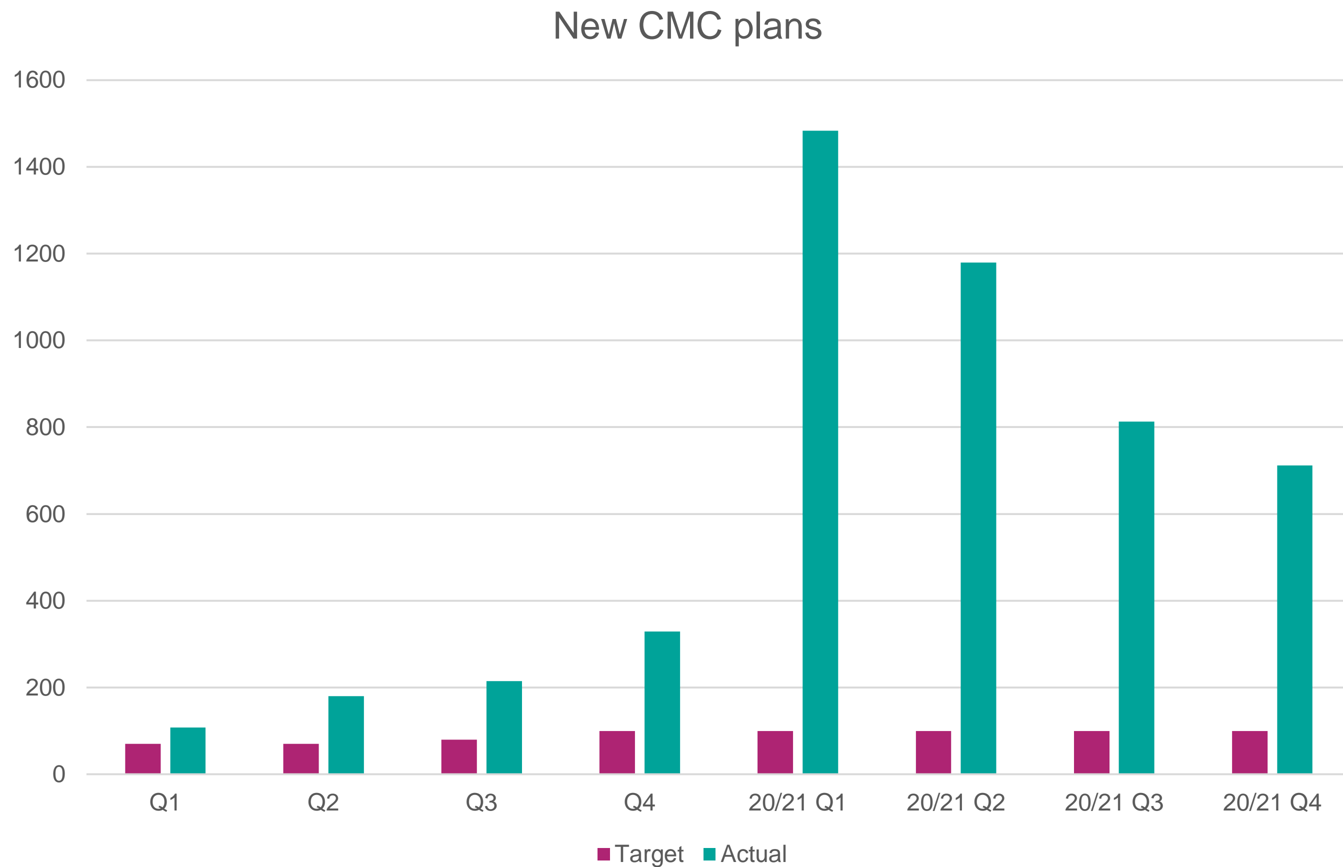
Quarterly activity

Data Source: SUS

Key Notes

- The 2nd wave has impacted on the recovery of emergency services with Q4 showing a reduction of 23% against the same period the previous year.
- The Q3 year on year Attendances and Admissions (pre-Covid - 18/19 to 19/20) for people >65 continued showed a reduction of 3% which is very positive.
- To supplement the acute trends skewed by Covid, the following slides for Older People (OP) includes the performance of local scheme metrics to provide further information of how OP initiatives are contributing overall reduction in Acute activity for Older People

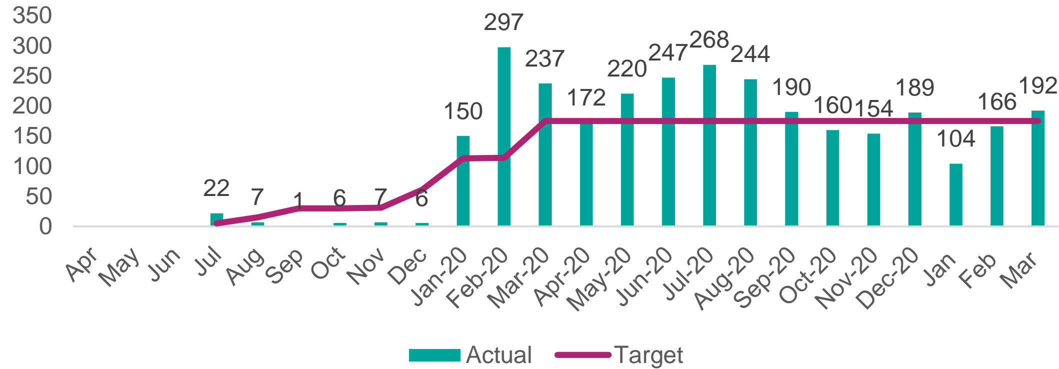
End of Life Trends



Key Notes

- Creation and uploading of CMC plans remains very high.
- There are just under 4,000 plans "Live" and online.
- The quality aspect of plans is being reviewed in Q1/2 and Marie Curie Advance Care Plan nurses have been commissioned to support the system to review, advise and support the production of good quality plans to enable the best possible utilisation of CMC by all professionals and to promote patients dying in their preferred place of care. This will also reduce unnecessary LAS conveyances.

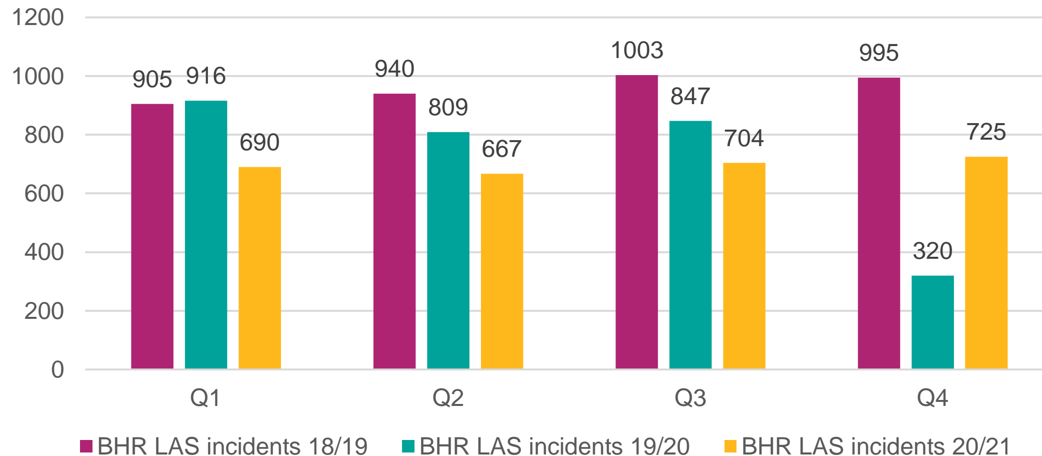
ACUTE FRAILTY SERVICE REFERRALS



Key Notes

- Referrals into the AFS service have decreased slightly in Q4 20/21 compared with previous quarterly data. This was due to the closure of Beech Frailty Unit at BHRUT in January where the majority of the team are based. Beech closed and was replaced as an oxygen receiving unit to support the COVID pandemic.
- The new Queen's Frailty Unit is opening up on May 17th and will see the CTT and AFS team move back to Queen's. This should have a positive effect on patients being seen by the service and it is anticipated that numbers will continue to rise in line with the previous data.
- Although the service has operated throughout the pandemic, referrals into the service for 20/21 have remained high and the service has achieved greater numbers than the target resulting in a significant reduction in NEL admissions across BHR.

LAS CONVEYANCES FROM CARE HOMES

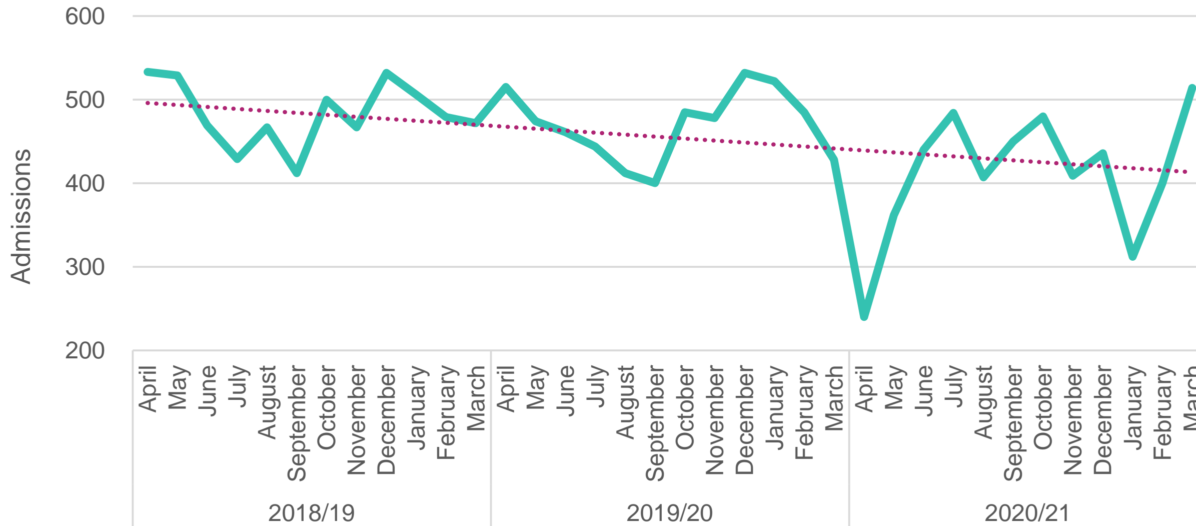


Key Notes

- LAS incidents even with the pandemic remain lower than the 18/19 target
- Primary Care Network (PCN) care home DES in place
- PCN DES includes advanced care planning recorded via CMC, weekly virtual "ward rounds" and development of regular MDT discussions.
- Significant 7 training and support to care home staff restarted
- The CHS and MDT offer to aligned PCNs for care homes is to be developed and embedded during 2021/22

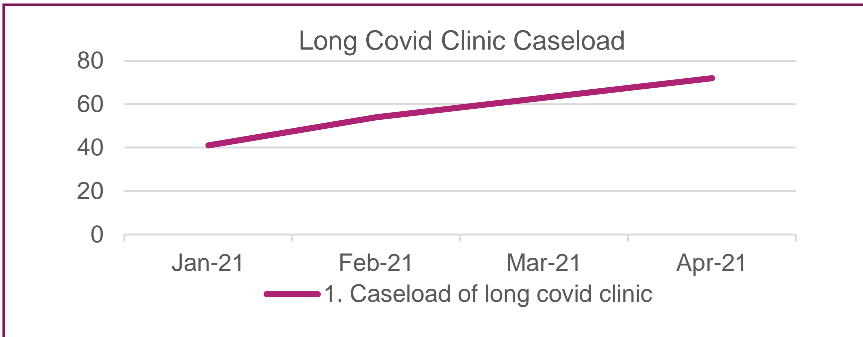
Long Term Conditions (LTC)

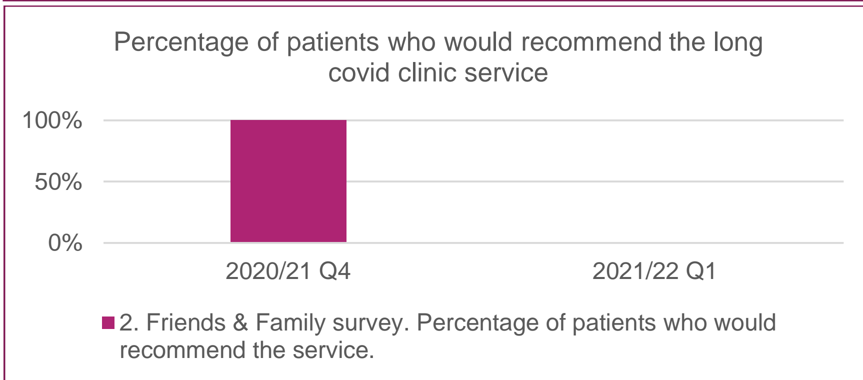
Objectives: Improve prevention & early detection, Whole system pathway development; standardising and integrating services across our Integrated Care Partnership, provide enhanced support and improved outcomes for patients with LTCs and promote a digital first agenda

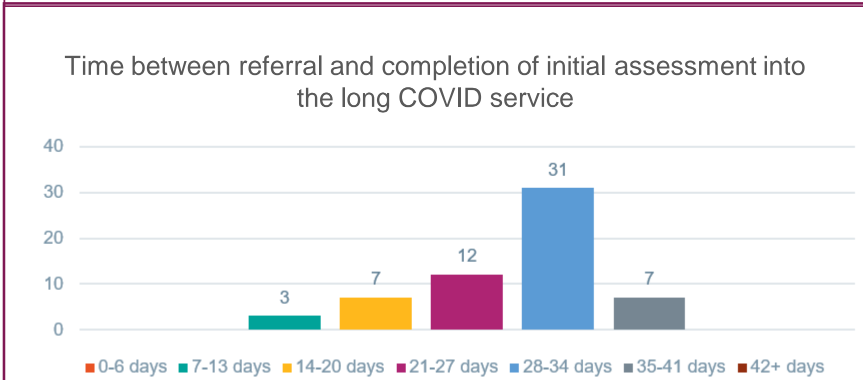


Key Notes

- Service developments and investments throughout 18/19, 19/20 and 20/21 into services for Atrial Fibrillation (AF), Diabetes, Asthma and COPD resulted in emergency admission levels reducing or being maintained despite increases in prevalence. The net result for the LTCs collectively is an overall reduction in emergency admissions. Emergency admissions reduced by 159 (3%) when comparing 19/20 with 18/19.
- Whilst activity levels have increased post covid with ongoing management of patients with LTC's, a sustained reduction in emergency admissions is expected in the longer term.
- Correspondingly, pre covid GP referrals for the these conditions increased evidencing that improved management and planned care for this cohort of patients is having a positive impact resulting in a reduction in emergency admissions. Since Covid this trend has been reversed, but it is expected that in the longer term we will get back to pre-covid levels.



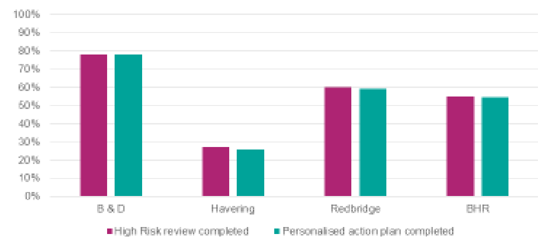




Key Notes

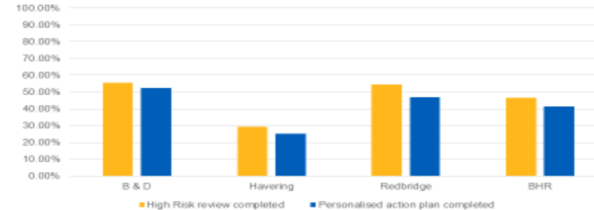
- The long COVID rebab clinic was approved in Autumn 20. This is a joint venture between BHRUT and NELFT.
- By January 21, the service had access to key clinical support, with input from secondary care, physiotherapy, occupational therapy and clinical health psychology
- The service is currently supporting over 100 patients to recover from COVID 19. 40% of patients are experiencing difficulties with finances and 50% are experiencing vocational/ employment issues.
- The first full service review was carried out in April 21, these are scheduled every three months to ensure that the service can respond to learning about this new illness as it becomes available
- The service has attracted very positive media attention https://www.standard.co.uk/news/london/surge-long-covid-patients-first-clinic-ilford-east-london-b925216.html

Asthma High Risk Review - BHR
% Completion of High Risk review per borough



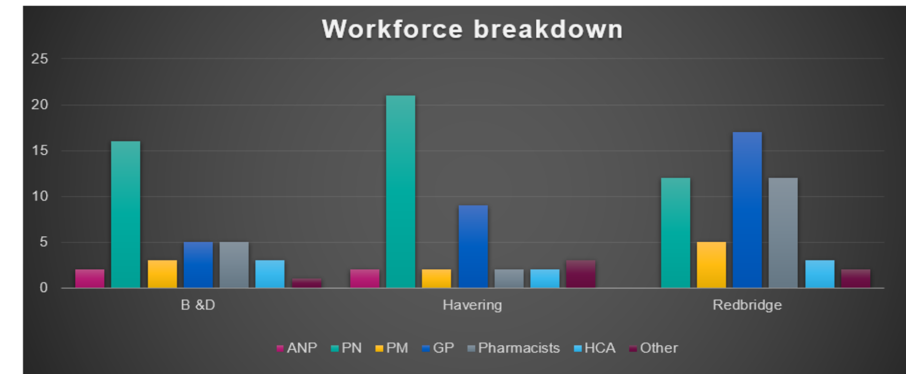
- 55% of asthma high risk patients received high risk review in BHR
- 54.3% of asthma high risk patients received Asthma PAP (Personalised Action Plan) in BHR
- B & D has achieved a significant proportion of high risk reviews despite covid impact, followed by Redbridge

COPD High Risk Review – BHR
% Completion of High Risk review per borough



- 46% of COPD high risk patients received a high risk review in BHR
- 41.5% of COPD high risk patients received a COPD PAP in BHR
- B & D and Redbridge have achieved a significant proportion of high risk reviews despite covid impact

Respiratory Training

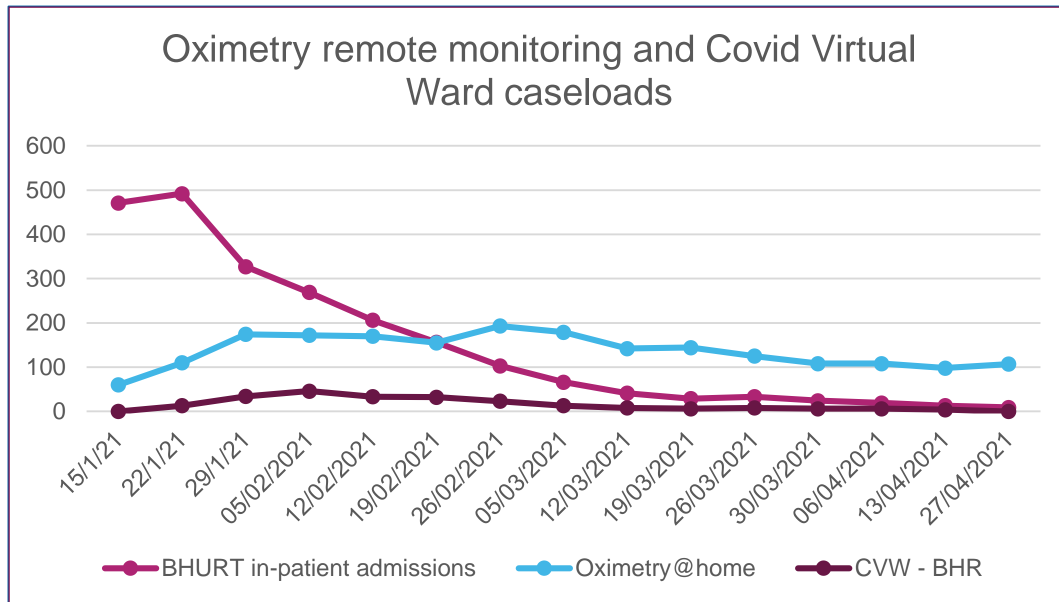


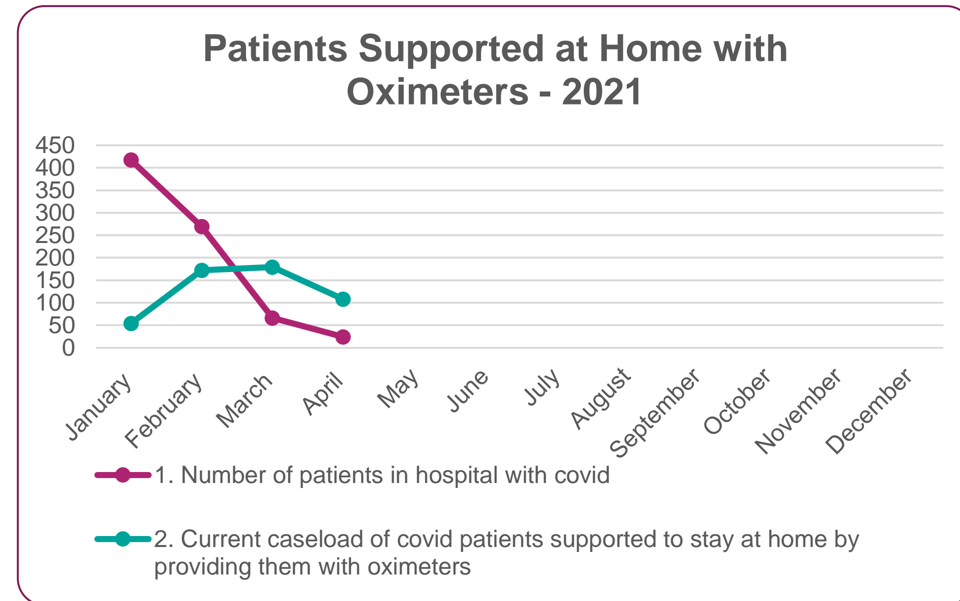
- 69 out of 116 practices have signed up to the platform
- 127 Health care professionals are currently training

Key Notes

- The COPD/Asthma LIS introduced in 20/21 focuses on management of high risk asthma and COPD patients within primary care and training workforce to create a sustainable service delivery at PCN level, including diagnostic provision for Spirometry and Feno.
- Phase I achieved 55% (3,389 patients) of high risk asthma and 46% (1,692) of high risk COPD patients receiving their high risk reviews along with personalised management plans, exceeding the target of 40%. This has contributed to the reduction of emergency admissions due to increased reliance on self- management and self-care.
- As at April 21, 127 health care professionals are being trained via virtual programme and this continues to grow.

Acute COVID-19 remote monitoring (Oximetry @ Home and Covid Virtual Ward)





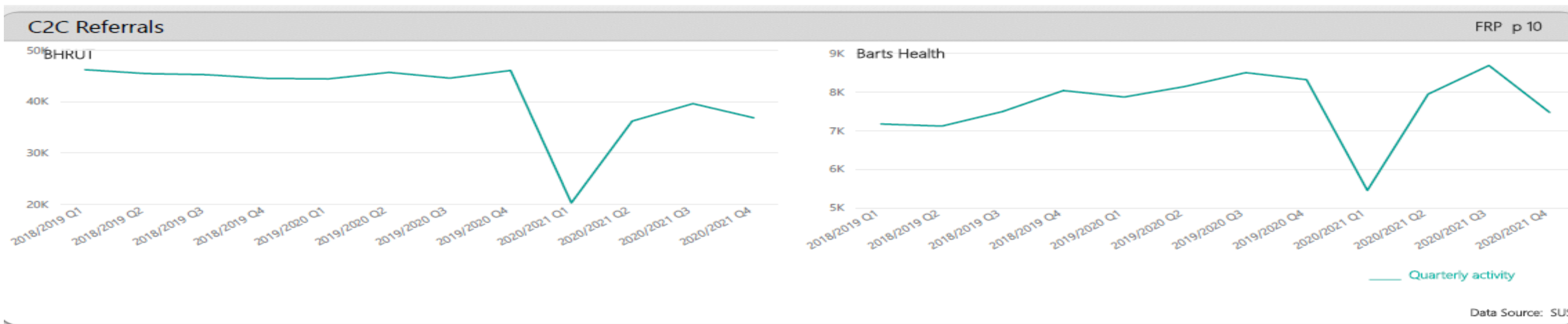
Key Notes

- In late December/early January Pulse Oximeters (PO) were supplied to primary care for use by patients with Covid-19 at higher risk of hospitalisation (over 65 or those with underlying conditions)
- COVID Virtual Wards are led by BHRUT who provide assisted discharge from an inpatient ward to enable patients to continue their recovery at home and reducing the length of stay in hospital.
- Since 15 January 21, 86 patients have been given a PO via the BHRUT Covid Virtual Ward (CVW) allowing them to receive their care and recuperation in the setting of their choice. Without the PO this would have required additional acute bed days.

Planned Care

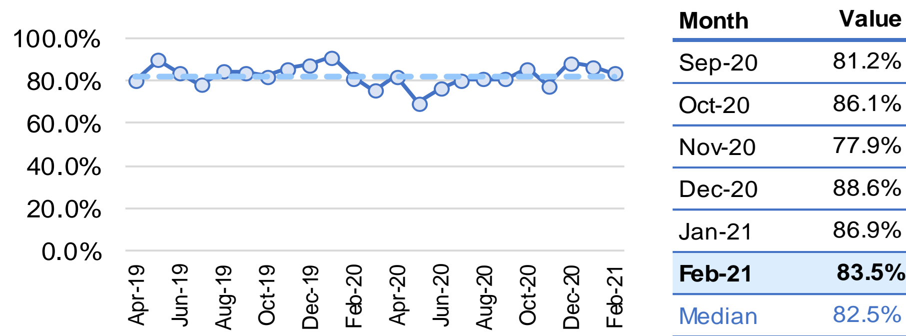
Objectives: Ensure patients are seen in the right location, only attending the acute sites when clinically required. Improve Access. Develop Transformation Initiatives to support delivery of the System Elective Recovery Plan and strategy. Ensure patients have access to emotional support and wellbeing all the way through the planned care journey, including during recovery.

F.Year	2018/2019				2019/2020				2020/2021			
ProviderShort	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	11,190	9,782	10,714	11,680	11,457	12,228	11,934	10,786	2,327	7,717	8,718	6,207
Barts	2,761	2,877	2,934	2,966	2,893	2,890	2,720	2,498	722	1,563	2,066	958
Total	**13,951**	**12,659**	**13,648**	**14,646**	**14,350**	**15,118**	**14,654**	**13,284**	**3,049**	**9,280**	**10,784**	**7,165**

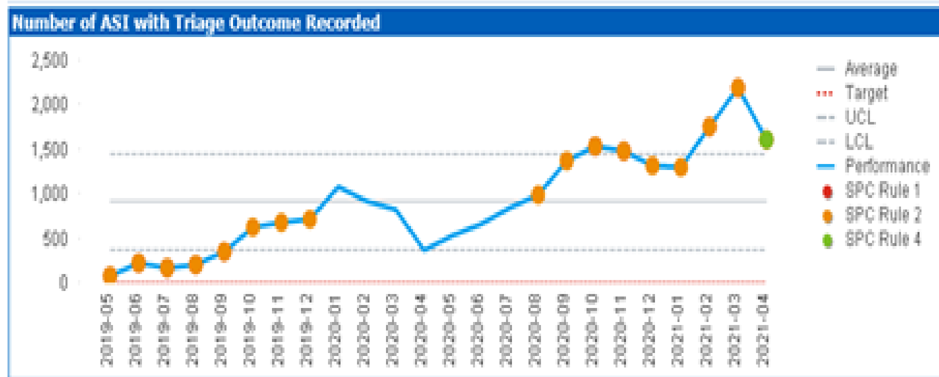


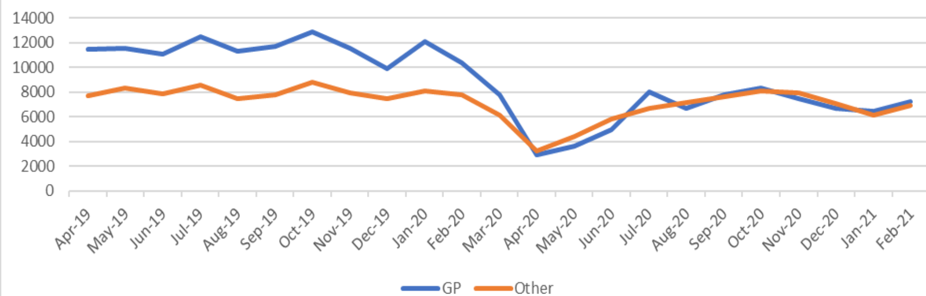
Key Notes

- Consultant to Consultant (C2C) referrals has been on a downward trend (c10%) throughout 19/20 and 20/21 and are still below pre pandemic levels. The additional triage process and expansion of Advice & Guidance service is ensuring patients access the appropriate sub specialties clinics and consultants first time, thus, reducing C2C referrals.
- The pandemic has facilitated a rapid acceleration of the digital agenda with the roll out of virtual clinic appointments to all specialties and by default. Following the winter Covid wave, specialties are restarting face to face consultations and keeping virtual appointments for at least 28% of activity.



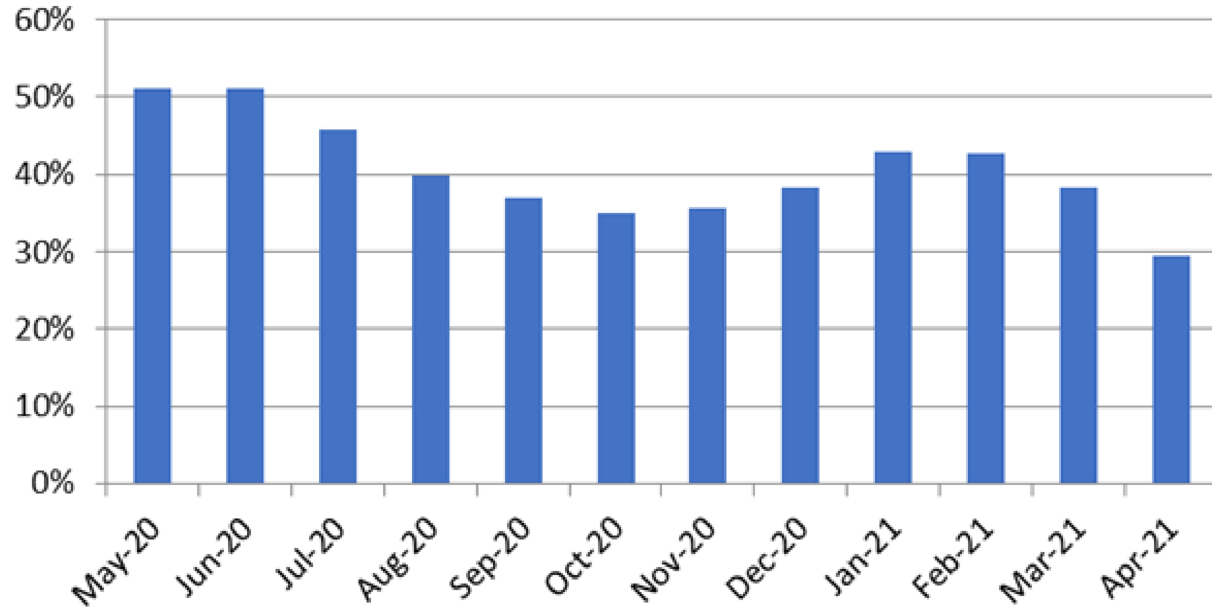
Month	Value
Sep-20	81.2%
Oct-20	86.1%
Nov-20	77.9%
Dec-20	88.6%
Jan-21	86.9%
Feb-21	**83.5%**
Median	82.5%





Key Notes

- Advice and guidance responses at BHRUT within 48 hours continues to exceed the 80% target.
- The provision of A&G and Single Points of Access (SPA) has contributed to the overall reduction in the level of GP referrals. These services will also contribute to the ongoing management of demand on the Acute Sector.
- The level of Patients triaged prior to outpatient attendance has continued to grow, with significant progress made during the past year, following the first wave of Covid. There has been over 100% growth in the number of triages undertaken since August 20.
- The increase in triage has contributed to the a reduction in unnecessary inter-specialties referral (C2C referrals), due to patients being directed to the correct sub-specialty first time, and therefore releasing outpatient capacity within the Trust



Key Notes

- BHRUT has consistently exceeded the 28% target of Outpatients appointments being delivered virtually.
- Virtual activity will continue in new virtual clinic PODs and rooms to ensure maximum privacy. Utilisation is tracked and monitored and communicated to specialties to ensure they maintain at least the 28% target as required in the Operating Plan.

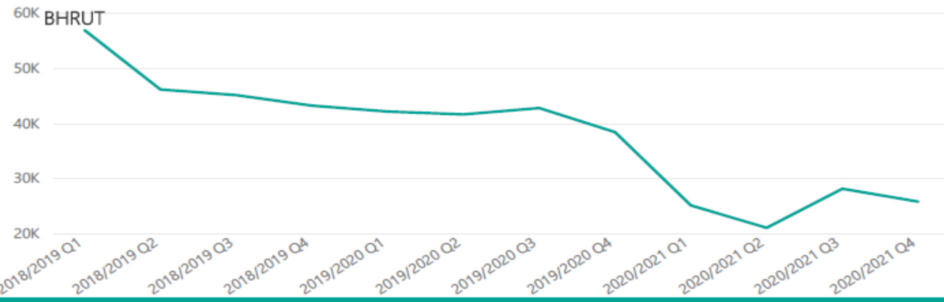
Consultation Type	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Number of patients with face to face / other attendance	10181	13863	17348	17238	21215	22623	23644	20859	17054	19649	27102	22495
Number of patient with telephone / video consultation	10676	14546	14609	11420	12460	12215	13129	12981	12841	14677	16744	9410
Total Consulations	20857	28409	31957	28658	33675	34838	36773	33840	29895	34326	43846	31905
% virtual consultations	**51%**	**51%**	**46%**	**40%**	**37%**	**35%**	**36%**	**38%**	**43%**	**43%**	**38%**	**29%**

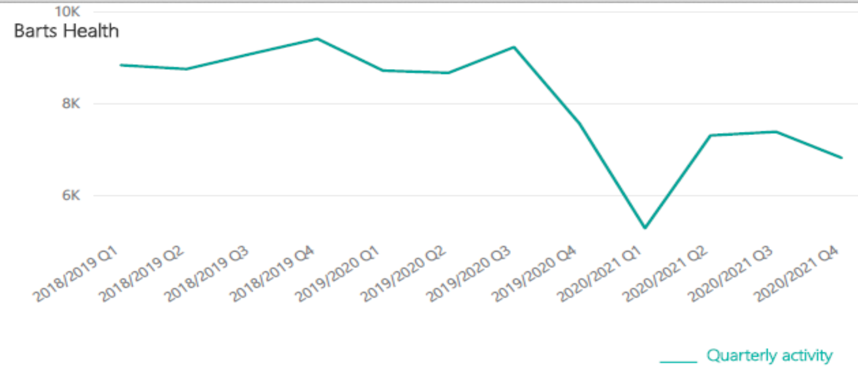
Note: The values reported in April relates to an incomplete month

Urgent & Emergency Care

Objectives: Development of a more robust, resilient and response across the BHR urgent and emergency care system through establishing UTCs as the front door to urgent care, increase urgent care advice and treatment options and improve ambulance and community pathways in the community

A&E Attendances (All Ages) Type 1



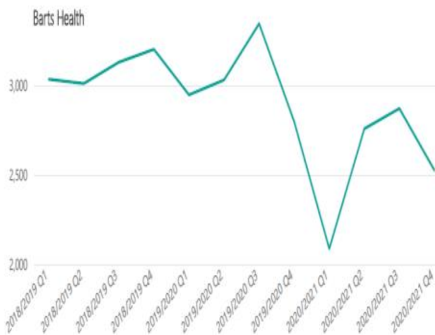


F.Year	2018/2019				2019/2020				2020/2021			
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	56,830	46,067	45,049	43,138	42,068	41,549	42,703	38,328	25,041	20,969	28,061	25,724
Barts	8,824	8,740	9,074	9,397	8,706	8,657	9,216	7,555	5,283	7,297	7,377	6,811
Total	**65,654**	**54,807**	**54,123**	**52,535**	**50,774**	**50,206**	**51,919**	**45,883**	**30,324**	**28,266**	**35,438**	**32,535**

Data Source: SUS

Ambulance arrivals

FRP p7



F.Year	2018/2019				2019/2020				2020/2021			
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	14,744	14,490	15,130	15,060	14,562	14,408	14,435	12,921	11,299	8,805	12,810	12,053
Barts	3,031	3,007	3,126	3,198	2,944	3,027	3,341	2,795	2,086	2,755	2,868	2,523
Total	**17,775**	**17,497**	**18,256**	**18,258**	**17,506**	**17,435**	**17,776**	**15,716**	**13,385**	**11,560**	**15,678**	**14,576**

Data Source: SUS

Emergency Admissions

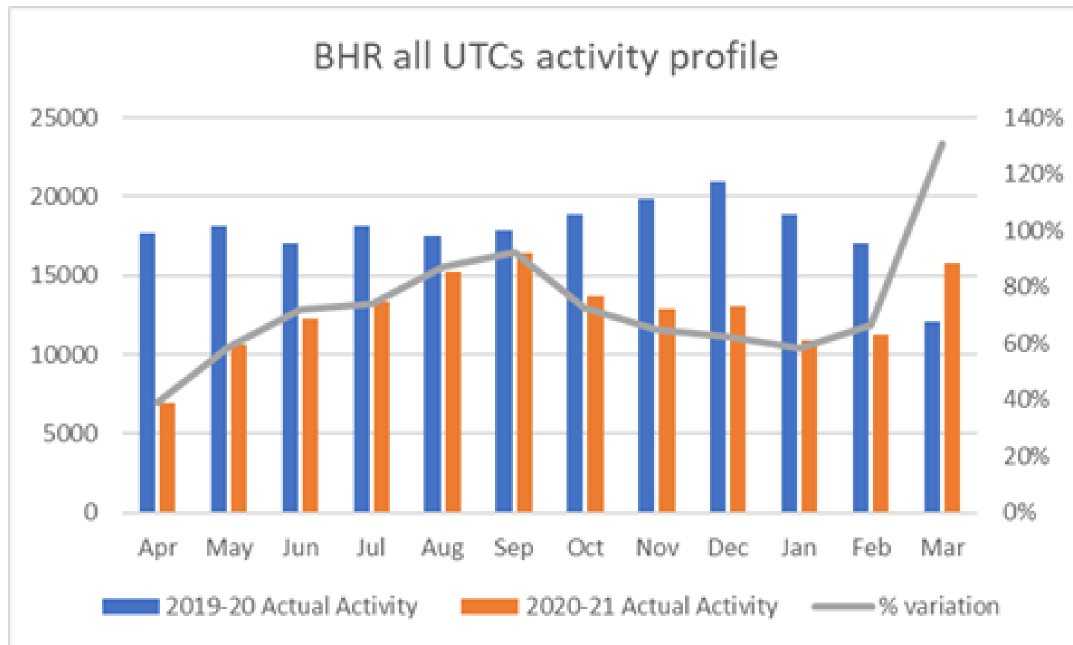
F.Year	2018/2019				2019/2020				2020/2021			
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	13,361	12,555	12,659	12,005	12,342	12,318	12,758	11,925	9,539	11,746	11,405	11,228
Barts	3,246	3,275	3,440	3,384	3,318	3,497	3,579	3,235	2,572	3,374	3,285	3,036
Total	**16,607**	**15,830**	**16,099**	**15,389**	**15,660**	**15,815**	**16,337**	**15,160**	**12,111**	**15,120**	**14,690**	**14,264**

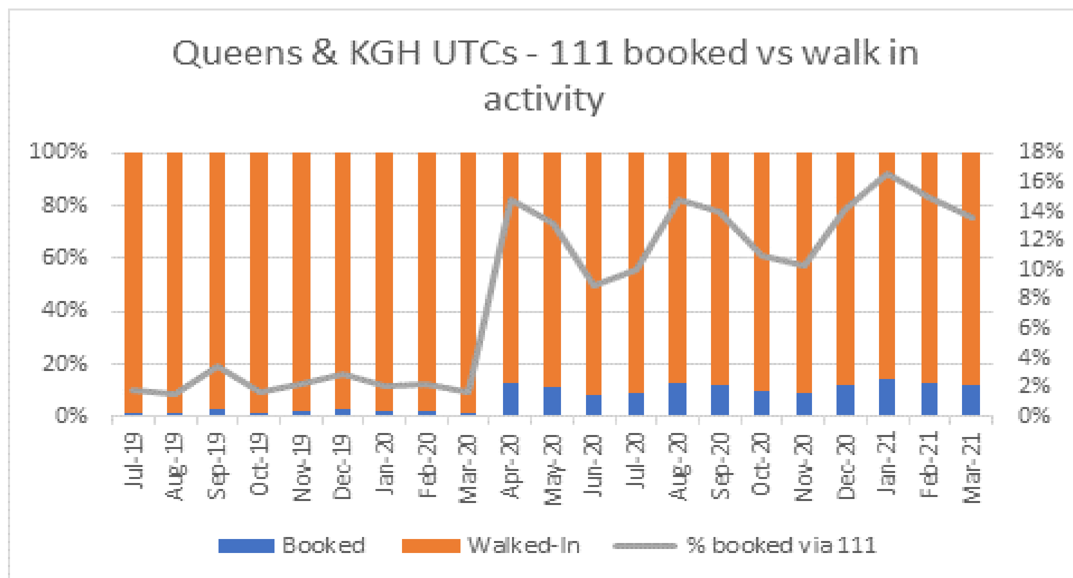
Data Source: SUS

Key Notes

- Type 1 A&E Attendances at BHRUT continue to show an overall downward trend with a 39% reduction in A&E attendances in 20/21 compared to the previous year. This significant reduction is attributed to COVID-19.
- Over the same period (20/21 vs 19/20) Emergency admissions had reduced by 11% and ambulance arrivals by 20%.

111 'Talk Before You Walk' Initiative





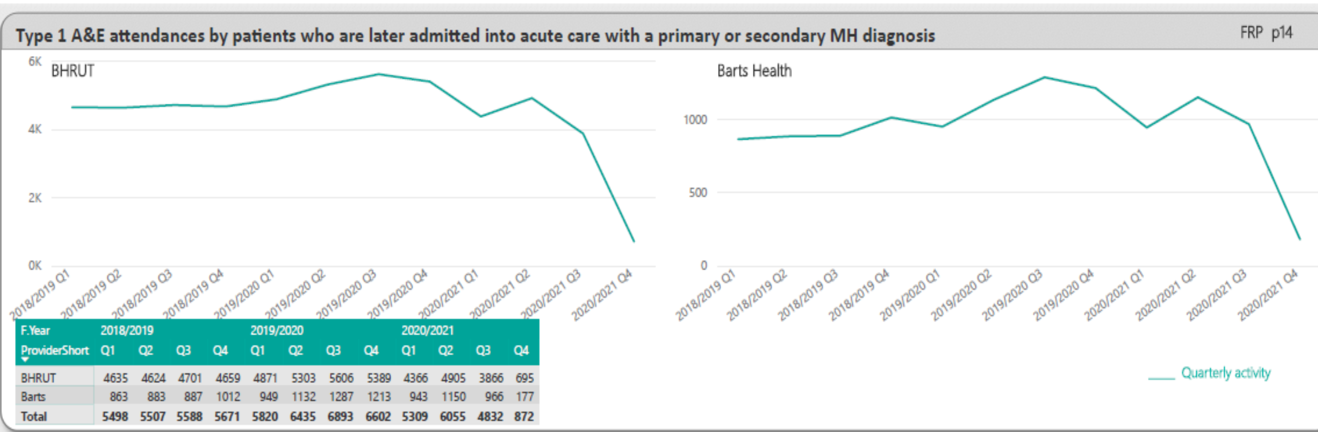
Key Notes

The 111 'talk before you walk' services deliver slot booking from 111 into Urgent and Emergency Care settings to support the delivery of the IPC requirements:

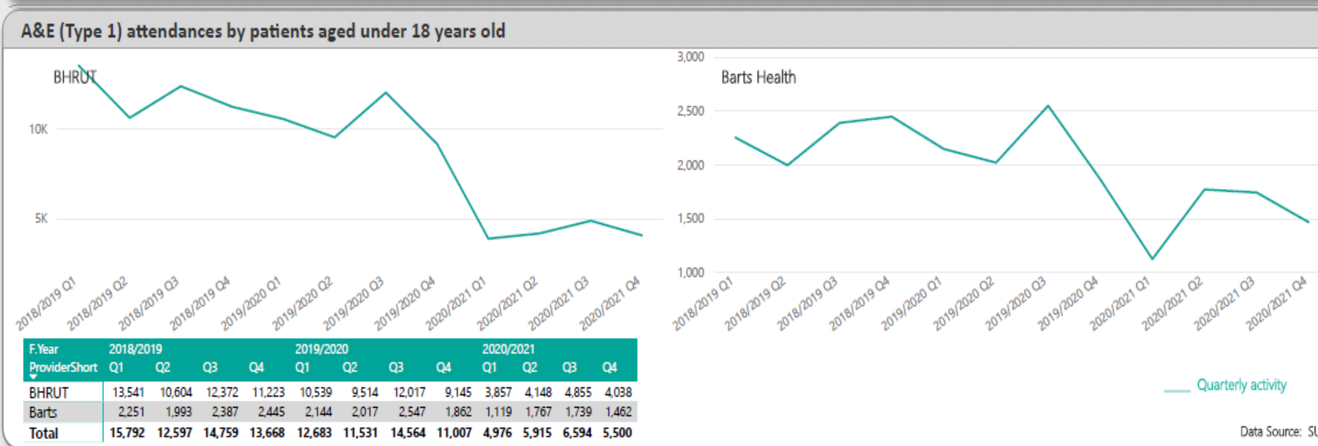
- Emergency Department Digital Integration (EDDI) 'Slot booking' from 111 telephone and online into all Emergency Departments was jointly implemented in just 3 weeks by PELC, BHRUT and commissioners - an example of partnership working under pressure. As PELC manage the front door to ED, it was determined that PELC would manage this process. From 12-25 April 43% of all KGH ED cases (5.5 slots per day) and 37% at Queen's (7 slots per day) were given a time to arrive.
- UTC bookings show a 13% increase in bookings (ave 1,453 bookings per month) compared to Q4 last year. This is reducing the level of walk-in attendances and supports the current IPC measures in place to manage the level of patients in the UTC. Given the increase in March of an additional 31% in UTC presentations compared to last year seen (15,823 attendances), changes to the DOS profiles have been made with the intention to re-direct suitable 111 bookings from the UTCs into the GP access hubs.
- Direct booking from 111 into the GP Access Hub services has increased from 18% in January 2019 to 29% across Q4 2021 - an increase of 11%
- Direct Booking from 111 into primary care - in April 2020 NEL asked GP practices to release 1 slot each day for every 3000 people registered with their practices to support covid. A NEL wide task and finish group has been formed to increase utilisation of these slots. As a result of this work the number of booked appointments per week increased by 4,458 from January to April (w/e 7/1 9,375: w/e 8/4 13,833).

Children and Young People (CYP)

Objectives: Develop a comprehensive community children nursing services offer for personalised care close to home and school. Increase children and young people's access to NHS funded community Mental Health Services. Create an integrated multi agency ASD/ADH and Challenging Behaviour service



F.Year	2018/2019				2019/2020				2020/2021			
ProviderShort	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	4635	4624	4701	4659	4871	5303	5606	5389	4366	4905	3866	695
Barts	863	883	887	1012	949	1132	1287	1213	943	1150	966	177
Total	**5498**	**5507**	**5588**	**5671**	**5820**	**6435**	**6893**	**6602**	**5309**	**6055**	**4832**	**872**

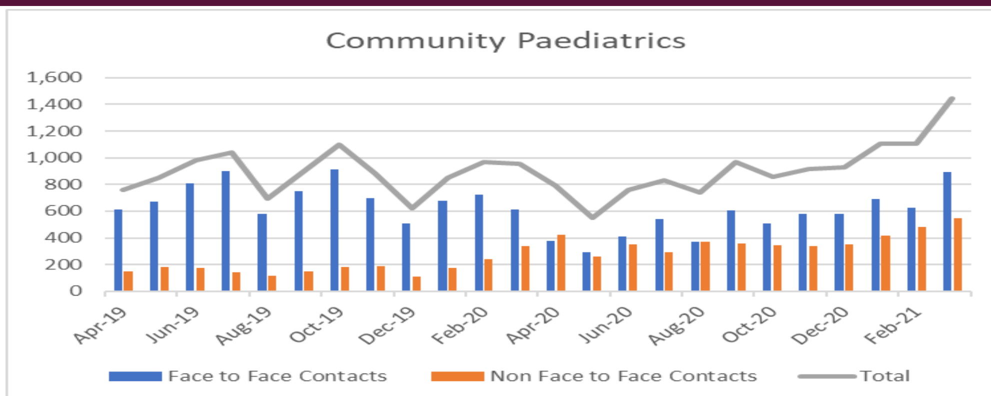


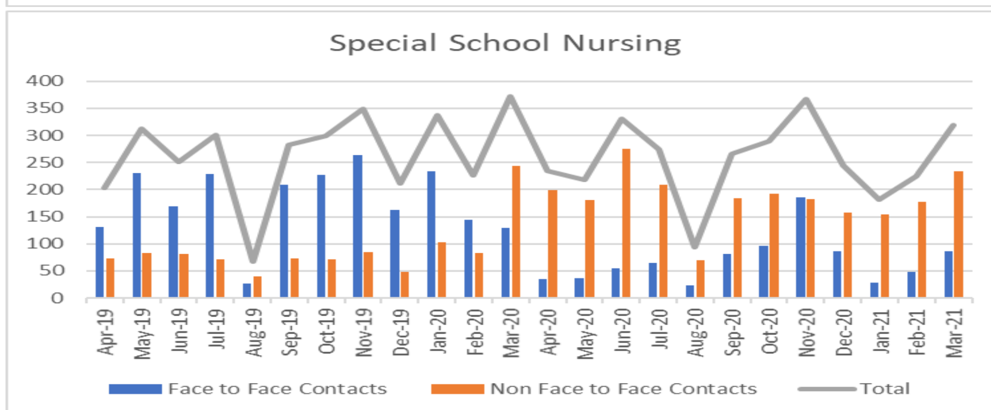
F.Year	2018/2019				2019/2020				2020/2021			
ProviderShort	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHRUT	13,541	10,604	12,372	11,223	10,539	9,514	12,017	9,145	3,857	4,148	4,855	4,038
Barts	2,251	1,993	2,387	2,445	2,144	2,017	2,547	1,862	1,119	1,767	1,739	1,462
Total	**15,792**	**12,597**	**14,759**	**13,668**	**12,683**	**11,531**	**14,564**	**11,007**	**4,976**	**5,915**	**6,594**	**5,500**

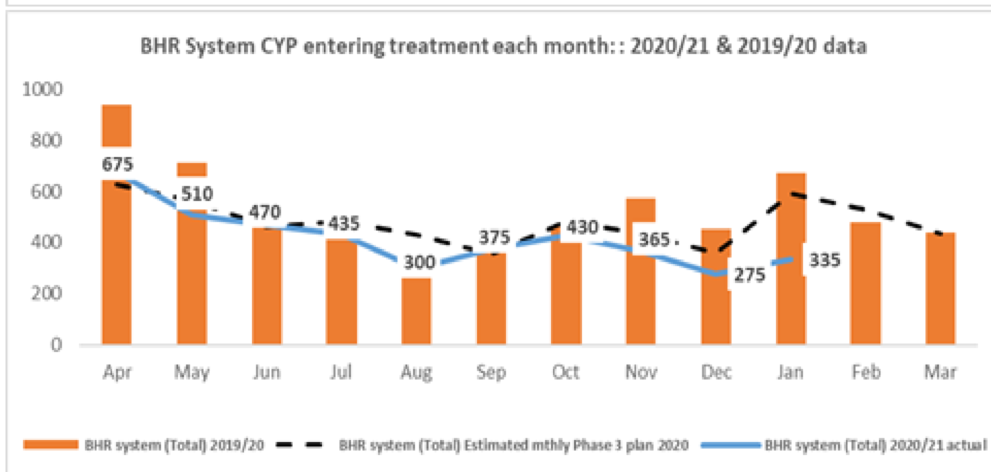
Key Notes

- From Q4 2019-20, Type 1 A&E Attendances with a primary or secondary MH diagnosis have shown a large level of reduction in activity, with a 16% decrease in footfall between Q4 19-20 and Q3 20-21 (excluding Q4 20/21 due to data quality issues).
- During the pandemic the BHR System provided support to children and families to manage increased levels of anxiety and acuity in schools and community settings.
- Despite the pandemic, BHR established a new 'end to end' and multi-agency framework to deliver system solutions to young people attending Emergency Departments in CAMHS crisis and experiencing long stays in inappropriate settings
- Paediatric type 1 attendances have reduced 20% in Q1 19-20 compared to Q1 18-19, following the implementation of the PELC UCC across both sites. 20-21 has seen a large drop in activity due to the pandemic.
- BHRUT has continued to run Paediatric telephone hot clinics supporting GPs and keeping children out of hospital. The Trust is also working to add Paediatric specialty onto e-RS and start an Advice & Guidance service for GPs with less urgent requests.
- Children and Young People's Assessment Unit (CYPAU) was implemented in Oct-20 and April-21 (post second Covid wave) following best practices learned during Covid. This and the Acute Hospital at Home Service in development is expected to support a sustained reduction in the level of overnight admissions and provide additional paediatric 'step down' capacity in the community.

CYP – Mental Health Trends

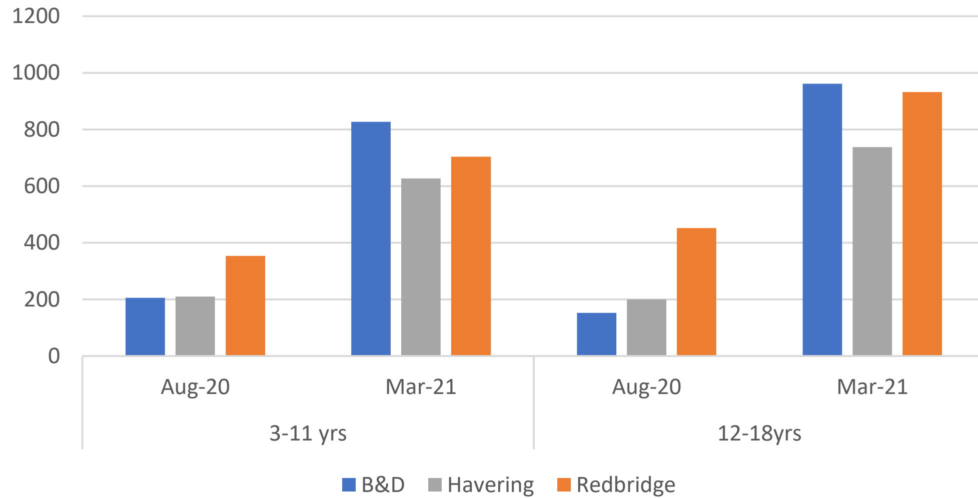


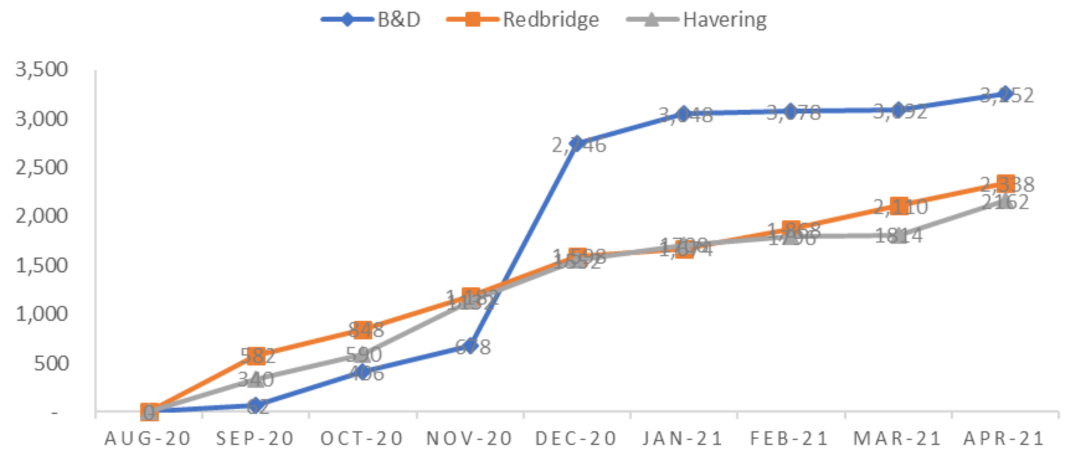




Key Notes

- Acceleration of digitalisation has increased the level of appointments and contacts made via the Community Paediatrics service.
- The level of Community Paediatric virtual (non face-to-face) contacts has increased from c20% at the beginning of 19/20 to c40% by March 21
- The number of contacts has increased by 32% (c900 contacts) in Q4 20/21 when compared to Q4 19/20.
- School Nurse utilisation of Zoom calls to maintain contact with CYP, where children have not returned to school because of shielding. Virtual contacts accounted for c30% of all Special School nurse contacts at the beginning of 19/20. Virtual now account for over 70% of contacts at the end of 20/21.
- Additional contacts related to Covid-19 have been delivered through expanded on-line platforms (KOOTH) and non-face face and / or group work to support recovery. This has allowed the service to maintain a stable level of access throughout Covid.
- Digitalisation has also been rolled out across nearly all services with similar trends observed throughout.





Key Notes

- The Sustainable Asthmas LIS, developed and implemented in response to the Regulation 28 review has resulted in a 200% increase in the number of care plans issue since its implementation (from 1,574 in August 20 to 4,790 at the end of March 21).
- The BHR asthma reviews completed also grew exponentially between August 2020 to date with many PCNs in the sector hitting and exceeding the 80% target.
- Improved support to families and children to help manage Asthma has contributed to the overall reduction in children and young people presenting to ED.

Transformation Board – Other Key Achievements

A number of schemes and initiatives have been delivered and implemented by the Transformation Boards since 2018 up to March 2021 which are not included in the above as:

- The schemes are not yet quantifiable as the schemes have only recently been implemented and data is not yet available
- The initiatives are developed and implemented in phases and therefore the impact of the whole scheme is not yet quantifiable
- Baseline data is not available e.g. Covid response related schemes
- The schemes have been implemented and have completed the review and evaluation stage and now form part of 'BAU'. Therefore scheme specific metrics are no longer measured.

The impact of all Transformation Board schemes collectively contributes to the following underlying principles driving the work and the priorities for the Transformation Boards and reducing the reliance and pressures on the acute setting:

- Improving medium to long-term outcomes for our population
- Focus our Out of Hospital investments on tackling inequalities and inequities that are a contributor to poor health outcomes;
- System Wide Transformation to shift activity into the most appropriate setting (whilst respecting patient choice where appropriate)

The following slides provides additional details of the schemes implemented to end March 2021.

BHR TRANSFORMATION BOARDS - KEY ACHIEVEMENTS

OLDER PEOPLE

- St. Francis Hospice specialist palliative nurses facilitated to be able to prescribe via non-medical prescribing (NMP) in the community as needed reducing reliance on GPs or need for transfer to acute setting for EOL medication prescription.
- Implemented falls prevention initiatives including the employment of a Falls Practitioner, a Therapy Assistant and a BHR wide falls service for complex patients to support the proactive management of patients at risk of falling.
- Implemented the Integrated Nursing initiative (now superseded by the Care Home DES) to align each BHR Care home to a PCN, and ensuring that Care Homes receive the support and clinical advice needed to manage patients in the home and reducing conveyances to A&E.
- Implemented the Significant 7 Programme across Care homes to educate and support Care home staff to identify signs and symptoms of deterioration in a patients conditions, and therefore provide earlier interventions to mitigate against further decline in the patients' health and therefore supporting a reduction in presentation to ED and/or admissions.

URGENT AND EMERGENCY CARE

- A pathway for direct Early Pregnancy Assessment Unit (EPAU) bookings has been put in place as of April 2021 for early pregnancy scans. As a result of this pathway cases will not need to present at ED.

PLANNED CARE

- Development of a community minor surgery service to enable appropriate surgical procedures to be undertaken within community settings, including a training and development programme led by BHRUT Consultants.
- Enhanced Triage/Rapid Access Service (RAS) implemented to support the re-direction of patients to correct sub-speciality and reducing C2C referrals and unnecessary attendances.

BHR TRANSFORMATION BOARDS - KEY ACHIEVEMENTS

CHILDREN & YOUNG PEOPLE

- Development of a fully integrated Autism ADHD and Challenging Behaviour service helping children, their families and primary and secondary care with the correct levels of support to deliver best practice inputs at pre diagnosis, within education, ED / Crisis and transition.

LONG TERM CONDITIONS

- The implementation of the Redbridge Heart Failure MDT aims to assess complex cases in the community to support the prevention of unnecessary outpatient appointments and deliver care Out of Hospital.

- The investment of additional nursing capacity in Parkinson's services has significantly improved service provision so that all patients in BHR have consistent access to the same high level of treatment for Parkinson's care.

BHR TRANSFORMATION BOARDS – 2020/21 Year End Position

The following schemes have been delivered over the course of the last year, despite and often in support, of the covid pandemic pressures

LONG TERM CONDITIONS

- Low Calorie Diet Pilot – 25 patients have been successfully enrolled into the programme since February, 175 places are available. The aim is to get all 175 patients to remission and remove their need for medication and avoid all the GP and Hospital activity associated with having diabetes.
- Long Covid Rehab Clinic - The service has provided an MDT clinic for 100 patients’ so far experiencing long covid to see specialists from secondary care, physio, occupational therapist and clinical health psychology as required. All 100 patients seen so far have been given a personalised, goal orientated action plan to aid their recovery that aims to keep them out of hospital and reduce the burden on GP practices.
- Commissioned IPORT devices - for use from April 2021. The device helps prevent poor adherence to insulin therapy which risks poor glycaemic control and associated persistent hyperglycaemia, Diabetic Keto Acidosis (DKA), hospitalisation for treatment and long-term health problems.
- Blood Pressure Monitoring @ Home – Since January 2021, 490 blood pressure machines have been distributed to practices to allow patients to be monitored from home. This has saved at least 490 GP appointments.
- Heart Failure @ Home, - we have successfully secured £28k of funding for a NELFT heart failure nurse. This post will remotely monitor up to 60 patients across BHR at any one time, which will help avoid at least 60 community hospital appointments.

CHILDREN & YOUNG PEOPLE

- Development of the Paediatric Integrated Nursing Service (PINS) bringing together (Community Nursing Teams, Continuing Care, Clinical Nurse Specialists, School Nurses in Special and Mainstream Schools and support services) into a fully integrated provision. This supports the LTP, moving care closer to home with managing long term condition and avoiding inappropriate referrals.
- Development of the Prototype Integrated Child Health Hub (PITCHH) that aims to establish a Multi-Disciplinary Team (MDT) approach centred around PCNs to help children and their families in an holistic way, maximise services delivered and significantly reduce ED and OP activity. Integrated access includes specialist paediatrics, integrated community services, maternity and early intervention, social prescribing and emotional wellbeing and positive behaviour.
- Established a Paediatric Assessment Unit at Queen’s to support the reduction in unnecessary Emergency Paediatric Admissions.

BHR TRANSFORMATION BOARDS – 2020/21 Year End Position

URGENT AND EMERGENCY CARE

- Additional specialty hot clinics established at BHRUT which facilitates direct referrals from GPs thereby reducing the need to attend ED.
- A UTC minor injuries diagnostic pathway pilot live as of October resulting in patients referred directly for diagnostics and receiving treatment faster.
- Three new ED hotlines implemented for General Surgery, Neurology and Paediatrics allowing GPs to contact these specialties to mitigate the need for the patients to go to the emergency department.
- Additional GPs were placed in ED as pilot programme and on wards for a session on Saturdays to support patients to be discharged safely at an earlier stage. The placement of GPs in ED supported patients to be safely discharged from ED rather than admitted.

PLANNED CARE

- Development of a new out of hospital service for MSK services across the BHR system bringing together partners in acute, community and third sector services to agree a fully integrated model, largely based within primary and community care with the aim of preventing secondary care intervention. Phase 1 has been implemented with Phase 2 currently in development.
- Further extension of the Gastroenterology Single Point of Access to include all Endoscopy referrals, to ensure that patients only undergo an Endoscopy when it is clinically required.
- Initiated Patient Initiated Follow Up (pilot in Neurology and currently rolling out to T&O and Ophthalmology for Medical Retinal patients and Rheumatology) to support patients self-management of care and reducing unnecessary outpatient follow up attendances.

BHR Integrated Care Partnership

Better care, better lives, together for all

Integrated Care Partnership Board

27 May 2021

Title of report	BHR Transformation Board Key Priorities
Item number	6.2
Author	Hanh Xuan-Tang, Deputy Director of Recovery Planning, NEL CCG (BHR ICP)
Presented by	Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Contact for further information	Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Executive summary	In 2018 Barking & Dagenham, Havering & Redbridge (BHR) became the first system in London to agree an Integrated Financial Recovery Plan (FRP). The plan recognised that the only way to improve patient outcomes and achieve a sustainable financial position was to invest more into Out of Hospital services and shift care Out of Hospital, with focus on prevention, early diagnosis and early intervention as well as improve on-going support for people with Long Term Conditions, the Frail Elderly and those in the End-of-Life phase. Following the recovery from the pandemic and the system moves towards establishing a 'new normal', Transformation Boards have re-started and are in the process of developing their priorities for the first 6 months of 21/22. The key underlying principles driving the priorities for the Transformation Boards remain the same. In line with the principles, the following slides provide information of the key priorities and

	workplan of each of the Transformation Boards for the first half of 20/21. It also sets out the priorities for the NEL-wide LD and Autism Transformation Board, which Sharon Morrow, Director of Integrated Care for BHR leads on. Also included is a slide setting out the interdependencies of each scheme where it impacts across more than one Transformation Board, as requested by the Integrated Care Executive Group (ICEG) at their meeting on 20th May 2021. It should be noted that the delivery of the priorities maybe impacted by the funding available, which is currently being worked through across the ICP and NEL.
Action required	Note/ Discussion/ Approve
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	A version of this paper will be shared with the Health and Care Cabinet and BHR ICP Clinical Leaders Group.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The delivery of the priorities set out within this report will ensure improved services for our patients/residents, closer to home (where possible) and streamlined pathways, working across various care settings.
Conflicts of interest	None
Strategic fit	Transformation of services – resulting in delivering a sustainable position for BHR ICP
Impact on finance, performance and quality	Should these priority schemes be successfully delivered improvements in the quality of services provided, improved performance and financial benefits are anticipated.
Risks	• Uncertainty in relation to the funding available may impact on the timely delivery of these priorities. • Any ongoing impact of covid i.e. system pressures may impact on the delivery of schemes, as a result of reduced resources.
Equality impact	N/A – EIAs will be completed at a scheme level

North East London
Clinical Commissioning Group

BHR Transformation Boards: Key Priorities

Meeting name: Integrated Care Partnership Board
Presenter: Tracy Welsh, Director of Transformation
Date: 27 May 2021

Introduction

In 2018 Barking & Dagenham, Havering & Redbridge (BHR) became the first system in London to agree an Integrated Financial Recovery Plan (FRP).

The plan recognised that the only way to improve patient outcomes and achieve a sustainable financial position was to invest more into Out of Hospital services and shift care Out of Hospital, with focus on prevention, early diagnosis and early intervention as well as improve on-going support for people with Long Term Conditions, the Frail Elderly and those in the End-of-Life phase.

Following the recovery from the pandemic and as the system moves towards establishing a 'new normal', Transformation Boards have re-started and are in the process of developing their priorities for the first 6 months of 21/22.

The key underlying principles driving the priorities for the Transformation Boards remain the same:

- Improving medium to long-term outcomes for our population
- Focussing our Out of Hospital investments on tackling inequalities and inequities that are a contributor to poor health outcomes;
- System Wide Transformation to shift activity into the most appropriate setting (whilst respecting patient choice where appropriate)

In line with these principles and in line with the direction of Integrated Care Partnership Board (ICPB) for each Transformation Board to focus on a smaller number of areas at any one time, the following slides provides information on the key priorities and workplan of each of the Transformation Boards for the first half of 20/21.

It should be noted that the delivery of these priorities maybe impacted by the funding available, which is currently being worked through across the ICP and NEL.

Older People Transformation Board

Sponsor: Barbara Nicholls, Director of Adult Services, London Borough Havering (Havering Borough Partnership Lead) - TBC
Convenor: Sharon Morrow, Director of Integrated Care, NEL CCG (BHR ICP)

- **Extension of Acute/Community Frailty Services**
  - Develop business case for Queen's Frailty unit
  - Implement the community frailty hub model
- **Integration of Falls Services**
  - Single point of access email for all services to refer to including Emergency Department
  - Develop an integrated and collaborative model between the voluntary sectors and NHS offer
- **Implement Complex Dementia Pathway**
- **Further develop Care Homes services**
  - Roll out remote monitoring project
  - Develop a domiciliary care pilot
- **Further develop End of Life services**
  - Business case for rapid response service
  - Develop satellite hospice approaches
- **Hospital Discharge**
  - Develop and implement Single Point of Access

Mental Health Transformation Board

Sponsor: Oliver Shanley, Interim Chief Executive, NELFT
Convenor: Jacqui Van Rossum, Executive Director of Integrated Care, NELFT

- **Improving the experience for those facing Mental Health crisis**
    - Piloting a Crisis House
    - Evaluating the impact of the Mental Health Crisis Hub at Goodmayes
    - Changes to Section 136

- **Establishing an integrated primary and secondary Mental Health offer**
    - Partner with local authority and 3rd sector agencies as part of integrated community Mental Health offer
    - Establish a peer support model
    - Multi-disciplinary, person-centred and place-based neighbourhood teams in each Primary Care Network (PCN) and establishment of Mental Health practitioner roles in each PCN
    - Enhanced models of Serious Mental Illness (SMI) physical health checks

- **Continued investment in core services**
    - Increasing Access to Psychological Therapies (IAPT) – Increased access and maintain recovery as per Long Term Plan (LTP)
    - Early Intervention in Psychosis (EIP) – to achieve compliance at level 3
    - Secondary Care psychology – to reduce waits for services
    - Children and Young People – to improve access
    - Children and Young People - Eating Disorders
    - Mainstreaming of Learning Disability (LD) and Autistic Spectrum Condition (ASC)
    - Review and development of new model of care for rehabilitation

Long Term Conditions Transformation Board

Sponsor: Adrian Loades, Corporate Director of People, London Borough of Redbridge (Redbridge Borough Partnership Lead)
Convenor: Jeremy Kidd, Deputy Director of Transformation, NEL CCG (BHR ICP)

- **Improving prevention and early detection**
    - Implement Atrial Fibrilation (AF) Integrated Case Finding – Havering Pilot
    - Develop Tier 3 Weight Management Service
    - Roll out of Asthma/Chronic Obstructive Pulmonary Disease (COPD) LIS – Phase 2
- **Implement Whole system pathway development & integration**
    - Develop Stroke Rehab services (Phase 1&2)
    - Implement Non-Invasive Ventilation local service
    - Community Foot Protection Service and Multidisciplinary (MDT) Foot Service
- **Improved management & outcomes**
    - Implement Community Foot Protection Service and MDT foot Service
    - Finalise Long Term Conditions (LTC) Directory of Services
- **Increase use of virtual consultations & technology**
    - Implement Virtual Chronic Kidney Disease (CKD) Clinic Pilot

Planned Care Transformation Board

Sponsor: Tony Chambers, Acting Chief Executive, BHRUT
Convenor: Richard Pennington, Acting Chief Operating Officer – Elective, BHRUT

- **Moving Care Closer to Home**
    - Develop and launch Community Minor Surgery Service
    - Continual Development of Musculoskeletal (MSK) Phase 2
- **Empowering Decision Making**
    - Continual roll of Advice and Guidance and Triage
    - To implement Patient Initiated Follow Ups (PIFU) in 3 specialties post treatment (non Referral To Treatment (RTT))
    - Improve and facilitate shared care protocols working across primary, secondary care and medicine management/pharmacy.
- **Improving Access**
    - Think Digital First- use technology to enable care out of hospital e.g. use of video and telephone conferencing and Patient Knows Best
    - Complete review of blood test provision across BHR
- **Covid Elective Recovery**

Children and Young People (CYP) Transformation Board

Sponsor: Elaine Allegretti, Director of Adult and Children's Services, London Borough of Barking and Dagenham
Convenor: Doug Tanner, Children Young People Maternity CAMHS Commissioning Lead, NEL CCG (BHR ICP)

- **Develop a comprehensive community children nursing services offer for personalised care close to home and school**
    - Establish an Acute Hospital at Home Nursing Care Model and take referrals from Emergency Department (ED)/Paediatric Assessment Unit/Inpatients
    - Develop a Complex Disability Pathway for those Children and Young People (CYP) with a wide range of diagnosis, input from Special School Nurses (SSN) and continuing care
    - Integrated Palliative, End of Life provision to introduce as much advanced planning as possible to enable joint hospice, CNN and private agency package to support CYP and family.
    - Develop a Long Term Conditions Support service (including epilepsy, eczema, cystic fibrosis) for delivering care on behalf of specialist services in the community.

- **Increase children and young people's access to NHS funded community Mental Health Services**
    - Establishment of a system group overseeing all aspects of escalation avoidance, standardisation of escalation protocols and reducing inappropriate stays in ED
    - Establishment of 24/7 ED Crisis assessment response provision and targeted support for community de-escalation

- **Create an integrated multi agency ASD/ADH and Challenging Behaviour service**
    - Delivery of an integrated multi-agency system model for pre-diagnostic support for children and their families
    - Delivery of an integrated multi-agency system model for post-diagnostic

Urgent and Emergency Care Transformation Board

Sponsor: Tony Chambers, Acting Chief Executive, BHRUT
Convenor: Kirsty Boettcher, Deputy Director of Transformation, NEL CCG (BHR ICP)

- **Establishing Urgent Treatment Centres as the Front Door for urgent care**
  - Develop and implement Urgent Treatment Centre (UTC) DVT pathway aligned with BHRUT DVT clinic/ primary care
  - Develop and implement cancer referral pathways
  - Roll out of virtual assessment service for minor injuries
  - Implement UTC redirection to primary care
  - Develop UTC pathway covering – Pulmonary Embolism (PE), low risk chest pain and Troponin

- **Increasing urgent care treatment and advice options**
  - Expand ED advice line pilot to Community Treatment Team (CTT)
  - Establish neurology Hot Line
  - Discharge portal pilot – wards and service from the Emergency Department
  - Develop Same Day Emergency Care (SDEC) low risk chest pain, acute abdominal pain and frailty pathway
  - Develop direct to medical specialty pathway
  - Develop Service directory – support discharge from ED and wards

- **Improving ambulance and community pathways**
  - Implement Co-ordinate My Care (CMC) for High Intensity User (HIU) cases
  - UTC booking into GP Slots

Cancer Transformation Board

Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham
Convenor: Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)

- **Increase awareness of Public health and prevention**
  - Develop education strategies for Patients and Primary Care
  - Implement Local Be clear on cancer campaign and increase population awareness of cancer symptoms and increase screening uptake
  - Implement Faecal Immunochemical Test (FIT) Testing in primary care
  - Develop Lung SUMMIT
- **Improve diagnostic and treatment pathways**
  - C the Signs implementation in Out of Hours (OOH)
  - Development of the Rapid Diagnostic Centre (RDC)
  - Develop Timed diagnostic pathways
- **Increase Social and Personalised care for Cancer**
  - Implement Remote Monitoring systems
  - Implement Personalise care including Prostate Stratified Follow Up
  - Development of cancer care in the community
  - Increase Health and wellbeing events, treatment summaries and Health Needs Assessments
- **Improve UEC front door for Cancer**
  - C the Signs implementation in UTC and ED
  - Develop Cancer Emergency Presentation pathway

Primary Care Transformation Board

Convenor: Sarah See, Director of Primary Care, NEL CCG (BHR ICP)

- Testing the new model of care with primary care, residents and other stakeholders (to be managed at a borough level and feedback to NEL)
- Planning for Flu 21/20 and the covid vaccination booster campaign
- Improving uptake in flu and cervical screening (linking with the Cancer TB work)
- Implementation of a Duty Doctor scheme
- Ongoing maturity of PCNs – developing the inclusive ‘neighbourhood’ model (ie all partners working as part of PCNs)

Please note – the Board are currently in the process of refreshing plans and so this is an “interim” list.

Learning Disabilities and Autism

BHR Link: Sharon Morrow, Director of Integrated Care, NEL CCG (BHR ICP)

- To increase the numbers of people on borough Learning Disability Registers.
- For 75% of patients with a learning disability to have an annual health check within a 12 month period, in accordance with our 3-year trajectory
- To increase uptake of flu vaccinations in the learning disability and autism cohort.
- To continue to ensure that the Covid-19 vaccination programme, and any future vaccination offers, are accessible to people with a learning disability and autism and that uptake is maximised.
- To maintain the number of adults aged 18 or over who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by the CCG or Provider Collaborative in accordance with our 3-year trajectory
- To reduce the number of and young people per million children aged under 18 years from the STP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, in accordance with our 3 year trajectory
- To expand our out of hours crisis offer for adults and children with learning disabilities and/or autism
- To agree a behaviours that challenge strategy and behavioural pathway across NEL
- Pilot the key worker role for children and young people with learning disabilities and/or autism
- Reduce the number of long stay inpatients in BHR
- To reduce our autism diagnosis wait times for both adults and children, and to improve or pre- and post-diagnosis offer
- To implement the new Learning Disability Mortality Review policy

NEL TRANSFORMATION BOARD – Interdependencies

SCHEME	Transformation Board							
	LTC	CYP	OP	MH	UEC	PLANNED	CANCER	LD & AUTISM
OLDER PEOPLE								
Further develop End of Life services			X	X	X		X	
Further develop Care Homes services	X		X	X	X		X	X
Implement Complex Dementia Pathway	X		X	X	X	X	X	
Extension of Acute/Community Frailty Services	X		X	X	X		X	
Hospital Discharge -Develop and implement Single Point of Access	X	X	X	X	X	X	X	X
Integration of Falls Services	X		X	X	X		X	
PLANNED CARE								
Community Minor Surgery						X	X	
MSK New Model of Care	X		X			X		
Continue Roll out of A&G and Triage	X	X				X		
Use of Technology to enable Care out of Hospital	X	X	X			X		
CYP								
Develop Comprehensive Community Children Nursing Services (Paediatric Integrated Nursing Service (PINS))	X	X			X	X		X
Increase CYP Access to MH Services		X		X	X			
Create a Multi-Agency ASD/ADH and Challenging Behaviour Service		X		X				
Mental Health								
Piloting a Crisis House				X	X			X
Evaluating the impact of the Mental Health Crisis Hub at Goodmayes				X	X			
Continued investment in core services		X		X				X
LTC								
Stroke Rehab services (Phase 1&2)	X		X		X	X		
Long Term Conditions (LTC) Directory of Services	X	X	X	X	X	X	X	X
Virtual Chronic Kidney Disease (CKD) Clinic Pilot	X				X	X		
UEC								
Discharge portal pilot – wards and service from the Emergency Department			X		X	X		
Roll out of virtual assessment service for minor injuries					X	X		
CANCER								
C the Signins Implementation in Out of Hours (OOH)					X		X	
Develop Cancer Emergency Presentation pathway					X		X	
Implement Personalise care including Prostate Stratified Follow Up						X	X	
LEARNING DISABILITIES AND AUTISM								
Pilot the key worker role for children and young people with LD and/or autism		X		X				X
To implement the new Learning Disability Mortality Review policy		X		X				X
Expand out of hours crisis offer for adults and children with LD and/or autism		X		X				X

Note: Blue X – Responsible Transformation Board

Integrated Care Partnership Board

27 May 2021

Title of report	BHR Integrated Sustainability Plan
Item number	6.3
Author	Mark Eaton, System Recovery Adviser
Presented by	Steve Rubery, Director – Planning & Performance
Contact for further information	Mark.eaton1@nhs.net 07841-464916
Executive Summary	In 2018/19 the NHS partners within BHR agreed an Integrated Financial Recovery Plan (FRP) with NHSE/I. Initial implementation showed almost immediate benefits that are outlined in an accompanying paper for ICPB. Following the need to respond to the national emergency it is time to revisit the FRP and to convert this into an Integrated Sustainability Plan (ISP) covering not only physical health but also the transformation required for Mental Health and Learning Disabilities services as well. The aim of the ISP is to set the aspirations around meeting the population health needs, transforming outcomes and through this route, returning the system to financial balance and a plan for achieving it.
Action Required	ICPB is asked to: • **DISCUSS** the questions in Section 4.0 of this report. • **AGREE** the next steps outlined in Section 4.0.

Where else has this paper been discussed?	This is a new paper for ICPB but has been discussed at ICEG. It should be noted that the preceding FRP was discussed at a number of similar meetings prior to approval and the impacts discussed at ICEG following the start of implementation.
Next steps/ onward reporting	Outlined in Section 4.0 of the report.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The focus of the ISP is on transforming outcomes, tackling inequalities and inequities and on ensuring we can sustainably deliver our commitments.
Conflicts of Interest	Due to the impact of the proposed ISP on all partner organisations there are numerous potential conflicts and these will need to be managed via ICEG.
Strategic Fit	This is a key pillar of the BHR Partnership strategy, relating to achieving financial balance and sustainability.
Impact on finance, performance and quality	Outlined in the body of the report.
Risks	The main risk of not implementing an ISP is that the growth in secondary care spend and activity will continue to exceed the growth available to the system hindering the implementation of investments Out of Hospital that would impact on medium to long term outcomes.
Equality Impact	Not applicable at this stage.

Integrated Sustainability Plan

1.0 Introduction

In 2018/19 the NHS Partners in BHR produced a Financial Recovery Plan that was approved by NHS England and NHS Improvement. The early stages of implementation demonstrated a significant benefit to the finances for the system and outcomes for our population.

With the interruption caused by the COVID National Emergency this paper refreshes members on the background to the FRP and sets out how we propose to refresh this document and expand the scope via an Integrated Sustainability Plan (ISP).

2.0 Drivers of the BHR System Deficit

In producing the original FRP in 2018 we were asked by NHSE/I to explore the underlying reasons for the ~£100m system deficit in BHR. Table 1 summarises the findings that resulted from the investigation that was undertaken. This shows the areas explored and whether or not there was evidence to show each was a driver of the deficit.

Table 1: Summary of the Drivers of the BHR System Deficit

Potential Driver	Deficit Impact	Narrative
Demographics	**Low to Medium**	Whilst there are demographic challenges within BHR (most notably with B&D) they cannot explain the variance in spend compared to areas such as Tower Hamlets, Waltham Forest and Enfield where across a wide range of public health metrics the BHR population are not substantially different to the wider area.
Primary Care	**Very High**	Historic under-investment in Primary Care resulting in high clinician to patient ratios (for both GPs and Practice Nurses) and the excess use of Locums is a significant driver of the system deficit. The under-investment limits the care available for the frail elderly and those with one or more Long Term Condition (LTC) resulting in higher non-elective activity and the lack of options for Out of Hospital elective care results in elevated elective referrals.
Community Services	**Unknown but possibly Medium/High**	The amount invested by BHR on a 'per head' population appeared to be at the average for the rest of NEL and NCL but given problems with comparing Community Services across areas it was unclear whether or not this was a driver of the deficit. However, given the relationship between such services as District Nursing and the outcomes for the frail elderly it is likely that there is a correlation.
Excess Low Acuity Care in a Secondary Care Setting	**Very High**	BHRUT's market share of Outpatient Activity for BHR had consistently increased over a period of at least 4 years whilst the BHRUT share of higher acuity care (Daycase/Elective) had consistently fallen. This was a significant driver of system deficit and the BHRUT deficit. For the system the higher acuity care was occurring in higher cost settings (such as the Independent Sector and at trusts with higher Market Force Factor (MFF) Rates) whilst for BHRUT it was limiting the 'earnings per clinical hour'.

The impact of these drivers cannot be over-stated. Collectively they created a destructive cycle involving an ever increasing spend in secondary care (peaking at £106m/Year above the average) therefore limiting available finances to invest Out of Hospital to tackle prevention and early intervention which in turn drove poor outcomes and ever more activity flowing into secondary care.

3.0 Moving to an Integrated Sustainability Plan (ISP)

With the advent of the pandemic and the temporary suspension of the implementation of the FRP, it is now time to consider how we create an Integrated Sustainability Plan (ISP) for BHR covering physical and mental health as well as Learning Disabilities that delivers the aspirations around meeting population health needs, improved outcomes and as a consequence, long-term financial sustainability.

The proposed principles for creating an ISP are:

- We will focus on improving medium to long-term outcomes for our population, reducing the frequency of unplanned care needs arising and through this will drive down pressures on our A&E departments;

- We will reduce our excess spend in secondary care and shift the investment Out of Hospital to support both improved care and the shift of low acuity activity, allowing our main NHS providers to focus on patients with higher acuity needs;

- In line with 21/22 Planning Guidance and our own aspirations we will focus our Out of Hospitalinvestments on tackling inequalities and inequities that are a contributor to poor health outcomes;

- We will work together through our System Wide Transformation Boards to shift activity into the most appropriate setting (whilst respecting patient choice where appropriate);

- We will monitor progress toward our aims and as a system make collective decisions about where we may need to change or adapt our focus to ensure we achieve our aims;

- We will work together to ensure that no partner is disadvantaged in the long-term journey whilst recognising that there will be a need to take difficult decisions (particularly financial ones) in the short to medium term.

To accompany these proposed principles the following financial aspirations are proposed;

- The financial sovereignty of each organisation will be maintained and we will not be seeking to transfer deficits or surpluses between partners;

- We will aim to reduce our secondary care variance to £0 by 2024/25 and to become 5% better than the average in 2025/26;

- We will invest 50% of the reduction in secondary care excess spend in transforming pathways and increasing Out of Hospital services and care to improve outcomes;

- We will align workforce and activity plans across the system.

This will not be an easy journey and is a challenge for every partner. The benefits are significant with improved long-term health outcomes for our population and a sustainable financial position for all system partners.

4.0 Questions Arising & Next Steps/Recommendations

The questions arising from this paper for discussion are:

1. What changes would you want to make to the proposed principles?

2. Should we seek to align Local Authority Finances/Activity plans within the ISP?

3. Is there agreement on the following?

    a. We need to reset our areas of focus based on the latest data;

    b. We need to reset aspirations for our Transformation Boards and seek to provide them with a delegated budget to tackle the agreed areas of focus;

    c. We need to establish a robust monitoring process to track delivery;

    d. We need to achieve a 5 Year outline financial model and how funds will flow across BHR between the partners.

In terms of Next Steps/Recommendations, obviously these will depend on the outcome from the discussions on the points above but the main headline actions are:

1. A version of this paper is currently planned to go to NHS Partner Boards in June/July;

2. We will be finalising the refreshing of the data to help with identifying priorities in May;

3. We will align Activity and Workforce Plans for 21/22 and into 22/23 between the CCG and BHRUT and NELFT by June;

4. We will produce (and agree) a Finance & Activity plan for the full 5 years with indicative numbers where we do not have detailed information by July;

5. We will produce aligned aspirational plans for Transformation Boards that set out how they plan to meet the needs of our population and improve outcomes from care. This will include delegated budgets for them to invest in for at least 21/22 and 22/23 by July/August. This is intended to release clinicians to more quickly take the decisions necessary to improve patient and resident outcomes across organisational boundaries ;

6. Develop the Monitoring Process and Governance to be able to track progress and impact by July;

BHR Integrated Care Partnership

Better care, better lives, together for all

NHS

North East London

Clinical Commissioning Group

Key Data for the BHR Integrated Sustainability Plan (ISP)

Meeting name: Integrated Care Partnership Board

Presenter: Steve Rubery, Director – Planning & Performance

Date: 27 May 2021

Background To This Document

This appendix collates together the key supporting data needed for the ISP in terms of identifying areas of focus for transformation and Out of Hospital investment.

This document is expected to grow as additional information and data is obtained

The document is broken into the following sections:

Core Metrics – The section has the key metrics relevant to selecting the key areas of focus for the ISP.

Public Health Metrics – This section has the detail about the key Population Health metrics used as part of both the original FRP and have been updated where possible for the ISP.

Long Term Conditions – This summarises key QOF, Prevalence and other data related to the BHR population with 1+ LTC.

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Population Health Metrics

This section provides an update on key population health data for BHR. In the original FRP one of the assumptions tested was whether or not demographics was a significant driver of the financial deficit.

The data suggests that whilst there are some significant challenges (particularly in B&D) they are not dissimilar to those seen elsewhere in North East London and parts of North Central and South East London.

Therefore the firm conclusion is that demographics is a driver but not a significant driver of the financial deficit in BHR.

Key Population Health Metrics for BHR

The table below is drawn from PHE Data for 2018/19 (or 2019 where stated) and shows the variance for the BHR Boroughs Compared to the London average (or England where no London average is available). This shows significant issues with deprivation for B&D, albeit not the worst in London, but more worryingly it shows poor outcomes against a range of LTCs for BHR.

Area	Metric	B&D	Havering	Redbridge		Worst 3 in London (Not in Order)		
Diabetes	Type 1 Receiving All 8 Care Processes	12.9%	-8.0%	2.5%		Newham	Enfield	Waltham Forest
	Type 2 Receiving All 8 Care Processes	19.1%	1.0%	13.7%		Waltham Forest	Enfield	Hounslow
	Major Diabetic Limb Amputation	30.5%	12.2%	62.2%		Newham	Tower Hamlets	Redbridge
COPD & Respiratory	Emergency Hospital Admissions	43.9%	-12.5%	-35.9%		Southwark	Tower Hamlets	B&D
	<75 Mortality Rate Respiratory Disease	78.7%	-4.4%	-20.2%		B&D	Tower Hamlets	H&F
	65+ Mortality Rate Respiratory Disease	46.4%	1.9%	-11.1%		Tower Hamlets	Lewisham	B&D
Cancer	% Diagnosed at Stage 1 and 2	-1.1%	0.7%	9.5%		Brent	City of London	Newham
MSK	% Reporting Long Term MSK Problem	-14.1%	3.8%	-20.0%		Enfield	Bexley	Havering
Cardiology	CHD Admissions (All Ages)	11.4%	-15.9%	15.4%		Hounslow	Ealing	Hillingdon
	Heart Failure Admissions (All Ages)	26.8%	-6.1%	0.3%		Lambeth	Brent	City of London
	Coronary Heart Disease Mortality (<75)	27.2%	0.5%	-10.9%		Newham	Hackney	Tower Hamlets
	Mortality Rate 65+ Cardiovascular Disease	1.7%	-4.0%	-9.9%		Enfield	Hounslow	Haringey
Life Expectancy	Life Expectancy at Birth (Male)	-2.1%	0.4%	2.1%		Lambeth	B&D	Lewisham
	Life Expectancy at Birth (Female)	-1.3%	0.8%	2.2%		Islington	B&D	Greenwich
	Healthy Life Expectancy at Birth (Male)	-5.2%	1.3%	4.9%		Newham	B&D	Hackney
	Healthy Life Expectancy at Birth (Female)	-2.2%	3.1%	-1.6%		Tower Hamlets	Croydon	Hillingdon
	Life Expectancy at Age 65 (Male)	-8.4%	-2.1%	5.8%		Lewisham	B&D	Havering
	Life Expectancy at Age 65 (Male)	-4.7%	1.4%	6.1%		Islington	B&D	Greenwich
Deprivation	% of People 16-64 in Employment	-6.7%	0.3%	-6.6%		Hackney	B&D	Redbridge
	Deprivation Score (2019)	51.2%	-22.6%	-20.7%		Newham	B&D	Hackney
	Children <16 in Low Income Families	32.4%	-2.9%	-13.5%		Camden	Islington	Tower Hamlets
Mental Health	Prevalence of Common MH 16+	32.5%	-5.9%	4.7%		Islington	Hackney	Newham
	Prevalence of Common MH 65+	35.3%	-2.9%	5.9%		Islington	Newham	Hackney

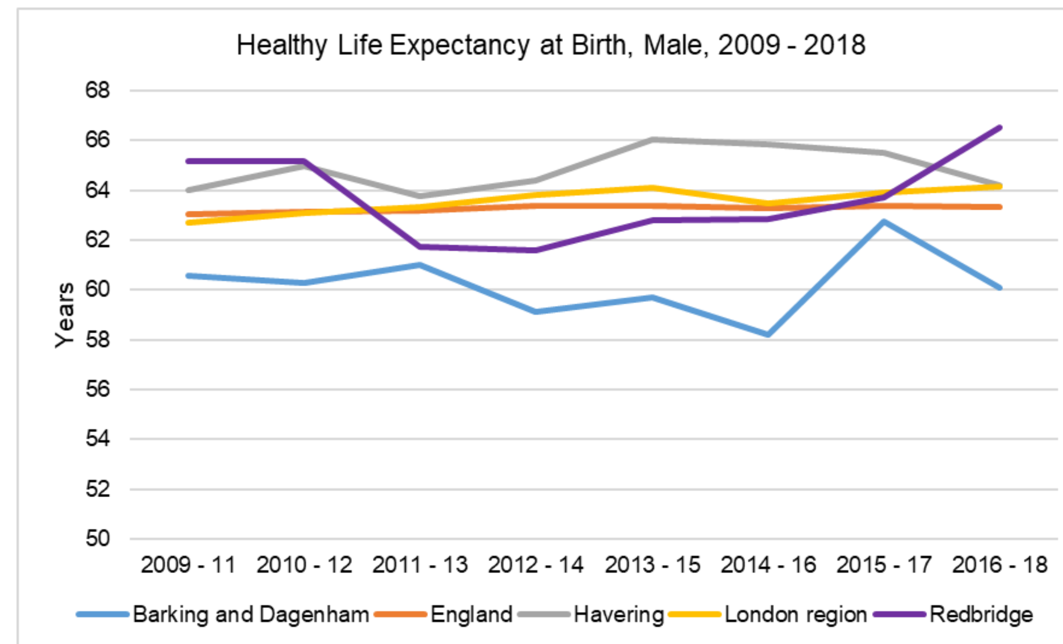
Over the period 2009 to 2018 the HLE for the BHR Boroughs have changed as follows:

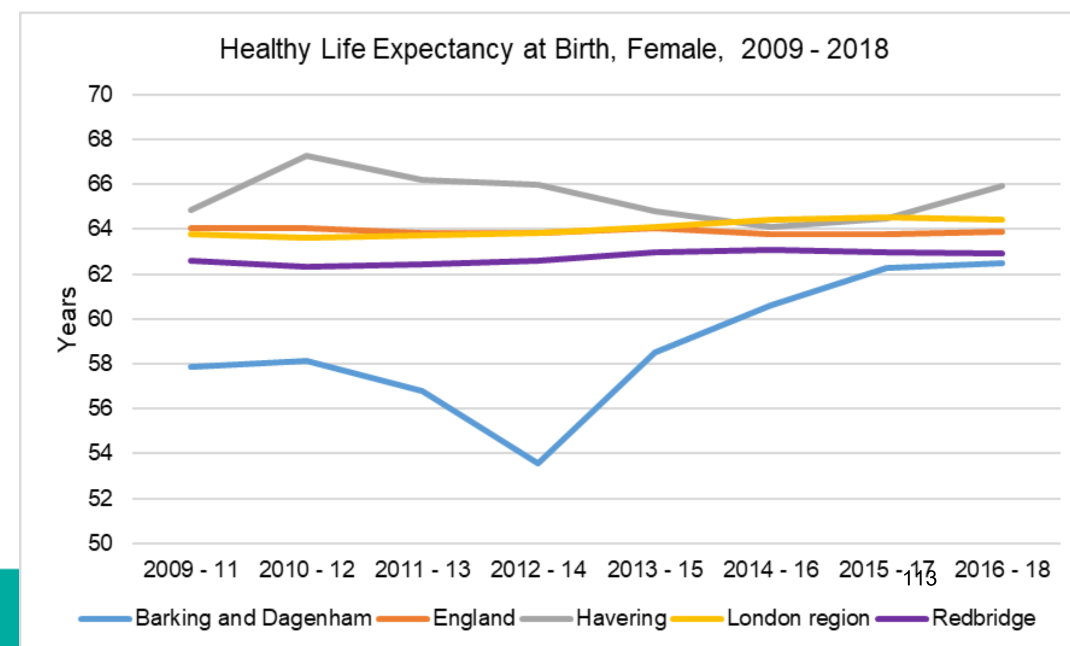
B&D – Significantly below the London Average for both males and females with the improvement in male HLE much slower than that of the London improvement trajectory.

Havering – Has declined over the period but there has been a significant improvement for females in the last 2 years.

Redbridge – For males the growth has been above the London Trajectory in the last 2 years and is the highest in the region. For females the rate of improvement has been minimal and remains below the London Average.

Source: PHE Fingertips





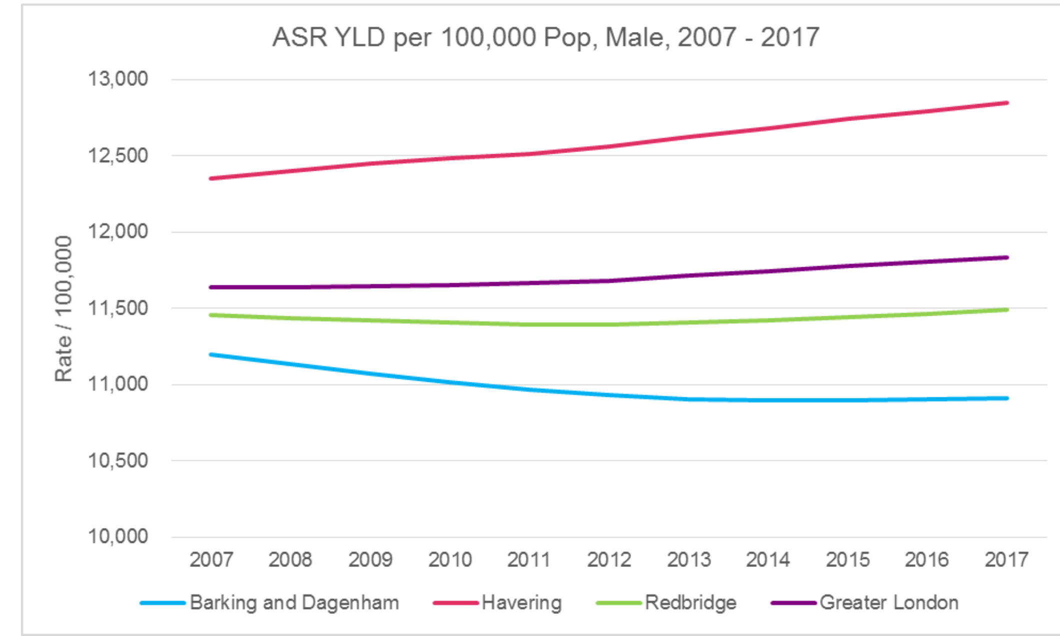
BHR Years Living with Disability

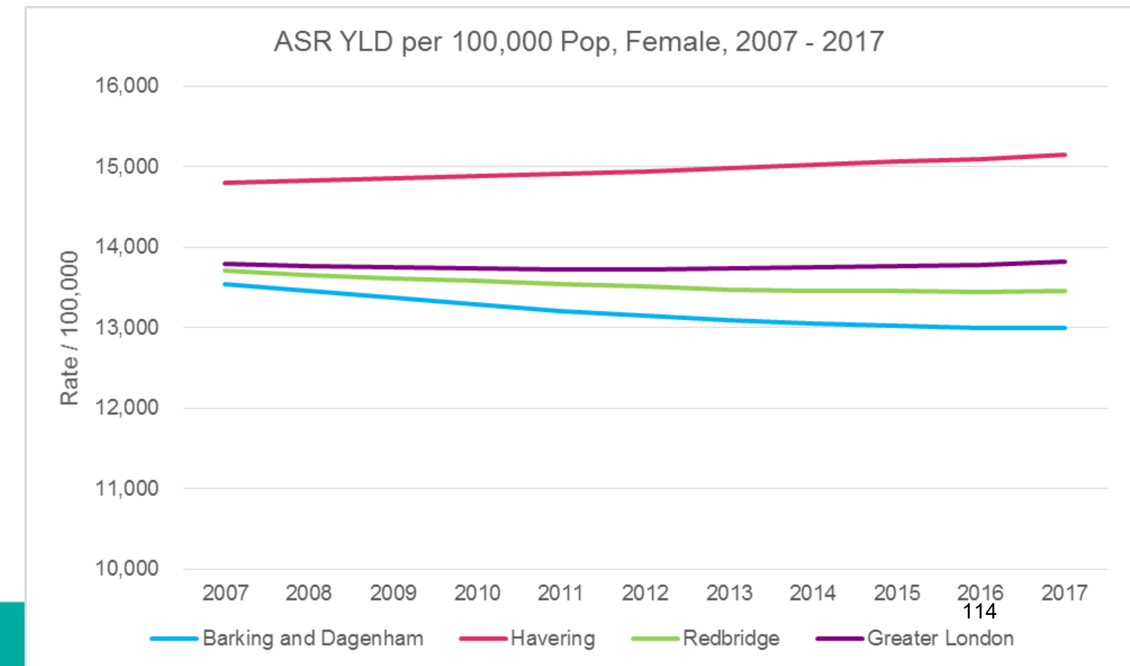
Over the period 2007 to 2017 the YLD for the BHR Boroughs have changed as follows:

B&D – Whilst tracking at a rate better than the London Average the improvement trajectory has slowed over the last 4-5 years for both makes and females.

Havering – Havering YLD has increased at a rate in excess of the London Average over the period. This will probably be related to most of the YLD factors being age related.

Redbridge – Whilst Redbridge also tracks at a better rate than the London average the rate of improvement for males has reversed (so is now worsening) and has flattened for females.





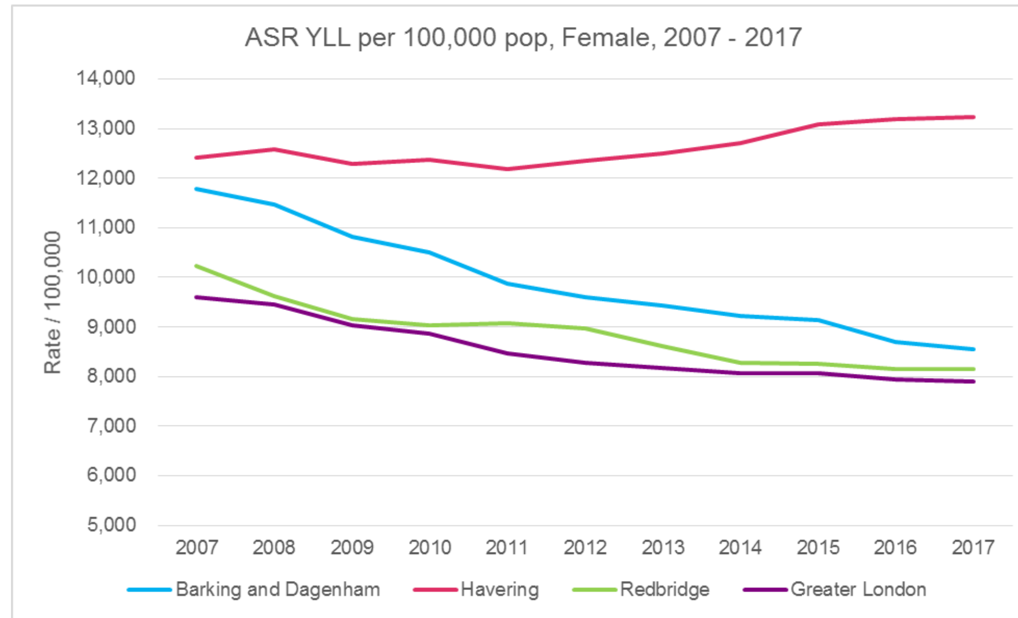
BHR Years of Life Lost

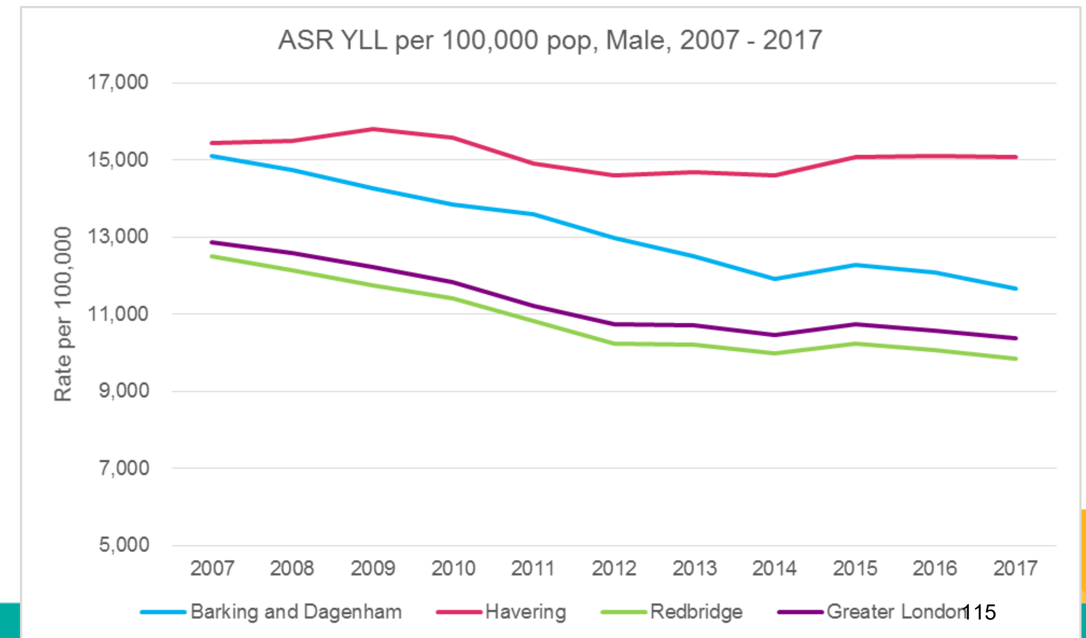
Over the period 2007 to 2017 the YLL for the BHR Boroughs have changed as follows:

B&D – Whilst tracking at a rate worse than the London Average, YLL has improved over the period.

Havering – Whilst also tracking at a rate worse than the London Average YLL has worsened further over the period.

Redbridge – For males the YLL has tracked just above the improvement trajectory for London and for females just below although there are signs of a slight slow down in more recent years.





Key Population Health Comparisons

Mortality Due To Preventable Causes

Area	Value
England	181
London region	161
Islington	210
Hackney	207
Tower Hamlets	202
Barking and Dagenham	201
Lambeth	199
Greenwich	196
Lewisham	191
Southwark	190
Hammersmith and Fulham	190
Hounslow	173
Newham	173
Ealing	169
Hillingdon	167
Havering	167
Wandsworth	167
Waltham Forest	166
Haringey	163
Bexley	162
Croydon	159
Camden	157
Brent	154
Merton	150
Enfield	149
Sutton	149
Kingston upon Thames	144
City of London	141
Kensington and Chelsea	138
Richmond upon Thames	136
Redbridge	134
Bromley	132
Westminster	126
Barnet	124
Harrow	121

Healthy Life Expectancy (F)

Area	Value
England	63.9
London region	64.4
Richmond upon Thames	69.7
Brent	68.9
Harrow	67.8
Camden	67.0
Kingston upon Thames	67.0
Bromley	66.8
Kensington and Chelsea	66.6
Southwark	66.3
Haringey	66.3
Havering	65.9
Wandsworth	65.8
Sutton	65.6
Westminster	65.6
Waltham Forest	65.3
Lewisham	64.7
Barnet	64.7
Bexley	64.5
Enfield	63.8
Ealing	63.3
Redbridge	62.9
Hammersmith and Fulham	62.8
Lambeth	62.8
Barking and Dagenham	62.5
Greenwich	62.4
Hounslow	62.2
Merton	62.1
Hackney	62.0
Islington	61.7
Newham	61.4
Hillingdon	61.0
Croydon	59.5
Tower Hamlets	56.6

Healthy Life Expectancy (M)

Area	Value
England	63.4
London region	64.2
Richmond upon Thames	71.9
Wandsworth	68.9
Harrow	68.5
Kingston upon Thames	67.9
Redbridge	66.5
Hillingdon	65.9
Bromley	65.8
Bexley	65.5
Haringey	65.3
Merton	65.2
Sutton	65.2
Croydon	65.0
Havering	64.2
Brent	64.0
Enfield	63.9
Barnet	63.8
Kensington and Chelsea	63.8
Ealing	63.8
Camden	63.5
Hammersmith and Fulham	63.5
Hounslow	63.0
Westminster	62.9
Waltham Forest	62.7
Southwark	62.7
Islington	62.6
Greenwich	61.3
Lambeth	60.9
Lewisham	60.6
Tower Hamlets	60.5
Barking and Dagenham	60.1
Hackney	58.6
Newham	58.4

Source: PHE Fingertips (Latest data -2018)

Key Population Health Comparisons

Gross Annual Pay Median (£)

Borough	Value
Barking and Dagenham	23,900
Newham	24,100
Brent	24,700
Waltham Forest	25,500
Enfield	26,300
Hounslow	26,400
Ealing	26,700
Bexley	26,900
Haringey	27,100
Hillingdon	27,100
Lewisham	27,300
Croydon	27,500
Greenwich	27,600
Harrow	27,600
Havering	27,900
Redbridge	28,000
Sutton	28,200
Barnet	28,700
Hackney	29,400
Southwark	29,400
Lambeth	29,900
Merton	30,200
Tower Hamlets	30,200
Bromley	32,000
Kingston-upon-Thames	32,400
Hammersmith and Fulham	33,200
Islington	33,400
Wandsworth	34,500
Richmond-upon-Thames	36,100
Camden	37,300
Westminster	39,700
Kensington and Chelsea	40,400
London	28,800
England	24,700

% Earning Less Than London Minimum Wage

Borough	Value
Redbridge	48.7
Sutton	44.1
Enfield	40.9
Waltham Forest	39.7
Harrow	38.4
Brent	36.9
Barnet	36.3
Bexley	35.3
Merton	35.1
Newham	33.8
Bromley	33.5
Havering	32.8
Ealing	30.2
Hillingdon	29.1
Haringey	28.6
Croydon	28.5
Kingston upon Thames	27.9
Hounslow	26.6
Barking and Dagenham	25.8
Greenwich	25.0
Lewisham	23.6
Richmond upon Thames	23.4
Wandsworth	22.3
Hackney	22.1
Kensington and Chelsea	21.2
Lambeth	20.8
Southwark	14.1
Islington	13.3
Camden	13.0
Westminster	12.4
Hammersmith and Fulham	12.2
Tower Hamlets	11.7

Source: London data store (latest data - 2018)

Employed Population (%)

Borough	Value
Barking and Dagenham	67.3
Camden	69.6
Enfield	69.8
Brent	70.4
Waltham Forest	71.5
Kensington and Chelsea	72.2
Hackney	72.5
Newham	72.7
Harrow	73.6
Redbridge	74.0
Tower Hamlets	74.4
Hillingdon	74.8
Islington	75.0
Hounslow	75.2
Haringey	75.3
Barnet	75.6
Greenwich	75.6
Ealing	75.7
Croydon	76.7
Hammersmith and Fulham	76.8
Kingston upon Thames	77.2
Bromley	77.4
Lambeth	77.4
Sutton	77.4
Havering	77.5
Bexley	78.7
Merton	79.1
Southwark	79.4
Richmond upon Thames	80.1
Lewisham	80.8
Wandsworth	84.9
City of London	100.0
London	75.3

Unemployment Rate %

Borough	Value
Westminster	12.3
Waltham Forest	10.2
Barking and Dagenham	9.6
Lambeth	9.1
Hillingdon	8.7
Southwark	7.9
Hammersmith and Fulham	7.7
Harrow	7.5
Newham	7.3
Ealing	6.9
Sutton	6.3
Greenwich	6.2
Merton	6.2
Croydon	5.9
Enfield	5.8
Kensington and Chelsea	5.7
Tower Hamlets	5.7
Haringey	5.3
Hounslow	5.3
Lewisham	5.3
Camden	5.2
Islington	5.2
Barnet	4.9
Bexley	4.8
Hackney	4.8
Kingston upon Thames	4.7
Havering	4.2
Brent	3.6
Bromley	3.4
Wandsworth	2.7
Richmond upon Thames	2.1
Redbridge	1.9
England	4.8
London	6.0

Note: These two columns will not add up to 100% for any Borough as it does not include those who are economically inactive.

Source: London data store (Latest data – Dec 2020)

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BHR Financial Variance

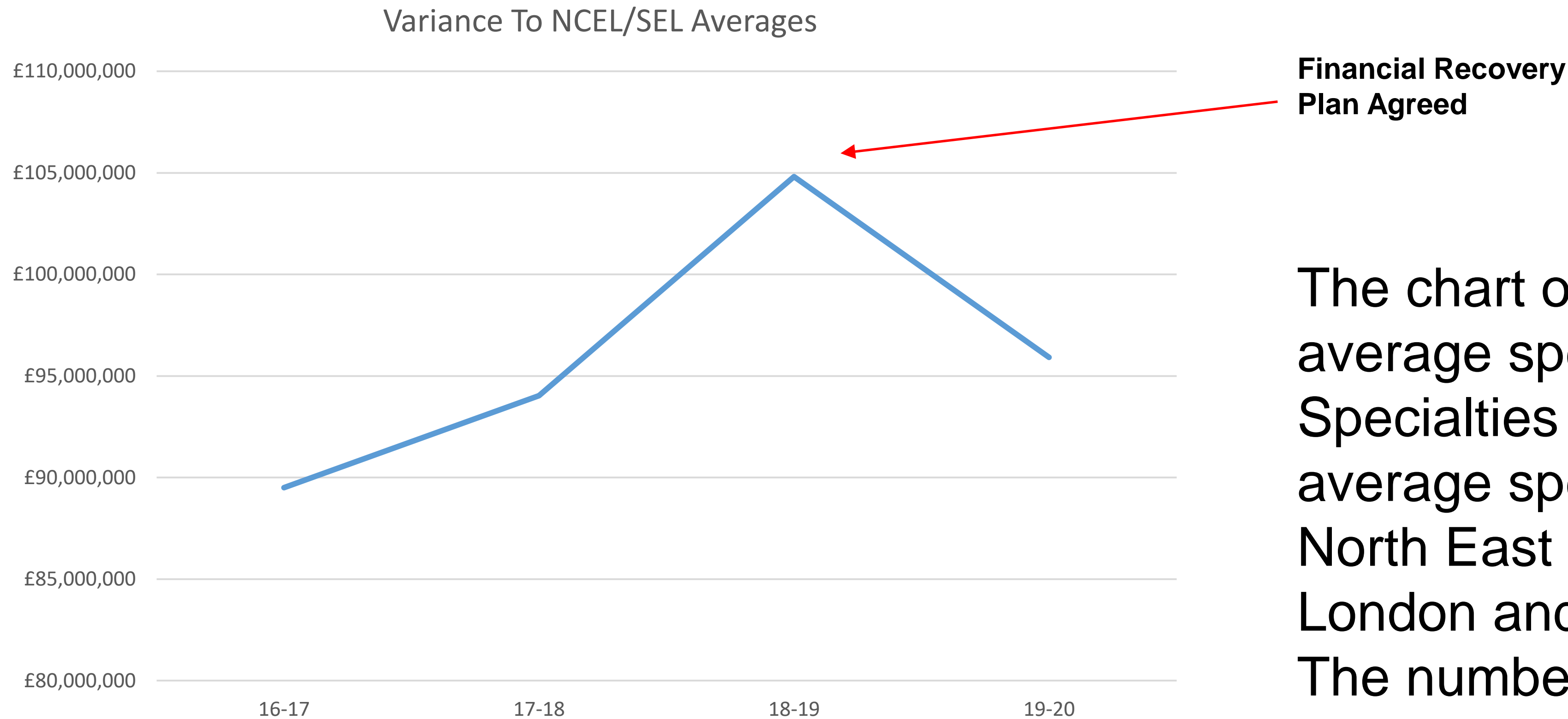
Background

A major driver of the deficit for BHR is the variance in secondary care spend compared to the rest of North East London plus North Central and South East London.

The variance has been growing since at least 2012/13 and reached a peak of £106m in 2018/19 (the year the System Financial Recovery Plan was approved).

The following slides show how the variance changed between 2016/17 and 2019/20 (the last year reliable data is available) and also the areas of most significant change from 2018/19 into 2019/20.

Financial Variance 2016/17 to 2019/20



The chart opposite shows how the average spend for BHR across 25 Specialties has varied from the average spend across the rest of North East London, North Central London and South East London. The numbers are over-stated by about £7m for each year because of the anomaly in Sports & Exercise Medicine that is a coding artifact but as the value is consistent across the period it has been left in.

Year	16-17	17-18	18-19	19-20
Variance	£89,505,893	£94,034,784	£104,807,565	£95,922,747

Financial Variances 2018/19 – 2019/20

These tables show how the variance in secondary care spend across BHR from the NEL, NCL and SEL has changed over the period from 18/19 to 19/20. Significant areas to note are flagged in Yellow.

Specialty	POD	Total Variance 18/19	Total Variance 19/20	Net Change
Trauma & Orthopaedics	OPFA	£1,660,703	£1,578,453	-£82,250
	OPFU	£257,398	£1,103,204	£845,806
	OPPROC	£1,272,446	£643,344	-£629,102
	ELECTIVE	£8,622,071	£6,803,082	-£1,818,989
	NON-ELECTIVE	£2,672,120	£1,220,060	-£1,452,060
General Surgery	OPFA	£1,265,181	£1,070,793	-£194,388
	OPFU	£422,270	£509,301	£87,031
	OPPROC	£596,978	£515,686	-£81,292
	ELECTIVE	£2,318,905	£3,045,106	£726,201
	NON-ELECTIVE	£4,401,991	£3,592,602	-£809,389
Geriatric Medicine	NON-ELECTIVE	£20,886,043	£18,783,728	-£2,102,315
Gastroenterology	OPPROC	£694,237	£1,163,317	£469,080
	ELECTIVE	£3,075,391	£2,284,291	-£791,100
	NON-ELECTIVE	£4,310,095	£3,043,407	-£1,266,688
Gynaecology	OPFA	£2,740,938	£2,314,380	-£426,558
Ophthalmology	OPFA	£961,010	£292,029	-£668,981
	ELECTIVE	£1,456,946	£1,387,818	-£69,128
Cardiology	OPFA	£703,168	£694,185	-£8,983
	OPPROC	£818,244	£465,688	-£352,556
	NON-ELECTIVE	£410,235	£424,201	£13,966
Urology	OPPROC	£717,966	£1,040,254	£322,288
	ELECTIVE	£666,566	£732,461	£65,895
	NON-ELECTIVE	£1,677,204	£1,103,854	-£573,350
ENT	ELECTIVE	£1,241,235	£1,196,414	-£44,821
	NON-ELECTIVE	£615,929	£520,144	-£95,785
Respiratory Medicine	OPPROC	£1,033,898	£1,182,025	£148,127
	NON-ELECTIVE	£2,019,211	£2,289,463	£270,252

Financial Variances 2018/19 – 2019/20

These tables show how the variance in secondary care spend across BHR from the NEL, NCL and SEL has changed over the period from 18/19 to 19/20. Significant areas to note are flagged in Yellow.

Specialty	POD	Total Variance 18/19	Total Variance 19/20	Net Change
Nephrology	NON-ELECTIVE	£3,041,398	£2,280,652	-£760,746
Rheumatology	OPFU	£770,664	£733,519	-£37,145
	ELECTIVE	£340,691	£376,463	£35,772
Interventional Radiology	ELECTIVE	£3,662,924	£3,115,831	-£547,093
	NON-ELECTIVE	£223,276	£565,178	£341,902
Breast Surgery	OPFA	£290,937	£0	-£290,937
	ELECTIVE	£683,123	£459,466	-£223,657
Neurosurgery	OPFA	£664,691	£572,555	-£92,136
	OPFU	£314,308	£0	-£314,308
	ELECTIVE	£1,176,516	£1,051,540	-£124,976
	NON-ELECTIVE	£208,006	£226,470	£18,464
Pain Management	OPFA	£346,043	£318,938	-£27,105
	OPFU	£275,622	£403,922	£128,300
	ELECTIVE	£1,065,008	£1,501,542	£436,534
Vascular Surgery	ELECTIVE	£379,210	£0	-£379,210
	NON-ELECTIVE	£754,546	£203,353	-£551,193
Stroke Medicine	OPFA	£283,382	£227,568	-£55,814
	OPFU	£226,143	£0	-£226,143
	NON-ELECTIVE	£4,689,279	£2,770,117	-£1,919,162
Gynaecological Oncology	OPPROC	£380,288	£303,405	-£76,883
	ELECTIVE	£714,506	£1,135,964	£421,458
Neurology	OPFA	£286,790	£0	-£286,790
	OPFU	£262,244	£0	-£262,244
	ELECTIVE	£260,723	£0	-£260,723
Clinical Oncology	NON-ELECTIVE	£748,113	£842,585	£94,472
Physiotherapy	OPPROC	£1,409,936	£0	-£1,409,936
Obstetrics	ELECTIVE	£984,840	£980,040	-£4,800
Neonatology	OPFU	£110,017	£107,005	-£3,012
	NON-ELECTIVE	£135,882	£133,800	-£2,082
Paediatric Clinical Haematology	OPFU	£168,818	£166,918	-£1,900

Key Areas of Focus

The following is a summary of areas of focus by specialty where BHR are significantly in excess of London wide activity where there is a possibility of intervention in the community to drive down admissions or hospital based support to avoid an admission:

Specialty	Conditions with High Levels of Non-Elective Admissions
Geriatric Medicine	Pneumonia, Asthma, Lower Respiratory Infections, COPD, Heart Failure, Arrythmia, Gastrointestinal Infections, Falls, Diabetes, Kidney/Urinary Tract Infections, AKI, Iron Deficiency, Sepsis
Endocrinology	Pneumonia, COPD, Heart Failure, Kidney/Urinary Tract Infections, AKI, Sepsis
MSK	Falls (reflected in Very Major & Major Hip Procedures)
General Surgery	Gastrointestinal Tract Disorders, Skin Disorders
Gastro	IBD, Gastrointestinal Tract Disorders
Urology	AKI, General Renal Disorders
Respiratory	Pneumonia, COPD, Heart Failure, Sepsis

Based on the above there is a clear need to address support for COPD Patients, CKD/AKI and HF Patients. In addition, increased focus on Falls and tackling infections more proactively would also appear to be a key area of focus for BHR.

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Long Term Conditions Summary Slides

Background

The following slides combine Finance/Activity, Public Health and available QOF Data to create a ‘one slide’ view of the major LTCs that need to be addressed within BHR.

Diabetes Summary Slide

Prevalence Gap	Gap (Pts)
B&D CCG	1,310
Havering CCG	3,209
Redbridge CCG	9,487
Total	**14,006**

Variance (£)	18/19	19/20
	Net Change	**TBD**

With an estimated total of 14,000 people across BHR with undiagnosed Diabetes it may not be unsurprising that all three Boroughs have poor outcomes with regards to Limb Amputations with Redbridge amongst the worst 3 Boroughs for this outcome in London.

There was an apparent increase in non-elective spend for Endocrinology that appears on more detailed investigation this appears to be an artifact so has been excluded.

Area	Metric	B&D	Havering	Redbridge
Diabetes	Type 1 Receiving All 8 Care Processes	12.9%	-8.0%	2.5%
	Type 2 Receiving All 8 Care Processes	19.1%	1.0%	13.7%
	Major Diabetic Limb Amputation	30.5%	12.2%	62.2%

AF & Heart Failure Summary Slide

Prevalence Gap	AF Gap (Pts)	HF Gap (Pts)
B&D CCG	1,311	1,393
Havering CCG	1,849	2,394
Redbridge CCG	2,223	1,541
Total	**5,383**	**5,328**

Variance (£)	18/19	19/20
Cardiology OPFA	£703,168	£694,185
OPPROC	£818,244	£465,688
NON-ELECTIVE	£410,235	£424,201
	Net Change	**+£0.4m**

Across the 3 Boroughs only Havering has an observed prevalence of AF and HF above the London average.

This may be a driver of the fact that both B&D and Redbridge have poor outcomes associated with CHD Admissions. In addition there is a clear need to address HF and overall CHD Mortality in B&D.

The variance in spend on Cardiology (used as a proxy) appears to be essentially flat over the period from 18/19 to 19/20.

Area	Metric	B&D	Havering	Redbridge
Cardiology	CHD Admissions (All Ages)	11.4%	-15.9%	15.4%
	Heart Failure Admissions (All Ages)	26.8%	-6.1%	0.3%
	Coronary Heart Disease Mortality (<75)	27.2%	0.5%	-10.9%
	Mortality Rate 65+ CVD	1.7%	-4.0%	-9.9%

Respiratory Summary Slide

Prevalence Gap	COPD Gap (Pts)	Asthma Gap (Pts)
B&D CCG	6,426	8,942
Havering CCG	6,854	10,607
Redbridge CCG	7,441	11,889
Total	**20,721**	**31,438**

Variance (£)	18/19	19/20
Respiratory (Non-Elective)	£2,019,211	£2,289,463
	Net Change	**+£0.2m**

Across the 3 Boroughs Redbridge is below the observed prevalence rate for London whilst B&D is slightly below the rate for Asthma.

The fact that B&D is above the London observed prevalence rate for COPD does not seem to be translating into good outcomes for patients. Of course there are complicating factors such as smoking, obesity and deprivation but the Outcomes below show a clear need for change.

Overall variance in Respiratory Medicine has remained flat over the period.

Area	Metric	B&D	Havering	Redbridge
COPD & Respiratory	Emergency Hospital Admissions	43.9%	-12.5%	-35.9%
	<75 Mortality Rate Respiratory Disease	78.7%	-4.4%	-20.2%
	65+ Mortality Rate Respiratory Disease	46.4%	1.9%	-11.1%

CKD Summary Slide

Prevalence Gap	Gap (Pts)
B&D CCG	5,199
Havering CCG	10,389
Redbridge CCG	9,190
Total	**24,778**

Variance (£)	18/19	19/20
Nephrology (Non-Elective)	£3,041,398	£2,280,652
	Net Change	-£0.8m

Note: The CKD Prevalence Gap numbers seem excessively high and need to be verified.

All three Boroughs are at or below the London average for observed prevalence (QOF). Only B&D is marginally below the ELHCP value.

Whilst the overall prevalence gap (in terms of numbers of patients) seems high based on available data the actual variance in non-elective activity associated with Nephrology (as a proxy for CKD) has reduced by £0.8m.

There are no publicly available outcomes for CKD that have been located to comment further in this area.

BHR Integrated Care Partnership
Better care, better lives, together for all

NHS
North East London
Clinical Commissioning Group

Long Term Conditions QOF & Prevalence

Background

These slides provide a more granular view of QOF and Prevalence Data for a wider range of LTCs relevant to BHR.

Diabetes

Since the Diabetic Prevalence Data was first run in 2017/18 the Prevalence Gap for diabetes has remained static across BHR although there has been a significant reduction in the gap for Havering being offset by smaller increases in B&D and Redbridge.

	Expected Prevalence (18/19)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	9.2%	8.57%	0.63%	1,310
Havering CCG (271,977 Pop)	8.7%	7.52%	1.18%	3,209
Redbridge CCG (296,474 Pop)	10.9%	7.70%	3.2%	9,487
Benchmark (QOF Rates)	**England – 7.08% London – 6.76% East London Health and Care Partnership (STP) – 7.60%**			
Prevalence Source	**https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20**			

Since the AF Prevalence Data was first run in 2017/18 the Prevalence Gap for BHR has reduced with the unidentified patient cohort dropping from 6,844 to 5,383 (21% reduction) over a 2 Year period.

	Expected Prevalence (18/19)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	1.5%	0.87%	0.63%	1,311
Havering CCG (271,977 Pop)	2.6%	1.92%	0.68%	1,849
Redbridge CCG (296,474 Pop)	1.8%	1.05%	0.75%	2,223
Benchmark (QOF Rates)	**England – 2.05% London – 1.13% East London Health and Care Partnership (STP) – 0.92%**			
Prevalence Source	**https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20**			

Heart Failure

In the previous iteration of the work on prevalence we were unable to locate prevalence rates for Heart Failure therefore it is difficult to state how this changed over the last two years.

	Expected Prevalence (18/19)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	1.1%	0.43%	0.67%	1,393
Havering CCG (271,977 Pop)	1.6%	0.72%	0.88%	2,394
Redbridge CCG (296,474 Pop)	1.0%	0.48%	0.52%	1,541
Benchmark (QOF Rates)	England – 0.9% London – 0.55% East London Health and Care Partnership (STP) – 0.54%			
Prevalence Source	https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20 https://fingertips.phe.org.uk/profile/prevalence/data#page/0/gid/1938133099/pat/6/par/E12000007/ati/101/iid/92659/age/164/sex/4/cid/4/tbm/1			

Since the COPD Prevalence Data was first run in 2017/18 the Prevalence Gap has remained static with approximately 20,000 unidentified patients within BHR who have COPD but are not recorded on the COPD QOF Register.

	Expected Prevalence 16+ (18/19)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	4.6%	1.51%	3.09%	6,426
Havering CCG (271,977 Pop)	4.3%	1.78%	2.52%	6,854
Redbridge CCG (296,474 Pop)	3.3%	0.79%	2.51%	7,441
Benchmark (QOF Rates)	England – 1.94% London – 1.14% East London Health and Care Partnership (STP) – 1.13%			
Prevalence Source	https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20			

Since the Asthma Prevalence Data was first run in 2017/18 the Prevalence Gap for BHR has reduced with the unidentified patient cohort dropping from 36,556 to 31,437 (14% reduction) over a 2 Year period.

	Expected Prevalence (18/19)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	9.1%	4.8%	4.3%	8,942
Havering CCG (271,977 Pop)	9.2%	5.3%	3.9%	10,607
Redbridge CCG (296,474 Pop)	9.1%	5.09%	4.01%	11,889
Benchmark (QOF Rates)	**England – 6.48%** **London – 4.95%** **East London Health and Care Partnership (STP) – 4.9%**			
Prevalence Source	**https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20**			

Since the CKD Prevalence Data was first run in 2017/18 the Prevalence Gap for BHR has remained broadly static.

	Expected Prevalence (18/19) (16+)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	4.7%	2.20%	2.5%	5,199
Havering CCG (271,977 Pop)	6.7%	2.88%	3.82%	10,389
Redbridge CCG (296,474 Pop)	5.5%	2.40%	3.1%	9,190
Benchmark (QOF Rates)	England – 4.05% London – 2.41% East London Health and Care Partnership (STP) – 2.81%			
Prevalence Source	https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20			

Note: The CKD Prevalence Gap numbers seem excessively high and need to be verified.

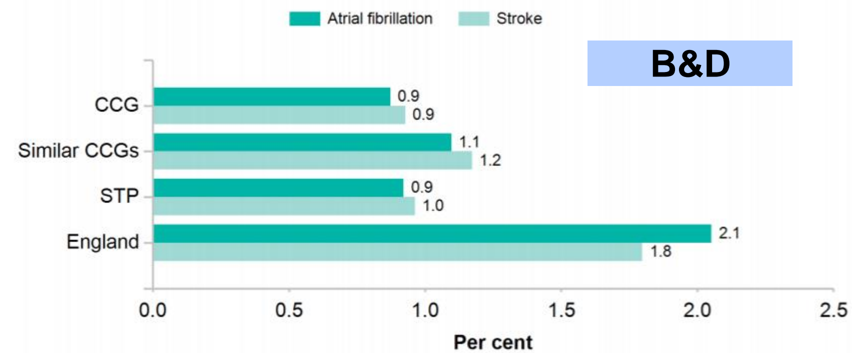
Hypertension

Since the Hypertension Prevalence Data was first run in 2017/18 the Prevalence Gap for BHR has remained broadly static.

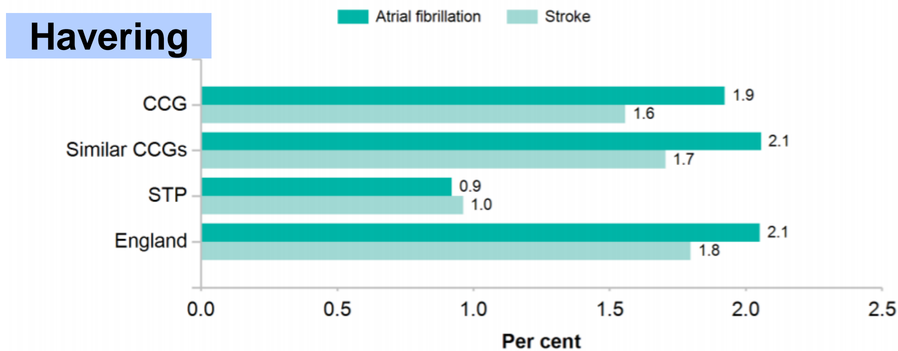
	Expected Prevalence (18/19)	Observed Prevalence (QOF 19/20)	Gap (%)	Gap (Pts)
B&D CCG (207,968 Pop)	19.9%	11.31%	8.59%	17,864
Havering CCG (271,977 Pop)	23.8%	14.41%	9.39%	25,538
Redbridge CCG (296,474 Pop)	20.7%	11.65%	9.05%	26,830
Benchmark (QOF Rates)	**England – 14.10% London – 11.02% East London Health and Care Partnership (STP) – 10.61%**			
Prevalence Source	https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2019-20			

Stroke & AF Prevalence in BHR

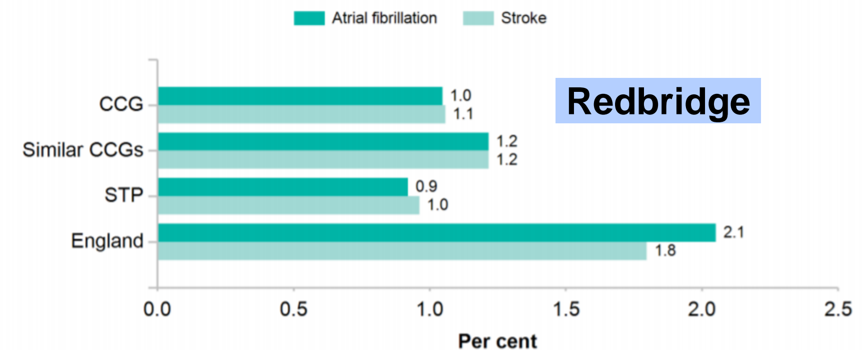
This slide shows Stroke/AF prevalence for BHR. From this data it is clear that Havering's prevalence is above that of the STP by a significant margin.



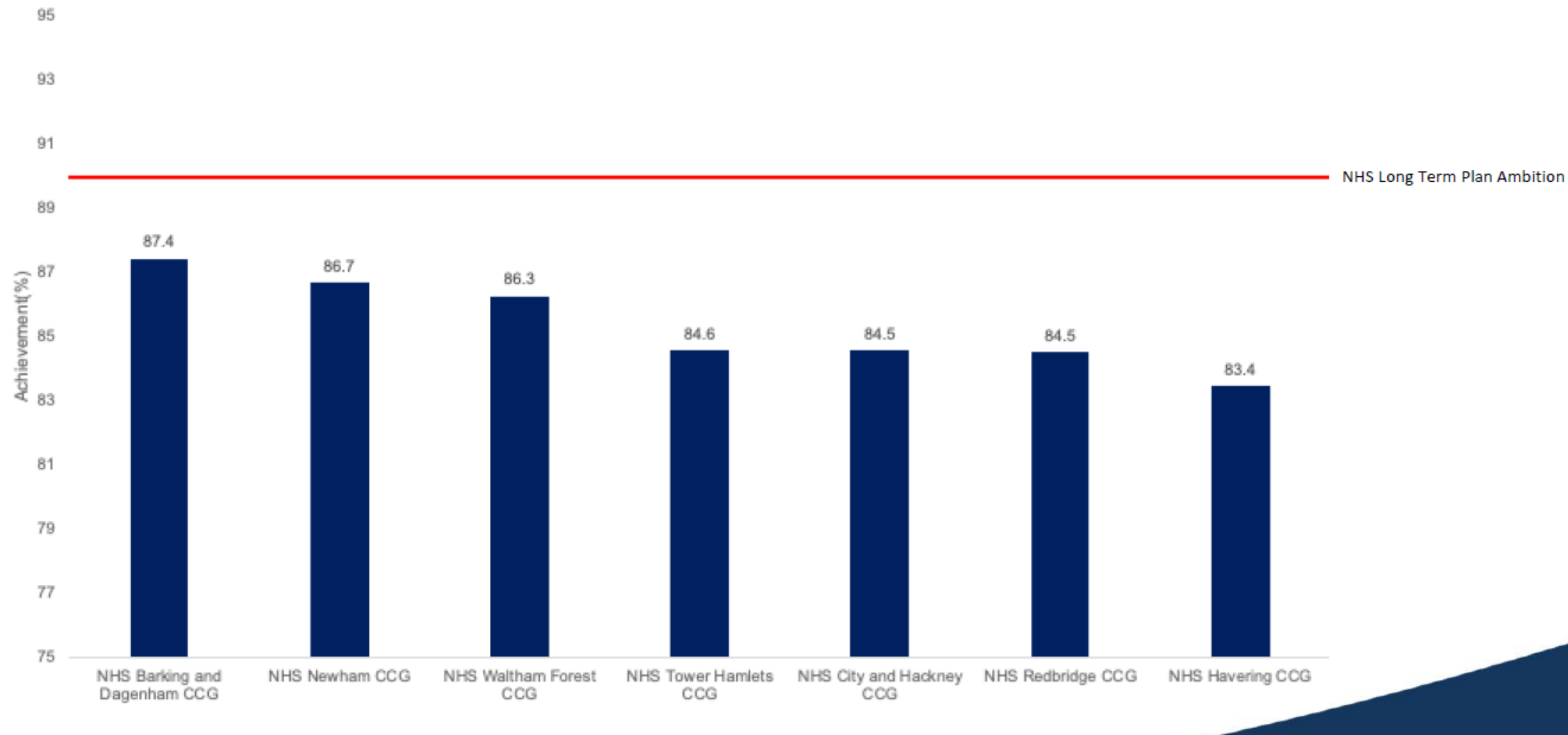
Source: Quality and Outcomes Framework, 2019/20



Source: Quality and Outcomes Framework, 2019/20



Source: Quality and Outcomes Framework, 2019/20



This slide shows that all of NEL needs to address rates of anticoagulation for AF patients to reach the LTP ambition.

Integrated Care Partnership Board

27 May 2021

Title of report	Quality & Safeguarding update
Item number	7.1
Author	Mark Gilbey-Cross – Deputy Nurse Director
Presented by	Mark Gilbey-Cross – Deputy Nurse Director
Contact for further information	m.gilbey-cross@nhs.net
Executive summary	• This purpose of this report is to provide an overview to the BHR Integrated Care Partnership Board of quality and safeguarding issues and updates across the BHR system.
Action required	• Note the detail of the report • Agree actions being taken to date to mitigate the identified risks • Suggest any further actions to address quality and safeguarding risks for local people
Where else has this paper been discussed?	BHR System Quality & Performance Oversight Group
Next steps/ onward reporting	Continuation through agreed governance routes
What does this mean for local people? **How does this drive change and reduce health inequalities?**	As outlined within the report
Conflicts of interest	None
Strategic fit	High Quality, Safe and Compassionate Care
Impact on finance, performance and quality	As outlined within the report
Risks	As outlined within the report
Equality impact	N/A

1. Introduction

The Barking & Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership (ICP) Health System Quality & Performance Oversight Group (QPOG) receives a monthly quality and safeguarding report that over time appraises members of quality and safeguarding concerns, issues, mitigating actions across the BHR geographical area. Details within the report are expanded on month by month.
From a governance perspective, this report is shared with the BHR Integrated Care Executive Group (ICEG) and the newly formed north east London Clinical Commissioning Group (NEL CCG) Quality Committee.

2. Quality Oversight and Assurance during the Covid-19 Pandemic

To allow providers and the quality and safeguarding team to respond to the COVID-19 pandemic and vaccination programme, and as with the first wave of the pandemic, elements of regular provider quality reporting requirements and work of the quality team were paused, including regular meetings of the BHR System Quality and Performance Committee. A full restart of these functions took effect from 1 April 2021. During the recent wave, we continued monitoring, review and oversight of elements such as Serious Incidents (SI), Never Events (NE) and Regulation 28 (Prevention of Future Deaths) Reports.

As the system moves further towards business as usual, we are adopting an incremental approach to return to full quality requirements in order to support colleagues across the system to recover and regroup.

For SI's and NE's, this means continuation of reporting upon identification, however, following advice from NHSE/I Regional Patient Safety Team, the 60-day requirement for submission of Root Cause Analysis Reports (RCA) will continue to be paused. Providers have however, been requested to continue the usual reporting and submission requirements for Never Events and all maternity related SI's.

3. Quality Oversight (BHRUT)

Never Events – Since the last reporting period, no Never Events have been declared by BHRUT.

Cancer and Incidental Findings Task & Finish Group – Due to the system-wide response to the pandemic, the Task and Finish Group had been unable to meet, meetings recommenced from May 2021. Despite the impact of the pandemic, actions from the group have continued to be progressed. Following the next meeting within 6-8 weeks we expect the group to be stood down. A full oversight and closure briefing will be presented to the Quality & Performance Oversight Group of July 2021.

Queen's Hospital Emergency Department (ED) Governance Concerns
At the Quality and Performance Committee of August 2020, BHRUT identified concerns regarding the governance arrangements with the Emergency Department (ED) at Queen's Hospital.

BHRUT colleagues have previously outlined actions that have been taken as a result to manage and strengthen governance arrangements. A significant number of the governance actions relate to the investigation, review and sharing of learning from serious incidents (SI) and red incidents.

Since the last Quality & Performance Committee meeting, an external organisation has been commissioned by BHRUT to conduct a review of all the Trust's Serious Incidents (SI) spanning the previous two years. We expect this review to be completed soon with results being fed back into the Quality & Performance Oversight Group of July 2021.

4. Quality Oversight (NELFT)

Never Events – Since the last reporting period, no Never Events have been declared by NELFT.

Initial Health Assessments (IHA) and Review Health Assessments (RHA) for Looked After Children (LAC) - Due to ongoing concerns regarding the quality of IHA's a meeting took place between senior leaders from both NELFT and BHR CCGs 11 September 2020 with a follow-up meeting taking place 13 October 2020. The outcome of these discussions was that NELFT agreed to commission an independent audit of IHA's.

The audit will be conducted by a specialist in IHA's from the Royal College of Paediatrics and Child Health; the draft terms of reference have now been received by BHR CCGs that are undergoing a review to ensure the audit covers all areas of concern. Due to the recent pandemic the review of IHA's has been unable to commence. We expect that the audit will commence during June 2021.

Acute & Rehabilitation Directorate (ARD) incidents – Following a number of Serious Incidents within Sunflowers Court (Mental Health Inpatient Unit), NELFT called an internal extraordinary quality summit to conduct a review of the incidents with plans drawn up to address any immediate concerns. A complex and robust action plan has been developed with a number of actions completed. Regular update meetings are being held with representation from NEL CCG. A summary of concerns and details of actions taken/planned will be presented to the Quality & Performance Oversight Group of June 2021.

Thematic Reviews – To effectively manage the SI process and ensure the continued safety of patients, the BHR ICP quality team requested that NEL CSU colleagues conduct sperate thematic reviews of SI's related to community acquired pressure ulcers and the physical health needs of mental health patients.

These are two areas that have been of concern previously and where we feel that further improvements could be made. Joint presentation by NELFT and the BHR Quality Team of these thematic reviews will be presented to the Quality & Performance Oversight Group of June 2021.

5. Quality Oversight (PELC)

Clinical Quality Commission (CQC) Inspection – During the latter part of April 2021, the CQC conducted a two-part inspection of PELC, the first part related to the well-led domain and the second part to the remaining CQC domains.

Initial feedback regarding the well-led domain raised concerns regarding PELC's constitution and council functions, resulting in a referral to the Financial Standards Authority (FSA). In relation to the other domains, no immediate concerns or must do actions were identified.

6. Quality Oversight (General)

Children and Young People (CYP) with Mental Health Presentations and 12 Hour Waits in Emergency Departments (ED) - It was highlighted by the Designated Nurses for Safeguarding Children and LAC that there has been a recent significant increase in the number of CYP experiencing long waits within ED's at BHRUT.

In addition, this has also resulted in the accommodation of CYP with mental health presentations within general paediatric wards at BHRUT. Although this arrangement is far from ideal, we are assured that appropriate clinical decisions are being made to ensure the safety and welfare of all involved. Discussions have taken place with BHRUT relating to escalation processes both within the organisation and out to the wider system.

Collaborative work is underway led by the BHR ICP Maternity & Children's Commissioning Team including BHRUT, NELFT and Local Authority Colleagues with input from the NCEL CAMHS Collaborative.

7. Regulation 28 (Prevention of Future Deaths) Reports

The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths.

Any full response to a Regulation 28 Report should be made within 56 days of the date of the report. Extensions can be granted at the discretion of the individual coroner who issued the report.

There has been one Regulation 28 Report submitted to services across BHR since the previous report.

The report which was sent to Barts Health and NELFT, relates to the care and treatment of patient that died from a dissecting aortic aneurysm. A response to the coroner from Barts Health and NELFT is required by 23 June 2021. Full details of this Regulation 28 will be presented to the Quality & Performance Oversight Group of June 2021.

8. Safeguarding

Clinical Commissioning Groups (CCGs) have a duty to take measures to safeguard people who are unable to protect themselves from abuse and neglect in their commissioned services and across the local health economy. This includes working within a multi-agency framework to take measures to reduce the risk of neglect and abuse and responding where abuse has occurred or is suspected of occurring. CCGs also have duties to take additional measures in establishing effective structures for safeguarding within their own organisations. This includes the development of a clear strategy, robust governance arrangements and leadership.

North East London Clinical Commissioning Group (NEL CCG) commissions a range of health services provided by NHS acute, mental health and community trusts General Practitioners (GP's) and other organisations from the voluntary and private sectors.

Key National changes during year 2020/21

At the end of the March 2020, the World Health Organisation (WHO) declared a global pandemic. The Department of Health in the UK response included a number of easements to UK Legislation and Guidance relating to Safeguarding. The 'Coronavirus Act' came into effect on 25th March 2020 and is intended to remain in force until the end of the Coronavirus Pandemic.

In response to the Covid-19 pandemic in March 2020, safeguarding was identified as a business priority area and the Quality and Safeguarding Team within BHR provided safeguarding support locally and obtained assurance from local health providers of their Covid-19 business continuity plans in respect of safeguarding. The impact of Covid-19 has highlighted vulnerabilities nationally and the themes and learning identified will be a key priority in the coming year.

As the number of coronavirus cases rose rapidly across the country this year, a second national lockdown was introduced on 31st October 2020, during which safeguarding remained a priority. Cohorts of the population were deemed to be more vulnerable to abuse and neglect, as others sought to exploit disadvantages due to age, disability, mental or physical impairment or illness.

Despite the additional pressures on the NHS and Social Care, the tri-borough Safeguarding Adult Boards (SAB's) and Safeguarding Children Partnerships (SCP) have continued to comply with legal requirements and followed the advice provided within in the 'The Coronavirus Act 2020'.

The CCG advised safeguarding teams and the majority of staff to 'work from home' whilst continuing to fulfil safeguarding requirements. Designated Professionals provided updates to commissioned agencies on the implications of rapidly changing regulations and how to prepare for emerging threats.

Safeguarding Adults - The appointment of 2 WTE additional Designated Nurses for Adult Safeguarding in November 2020 has significantly improved the staffing resources for Adult Safeguarding across the tri-borough partnership and has enabled closer working with partner agencies and care home providers.

BHR key Adult Safeguarding priorities for 2021-2022

- Ensure robust pathways and collaboration between statutory and other provider services.
- Continue to ensure CCG staff are compliant with safeguarding adults and Prevent training in accordance with the "Adult Safeguarding: Roles and Competencies for Health Care Staff 2018" and that all Continuing Heath Care staff are trained in:
    - ✓ Safeguarding Adult Level 3.
    - ✓ Mental Capacity and Deprivation of Liberty Safeguards
    - ✓ Liberty Protection Safeguards (LPS).
- Develop a robust monitoring system for Care Homes with Nursing and ensure that the Local Quality Surveillance Group oversees the quality monitoring of care homes with nursing in 2021/22.
- Ensure that NEL CCG and provider organisations are resourced, trained and prepared for LPS implementation in April 2022.
- Support for GP practices and the primary care sector in all activities relating to adult safeguarding.
- Review development against the national Safeguarding Adults at Risk Audit Tool

- LeDeR review process to be seamless at the time of transition from Bristol database to the new web-based platform in June 2021, reviews progressed and lessons learned and shared with partner agencies.
- Monitor and support the implementation of recommendations from Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs).
- The impact of Covid-19 has highlighted vulnerabilities nationally and the themes and learning identified will be a key priority.

9. Primary Care

As part of NEL CCG's delegated commissioning responsibilities, it is responsible for supporting and ensuring that the GP services have effective adult safeguarding arrangements and that they are compliant with the Mental Capacity Act 2005 and Care Act 2014.

Designated Nurses for Adult Safeguarding and Named GP colleagues have contributed to CPD approved GP Protected Time Initiative (PTI) training to cover a range of topics relating to adult safeguarding in order to support and improve GP knowledge and skills.

10. Care Homes with Nursing

The Local Quality Surveillance Group (LQSG) is chaired by one of the Designated Nurse for Adult Safeguarding continues to monitor quality and assurance and safeguarding issues in Care Homes with Nursing across the three boroughs.

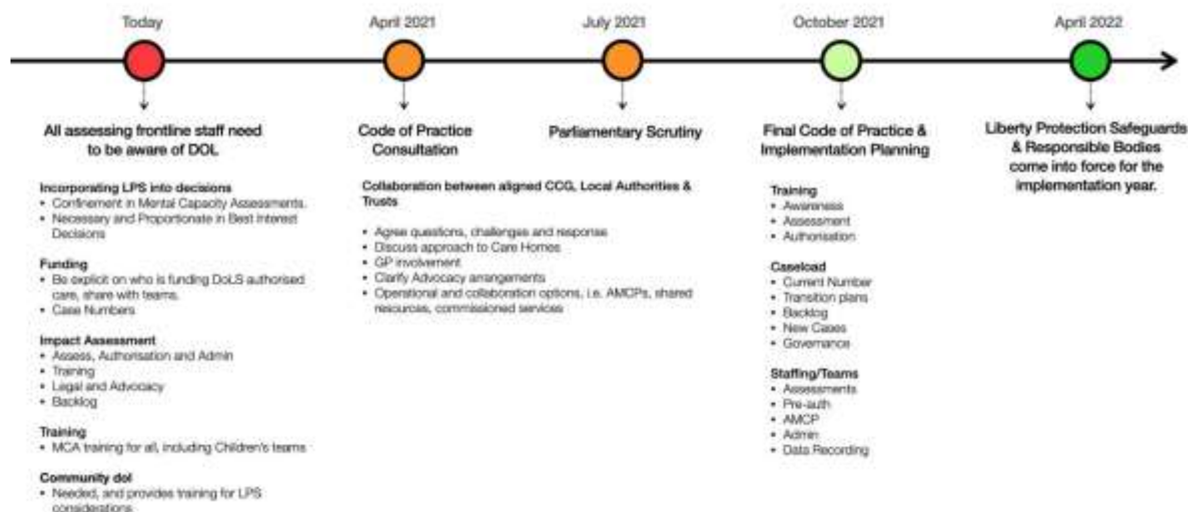
The CQC is represented at this meeting and regular update provided about providers concerns. Healthwatch members are also represented at these meetings,

Updates on Care Homes with Nursing are provided in safeguarding reports and details of specific homes where there are concerns or where restrictions imposed are reported to the monthly CCGs Integrated Safeguarding Assurance Board (ISAB).

In order to meet NEL CCG's responsibilities, there are assurance processes in place to monitor that health providers have a named lead professional for MCA, there are up to date policies and procedures in place, and MCA/DoLS is a mandatory training requirement for relevant staff.

11. Planned milestones for implementation of LPS:

The government has committed to bringing LPS into force to replace the DoLS. It is paramount that implementation of LPS is successful so that the new system provides the safeguards required. It is intended that full implementation of LPS will occur by April 2022 with some provisions, covering new roles and training, coming into force ahead of that date.



Once the Liberty Protection Safeguards come into force, there will still be people who have authorisations in place under the current Deprivation of Liberty Safeguards system and transitional arrangements are being developed, but it is expected that such people will remain under their existing authorisation until it expires. LPS initially will be authorised for a year and can then be authorised for 3 years, where appropriate.

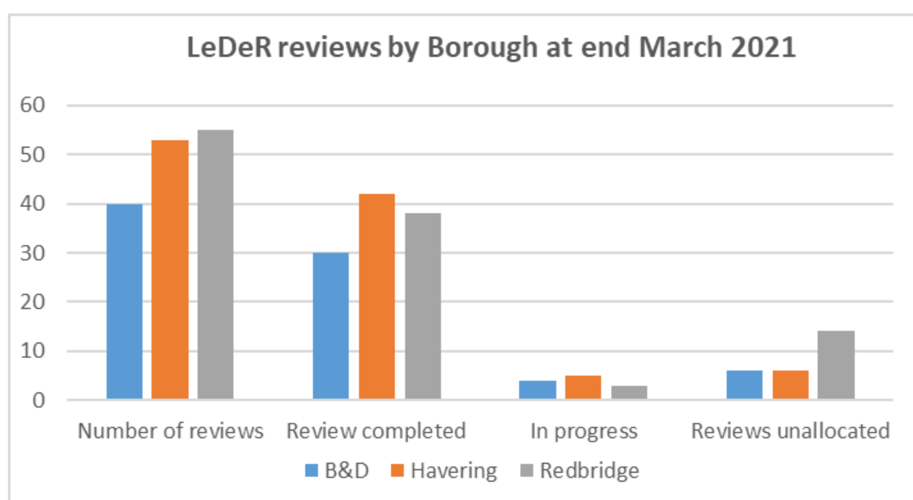
12. Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities.

The Designated Nurse Adult Safeguarding (Havering) is the Local Area Coordinator (LAC) for the tri-borough partnership and as such is responsible signing off completed reviews and identifying and sharing lessons learned, good practice and areas where care could be improved. The NEL LeDeR Project Lead continues to support the allocation of LeDeR reviews and reporting to NHSE.

Within the context of national progress with LeDeR reviews, the boroughs of Barking & Dagenham, Havering and Redbridge are progressing well overall.

There has been significant progress with allocation and completion of LeDeR reviews over the past year as shown in the graph below:



The current position with local LeDeR reviews as of end Febuary 2021 is that there have been 148 cases allocated to BHR over the previous 4 years of which:

- 110 have been completed
- 12 are in progress
- 26 are currently unallocated (due to shortage of reviewers and increase in death notifications during April and May 2020).

There were a disproportionate number of deaths amongst the Learning Disability population reported since the outbreak of the Covid19 Pandemic across London and nationally. During the early stages of the Pandemic LB Barking & Dagenham, Havering & Redbridge reported 16 deaths where the cause of death was reported to be Covid related, but during May, June and July 2020 there were no further Covid19 related LeDeR deaths reported. This would suggest that protective measures put in place for residents living in care homes and supported living accommodation have reduced this risk.

In July 2020, the Designated Nurse for Adult Safeguarding and the North East London (NEL) LeDeR Project Lead shared the learning from NEL LeDeR COVID-19 related deaths with the three Safeguarding Adult Boards.

During November 2020 when there was a further surge in deaths nationally, we were notified of one LeDeR case where the person tested positive to Covid-19 at the time of death in LB Redbridge. This was the first Covid-19 related death notification since May 2020 across the tri-borough partnership since May 2020. Since then there have been 16 further LeDeR cases with positive Covid-19 test results at the time of death across the three boroughs.

Updates on progress with LeDeR case reviews are provided in Safeguarding Adult reports which are submitted to at the monthly BHR Integrated Safeguarding Assurance Board (ISAB) meeting.

13. Safeguarding Children

BHR ICP safeguarding children professionals were redeployed during the third lockdown (not during the first or second). However, in order to maintain quality and a high level of service and in line with business continuity plans, team members covered across the footprint and maintained regular contact with redeployed staff, prioritising work and escalating concerns as necessary.

In April 2020 the National Network of Designated Health Professionals agreed to host daily dial ins to allow for discussion on emerging safeguarding children themes and trends. NEL

CCG designated health professionals engaged fully with the group, bringing back messages to the BHR footprint. Discussions at this network influenced national conversations e.g. the impact of the stay at home message and pandemic on those experiencing domestic abuse, the unseen/unheard child and parents/carers not accessing health care in a timely manner due to fear etc. Guest speakers, e.g. from RCPCH, DHSC, NHSEI, CNO office, NSPCC, were welcomed and appropriate challenge offered.

Successful selection and recruitment into post of both the CDOP Manager and CDOP Co-ordinator occurred in November 2020.

14. Key Trends

Increase in suicidal ideation in adolescents, increase in domestic abuse during lockdowns.

15. Good Practice

In March 2020 all children with special educational needs attending one of our designated special schools were assessed by health and education colleagues and RAG rated according to their identified and known needs. This allowed for services to share information and escalate any emerging concerns with this highly vulnerable group of children in a timely manner.
In all three boroughs a complex care needs panel was established to provide oversight and discussion for children with complex care needs. This allows for practitioners from health providers (NELFT and BHRUT), children's social care, the CCG, local authority commissioners and commissioned services to come together to discuss and manage support for children and their family during the pandemic and escalate any issues of concern as appropriate. This panel continues to meet in Barking and Dagenham to date, however in Havering and Redbridge the meetings have been stood down and continuing business as usual.

16. Looked After Children

All three boroughs now have an established LAC Health Sub Group to progress the health needs of looked after children which has engagement from the CCGs, children social care and the health provider NELFT.
Initial work focused on the journey of the child through the system when an Initial Health Assessment was required and identification of the system barriers that impacted this journey. Early evidence indicated that consent, interpreting services, submission of paperwork, quality of assessments, return of completed paperwork were impacting on the ability to meet the 20-working day statutory timeframe set for this assessment. Through partnership working, candid conversations, reliable data and professional challenge, improvements are now seen. The Barking and Dagenham position on IHAs has now moved from 12% in Jan 2020 to 70 % in February 2021 despite the challenges of Covid-19.
Havering's biggest issue was in relation to IHA/section 20 and consent but they now have an integrated IHA/Section 20 consent form (based on B&D) which has significantly improved the timeliness of IHA requests from the local authority.
Redbridge have introduced zoning meetings in line with B&D and Havering.

17. Challenges

Since March 2020 due to constraints and redeployment of staff, data from some providers has not been provided or validated. During the first lockdown, with the strong stay home guidance and emerging fear, parents were reluctant to access health services (primary and emergency)

in a timely manner. With the support of the RCPCH national guidance was drawn up (traffic light system) and shared across NEL.

15. Borough Specifics

Barking and Dagenham

The Local Authority and health partners met weekly from March 2020, now fortnightly, to allow for early identification of emerging risks and concerns to adult and children due to the pandemic and new ways working.
BDSCP continued to meet throughout the pandemic. In February 2021 the SCP agreed their priorities which included: safeguarding children from exploitation, working towards early recognition of neglect and domestic abuse, safeguarding children with additional needs and protecting children from child sexual abuse.
The IRISI programme continues to roll out across Barking and Dagenham primary care services, slowed down by the impact of the pandemic. The aim is to training all GP staff (clinical and non-clinical) to identify and respond to disclosures of domestic abuse.

The BDSCP Child Sexual Abuse Working group was established in Autumn 2020 and aims to develop a CSA strategy and practice standards as well as monitor the journey of the child through the specialist health services.
Work continues to develop the neglect strategy and early help offer across Barking and Dagenham. This work is being progressed by the Director of Children's Services across the partnership.

London Borough of Barking & Dagenham (LBBD) have recently received notification from Ofsted of a Focused Visit, this will take the form of a visit that looks at progress and impact on children, young people and their families during the last 6 months. The preparation and fieldwork started 13 May 2021 from today, with inspectors on site (in person and virtually) on Wednesday 26th and Thursday 27th of May.

Havering

Following the identification of serious knife crime being a significant problem in Havering, Havering Safeguarding Children Partnership (HSCP) decided to develop an adolescent strategy along with the development of an adolescent service within children's services.
Work remains ongoing in relation to the delivery of the adolescent strategy, but the adolescent team have now been recruited to and work is underway in relation to aligning services.
The local authority is in the process of launching a new Multi-Agency Safeguarding Hub (MASH) e-portal to enable an improved quality of information sharing of safeguarding concerns across the multi-agency partnership. This has yet to go live but it is anticipated it will launch in spring 2020, which is significantly delayed due to Covid but Havering will roll this out as soon as its practical to do so.
Following a learning review in relation to childhood obesity, work is underway to strengthen existing obesity pathways and this is also feeding into the borough wide neglect strategy that the CCG is leading on.

London Borough of Havering we subject to an Ofsted focused inspection visit on 12th and 13th May. This is in line with the inspection of Local Authority Children's Services (ILACS) framework and will result in feedback and a letter, but not a formal judgement.

Havering are starting from a position of Good overall as of the last full inspection and this process will consider how well we have worked together to protect the most vulnerable children and young people and note where we need to make further improvements. This will include responses to challenges presented by the pandemic.

Redbridge

RSCP meetings and subgroups have reconvened.
RSCP self-assessment in response to the report by the Child Safeguarding Practice Review Panel 'It was hard to escape – safeguarding children at risk of criminal exploitation' Multi agency self-assessment tool developed for completion. The date for completion has been put back from February 2020 due to 2nd wave of Covid-19 and pressure on resources, now confirmed as the end of May 2021.

RSCP priorities link into a previous Joint Targeted Area Inspection (JTAI) in relation to child sexual abuse (CSA). Although Redbridge was not part of that JTAI, the resulting report found nine areas for improvement of practice in the area of CSA in the family. RSCP is developing a multi-agency self-assessment tool for CSA.

16. Future Plans and Priorities

- BHR Safeguarding Partnership (BHR) Multi Agency Audit re suicidal ideation and suicidal intent to be undertaken. The audit tool is in the process of being finalised. Fifteen cases to be audited, five from each of the three boroughs.

- Supporting the GP federations in discharging their statutory functions for safeguarding children.

- Ensuring that safeguarding children is adequately considered in moving towards a single ICS.

- Ensuring that the CCG understand the impact that Covid-19 has had on safeguarding children and effectively manage the impact.

- Strengthen how the health economy contributes to the local safeguarding children partnerships.

- To provide strategic oversight and scrutiny on the delivery of the child death review requirements.

- The CCG will support the local authorities and NELFT in ensuring the timeliness of initial and review health assessments.

- To refresh the RHA audit tool to ensure informative, qualitative data is captured.

- To continue to support providers in improving the quality of health assessments.

- To understand the impact of Covid-19 on the LAC population.

- To ensure the CCG continues to meet its statutory responsibilities for looked after children

Author: Mark Gilbey-Cross, Deputy Nurse Director
Date: 13 May 2021

Integrated Care Partnership Board

27 May 2021

Title of report	Performance Report
Item number	7.2
Author	Steve Rubery, Director of Planning & Performance, BHR ICP, NEL CCG
Presented by	Steve Rubery, Director of Planning & Performance, BHR ICP, NEL CCG
Contact for further information	Steve Rubery
Executive summary	This paper provides a proposal for performance reporting within the BHR Integrated Care Partnership and the relationship and feeding into the wider North East London Integrated Care System. An initial set of indicators have been developed from available data but whilst starting to bring in some prevention/early intervention data are still very health focused. A Public Health facilitated workshop will be held to look at developing a wider range of 'upstream' indicators focusing on prevention and early intervention in the non-Health space as many of the health constitutional targets will be tracked through the Quality and Performance committee with areas of concern escalated to ICEG and ICPB through the regular report The also provides an update by exception on performance against constitutional standards. ICPB is asked to discuss and agree the proposal and to receive an update of the development of a new indicator set at its July meeting
Action required	Discuss / Approve
Where else has this paper been discussed?	N/A

Next steps/ onward reporting	Revised indicator set reported to ICPB meeting 29th July 2021
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Monitoring system performance against key indicators will inform the areas where Transformation Boards will need to focus their efforts and monitor the impact of schemes implemented.
Conflicts of interest	None
Strategic fit	• Starting well in life • Living well • Ageing and dying well • Bringing care closer to home
Impact on finance, performance and quality	Ensures robust performance reporting against constitutional standards, ICP priorities and Transformation Board schemes
Risks	N/A
Equality impact	N/A

Performance Reporting in the BHR Integrated Care Partnership

1.0 Background/Introduction

1.1 Historically BHR Clinical Commissioning Groups have reported against a range of indicators, largely aimed at monitoring performance against constitutional standards. By definition these indicators have been exclusively Health based and whilst still necessary for oversight of the performance of the health system, they do not in isolation provide meaningful data in support of the wider objectives of the Integrated Care Partnership.

1.2 The purpose of this report is to describe a proposed reporting structure for the BHR ICP which ensures appropriate oversight of performance against constitutional standards and indicators supporting the overarching ICP objectives of

- Starting well in life;
- Living well;
- Ageing and dying well;
- Bringing care closer to home.

The reporting structure will also cover the key priorities agreed at the ICEG development session of

- Recovering well;
- Addressing inequalities and prevention;
- Anchor organisations;
- Leadership culture and leading change.

2.0 Constitutional Standards

2.1 Reporting on performance against constitutional standards as well as any associated remedial action plans will still be required at ICP level, feeding into the wider ICS level reporting structure.

2.2 It is proposed that this continues to be overseen by the BHR ICP Quality and Performance Oversight Group with any specific issues or risks escalated to ICEG and/or ICPB as appropriate.

2.3 The BHR ICP Quality and Performance Oversight Group will report to the North East London CCG Quality Committee in the CCG governance structure and to ICEG/ICPB in the BHR local governance structure.

2.4 It is not proposed to bring a routine report against constitutional standards performance to ICEG/ICPB. Areas of concern will be escalated as required (attached at appendix 1).

3.0 ICP Objectives and Priorities

3.1 It is proposed to develop a set of indicators and a report for ICEG and ICPB that support the overarching ICP objectives of

- Starting well in life;
- Living well;

- Ageing and dying well;
- Bringing care closer to home.

The indicators will also encapsulate the ICEG priorities of

- Recovering well;
- Addressing inequalities and prevention;
- Anchor organisations;
- Leadership culture and leading change.

3.2 The report will describe how each part of the system and each transformation board is delivering against these objectives

3.3 The report will provide an integrated view of performance, including metrics and indicators specific to organisations including the work of the transformation boards

3.4 There are currently a large range of health indicators but more limited indicators and measures related to Local Authority work and interventions which are often precursors to the outputs which are seen in Health ('upstream' indicators) and a Public Health facilitated workshop will be held to develop a set of 'upstream' indicators which focus on Local Authority work in the prevention and early intervention space (eg actions on improving air quality to impact on children with asthma)

4.0 Recommendations

4.1 Performance and remedial action plans against constitutional standards continue to be overseen and monitored by the BHR ICP Quality and Performance Committee.

4.2 A Public Health facilitated workshop is held in the near future to develop the 'upstream' indicators aimed at providing greater oversight of Local Authority work in the prevention and early intervention space

5.0 Equalities

5.1 The reporting structure will enable the ICP to monitor the impact of actions to address inequalities across all three Boroughs.

6.0 Risk

6.1 Risks and mitigations will be identified for each of the objectives and priorities within the performance report.

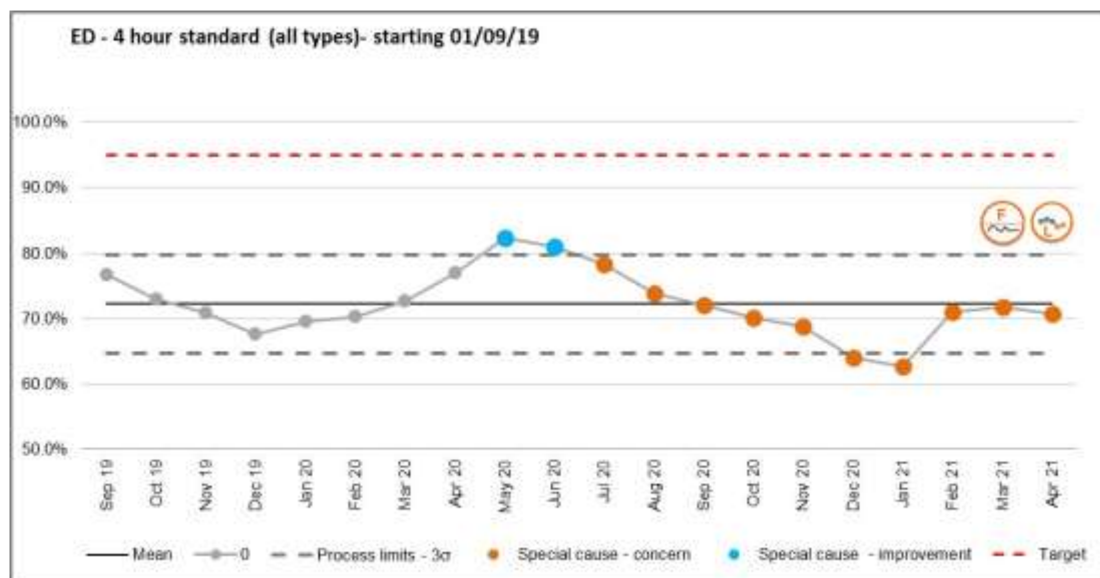
7.0 Managing conflicts of interest

7.1 There are no conflicts of interest to note, related to this report.

Appendix 1: Constitutional Standards Exception Report

Constitutional Standards Exception Report – May 2021

1. Accident and Emergency – 4-hour standard



1.1 Performance against the four-hour standard continues to be a major challenge at BHRUT with all-type performance at 70.76% in April 2021

1.2 Four-hour performance for all types was 78.19% at King George Hospital and 66.25% at Queen's Hospital

1.3 Four-hour performance for Type 1 was 62.80% at King George and 45.77% at Queen's

1.4 A number of actions have been taken this month in response to the continued poor performance against the standard:

Front Door:

- Executive to Executive dialogue has taken place between BHRUT and PELC in order to improve the front door model and understand the challenges impacting on Type 3 and Type 1 performance;

Queens Frailty Unit:

- The Queens Frailty Unit went live on 17/05/2021. This will ensure that all frail and older patients are seen by a multi-disciplinary team outside of the Emergency Department and improve both flow through the ED and the quality of care and experience for this patient group

Onward Care:

- BHRUT have commenced work on 'onward care' element of the patient journey with Acute Medicine (SDEC), Respiratory Medicine, Cardiology and Gastroenterology to move patients out of the ED as soon as they are 'clinically ready to proceed'

Governance:

- The Urgent and Emergency Care Transformation Board and Whole Hospital Improvement Plan work streams have been combined to ensure a more joined up approach across the whole of the health system

2.0 RTT 52-week waits

2.1 The number of 52-week waiters increased significantly during the second wave of the pandemic, peaking at 2430 in March 2021

2.2 Theatre capacity at King George Hospital and Queens Hospital was ramped up from 19th April 2021 up to 7 and 4 theatres respectively

2.3 BHRUT are continuing weekend insourcing clinics for Ophthalmology long-waiting patients during quarter 1

2.4 BHRUT are continuing outsourcing to the independent sector on full and admitted pathways during quarter 1 that are long waiters for trauma & orthopaedics and gynaecology

2.5 BHRUT commenced full pathway transfers to the independent sector for general surgery in April

2.6 BHRUT are clinically reviewing patients over 40 weeks on the non-admitted waiting list and planning appropriate next actions for their pathway

2.7 BHRUT specialities are continuing to track patients on the waiting list over 38 weeks completing clinical reviews and diagnostics where required

2.8 Funding has been agreed for outsourcing and insourcing for quarter 1 to reduce long waiters

2.9 The number of 52-week waiters at the end of April is expected to be 1940 which is significantly lower than was previously forecast

Integrated Care Partnership Board

Date 27 May 2021

Title of report	Finance Report
Item number	7.3
Author	Julia Summers, BHR ICP Head Of Finance
Presented by	Ahmet Koray, BHR ICP Director of Finance
Contact for further information	Ahmet Koray, BHR ICP Director of Finance
Executive summary	• Key issues – final outturn position of BHR CCGs and operating plan submission to 30 September 2021 for NEL CCGs. • Recommendations – to note. Further updates on performance against plan will be given to future committees.
Action required	Note
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	Monthly updates to ICEG
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Delivery of Financial plan Delivery of Financial plan
Conflicts of interest	N/A
Strategic fit	Finance – delivery of financial position
Impact on finance, performance and quality	Delivery of Financial Plan
Risks	Financial risks are outlined in the attached paper.
Equality impact	N/A

North East London
Clinical Commissioning Group

Finance Report – 2020/21 outturn and 21/22 Plan

Meeting name: Integrated Care Partnership Board
Presenter: Ahmet Koray
Date: 27 May 2021

Finance Report

Contents:

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- NEL CCG Operating Plan – Risks and Mitigations Finance……….Page 5
- Next Steps……………………………………………………………….Page 6

2020/21 Outturn – BHR Finance Summary

BHR CCGs Month 12 2020/21	B&D £000's	Havering £000's	Redbridge £000's	BHR Total £000's
Resource Limit (Excluding Historical Deficit)	366,663	429,851	459,867	1,256,381
Month 12 Outturn	(366,242)	(429,584)	(459,279)	(1,255,105)
Surplus	**421**	**267**	**588**	**1,276**

- Final reported year end surplus of £1,276k surplus across the three BHR CCGs.
- Covid costs of £32.7m were incurred, of which the Hospital Discharge Programme represented £26m. These costs were recovered through NHSE.
- The Annual Report and Accounts were submitted on time and presented to the Audit Committee on 30th April 2021.
- The auditors are currently reviewing the Annual Report and Accounts and will provide their opinion once this process is finalised during June 2021.

NEL Operating Plan Assumptions - Finance

- The **operating plan submission is for the first six months of the year to 30 September 2021 (H1 plan)**. The plan submitted assumes that the system is in **financial balance** and the BHR ICP commissioning element is also in balance.
- The **system envelope for the H1 plan is based on the system funding envelope for the second half of 2020/21** with adjustments applied for the mental health investment standard (MHIS), independent sector services and other baseline normalising adjustments.
- **Block contracts with NHS providers will remain** in place for the entirety of the H1 plan.
- Included in the CCG programme allocation **for 2021/22 is additional funding for activity growth and inflationary pressures.** This includes an estimate of the impact of changes to wages, prices and other inputs over which organisations have little control.
- Running alongside the operating plan submission is a separate mental health detailed plan submission – **CCGs are expected to increase mental health spend by 4.56%.** The BHR element of this is in line with expectations with the majority of increased investment flowing to NELFT NHS Foundation Trust.
- Detailed planning uplifts for the BHR commissioning element can be found in Appendix 1. These were applied consistently across all three sub systems with the exception of CHC where the sub systems used the AQP rate relevant to their areas.

NEL Operating Plan Summary - Finance

	NEL CCG	BHR
	Plan to 30/09/2021 £'000	Plan to 30/09/2021 £'000
Total CCG allocations	**1,602,058**	**615,758**
Acute services - NHS Providers within the system (contract)	(647,474)	(251,184)
Mental health services - NHS Providers within the system (contract)	(159,870)	(50,870)
Community Health Services - NHS Providers within the system (contract)	(108,916)	(41,646)
Total CCG expenditure on NHS Providers within the system	**(916,260)**	**(343,700)**
Acute services - NHS Providers outside the system (contract)	(126,324)	(45,036)
Mental health Services - NHS Providers outside the system (contract)	(906)	0
Community health Services - NHS Providers outside the system (contract)	(2,941)	0
Total CCG expenditure on NHS Providers outside the system	**(130,171)**	**(45,036)**
Total contract with NHS providers	**(1,046,431)**	**(388,737)**
Acute services - Independent sector	(24,492)	(13,910)
Acute services - Other non-NHS	(7,451)	(4,796)
Mental health services - all other non-NHS providers (including independent sector)	(18,861)	(6,997)
Community health services - all other non-NHS providers (including independent sector)	(31,760)	(15,059)
Continuing care services	(80,270)	(38,300)
Primary care services (excluding prescribing)	(35,585)	(8,987)
Primary care prescribing	(122,216)	(51,597)
Primary care co-commissioning	(168,749)	(61,018)
Other programme services	(47,013)	(18,877)
Running costs	(19,230)	(7,481)
Total Non-NHS provider programme expenditure plus running costs	**(555,627)**	**(227,022)**
Contingency	0	0
Reserve	0	0
Total CCG other expenditure	**(555,627)**	**(227,022)**
Total CCG expenditure	**(1,602,057)**	**(615,758)**
Net position (revised local organisation contribution)	**0**	**0**

NEL CCG Operating Plan – Risks and Mitigations Finance

Risks and Mitigations	NEL CCG Plan 30/09/2021 £'000	C&H Plan 30/09/2021 £'000	BHR Plan 30/09/2021 £'000	TNW Plan 30/09/2021 £'000
Risks:				
Risk - Continuing Care Activity	(2,408)	(287)	(1,149)	(972)
Risk - Increase in prescribing cost / volume	(3,666)	(422)	(1,548)	(1,697)
Risk - Covid funding unavailable and other risks in relation to mitigations	(25,425)	(2,397)	(2,119)	(20,909)
Mitigations/benefits:				
Mitigations - non recurrent measures	31,499	3,106	4,816	23,577
Total	**0**	**0**	**0**	**0**

- Ongoing risks associated with Covid, increases to prescribing costs and volume, increased costs of continuing healthcare and the hospital discharge pathway.
- Risk of increased activity and costs in the Independent Sector.
- Cost control measures will need to be put in place to meet the reduction in running costs.
- Risk in relation to the Providers ability to recruit staff to deliver the services and activity planned.
- Risks will be mitigated by the use of in-year non recurrent measures, including balance sheet flexibility.

Next Steps

- These top-down financial plans will now be **converted into detailed ICP plans** to allow local management and monthly reporting.
- Availability of **recurrent investment will be confirmed once the detailed budget plan is completed**. This is not expected to identify a significant sum.
- **Ongoing work to support the ICP sustainability plan continues**. As the plan develops, the expectation is that it will identify areas of opportunity and potentially savings for reinvestment.
- Thought will need to be given to **developing plans for the second half of the year (H2)**, which may revert back to the traditional contracting and charging arrangements or a hybrid model that is a combination of block arrangements with some cost and volume charging. This will be confirmed by NHSE over the next few months.
- The ICP will need to be **prepared for the eventuality of finding savings for H2** that are more immediate than those being identified through the ICP sustainability plan process.
- Consideration will be need to be given to the **impact of savings on the local ICP and the wider ICS position** as the expectation is that the system continues to balance and collaboratively works to achieve this, i.e. financial problems are not simply shifted between organisation.

Integrated Care Partnership Board

Date: 27 May 2021

Title of report	Terms of reference - Finance Sub-Committee and Quality & Performance Group
Item number	8.1
Author	Anne-Marie Keliris, ICP Governance Programme Lead
Presented by	Alison Blair, Director of Transition, BHR System
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	The Finance Sub-Committee and Quality & Performance Group terms of reference are presented for approval.
Action required	Approval
Where else has this paper been discussed?	The terms of reference have been developed with all integrated care partners and are in line with delegation arrangements from North East London CCG.
Next steps/ onward reporting	The terms of reference will be kept under regular review to ensure they are fit for purpose.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The terms of reference will support the ICP to make sound decisions with a focus on tacking health inequalities and delivery of high quality, integrated health and care services for people living in BHR.
Conflicts of interest	There are no conflicts of interest (COI) to note, however the terms of reference and protocol for managing terms of reference will be used for managing COIs.
Strategic fit	The development of the ICP is in line with the national strategy around the development of integrated care systems and our governance is

	designed to support integration, in anticipation of the recent White Paper proposals and forthcoming Bill on ICSs.
Impact on finance, performance and quality	The terms of reference for the system quality and performance group and finance sub committee will support the ICP to deliver its priorities.
Risks	There are no significant risks identified.
Equality impact	There are no direct impacts.

NEL CCG – BHR ICP Finance Sub-Committee

Terms of Reference

Version 0.6

DRAFT

Document revision history

Date	Version	Revision	Comment	Author / Editor
03/02/21	v1	v1	Drafting of terms of reference	Rachael Tomlinson
22/02/21	v1	v2	Review of terms of reference	Browne Jacobson
22/02/21	v2	v3	Amendment of terms of reference	Rachael Tomlinson
05/03/21	v3	v4	Amendment of terms of reference	Rachael Tomlinson
22/03/21	V4	V5	Amendment of terms of reference	Anne-Marie Keliris
19/04/2021	V5	V6	Amendment of terms of reference	Anne-Marie Keliris

Document approval

Date	Version	Revision	Role of approver	Approver

1 Introduction

The ICP Finance Sub-Committee (the Sub-Committee), is established by the NEL CCG Finance and Performance Committee (CCGFPC). This Sub-Committee is accountable to the CCGFPC but also reports into the ICP Area Committee.

This Sub-Committee is established to support the exercise of delegated functions, performance and the management of budgets within the ICP Area. The Sub-Committee is accountable to the CCGFPC but it is expected to work closely with the ICP Area Committee and make recommendations to them. As such, it will report into both the CCGFPC and the ICP Area Committee.

The ICP Area Committee may request that the Sub-Committee supports it on areas of finance and performance work, for the delegated functions. The Sub-Committee is authorised by the CCGFPC to provide this.

This Sub-Committee is subject to the constitution, Standing Financial Instructions, Scheme of Reservation and Delegation. These terms of reference set out the remit, responsibilities, membership and reporting arrangements of the Sub-Committee. It is to undertake its duties in line with the National Health Service Act 2006 (as amended) and to assist the CCG in delivery of the plan within the financial envelope.

2 Purpose

2.1 The Sub-Committee is established to provide assurance to the ICP Area Committee, established by the Governing Body, and to the CCGFPC on the robustness of the financial plans and delivery of services within the delegated budgets.

2.2 The Sub-Committee is also required to gain assurance on the performance – financial and contractual – of providers within the ICP area and on the ICP Area Committee's management of provider performance.

2.3 The Sub-Committee will also make recommendations to the ICP Area Committees on areas of additional spend – including areas of transformation and development of health population initiatives.

3 Roles and responsibilities

3.1 To review and monitor the financial reporting for delegated budgets in the ICP areas – including, but not exclusively, income and expenditure, triangulation of activity and finances and delivery of local plan;

3.2 Work with providers in each of the ICP areas, as well as with the other ICPs in the CCG, to assess risks to the CCG and ensure delivery of savings where over performance has occurred or if in the interest of the patient services need to be re-aligned; in order to make recommendations to the ICP Area Committee(s).

3.3 To understand and take action on the drivers behind any variations to the ICP financial plan, in so far as it relates to delegated CCG budgets;

3.4 To agree, where necessary, a clear recovery plan with providers in order to ensure the ICP will deliver the annual financial commitments in relation to the delegated CCG budget. Including information on risk sharing, actions and indicators for recovery.

3.5 To review performance of acute, mental health, G.P.'s and other providers to ensure activity is being delivered in line with contractual arrangements;

3.6 Understand the financial and contractual risks to the CCG within each ICP and ensure action is taken to mitigate or escalate them to the CCGFPC;

3.7 To review the financial, quality and performance elements of transformation schemes in each ICP to ensure they offer value for money for the population, before recommendations are made to the ICP Area Committee;

3.8 Oversee implementation of investments/transformation schemes, receiving updates outlining financial activity and delivery against success measures for each scheme from the ICP Area Committee;

3.9 Where required, the Sub-Committee will consider and review any external financial monitoring returns and commentary;

3.10 The Sub-Committee will provide a report to the CCGFPC on how it discharges its responsibilities

3.11 Sub-Committee can endorse PIDs (investment and disinvestment) up to a value of £500k, with authorisation taken by the Managing Director and Director of Finance. This does not include PIDs with projects that are subject to public consultation, which will be considered by the governing body/ICP area committee.

Any schemes over the value of £500k must, after initial review at the Financial Sustainability Plan Delivery and Monitoring meeting (FSPDM), be referred to the governing body/ICP area committee for decision in line with the CCG's prime financial policies as outlined in the CCG's constitution.

The PIDs considered at this meeting must also pass through the assurance gateway with consideration and approval at the FSPDM initially.

4 Membership

The membership of the Sub-Committee is as follows:

- Chair – lay member
- Appointed Lay Member
- Managing Director
- Director of Finance
- Borough Clinical Chair (primary care/GP representative)
- Director of Finance from each partner: Trust and Local Authority
- Representative from the ICP performance team

Other CCG staff will be invited to attend the meeting when required. This will primarily relate to those who have performance, quality or clinical remits.

See section 5.6

5 Meetings

5.1 The meetings will be held on a monthly basis, with a minimum of eight being held during the year.

5.2 A meeting will be considered quorate if the following members are present:

- Chair or nominated Vice Chair and
- 3 members

5.3 The agenda and supporting documents will be circulated at least five working days before the meeting

5.4 Administration duties will be provided via the Director of Corporate Affairs Office

5.5 At the beginning of each meeting, the chair will ask members whether they have any interests to declare, in accordance with the CCG's Conflicts of Interests Policy. If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the CCG's Conflicts of Interests Policy and Procedure.

5.6 Where a CCG decision is required on a matter (a CCG Reserved Function) these decisions will be reserved to the CCG members of the Committee, acting within the scope of any delegated authority given to them by the CCG Governing Body. Members of the committee will be present at such times subject to the management of any conflicts of interest.

6 Reporting

A risk based report shall be sent to the CCG FPC and the ICP area committee along with any necessary progress reports, recommendations and formal requests for approval in relation to contracting activity.

The Financial Recovery Planning, Delivery and Monitoring (FRPDM) will report to the Committee.

7 Review

An annual review of the Sub Committee's performance and terms of reference will be undertaken to ensure it is operating effectively.

8 Glossary

The CCG	NEL CCG

CCGFPC	NEL CCG Finance and Performance Committee
Sub-Committee	ICP Finance Sub-Committee
ICP	Integrated Care Partnership
ICS	Integrated Care System
FSPDM	Financial Sustainability Plan Delivery and Monitoring Meeting

Barking and Dagenham, Havering and Redbridge ICP
Quality and Performance Oversight Group

Terms of Reference

Meeting	**BHR ICP Quality and Performance Oversight Group**
Constitution	Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership (ICP) have resolved to establish a Group of the Partnership Board to be known as the BHR ICP Quality and Performance Oversight Group.
Role of the Group	The group shall provide assurance on monitoring and improving the quality and performance of all services commissioned by the BHR ICP including any directly provided services. The group will monitor performance against the North East London CCG's constitutional standards. The group will receive oversight reports including CQC updates on practice status information and any managed performance issues in primary care.
Membership	**Members:** • Clinical Lead – BHR ICP (Chair) • Lay member • Clinical Director – NEL CCG • Director of Nursing & Quality – NEL CCG • Director of Planning & Performance – BHR ICP (Vice-Chair) • Deputy Nurse Director – BHR ICP • Chief Nurse - BHRUT • Medical Director - BHRUT • Director of Nursing, Quality and Safety - BHRUT • NELFT representative x 3 (which will include 2 clinicians) • Local Authority representatives – one director of public health, director of adult services, director of children services • PELC representative **Regular attendees:** • BHR ICP Managing Director • BHR ICP Directors and senior managers **Additional Attendees:** individuals may be invited to attend all or part of the meeting, as and when appropriate. Other individuals may be invited to attend all or part of the meeting depending on the specific range of risk areas identified. Independent clinical advice will be sought from outside the BHR area, as and when required to support the work of the group via reciprocal arrangements across North East London.
Chair	The group shall be chaired by a clinical lead. The vice-chair shall be the Director of Planning & Performance. The Chair will agree a work programme and approve each agenda.

Quorum	A meeting will be considered quorate if the following members are present: • Chair or nominated Vice Chair and • A representative from each partner organisation (CCG, BHRUT, NELFT, Local Authority), including at least three clinicians A duly convened meeting of the group at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the group.
Decision-making	The Chair of the group will work to establish unanimity as the basis for decisions of the group. If, exceptionally, the group cannot reach a unanimous decision, the Chair will put the matter to a vote, with decisions confirmed by a simple majority of those voting members present, subject to the meeting being quorate. The group will ensure that any conflicts of interest are dealt with in accordance with NEL CCG's/ICP Conflicts of Interest Policy.
Duties of the Group	The group shall provide assurance to the ICPB that there are robust and integrated mechanisms in place to ensure detailed review and oversight of the quality and performance of services delivered within the BHR ICP. The group shall: • Review performance against constitutional standards, operating plan requirements and patient outcomes. • Review significant quality and performance risks identified and request deep dives for consideration by the group into areas where required. • Review the contract quality and performance position for all major contracts. This will include a review of reports required under the contracts and monitoring quality performance and quality indicators in accordance with the provisions of the contract. • Review the safeguarding strategy and annual report for adults, children and looked after children. • Review reports covering key areas of performance, quality and safety for all major providers including safeguarding, GP alerts, infection prevention and control. • Review reports covering key areas of performance for primary care providers including an overarching view of performance of each primary care network within the ICP. • Review reports covering key areas of performance for independent sector providers. • Review strategic developments in relation to quality and performance including the CCG's quality strategy. • Review outcomes of serious incident and never event investigations including ratification and closure of the CCG's serious incidents process. • Agree an annual work plan using clinical audits, a forward planner and/or other appropriate benchmarking tools to review identified provider services.

Frequency of meetings	Meetings shall be held monthly.
Notice of meetings	Meeting dates are set by the governance team for each financial year in advance. Changes to meeting dates or calling of additional meetings should be provided to members and attendees within five days of the meeting. A minimum of five working days' notice and dispatch of meeting papers is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed and supporting papers. Where possible, virtual attendance will be facilitated for all meetings.
Administration and minutes of meetings	A member of the Governance team shall be secretary to the group and shall attend to take minutes of the meeting and provide appropriate support to the Chair and group members.
Reporting responsibilities	The group shall: • submit to the ICPB and the NEL Quality & Safety Committee complete copies of minutes of all meetings and assurance reports on its responsibilities; • submit to the ICPB an annual report of its work. The Integrated Safeguarding Assurance Board, Serious Incident Panel, Area Prescribing Committee and Infection Prevention and Control meeting will report to the group. The group will formally escalate any issues of concern that need to be managed using a contractual process to the relevant Contract Review Meeting.
Authority	The group is authorised by the BHR ICPB to investigate any activity within its terms of reference. It is authorised to seek any information it requires in this regard from any employee and all employees are directed to cooperate with any request made by the group. The group is authorised by the BHR ICPB to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The group will be responsible for determining any additional or reconfigured sub-structural arrangements to support fulfilment of the group's remit.
Other	The group shall at least annually, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the ICPB for approval.
Sign off dates	Approved at XX

BHR Integrated Care Partnership
Better care, better lives, together for all

BHR Integrated Care Partnership Board

27 May 2021

Title of report	Proposal for Patient and Public Involvement and Engagement approach for BHR ICP
Item number	8.2
Author	Melissa Hoskins, Head of Communications and Engagement (BHR), NEL CCG
Presented by	Melissa Hoskins, Head of Communications and Engagement (BHR), NEL CCG
Contact for further information	Melissa.hoskins@nhs.net
Executive summary	This proposal sets out an outline proposal for an approach to patient and public engagement to support the BHR Integrated Care Partnership (ICP). **Recommendations**: • Note and agree the proposed approach in principle • Agree to establish a structure to implementation the approach • Ask the borough partnerships to reflect on the proposal for patient and public voice at a borough level and develop the proposal to reflect borough population and needs • Endorse work to develop a framework for engagement for Primary Care Networks (PCNs), to be developed with PCNs and local patient representatives
Action required	• Note the report • Agree the recommendations
Where else has this paper been discussed?	The proposals are at an early stage to allow for co-design with patient representatives and partners. Discussions have been held with Healthwatch, with the CCG Patient Engagement Forums for BHR, and ‘in principle’ with

	communications and engagement leads in partner organisations. The work to develop a framework for PCNS was first proposed in early 2020 and in a previous paper to ICEG in December 2020.
Next steps/ onward reporting	• Proposals to go to BHR ICEG and ICPB, and then implement. • Development of PCN engagement framework. • Report back to ICEG and ICPB in six months.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The proposal sets out an engagement governance structure that will ensure the views of local people (patient and the public) are at the heart of decision-making. Patient and public voice and involvement is key to ensuring change is effective and meets local people's needs, supporting work to reduce health inequalities.
Conflicts of interest	None
Strategic fit	• Addressing inequalities and prevention • Leadership culture and leading change (and the governance that sits behind this)
Impact on finance, performance and quality	Positive impact on quality and performance through the effective use of patient and public feedback to shape and improve services. Potential financial implication from NEL-wide review of remuneration for patient involvement
Risks	Impact on ongoing Covid-19 response on communications and engagement resources. Local people and their representatives not engaged in the ongoing development of the model.
Equality impact	Digital exclusion will need to be carefully considered as part of the engagement strategy for all ICPB partners. No specific implications for equalities from this proposal.

Purpose of the report

Health and social care partners are all committed to ensuring patient and public voices are at the heart of any decision-making, whether at borough, BHR (Barking and Dagenham, Havering and Redbridge) or North east London (NEL) level.

To ensure the BHR ICPB's decision-making is informed by local people's views, a proposal has been developed for an engagement governance structure that aligns and supports the BHR ICP governance structure.

The ambition is to ensure patient /public voice is built into every level of the NEL ICS and BHR ICP governance structure, through the review, planning, decision-making, and delivery of local health and care services.

Similar discussions and proposals are taking place at North East London level and by the other systems within NEL CCG e.g. City and Hackney ICP and Tower Hamlets, Newham and Waltham Forest TNW) ICP.

The proposed approach aligns with the NEL CCG governance structure and avoids duplication by showing a clear 'golden thread' where patient and public voice is built into the governance structure all through the planning, decision-making, delivery and review of local health and care services.

It enables local people to shape services by working with all partners, including primary care services. It provides for strengthening of the engagement between PPGs and planning of local population health at Primary Care Network level. A structure will need to be developed that sets out an agreed formal way of working to ensure local people's voices are represented in the PCN level.

The Board is asked to:

- Note and agree the proposed structure in principle
- Support the implementation of the governance structure (including ongoing discussion with key stakeholders)
- Agree that relevant staff in partnership organisations should support the development of the specific committees and working groups as set out in the proposal
- Ask the borough partnerships to reflect on the proposal for patient and public voice at a borough level and develop the proposal to reflect borough population and needs
- Endorse work to develop a framework for engagement for PCNS, to be developed with PCNs and local patient representatives (including PPG leads)

Background

The NHS definition of Patient and Public Involvement describes:
"Active participation of citizens, users, carers and their representatives in the development of healthcare services, and as partners in their own healthcare"

Meaningful patient and public involvement is a legal obligation and is vital in developing services and initiatives which meet the needs of our local populations. It:

- improves quality and the effectiveness of services and enhances appropriate use of resources
- boosts citizenship and the understanding of patient rights and responsibilities
- reduces inequalities and helps people take ownership of their own health and wellbeing

The Covid-19 pandemic has changed the way we all engage and communicate with local people. We have moved rapidly from a reliance on face-to-face surveys onsite or in groups to increased use of digital channels such as webinars and online meetings, e-newsletters, chat-boxes, and online polling.

As we emerge from lockdown restrictions, we will all need to consider how we are able to reintroduce face-to-face engagement alongside their digital channels, and how we do this effectively to minimise or avoid digital exclusion which could naturally impact most on our most vulnerable and hardest-to-reach residents.

The impact of the pandemic on our communities has heightened our focus as partners of tackling the stark health inequalities that exist. With significant transformation of services likely in the future, we need to take steps now to ensure that local people are involved and help to shape our work.

It is also an opportunity to review and refine how we enable local people to shape and improve new and existing services from the earliest possible stage, by providing multiple ways of local patient and public representatives, the voluntary and community sector and individual residents to get involved.

This proposal also considers the need to strengthen the role of public engagement in the planning of local population health programmes and activity at Primary Care Network level. A structure will need to be developed that sets out an agreed formal way of working to ensure patient and public voice is represented in these PCN discussions and plans, and that it is able to inform and shape planning, delivery and decision-making at all levels of the governance structure.

Patient and public involvement and engagement

Better health and wellbeing outcomes are achieved when local people bring their own motivation, expertise and insight to the conversation and the solutions. When they play an active role, local people are also able to better understand the opportunities for and pressures on services, and can help others to understand these – becoming advocates for the system.

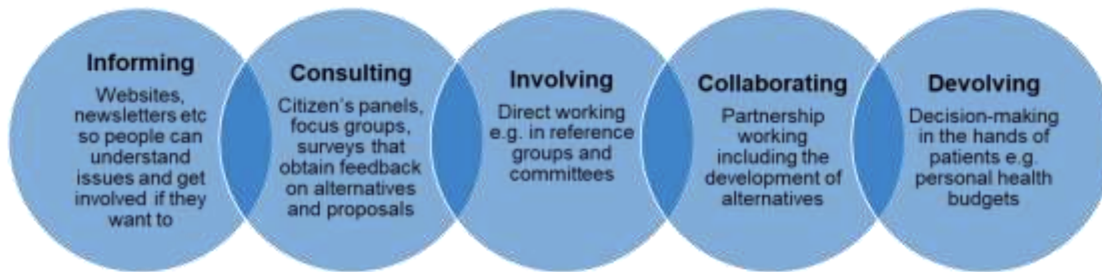
Local people fund health and social care through their taxes and engaging them creates an **open, transparent relationship of trust, care, respect and champions for health and care** services and initiatives.

We have a **legal duty** to involve patients and the public; to reduce inequalities; to promote patient choice and involvement of patients, their carers and representatives in their care.

We need an **infrastructure** that:

- Makes sense to local people and their ‘natural geography’
- Takes into account (and makes sense of two-way communications and involvement) multiple existing ‘communities’ e.g. local authority boundaries; neighbourhoods; primary care networks (PCNs); NHS provider geographies
- Enables representation in BHR and NEL decision-making and involvement

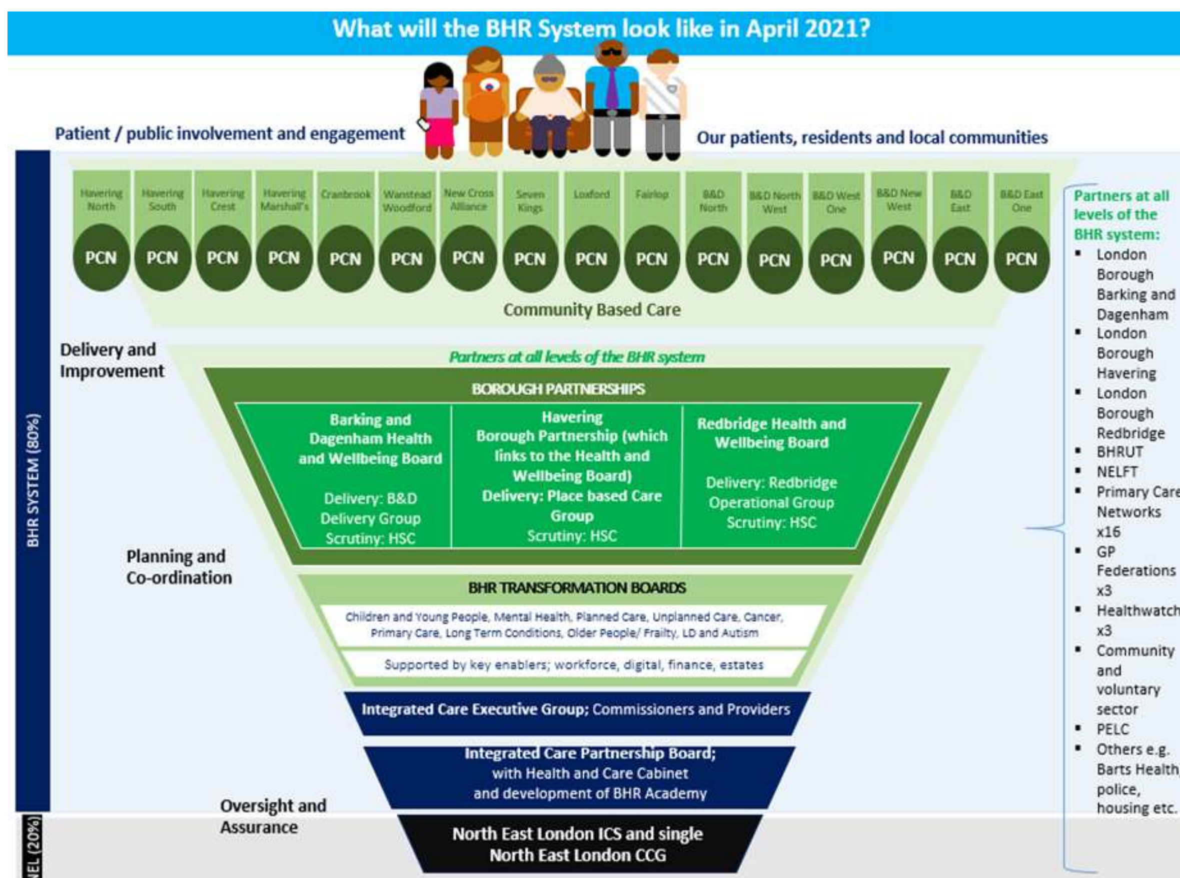
The NHS England ladder of engagement (shown in the diagram below) recognises that there are many different ways in which people may participate depending on their circumstances and interests. Crucially it states that ***“Patient and public voice activity on every step of the ladder is valuable***, although participation becomes more meaningful at the top of the ladder”

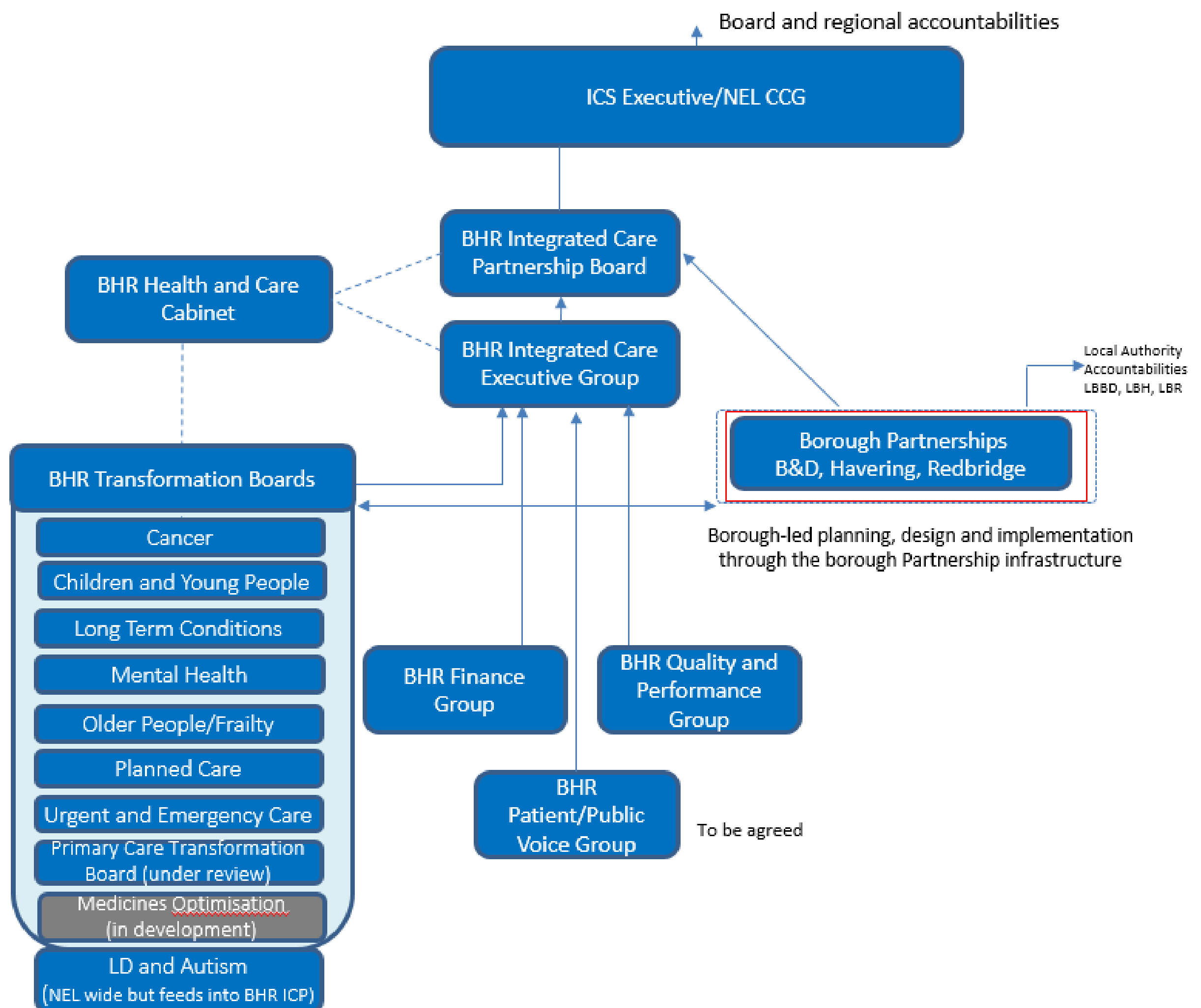


It is not possible co-produce every service with 2.2 million people – as Covid-19 in particular has highlighted. Different situations / different parts of the commissioning cycle will require different approaches; and sometimes more than one approach will be good practice.

Proposal for the engagement governance structure

ICPB members will be familiar with the proposed structure for the BHR system as shown below:

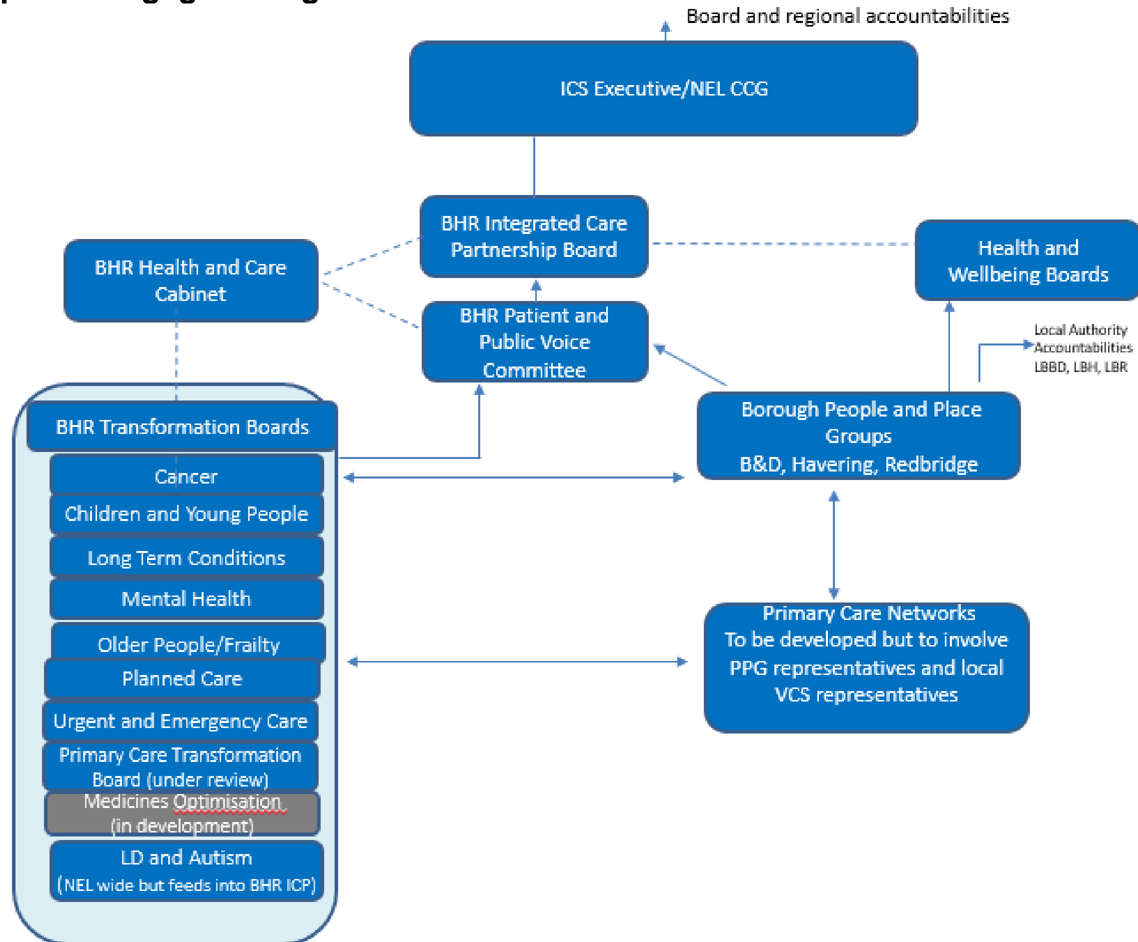




Patient and public involvement and engagement – how we work with those who live, work and study in our three boroughs – should run through every level of the structure. It's important we develop an engagement governance structure to support clinicians, staff and local people.

North east London CCG has appointed Khalil Ali, former Lay Member for Patient and Public Involvement (PPI) for Redbridge, as the Lay Member for Patient and Public Involvement For NEL. Recruitment is underway for an Associate Lay Member for Patient and Public Involvement for BHR, as part of the new governance structure for NEL CCG. The Associate Lay Member will play a key role in the proposed engagement governance structure for BHR ICP.

Proposed engagement governance structure for BHR ICP



Explaining the structure

BHR Patient and Public Voice Committee (PPVC)
The purpose of BHR Patient and Public Voice Committee would be to ensure appropriate assurance, advice and challenge is given to the BHR Integrated Care Executive Group (ICEG), the BHR ICPB, Transformation Boards and other committees, groups and workstreams, in the areas of:

- Patient and public involvement (through engagement, involvement, codesign, coproduction or consultation as appropriate – e.g. as set out in principle in the Ladder of Engagement)
- Equality and Diversity; and/or sustainability and social value (these could be shared with any shared with any other suitable group

This committee's formal role in the ICP governance structure would be to provide assurance to the BHR ICP that patients and the public have been involved in and helped to shape plans being considered by the ICP Board and Executive Group. It would also have a lead role in highlighting issues and concerns raised by the local community.

It is not a delivery group. The individual workstreams, project and programme teams would be responsible for delivering the engagement with the support of the engagement teams

across the partnership. The PPV committee would be responsible for providing advice and challenge on how best to ensure residents views, especially those of people with lived experience, are heard at the earliest stage and throughout the development of new ideas and services, and in improvements to existing services.

Borough Partnerships and engagement

It is expected that the Borough Partnerships will build public engagement into their emerging Roadmaps. It's vital that residents' voices are heard in decision-making on health and social care issues across each borough. Providing a clear place in the structure for patient and public voice would support this.

The Borough Partnerships will bring together representatives from each of the key statutory partners in the boroughs – commissioners (NEL CCG), the Council, NHS providers such as NELFT, BHRUT and Barts Health, local primary care leaders, and the community and voluntary sector.

This could be supported by a formal group that builds on the collaborative working in each of our boroughs during the last 12 months as part of the response to the Covid-19 pandemic.

The group's role could be to provide advice and guidance on issues being considered by the Borough Partnership, and to provide challenge and advice where it is felt the views of local people, especially those with lived experience, should be considered more fully before a decision is made.

The group could include:

- representatives of patient engagement and service user groups for each partner
- people with lived experience and carers or their representatives
- patient/ public representatives such as Healthwatch
- representation from the borough's community and voluntary sector

Primary Care Network patient representatives could also be part of these groups to support the involvement of patients and the public in primary care transformation and development at a borough level.

Primary Care Networks and engagement

GP practices are currently required to manage a Patient Participation Group (PPG) to support two-way feedback and communications with patients. PPG leads are currently invited to join CCG Patient Engagement Forums (PEFs), which facilitates information and feedback sharing between the CCGs and PPGs.

As part of the development of Primary Care Networks, it is vital that patient and public involvement is also considered as part of this structure, and that representation is able to be involved or informed of discussions and decision-making throughout the BHR ICP system.

It is proposed that work should be undertaken to develop or co-design a framework for engagement and a toolkit/ key principle for PCNs to ensure a consistent and quality approach to public involvement and to look at how PCNs can work together across a larger geographical patch to involve and engage with local people.

PCN leads and PPG representatives should be involved in this work, alongside patient/ public representatives of other partners in the PCN.

The aim should be to develop a framework that supports PCNs in working with their local community (including PPGs) on understanding and meeting local population health needs at

PCN, borough and BHR system level. It is also an opportunity to include a wider range of residents and voluntary/ community sector organisations to reflect the local community.

Patient and public involvement support for the Transformation Boards

It is proposed that each Transformation Board would have at least one patient representative as part of the board. This patient representative/s would be there to represent patient voice, but does not have sole responsibility for all patient feedback and experience.

The patient representative/s would be able to set out key issues that would need to be considered as part of any of the individual workstreams or programmes being developed or agreed by the Board.

The engagement and involvement work would be referred to the BHR PPV committee, which would look at an outline plan for engagement and ensure it is fit for purpose and meets the needs of patients.

Engagement work must always involve patients with lived experience of the specific condition/s that is the focus of the transformation work. This must be at the earliest possible point, before a proposal is fully worked out, and throughout the development process.

This could be through a group of people who act as an advisory group for each workstream, or through ongoing focus groups that bring people together at a certain point (but where different people can contribute as and when they are able).

What does this mean for existing patient and public engagement forums?

It is not proposed that the committees and groups set out engagement governance structure replaces all existing ways that individual partners work with local people. Indeed, representatives from these forums will be part of the proposed structure, ensuring the 'golden thread' of learning and feedback from local people remains a rich source of intelligence and advice for service planning and delivery.

The seven CCGs in North east London have now merged and there is ongoing discussion regarding the future of borough and system-based patient reference groups

While the proposal for patient and public engagement structure with the NEL CCG is still in development, this proposal looks at the proposed engagement structure for BHR ICP. In BHR, these are known as the Patient Engagement Forums. BHR PEF members are joining a workshop on 11 May to discuss the proposals and model in detail and understand any concerns following an initial outline at its March meeting.

Risks and mitigations

- Limited engagement resources within all partner organisations. Mitigation is commitment to joint partnership working, building on the excellent engagement partnerships and working seen throughout the last 12 months as part of the response to the pandemic
- Failure to involve patients and the public at every level of the structure creates a risk to delivering on the ICP's commitment to meaningful involvement at the earliest stage

Conclusion

The proposed engagement governance structure outlines an approach to patient and public involvement that could be embedded into the BHR ICP. Similar discussions and proposals

are being discussed at North East London level and by the other systems within NEL CCG e.g. City and Hackney ICP and Tower Hamlets, Newham and Waltham Forest (TNW) ICP.

In line with the principles of co-design, further discussion is required with patient/ public representative groups and the voluntary and community sector to ensure clear understanding of the principles and to ensure the structure is seen to allow for meaningful involvement and engagement at the earliest stage. It's also proposed that the Terms of Reference for each committee or group should be co-designed with the proposed membership.

The recommendations set out in this paper will enable this work to continue to ensure the structure is embedded at the earliest possible opportunity.

Melissa Hoskins, Head of Communications and Engagement (BHR), NEL CCG
11 May 2021

Integrated Care Partnership Board

27 May 2021

Title of report	Borough Partnership Development update
Item number	8.3
Author	Emily Plane, Programme Lead, BHR System Development
Presented by	Alison Blair, Director of Transition, BHR System
Contact for further information	e.plane@nhs.net
Executive Summary	Borough Partnerships are a key element of the BHR Integrated Care Partnership, bringing together delivery of health and care services around the needs of local people. This includes input around the wider determinants of health, at a community/place-based level. The White paper, '**next steps to building strong and effective integrated care systems across England**' set out plans to move to more formal partnership working as Integrated Care Systems from 2022, which will likely replace the CCG statutory bodies. This proposal is in line with, and builds on our plans and journey towards greater integration, with the ultimate aim of improving health and care outcomes for local people. It also places even greater emphasis on the importance of supporting the development and maturity of Borough Partnerships throughout 2021/22. The three BHR Borough Partnerships are in the process of producing their development roadmaps ahead of submission to the BHR Partnership at the end of May 2021. Leads from the three boroughs came together at a workshop on Wednesday 19th May to share their draft roadmaps and emerging key priorities.
Action Required	**The ICPB is asked to:**

	▪ Note this approach and progress to develop roadmaps for Borough Partnership development ▪ Receive in June/July the final Borough Partnership Roadmaps for review and endorsement
Where else has this paper been discussed?	ICEG and ICPB members have discussed and agreed the importance of supporting the development of Borough Partnerships in BHR, and this approach is in line with Integrated Care System strategy at a north east London level, as well as with national policy and guidance.
Next steps/ onward reporting	• Borough Partnerships will submit their Roadmaps (one for each Borough) by the end of May 2021 • Following submission of the completed roadmaps by the end of May 2021, the ICPB and Health and Wellbeing Boards will be asked to review and endorse the roadmaps in June 2021 • On the basis of an agreed roadmap (subject to approval and steps set out above), the CCG is looking to provide an additional non-recurrent allocation of monies for borough partnership development in 2021/22 to support Borough Partnerships to deliver their roadmaps and key priorities
What does this mean for local people? **How does this drive change and reduce health inequalities?**	One of the key aspirations for the BHR Borough Partnerships, is to support people to improve their physical and mental wellbeing before they deteriorate and require significant and/or long term, high costs interventions, supporting them to maintain a healthy life expectancy for as long as possible. We want to direct people to the right service and support that they need, first time, aiming to achieve the very best value for local people from every interaction that they have with health and care, local authority or community and voluntary sector staff across the system. This includes ensuring that local people receive a quality experience from each intervention / interaction with health and care services.
Conflicts of Interest	There are no expected conflicts of interest arising from this report at this stage.
Strategic Fit	This paper relates directly to the emerging BHR System priorities, particularly in relation to the

	development of place-based care; further strengthening of our BHR Integrated Care Partnership structure, and enhanced population health management. It also aligns to the national direction of travel as set out in the White Paper 'next steps to building strong and effective integrated care systems across England', and aligns to the North East London Integrated Care System Strategy for which Borough Partnerships are a key feature.
Impact on finance, performance and quality	Although Borough Partnerships will be significant contributors to performance and quality going forward, there is no specific impact to note at this stage. The CCG is in the process of identifying resource to support implementation of the Borough Partnership Roadmaps subject to endorsement of these in June/July 2021.
Risks	With legislative changes planned nationally to place Integrated Care Systems on a statutory footing from 2022, it is imperative that the BHR Partnership supports development of our Borough Partnerships in this 'shadow year', supporting them to establish and embed as much as possible ahead of April 2022.
Equality Impact	Not applicable at this stage.

See Appendix 1 - **Borough Partnership Development update**

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Borough Partnership Development update

May 2021

Developing Borough Partnerships - Introduction

Borough Partnerships are a key element of the BHR Integrated Care Partnership, bringing together delivery of health and care services around the needs of local people. This includes input around the wider determinants of health, at a community/place based level.

One of the key aspirations for the BHR Borough Partnerships, is to support people to improve their physical and mental wellbeing before they deteriorate and require significant and/or long term, high costs interventions, supporting them to maintain a healthy life expectancy for as long as possible. We want to direct people to the right service and support that they need, first time, aiming to achieve the very best value for local people from every interaction that they have with health and care, local authority or community and voluntary sector staff across the system. This includes ensuring that local people receive a quality experience from each intervention / interaction with health and care services. The need to focus on the wider determinants of health and wider wellbeing has been highlighted even further as the impact of the COVID pandemic on our population is taken into account.

'**The next steps to building strong and effective integrated care systems across England**' set out plans to move to more formal partnership working as Integrated Care Systems from 2022, which will likely replace the CCG statutory bodies. This proposal is in line with, and builds on our plans and journey towards greater integration, with the ultimate aim of improving health and care outcomes for local people. It also places even greater emphasis on the importance of supporting the development and maturity of Borough Partnerships throughout 2021/22.

Borough Partnership Boards will link to the work of Health and Wellbeing Boards to deliver the aspirations of more integrated care, closer to home, supporting local people to remain well for as long as possible, and drawing in support for the wider determinants of health (e.g. housing, debt management, employment) as required. They are essential vehicles to deliver on a key ambition of subsidiarity, with more decisions delivered locally where possible.

BHR Borough Partnership Development Approach

- Borough Partnerships are critical for planning and coordinating care at a local level
- In the Barking and Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP), Borough Partnerships have been forming and are at different stages of development
- To support their ambition and the next stage of development in line with the recent national guidance, BHR ICEG agreed to support work in each borough partnership to explore the next stage of their journey and scope out a development 'roadmap' for the period up to April 2022
- Resources are constrained so BHR CCGs offered each borough partnership £25,000 to support development of the roadmaps (£75,000 total for BHR)
- Each Borough Partnership was able to decide how they wanted to use this resource, to achieve the key deliverable that partners expect to see from this support of a roadmap submitted by the end of May 2021
- Borough Partnerships have been progressing development of their Roadmaps, and came together at a workshop on Wednesday 19th May to share their draft outlines, emerging priorities, and to identify what support they need from the BHR Partnership to progress Borough Partnership development
- Following submission of the completed roadmaps by the end of May 2021, the ICPB and Health and Wellbeing Boards will be asked to review and endorse the roadmaps in June 2021
- On the basis of an agreed roadmap (subject to approval and steps set out above), the CCG is looking to provide an additional non recurrent allocation of monies for borough partnership development in 2021/22 to support Borough Partnerships to deliver their roadmaps and key priorities

Borough Based Roadmaps – Expected Detail

Key elements	Detail
Timespan	The roadmap should set out each Borough Partnership's development journey to April 2022 and beyond
Membership of the Borough Partnership	Borough Partnerships may include the following key partners: Local Authority, GP Federation, Primary Care Networks, NELFT Community Services – both physical and mental health , Community and Voluntary Sector representatives, Pharmacy, BHRUT, CCG and wider partners as appropriate
Scope	▪ Description of what the borough partnership will achieve in year 1 (2021/22) and scale of ambition beyond this ▪ Key activities by quarter next year in relation to key priorities ▪ How the BP will develop a track record of success e.g. initial outcomes and impact especially in relation to service integration and prevention and delivery of greater quality interventions / improvement in quality indicators ▪ Consider and set out how partners to the plan will share accountability for its delivery ▪ Set out what Borough Parnterships want from ICP including transformation boards and enablers
Key Themes to include	▪ Vision for the Borough Partnership ▪ Leadership and governance ▪ Engaging partners more broadly including clinicians, resident/patients ▪ Resources and capacity ▪ Integration and service priorities that the Borough Partnership wants to deliver ▪ Requirements of the ICP now and in 2022 ▪ How the BP will use the development fund from the CCG, in 2021/22

Next steps:

- Borough Partnerships will submit their Roadmaps (one for each Borough) by the end of May 2021
- Following submission of the completed roadmaps by the end of May 2021, the ICPB and Health and Wellbeing Boards will be asked to review and endorse the roadmaps in June 2021
- On the basis of an agreed roadmap (subject to approval and steps set out above), the CCG is looking to provide an additional non recurrent allocation of monies for borough partnership development in 2021/22 to support Borough Partnerships to deliver their roadmaps and key priorities

The ICPB is asked to:

- Note this approach and progress to develop roadmaps for Borough Partnership development
- Receive in June/July the final Borough Partnership Roadmaps for review and endorsement

Integrated Care Partnership Board

Date 27 May 2021

Title of report	Proposed Primary Care Governance for the BHR Integrated Care Partnership
Item number	8.4
Author	Sarah See, Director, Primary Care Transformation
Presented by	Sarah See, Director, Primary Care Transformation
Contact for further information	sarahsee@nhs.net
Executive summary	After discussion and feedback from various primary care fora and groups over the autumn and winter, the attached slides present the revised, proposed governance for the 1) primary care transformation programme within the BHR Integrated Care Partnership (BHR ICP) and 2) the primary care commissioning (delegated) function within North East London Clinical Commissioning Group (NEL CCG). For both 'functions', the proposed structure looks to enable the 80:20 principle of direction, influence, design, implementation, delivery, and where possible, local decision-making within the BHR ICP whilst enable the local system to maximise the benefits of being part of North East London. It is looking to be agile, enable delivery, good partnership work, input of local people and avoid duplication of agenda, where possible in a complex system. • **The Integrated Care Executive Group are asked discuss the proposed governance structure, and subject to any further amendments, agree to implement within BHR and recommend to North East London Primary Care Commissioning Committee**

	its support of the proposed delegated primary care commissioning arrangements.
Action required	Discussion and Approve NB. Primary Care Delegated governance arrangements will need to be approved by North East London Primary Care Commissioning Committee – under delegated authority from NHS Commissioning Board
Where else has this paper been discussed?	In the earlier part of the year, draft proposals were taken to the former BHR Primary Care Transformation Board and BHR Primary Care Commissioning Committee for discussion and feedback outside of the respective fora. The revised primary care governance structure has been shared with PCN Clinical Directors, Federations and respective LMCs for comment.
Next steps/ onward reporting	• Will require sign-off by North East London Primary Care Commissioning Committee • Drafting of Terms of Reference, where appropriate Establishment of respective meeting fora, where it currently doesn't exist
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Provide the infrastructure to drive change via the delivery of the NEL primary care strategy, with input of local people and stakeholders.
Conflicts of interest	The proposed primary care governance structure aligns with BHR ICP decision-making bodies and abides by NEL CCG Standing Financial Instructions, therefore there are no conflicts of interest arising from this paper.
Strategic fit	Review of primary care meetings and governance arrangements in light of establishment of a single North East London CCG, and to ensure 80:20 principle of decision-making is within BHR integrated care partnership and its respective boroughs
Impact on finance, performance and quality	None
Risks	Please state any risks to the delivery and if possible relate to the CCG BAF risks
Equality impact	No Equality Impact assessments has been undertaken for this item.

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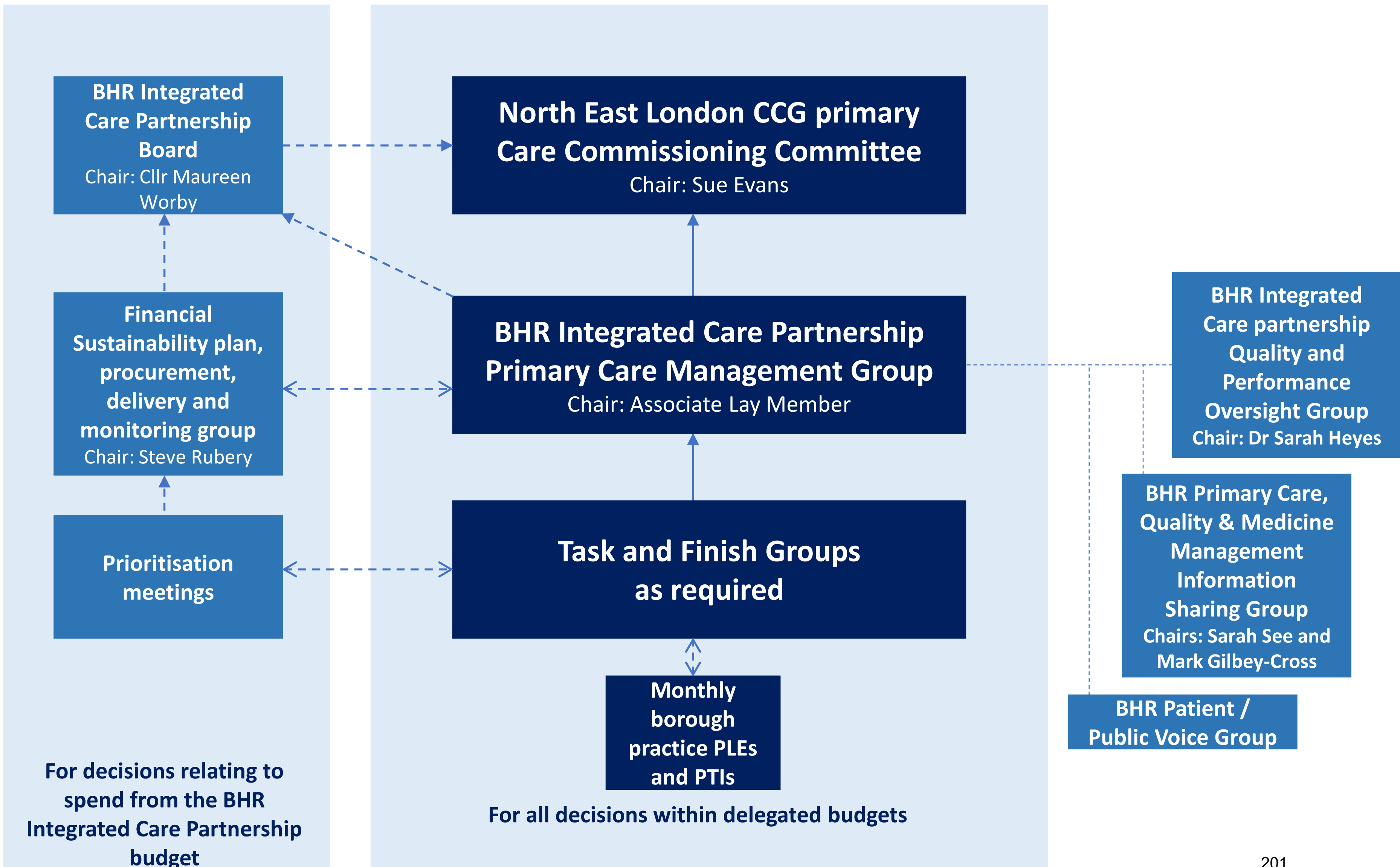
Primary Care Governance Proposal

May 2021

Primary Care Delegated Commissioning



BHR Primary Care Delegated Commissioning – Key meetings further detail

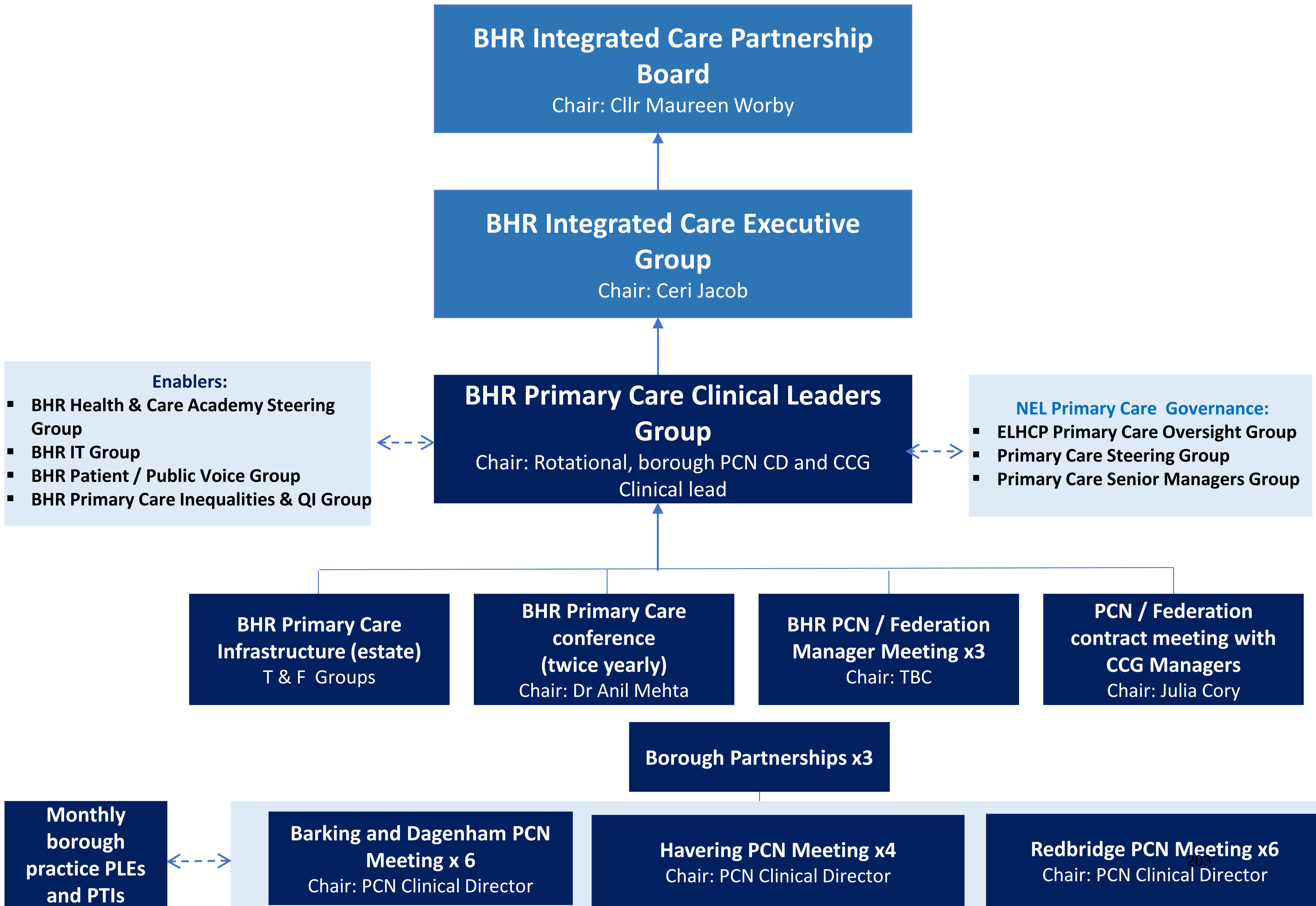
<table>
<tr><th>Meeting</th><th>Purpose</th><th>Members</th></tr>
<tr><td>North East London CCG primary Care Commissioning Committee</td><td>Take decisions relating to:
▪ Primary medical services contracts eg procurement and monitoring of contracts, taking contractual action, such as breach/remedial notices
▪ Enhanced services and local enhanced services
▪ Practices mergers
▪ Award of contracts

(See Appendix One for further information)</td><td>Voting members:
▪ Deputy Chair of the CCG (Chair)
▪ Lay Member for Patient Pubic Involvement
▪ Lay Member for Governance
▪ Independent Registered Nurse
▪ Independent Secondary Care Specialist
▪ Chief Finance Officer
▪ Managing Directors x3
Non-voting members include:
▪ Healthwatch representation
▪ LMC representation
▪ Public Health representation
▪ Independent GP
▪ Borough Clinical GP Leads
▪ Systems Directors of Primary Care x3</td></tr>
<tr><td>BHR Integrated Care Partnership Primary Care Management Group</td><td>Will be established as a sub-group of the NEL Primary Care Commissioning Committee.

Agree decisions relating to the following areas:
List closure, boundary changes, applications for additional space/rent reimbursement

Make recommendations to NEL PCCC:
▪ For final approval of new Local Incentive Schemes
▪ Practice mergers
▪ Relocation/major premises renovations
▪ Contract award/commissioning intentions
▪ PCN membership changes
▪ Following a practice closure to disperse or re-procure
▪ Breaches, remedial notices and contract terminations
(See Appendix One for further information)</td><td>▪ Associate Lay Member (Chair)
▪ PCN Clinical Director from each borough
▪ Redbridge LMC representation
▪ BDH LMC representation
▪ Director of Public Health representation on behalf of BHR
▪ Healthwatch representation from each borough
▪ CCG Managing Director for BHR
▪ CCG Director of Finance for BHR
▪ CCG Deputy Nurse Director for BHR
▪ CCG Director of Primary Care Transformation for BHR
▪ CCG Clinical Borough Lead with a portfolio for primary care</td></tr>
<tr><td>Task and Finish Groups as required</td><td>▪ Lead on time-limited projects, the output of which, will be taken to the BHR ICP Primary Care Management Group</td><td>▪ As appropriate</td></tr>
</table>

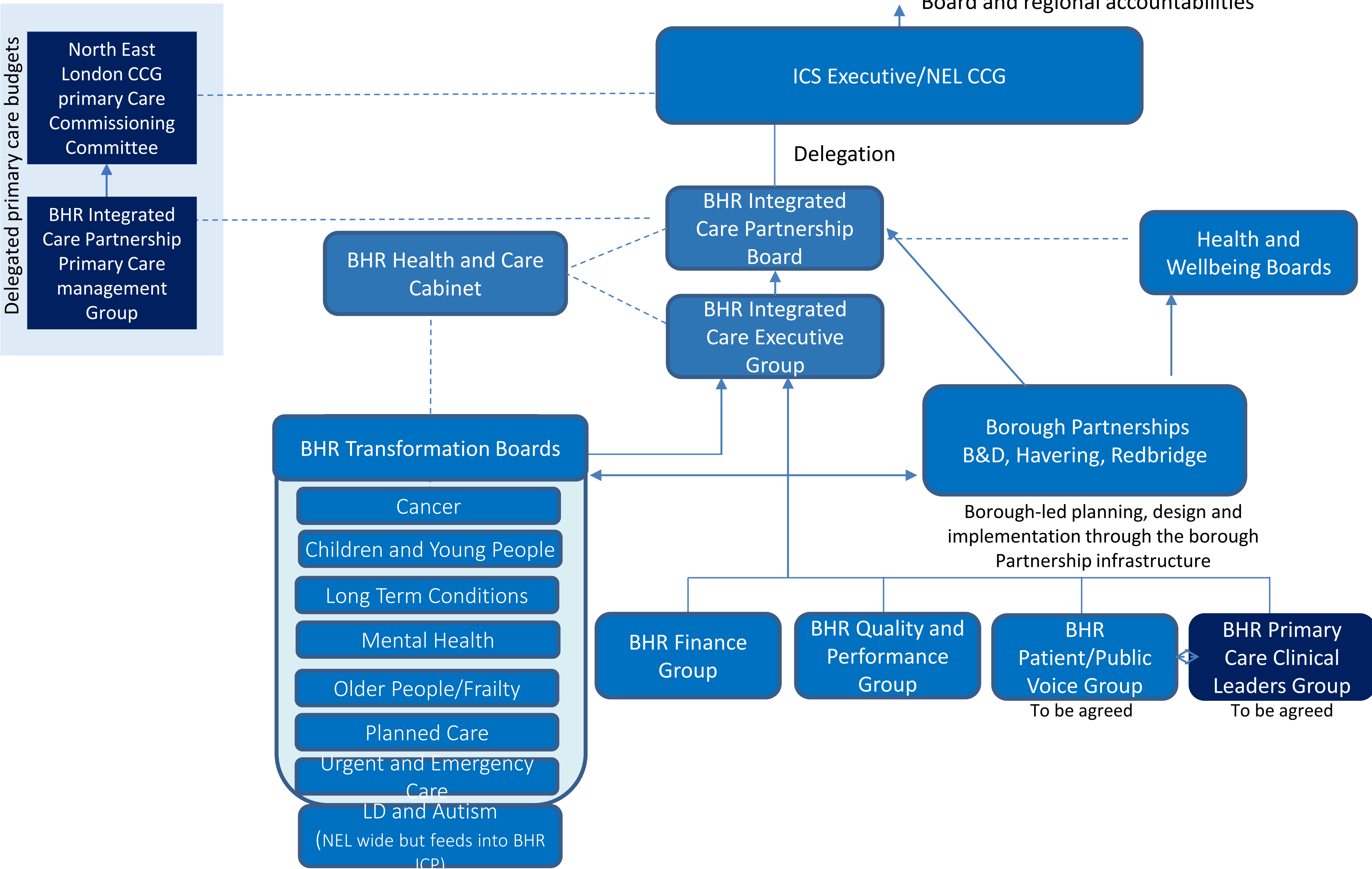
Primary Care Transformation



Primary Care Transformation – Key meetings further detail

Meeting	Purpose	Members
Primary Care Clinical Leaders Group	Discuss key primary care issues, required support and agree next steps to support operationalisation before taking to PCN or borough partnership for further discussion and implementation. Focussed on delivery.	▪ All BHR PCN Clinical Directors ▪ Federation Chairs and CEO x3 ▪ CCG Borough Clinical Leads x3 ▪ CCG Clinical Leads for primary care ▪ Managing Director for BHR ▪ Senior representatives of CCG's Primary Care Team
BHR Primary Care Infrastructure (estate) Task & Finish Group	As required, to develop Business cases and oversee premises' developments and moves	▪ Representatives of the CCG Estates Team for BHR ▪ Representatives of the CCG Primary Care Team for BHR ▪ Representative of respective LMC ▪ Representatives of respective practices and/or PCNs ▪ Representative of CCG Finance Team for BHR
BHR Primary Care Bi-annual conference	Consult, engage and share learning with CCG members on key priorities of the Primary Care Strategy	All members of the CCG from with BHR
BHR PCN / Federation Manager Meeting x3	Borough-level discussions on delivery of projects	▪ PCN managers ▪ Members of CCG primary care team for BHR (borough leads or project leads, as appropriate ▪ Other CCG or BHR ICP, as appropriate
PCN / Federation contract meeting with CCG Managers	Review of implementation of services/support required, contract management and performance review, escalation of isssues	▪ PCN/Federation Contract Leads (clinical and/or management) ▪ CCG Deputy Director of Primary Care for BHR ▪ Other CCG colleagues (clinical or management) as appropriate

Context within the BHR Integrated Care Partnership Governance arrangements



APPENDIX ONE

NHS
North East London
Clinical Commissioning Group

Sub-structures and decision making – NEL PCCC

NEL PCCC
Alison Goodlad, May 2021

Decisions to go to local fora and then recommendation made to PCCC for final decision

- Final approval of new Local Incentive Schemes
- Mergers
- Relocations/major premises renovations
- APMS contract award/commissioning intentions at contract end date
- Incorporation/change of control
- Significant PCN membership changes (i.e. major geographic change, impact on minimum list size etc, formation of new PCN, PCNs merging)
- Decision following a practice closure to disperse or reprocure
- Breaches, remedial notices, contract terminations
- Section 96 – Discretionary funding applications

Decisions made by local fora and then shared at PCCC for information

- List closure
- Boundary change
- Applications for additional space/rent reimbursement in existing premises
- Minor PCN membership changes (i.e a single practice moves PCN, no impact on geography, minimum list size).

Decisions to by made by officer decision and shared for information at local fora

- Practice name change
- PMS Partnership changes
- PMS GP 24 hour retirement

Integrated Care Partnership Board

27 May 2021

Title of report	Phlebotomy Case for Change
Item number	11.0
Authors	Jeremy Kidd, Deputy Director of Transformation, NEL CCG (BHR ICP) and Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Presented by	Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Contact for further information	Tracy Welsh, Director of Transformation, NEL CCG (BHR ICP)
Executive summary	Prior to the pandemic, Barking, Havering and Redbridge (BHR) had a range of providers across acute, community and primary care providing phlebotomy services/clinics across approximately 53 sites in total. This did not represent a strategically commissioned model of service, but rather an 'evolved' position, with a number of different providers, not acting in a co-ordinated fashion. During the first wave of Covid 19 BHRUT withdrew its community phlebotomy provision. In response, the CCGs and its community services and primary care providers worked closely together to ensure delivery of provision in the community, including the introduction of primary care provision of phlebotomy services. Due to the lengthy waits experienced by BHR residents for a blood test after the first wave of Covid-19, in October 2020 a system Serious Incident (SI) was declared. A recovery plan was put in place scaling up the provision offered by NELFT and bringing on line more primary care provision via a Local Incentive Scheme (LIS). The recovery plan was successful and the SI has now been closed operationally. The current service model is an interim solution only,

	elements of the current provision, including the GP LIS come to an end at the end of June 2021. Work to develop a new model for community phlebotomy provision has been carried out. The challenge in developing a new model for the delivery of phlebotomy in the community is the absence of empirical evidence upon which to base a model. As a result, the chosen service model will need to be piloted: this ensures that we are able to "test" ideas in an agile way and adapt the service as necessary to meet emerging demands as nationally we move out of the lockdown. As part of the development of the new service model a review of demand and capacity has been carried out and an options appraisal developed which sets out different models for deployment of phlebotomist capacity across the three boroughs. Financial modelling has been carried out based on the North East London price for phlebotomy. This proposal was supported by the Integrated Care Executive Group at its meeting on 20th May 2021.
Action required	• Endorsement of the ICEG agreement to progress with the recommended approach as set out in the options appraisal i.e. multiple medium sites in each borough, moving to a deployment of capacity which meets the borough's needs during the course of the pilot as a clearer understanding of patient behaviour develops. • Approval of the funding to meet the gap between existing provision and the modelled requirement: £818,857.
Where else has this paper been discussed?	BHR Executive Phlebotomy Steering Group, Integrated Care Executive Group (ICEG)
Next steps/ onward reporting	Planned Care Transformation Board (oversight)
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The new service model will ensure that patients/residents are able to access blood testing in a timely manner, closer to home and without the need to travel to an acute hospital site (in most cases). Through the use of bookable appointment slots and extended hours, it should also mean that services are more convenient and accessible to

	all, including those how require carer/family support to attend.
Conflicts of interest	**Due to providers involved in the delivery of these services, there is conflict for NELFT, Primary Care and BHRUT in relation to agreement of this new model as the first two organisations stand to financially increase and the latter reduce their income for these services.** Dr Jyoti Sood is a member of the Executive Phlebotomy Steering Group which has inputted into the development of this paper. Dr Sood is a member of a PCN which has been delivering phlebotomy testing as part of the recovery work. Dr Atul Aggarwal, Havering Borough Chair and Planned Care Lead is associated with Westlands Medical Centre (note – not part of the new model).
Strategic fit	Care closer to home
Impact on finance, performance and quality	• Increased financial requirement to fund "gap" identified between existing service model and proposed new service model. • Improved performance in terms of waiting times (for urgent and routine bleeds). • Improved quality – fewer complaints due to increased bleed times and more convenient provision. PCN model is also anticipated to reduce the number of "delayed samples" currently being seen through practice delivery.
Risks	There is a risk that should ICPB not authorise the development of a new model of care then by default option number 1: Do Nothing will have been selected. Significant elements of the existing provision, including the GP LIS will cease at the end of June. At present phlebotomy demand is low, this is likely as a result of the lockdown. The demand for phlebotomy is expected to rise to normal levels (or for there to be a surge in demand as patients begin to seek blood tests which they had delayed to due to lockdown) as a result of the lockdown coming to an end. If there is insufficient provision available in the remaining NELFT and primary care services there is the potential for delays leading to patient harm.
Equality impact	There are no equalities implications arising from this report. A full Equality Impact Assessment will

	be completed as part of the implementation of this new service (pending agreement) and there will be the opportunity through the pilot to adapt as necessary to mitigate any identified issues.

1.0 Purpose of the Report

1.1 To set out the case for change and proposed approach to community phlebotomy across BHR.

1.2 To seek ICPB approval to implement the agreed approach from 1st July 2021.

2.0 Background/Introduction

2.1 Prior to the pandemic, Barking, Havering and Redbridge (BHR) had a range of providers across acute, community and primary care providing phlebotomy services/clinics across approximately 53 sites in total. This did not represent a strategically commissioned model of service, but rather an 'evolved' position, with a number of different providers, not acting in a co-ordinated fashion.

2.2 Work had commenced prior to the pandemic to develop a new model of care, additional impetus has been added to this as a result of service changes during the pandemic, as described below.

2.3 During the first wave of the Covid-19 pandemic, the focus shifted to enabling providers to respond to the pandemic and to maintain stringent infection protection and control measures. It was therefore agreed in March 2020 that BHRUT would temporarily cease to provide community-based phlebotomy as part of the initial Covid-19 response and focus provision of phlebotomy services for priority groups only.

2.4 As we passed the first wave of the pandemic in June 2020, BHRUT was unable to re-open up its phlebotomy sites as its staff had been 're-purposed' to support inpatient care and as such could only continue with the limited provision for priority patient groups. In response, the CCGs and its community service and primary care providers worked closely together to restart community clinics (previously provided by BHRUT and NELFT), including the introduction of primary care provision of phlebotomy services.

2.5 Due to the lengthy waits experienced by BHR residents for a blood test after the first wave of Covid-19, in October 2020 a system Serious Incident (SI) was declared. A recovery plan was put in place scaling up the provision offered by NELFT and bringing on line primary care provision via a Local Incentive Scheme (LIS). The recovery plan was successful and the SI has now been closed operationally, with work on the Root Case Analysis and Clinical Harm elements working to a deadline of May 2021 (as agreed with NHSE).

2.6 The current service model is an interim solution only, elements of the current provision, including the GP LIS come to end at the end of June 2021 (following agreement to extend these arrangements for Q1 to allow for the necessary discussions prior to changes being made which had not been possible due to the covid vaccination programme particularly). At the time of drafting the number of people waiting for phlebotomy in the system is low and the majority of centres are able to bleed patients in less than a week (in many cases same/next day), however the demand for phlebotomy has also been low as a result of the lockdown. A longer-term solution which delivers a stable, high quality, cost effective solution which provides capacity to meet local demand needs to be commissioned therefore.

2.7 A separate evaluation of the GP LIS has been undertaken. The key findings include:

- In total 54 GP practices signed up to deliver phlebotomy under the LIS. However, at the time of writing only 33 practices are providing the service
- The volume of bleeds carried out by practices was well below forecast levels
- Patient satisfaction with the service is high

The evaluation report is available upon request.

2.8 In addition, the PCN in Havering operating the service served notice and ceased provision at the end of March. Arrangements at Westlands Medical Centre in Hornchurch have been continued to mitigate this.

2.9 It should be noted that Barts Health also provide Phlebotomy services to some Redbridge patients. For the purpose of the proposed model and this paper, the assumption is that these services will continue unchanged for the duration of the pilot.

3.0 Service Model Development

3.1 Work to develop a new model for community phlebotomy provision has been carried out with the input of the Executive Phlebotomy Steering Group which comprises Commissioners, GPs, NELFT and BHRUT.

3.2 The challenge in developing a new model for the delivery of phlebotomy in the community in BHR is the absence of empirical evidence upon which to base a model. Whilst there is data available on patient flows during the covid pandemic as a result of the work carried out during the recovery plan[1], there is extremely limited data available for community phlebotomy activity in a non-pandemic situation. There are clear examples that patient behaviour is different during a pandemic/lockdown situation, as such it would not be appropriate to use the recovery plan as a guide for the development of future community provision.

3.3 As a result, the chosen service model will need to piloted: this ensures that we are able to "test" ideas in an agile way and refine it so that we can finalise the best model for the future, including, very importantly, obtaining patient/user input and feedback around the services which has not been possible due to covid. This approach has been agreed in principle with BHRUT, NELFT, the Clinical Lead and with the Redbridge Health and Scrutiny Committee Lead, who acts on behalf of the other two boroughs on Phlebotomy. An engagement exercise will be carried out throughout the period of the proposed pilot to ensure public feedback is considered prior to the pilot ending and the new final model being commissioned. The recommendation set out in this paper therefore represents the starting point, rather than the final model necessarily.

3.4 Table one below sets out the requirements for the community model, these have been shared with and agreed by the Executive Phlebotomy Steering Group:

[1] During the recovery work all bookings to NELFT sites were made electronically using the 10to8 online booking system, GPs were paid by the bleed and GP activity and billing information can be used to triangulate patient flows in primary care. Walk in appointments were not available.

Requirement	Detail
Equity of Access	The community model should endeavour to provide equity of access to all non-domiciliary adult patients across the three boroughs. *(Note: domiciliary provision has also now been included in the scope of this project to ensure equity across this cohort too)*
Bookable slots	For patient convenience and to allow providers and commissioners to understand and respond to changes in capacity and demand. The demand for, and effectiveness of, also offering a proportion of slots as walk in will also be tested.
Urgent slots	Patients who require an urgent blood test should be able to book a test to be carried out the same day or next day, in line with KPI thresholds
On line booking and ease of cancellation	All booking can be made via an online portal. This will allow patients to have tests when it is convenient for them and eliminate the need for solely walk in testing. This will also allow better capture of demand/capacity during the year. Bookings will also be available by telephone.
Opening hours	Opening hours should be sufficiently broad to allow working people or those who require assistance e.g. from a family member, to get test at a time convenient for them (mornings/evenings/weekends)

Table 1 - Community Model Requirements

3.5 As part of the development of the new service model a review of demand and capacity has been carried out. The purpose of this review was to understand the volume of demand the new service model will have to service and to identify the number of Whole Time Equivalent (WTE) staff required to deliver the capacity. The output of this is set out in table 2 below. It should be noted that given the latest data available was 2019/20 (due to covid impact), a 3% increase has been included to accommodate population growth/spike in demand post lockdown.

New Community Model Activity	
	BHR
NELFT	33,454
Primary Care	5,054
Average Bleeds Per Month	**38,508**
Bleeds Per Annum	**462,096**
Hours per annum based on 9 bleeds	51,344
Clinical Hours per annum	1,480
WTE for 9 bleeds per annum	34.69
GP Activity included above	60,648
Hours per annum based on 9 bleeds	6,739
WTE for 9 bleeds per annum	4.55

Table 2 - BHR Phlebotomy Demand and WTE Calculations

It is noted that following discussion with BHRUT the Trust will ensure that it has sufficient internal capacity to deliver phlebotomy for patients requiring on site tests. This will include oncology, outpatient related tests etc. On the basis of this analysis 34.69 WTE will be required to provide phlebotomy in the community (in total across community and primary care). This is based on 9 bleeds per hour, which not only enables covid-safe practices to take place, it also, NELFT believe, provides a better quality of service (e.g. reduces complaint volumes).

3.6 The distribution of phlebotomists is the key factor in deciding on the model of care to pilot. This is illustrated in figure 1 below. The challenge in designing a phlebotomy service model is to balance between convenience and access for the patient and ensuring maximum optional efficiency and service stability, which are impacted on by the dispersal of sites. Operational issues may include the ability to cover leave/sickness, provision of equipment and sample collection

Figure 1 - Phlebotomy Model Development

The options set out below represent points on this spectrum and suggest the benefits and weaknesses of each model. It is noted that option 6 represents the potential to distribute the phlebotomist capacity unevenly, as noted above, we have no empirical basis on which to propose a distribution of phlebotomists in this manner.

It is noted that irrespective of the option recommended/selected the expectation is that the model of care is delivered in a clinically safe manner, with access to appropriate equipment, oversight and estate provided.

4.0 Options Appraisal

4.1 Option 1

Option 1 – Do nothing	
Description	Under this option services would revert to their previous configuration, which was an evolved rather than strategically commissioned model which was not meeting patients' needs in a timely fashion. BHRUT has indicated that it will not provide community phlebotomy in the future, therefore there would be a service gap.
Benefits	n/a

Weaknesses	• As a result of BHRUT's decision not to provide community phlebotomy services the 'do nothing model' is not viable as it would not provide sufficient capacity for phlebotomy in the community to meet demand • Online booking is not available meaning that it will be difficult to monitor demand against capacity • There are no dedicated priority or urgent slots • It is not possible to book an appointment and all services are on a walk-in basis

4.2 Option 2

Option 2 – Highly dispersed phlebotomy model	
Description	This model represents the broadest possible distribution of phlebotomists across the three boroughs in line with demand. To ensure the maximum distribution of capacity this would be 34.5 WTE individual phlebotomists working in individual centres across BHR. Selection of sites could be aligned to areas of greatest demand and centres with easy access by public transport, for example.
Benefits	• Highly accessible for patients
Weaknesses	• Assumes sufficient demand in a large number of separate centres every day such that individual sites do not experience excessive demand or 'down time' • Potentially challenging to deliver urgent slots in line with patient demand should patients requiring those slots prefer specific sites • Potential for popular locations to be overbooked at the expense of other sites • Potential constraints on the ability to train new staff members with a single qualified phlebotomist working alone • No back up for staff in the event of on-site operational challenges such as feinting patients, leading to delays (including staff sickness) • Potentially difficult to locate a sufficient number of sites with the free rooms and reception capacity • Costs associated with large numbers of rooms/sites/transport • A large number of single chair sites would be difficult to manage from an operational standpoint: o Arranging highly dispersed staffing could be challenging – particularly in regards to cover for leave/sickness o There would be considerable additional resource requirements/cost to arrange collections of samples from 35 sites relative to other models

4.3 Option 3

Option 3 – Multiple Medium Sized Sites in Each Borough	
Description	Under this model there would be multiple medium sized sites containing 3-5 chairs in each borough. Sites would be chosen which are close to public transport links and which have parking, to maximise the ease of patient access.
Benefits	• Represents a balance between accessibility for patients and operational stability • Limited sites will allow ease of sample collection, reducing cost/improving efficiency (easier to plan at the laboratory capacity for example) • Concentrating capacity on a smaller number of sites should ensure sufficient demand on those sites to ensure all individual chairs are more productive.
Weaknesses	• While the sites chosen will represent locations with good transport links and can be spread evenly across the boroughs, it is likely that some patients will have to travel further than they may have previously to get to their appointment

4.4 Option 4

Option 4 – Single Large Site Per Borough	
Description	Under this model there would be a single site, centrally located, near transport links and with sufficiently large parking and waiting areas in each borough
Benefits	• Operationally efficient solution – easy to manage and to maintain operational stability • Ease of sample collection
Weaknesses	• Location will be inconvenient to many in the borough • Potentially challenging to find sufficiently large sites • "Single point of failure" i.e. if anything happens to compromise the building e.g. flood, the entire service for that Borough would be affected

4.5 Option 5

Option 5 - Single Central Site	
Description	Under this model there would be a single site in BHR, centrally located, near transport links and with sufficiently large parking and waiting areas.
Benefits	• Operationally efficient solution – easy to manage and to maintain operational stability • Ease of sample collection

Weaknesses	• Location will be inconvenient to many across BHR • Potentially challenging to find a sufficient large site to accommodate 35 chairs, waiting areas etc. • "Single point of failure" i.e. if anything happens to compromise the building e.g. flood the entire service for BHR would be affected

4.6 Option 6

Option 6 - Mix of site sizes in each borough	
Description	Under this option the model would not be determined by having centres of regular size, instead the phlebotomists and centres would be dispersed in line with demand in individual areas and at different times of day.
Benefits	• A model aligned to demand would ensure that capacity is concentrated in locations and at times to best meet patient need
Weaknesses	• Insufficient data exists for phlebotomy outside of the pandemic to allow a planning exercise of this nature to be undertaken. Planning would be on the basis of assumption therefore • Refinement of this model would be in part reliant on patient feedback and it could take significant time to fit the model to demand

4.7 Recommended Option – It is recommended that **Option 3, Multiple Medium Sized Sites** in each borough is pursued, as a starting point. This option provides a balance between distribution of sites to allow easy patient access and operational efficiency and service stability. All other models have too significant weaknesses either in terms of patient access or operational efficiency. The expectation is that the model will be refined and changed as we understand how patients react to and interact with the chosen model. By the end of the pilot we will have moved to a model which in effect represents option 6. The initial size of the individual sites will need to be agreed with providers.

4.8 A KPI suite will be developed to assess the proposed service model and for the purpose of service monitoring during the pilot year.

4.9 Domiciliary Phlebotomy - To ensure equity a domiciliary phlebotomy service will also be provided by NELFT, alongside this service. The objective is to ensure the same metrics apply to this service as to the wider community Phlebotomy service.

5.0 Service Model Delivery

5.1 Delivery of the recommended model will require engagement with NELFT and the PCNs as providers. It is noted that NELFT have approached the CCG setting out their proposal to deliver a community model. Once there is clarity on the intentions of the PCNs work will be carried out to select sites. The selection of sites will be based on:

- dispersal across the boroughs,
- ease of access and
- availability of car parking

- availability of suitable sites

The selection of sites will be approved by the Executive Phlebotomy Group. Only sites with appropriate facilities and waiting space will be considered.

5.2 The current arrangements for the GP LIS and Westlands Medical Centre come to an end at the end of June 2021. The service provided by the Hurley Group is currently in place until the end of September 2021 (although there is an option to end this earlier in line with the new model). The new model of care will therefore need to be in place from 1st July. Table 3 below sets out at high level the key tasks which will be completed leading up to new model's start date:

Task	Timeline	Status
Case for change document finalised ready for sharing with key stakeholders for comments	12th May	Completed
Agreement of disposition of sites	17th May – 4st June	In progress
Sites confirmed to providers – service mobilisation begins	7th June	-
Service Go Live	1st July	-

Table 3- Mobilisation Timeline

6.0 Resources/investment

6.1 Table 4 below sets out the existing costs for phlebotomy based on the service as delivered prior to covid. Additional temporary funding during the phlebotomy recovery is not included in this table.

Current Funding	Cost
NELFT	£1,658,009
BHRUT	£1,114,454
Primary Care	£337,512
VOID Space	£55,260
	£3,109,975

Table 4 - Pre Covid Community Phlebotomy Costs

6.2 Table 5 sets out the costs of the proposed model. This is based on NELFT providing an element of the service based on staffing costs and overheads and PCNs providing the majority of the remaining activity in the community based on the NEL cost rate of £5.07 per bleed (an uplift from the current BHR LIS payment of £3.05 – note this price is for covid related provision and we anticipate this being in place for the remainder of 2021/22). An allowance has also been made within the budget for the proportion of activity to be retained by BHRUT. It is noted that some of the sites proposed to be used by NELFT currently attract void costs, therefore there is a system financial benefit to NELFT using these sites.

	Cost
NELFT New Model cost	£3,116,166
BHRUT Remaining OP Activity cost (12,943 x 12 months)	£473,714
Primary Care Activity	£337,512
GP Booking system (assume £30 per month per chair based on 4 chairs)	£1,440
	£3,928,832

Table 5 - Proposed Community Model Phlebotomy Cots

6.3 The total additional funding required for this model (the difference between the existing costs set out in table 4 and the proposed model in table 5) is £818,857.

6.4 As indicated above, there will also need to be movement of existing funding within the BHR system i.e. a reduction of £640,740 from BHRUT.

7.0 Equalities

7.1 There are no equalities implications arising from this report.

7.2 A full Equality Impact Assessment will be completed as part of the implementation of this new service (pending agreement) and there will be the opportunity through the pilot to adapt as necessary to mitigate any identified issues.

8.0 Risk

8.1 There is a risk that should ICPB not authorise the development of a new model of care then by default option number 1: Do Nothing will have been selected. Significant elements of the existing provision, including the GP LIS will cease at the end of June. At present phlebotomy demand is low, this is likely as a result of the lockdown. The demand for phlebotomy is expected to rise to normal levels (or for there to be a surge in demand as patients begin to seek blood tests which they had delayed to due to lockdown) as a result of the lockdown coming to an end. If there is insufficient provision available in the remaining NELFT and primary care services there is the potential for delays leading to patient harm.

9.0 Managing conflicts of interest

9.1 Due to providers involved in the delivery of these services, there is conflict for NELFT, Primary Care and BHRUT in relation to agreement of this new model as the first two organisations stand to financially increase and the latter reduce their income for these services.

9.2 Dr Jyoti Sood is a member of the Executive Phlebotomy Group which has inputted into the development of this paper. Dr Sood is a member of a PCN which has been delivering phlebotomy testing as part of the recovery work.

9.3 Dr Atul Aggarwal, Havering Borough Chair and Planned Care Lead is associated with Westlands Medical Centre (note – not part of the new model).

Attachments:
None

Author: Jeremy Kidd, Deputy Director of Delivery (Planned Care) and Tracy Welsh, Director of Transformation
Date: 24.05.21