BHR Integrated Care Partnership

Better care, better lives, together for all

BHR Integrated Care Partnership Board

29 July 2021

1.00pm – 3.00pm

via Microsoft Teams

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 and the chair will invite them into the conversation.

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	**1.00**	**Chair**		
1.1	Declaration of conflicts of interest			**Attached**	**Note**
1.2	Minutes of the meeting held on 27 May 2021			**Approve**	**Approve**
1.3	Actions/matters arising			**Attached**	**Note**
2.0	**Managing Director's report**	**1.05**	**CJ**	**Attached**	**Note**
3.0	**Update on the provider collaboration between BHRUT and Barts Health**	**1.15**	**TC**	**Attached**	**Discuss**
4.0	**BHR ICP risk management**	**1.30**	**PD**	**Attached**	**Note**
5.0	**Integrated Care System development**				
5.1	Borough Partnership development	**1.40**	**EP**	**Attached**	**Note**
6.0	**Transformation**				
6.1	Integrated Sustainability Plan	**2.00**	**ME**	**Attached**	**Approve**
6.2	BHR Health & Care Academy	**2.10**	**KH**	**Attached**	**Approve**
7.0	**BHR ICP performance**				
7.1	BHR Priority actions progress update	**2.20**	**CJ**	**Attached**	**Note**
7.2	Finance report	**2.30**	**SC**	**Attached**	**Note**
8.0	**Items for information**	**2.40**	**Chair**		
8.1	Hospital Discharge Service business case – *formal ratification following virtual approval by Area Committee members*			**Verbal**	**Note**
8.2	Minutes of committees and relevant fora: • Integrated care executive group • Health & care cabinet • Finance sub-committee			**Attached**	**Note**

	Item	Time	Lead	Attached/ verbal	Action required
	• Quality & performance oversight group				
9.0	**Any other business**	**2.45**	**Chair**	**Verbal**	**Discuss**
10.0	**Questions for the public**	**2.50**		**Verbal**	**Discuss**
	Date of next meeting – 30 September 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

Barking & Dagenham, Havering and Redbridge Integrated Care Partnership's Conflicts of Interest Register
Date - 21 July 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	Clayhall Group Practice	X				GP partner	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
			Healthbridge Direct (GP Federation)	x				Shareholder			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				Appraiser			No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	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	Councillor & Cabinet member for Social Care & Health Integration - LBBD	None									BHR ICPB

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

Draft minutes - Integrated Care Partnership Board

27 May 2021

1.00pm – 3.00pm

Via MS Teams

Members:

Cllr Maureen Worby (MW)	ICPB Chair (LBBD)
Kash Pandya (KP)	Lay Member, Governance & Area Committee Chair, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP
Ahmet Koray (AK)	Director of Finance, BHR ICP (rep SC)
Dr Jagan John (JJ)	NEL CCG Chair and B&D Clinical Chair
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Dr Anil Mehta (AMe)	Redbridge Clinical Chair
Mike Bell (MB)	Chair, BHRUT
Tony Chambers (TC)	Chief Executive, BHRUT
Joe Fielder (JFi)	Chair, NELFT
Oliver Shanley (OS)	Chief Executive, NELFT
Andrew Blake-Herbert (ABH)	Chief Executive, LBH
Cllr Mark Santos (MS)	LB Redbridge
Adrian Loades (ALo)	Corporate Director of People, LB Redbridge
Dr Narendra Teotia (NT)	PCN Clinical Director, Barking and Dagenham
Dr Dan Weaver (DW)	Havering GP Federation Chair (Rep Dr Singh)
Dr Sangeetha Pazhanisami (SP)	PCN Clinical Director, Redbridge

Attendees:

Dr Arun Sharma (AS)	Barking & Dagenham GP Federation, Chair
Diane Mckerracher (DM)	Redbridge GP Federation, Interim CEO
Dr Rami Hara (RH)	Deputy Barking & Dagenham Clinical Chair
Alison Blair (AB)	Director of Transition, BHR ICP
Tracy Welsh (TW)	Director of Transformation, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Melissa Hoskins (MH)	Head of Communications & Engagement, BHR ICP
Anne-Marie Keliris (AMK)	Governance Lead, BHR ICP
Emily Plane (EP)	Programme Lead, BHR ICP
Mark Eaton (ME)	BHR System Recovery Adviser
Anna McDonald (AMcD)	Business Manager, BHR ICP
Caron Bluestone (CB)	Lay Member, BHR ICP
James Shields	Member of the public, Circular Wave CEO
Rory O'D	Member of the public, medical equipment company
Emma O'Reilly	Member of the public

Apologies:

Henry Black (HB)	Acting Accountable Officer, NEL CCG
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Chris Naylor (CN)	Chief Executive, LB Barking & Dagenham

Cllr Jason Frost (JFr)	LB, Havering
Dr Caroline Allum (CA)	Chair – Health & Care Cabinet
Dr Gurmeet Singh (GS)	PCN Clinical Director, Havering
Sarah See (SS)	Director of Primary Care, BHR ICP

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	
1.1	**Declarations of conflicts of interest**	
	The register of interests was noted. The Chair reminded everyone of their obligation to complete and return a declaration of interests form if they have not already done so and reminded everyone of the importance of declaring any interest they may have on any of the items discussed at the meeting. JFi asked for the declaration of interests template to be resent to him. No additional conflicts of interest were declared.	All AMc
1.2	**Action notes from the last meeting**	
	The notes of the meeting held on 1 March 2021 were agreed as an accurate record.	
2.0	**Terms of reference**	
	2.1 Integrated Care Partnership Board AMK presented the report on behalf of AB. The first section of the Terms of Reference (ToR) required approval from all ICPB members. DW referred to the principle that 90% of decisions will be taken at a Borough Partnership level and questioned whether the ToR fully reflect the divide of responsibility and accountability. CJ clarified that the ToR are for 2021/22, as the Borough Partnerships become more established and mature, the Partnerships themselves will shape what they think should take place at a NEL, BHR and Borough Partnership level. The governance and terms of reference will then evolve to reflect this. AS asked whether progress is on track for 2022 in terms of the maturity that will be expected for significant decision making at Borough Partnership level. Attention was drawn to the Borough Partnership item scheduled later on the agenda for further discussion. JJ noted that although quality and outcomes are referenced, patient experience needs to be more clearly articulated. CJ confirmed that patient experience would be added in the quality and outcomes section. The Chair took the opportunity to confirm that the lay member for patient and public engagement has now been appointed. ICPB members approved the first section of the ICPB ToR. **2.2 Area Committee.** This second section of the ToR relating to the Area Committee was presented for approval by NEL CCG ICPB members only. Members were advised that one minor amendment had been made to the quorum in relation to the management of conflicts of interest. JFi asked for assurance that all	AB/AMK

	ICPB members will be informed of all the meetings involving only the NEL CCG component and AMK clarified that the Area Committee meetings will normally be held at the same time as the ICPB subject to the management of any conflicts of interest. NEL CCG ICPB members approved the Area Committee ToR.	
3.0	**Confirmation of Integrated Care Partnership Board chair and deputy chair**	
	CJ confirmed that MW will continue in the role of ICPB chair and explained that agreement was being sought from members for KP to take over the role of deputy chair. The reason for this change relates solely to the need for some items to be approved by NEL CCG members only. JFi was thanked for his role as deputy ICPB chair to date. ICPB members approved the arrangements for the chair and deputy chair roles for the remainder of 2021/22.	
4.0	**Managing director's report**	
	CJ presented the report which covered the following areas:- • Recovery & restoration of services • Ongoing development of the BHR Partnership • Identification of key BHR ICP priorities • Getting the Partnership governance right • Supporting the development of Borough Partnerships • Development of a BHR System Integrated Sustainability Plan • BHR Transformation Board priorities • Establishing the BHR Health and Care Academy • Primary Care Network development MS referred to the key priorities and asked for clarification as to how issues in regard to the work of the Transformation Boards (TBs) are escalated. CJ explained that the escalation route is either via the Health & Care Cabinet (H&CC) or the Integrated Care Executive Group (ICEG) depending on what the issue is. JJ made the point that a lot of scrutiny and problem solving takes place within the TBs and highlighted that they have delivered in quite a few areas despite Covid-19, however as a result of the pandemic, not everyone is sighted on their achievements. CJ drew attention to the TB reports scheduled later on the agenda for discussion which sets this out in more detail. OS referred to two of the key priorities; inequalities and Anchor Organisations and suggested it would be good to bring a proposal particularly in regard to Anchor Organisations to a future meeting that looks at what is needed so that ICP Board members can challenge themselves to drive this forward. CJ agreed and suggested a proposal could be taken to ICEG that considers the options for either a dedicated resource in regard to Anchor Organisations to either work across the organisations or one that supports an approach at an individual organisation level.	CJ/EP

	ALo referred to the recovery & restoration of services and suggested the need to look beyond recovery and backlogs and consider how we respond to the new level of need and different needs that are presenting as a result of the pandemic such as mental health. CJ agreed and suggested it is followed up at the System Operational Command Group (SOCG) as part of the recovery work.
	
	ICPB members:
	• Noted the progress to develop the key elements of the BHR Integrated Care Partnership
	• Agreed to receive the following at the July meeting for approval;
	  ○ Borough Partnership Roadmaps
	  ○ BHR ICP priority area detailed work plans
		SR
		
		AB/EP

5.0	**ICPB assurance**	
	5.1 BHR ICP risk management approach The report was presented to update the ICPB on the work that is being undertaken at a NEL CCG level. The CCG has recently introduced a risk management strategy and policy which sets out how the CCG will manage risks across the CCG and the three ICPs. Each ICP will have its own risk register which includes all of the key risks relating to that partnership, and any that are risk assessed to require escalation to the corporate level will be included in the NEL CCG Corporate Risk Register. 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. KP supported the work being undertaken but asked for all the current completion dates to be reviewed as they currently all state March 2022. KP also commented that the ICP risk register needs to be aligned with the risk registers of providers and local authorities. The Chair agreed and referred to a recent review of emergency and business continuity plans undertaken in LBBD following the pandemic and commented that Havering and Redbridge Local Authorities will have undertaken a similar review, and suggested these need to be considered and referenced on the BHR ICP risk register. CJ agreed to follow this up with the ICP risk lead outside of the meeting. MS commented that the risk relating to the change in governance arrangements between BHRUT and Barts Health should be included. Members agreed and CJ suggested working with BHRUT on the narrative. MB confirmed that TC has sent a letter to all stakeholders to announce an appreciative enquiry approach which will identify the metrics for the five key tests that will underpin the assessment of the management service agreement between Barts Health and BHRUT. He advised that the risks will be easier to identify from the five tests and suggested this is revisited on completion of the identification of the five key tests. The Chair advised that she would be formally raising the Barts Health and BHRUT collaboration as an item under 'any other business' later on the agenda. JFi voiced his support for the proposed approach to managing risks but commented on the size of the meeting papers and highlighted the need for an 'at a glance' dashboard that clearly demonstrates what the ICP is aiming	AMK CJ SR

	to achieve and the progress being made. CJ confirmed the plan going forward is to have a performance dashboard at every ICPB meeting. ICPB members: • Noted the proposed approach to manage risk and support further development of a risk register that covers the most critical risks to the BHR ICP.	SR
6.0	**Transformation**	
	6.1 BHR transformation board achievements to date and 20/21 year-end position TW presented the report which outlined the key achievements of the BHR TBs since their establishment. The report provided an update to members of the ICPB on schemes that have been delivered over the course of 2020/21 despite the pressures across the system in responding to the Covid-19 pandemic. Specific attention was drawn to schemes such as; Co-ordinate MymCare; asthma; and oximetry at home which have all been very successful. AS asked whether an external evaluation of the TBs will be undertaken to evidence that this is indeed the best way to transform the local system going forward. The Chair referred back to the point made earlier in the meeting about some TBs becoming Task & Finish Groups at they develop. CJ added that the areas that TW had drawn specific attention to were clinically led with clinicians from secondary care, primary care and community care driving transformation. Bringing clinicians together avoids duplication and is powerful in achieving positive outcomes. CJ highlighted that change is not always immediate and in some areas, it can take two to three years to see a significant impact. The need to be realistic was acknowledged together with the need to continually challenge the work. DW gave his thanks to GPs and the PCNs for their hard work in regard to many of the achievements. OS referred to the recent discussion at the BHR Integrated Care Executive Group whereby it was agreed that the system has a collective responsibility to work together to address and resolve any issues where TBs may not be achieving as much as is expected. The ICPB noted the update report. **6.2 BHR transformation board key priorities** TW advised that as we leave the second peak of the pandemic, each TB has re-convened and they are each developing their priorities for the first 6 months of 21/22. The report outlined the key priorities and workplan of each of the TBs for 20/21 together with the key priorities for the NEL-wide Learning Disabilities & Autism. The interdependencies of each scheme were also included. ICPB members were asked to note that delivery of the priorities may be impacted by the funding available; this is being worked through at a local and NEL-wide level. JFi referred back to his request made earlier in the meeting for a dashboard going forward and was assured that a dashboard is currently being designed which will have outcomes and metrics included. DM commented that primary care data needs to be included from across the system. TW agreed	

	and clarified that primary care is an enabler to all the workstreams. CJ highlighted that TBs provide a place to bring clinicians and provider colleagues together to maintain the 'end to end' view which has been the CCGs role up until now and that this needs to continue after April 2022. TW cited the role of convenors and sponsors that have been appointed to each TB and advised that a workshop is being arranged for mid-June 2021 where the escalation process and trigger points will be agreed. The ICPB noted the update report. **6.3 BHR integrated sustainability plan** SR recapped that in 2018/19 NHS partners within BHR developed and agreed a Financial Recovery Plan (FRP) for the BHR system. Initial implementation demonstrated some immediate benefits which were outlined in the report. Following on from the pandemic, the FRP will evolve into an Integrated Sustainability Plan (ISP) covering physical health, mental health and learning disabilities with the aim of setting the aspirations to meet population health needs, transforming outcomes and returning the system to financial balance. ME reported that within a year of introducing the original FRP, excess spend in hospital had reduced from £106m to £96m. The plan is to reach zero excess spend and re-invest 50% into primary and community care, working with Local Authority and BHRUT colleagues in order to improve outcomes. The ISP will highlight where the issues are so that the work of the TBs is targeted in the right areas, it will also set a budget for the TBs. The Chair referred to the number of people attending A&E who are not registered with a GP and gave her view that investing some money into the local voluntary sector to assist with encouraging people to register with a GP would help to address the problem. ME responded explaining that the TBs will be empowered to work out what the most effective way is to achieve the desired improved outcomes. DW highlighted the need to think about how the extra demand would be met and stressed the importance of aligning peoples' views with what the local system as a whole can offer and what the likely pathways are going to be. It was agreed that expectation management is crucial. ME pointed out that the ISP is a five-year plan and it is recognised that we do need to build capacity. CJ assured members that the plan is to continue to invest more money into primary care but emphasised that it takes time to increase primary care capacity and cited workforce recruitment as one of the issues in primary and community care. JFi gave his view that more could be done around Single Point of Access (SPA) including having one for primary care. ME responded explaining that SPA will be a function of support for older people adding that there will likely be SPAs for various specialities. ALo asked how Whips Cross Hospital features within the acute re-investment model and ME clarified that it is included in the plan in terms of reducing the number of non-elective presentations, repatriation of elective care and providing some funding to them to support the transformation. KP confirmed his agreement of the ISP but asked for consideration to be given to legacy assets and also to consider worst and best-case scenarios	SR/ME

	sooner rather than later as we may be required later in the year to make savings. In regard to legacy assets, AK advised that an estates strategy across BHR is being developed which will create a longer-term plan in regard to how the estate is utilised. The impact of Local Authority estate will also be looked at going forward. ABH welcomed this adding that it needs to include regeneration as well as the current infrastructure. TC supported the ISP and commented that he views it as an 'invest to save' proposition. He added that there needs to be risk alignment and risk sharing put in place so that all parts of the system are incentivised to make it work and commented that outcomes tracking is key. ME advised that the ISP will be presented to NHS partner boards and the final version will be signed off at a future meeting of the ICPB. The ICPB: • Agreed the next steps and recommendations outlined in Section 4.0 of the report on the basis that the suggestions put forward during the discussion are taken into account.	SR/ME
7.0	**Quality and performance**	
	7.1 Quality and safeguarding report CJ clarified that going forward, a separate report on this will not be necessary as there is a BHR ICP Quality & Performance Oversight Group where the issues will be picked up. The Chair asked for consideration to be given as to how safeguarding issues will be reported to the ICPB going forward. The ICPB noted the update report. **7.2 Performance report** SR advised that an initial set of indicators have been developed from available data but the data is still very health focused. The proposed structure of reporting was outlined and SR explained that performance and remedial action plans against constitutional standards will continue to be overseen and monitored by the BHR ICP Quality and Performance Oversight Group. There will be a set of indicators which support the four overarching ICP objectives; starting well in life; living well; aging and dying well; bringing care closer to home. The wider system piece will also include quality & safeguarding issues. Exception reports will be presented highlighting where the challenges are in relation to performance against the constitutional standards and what steps are being taken to address these. The plan is for the data to be at a BHR, and Borough Partnership level. A Public Health facilitated workshop is being planned in order to develop indicators aimed at providing greater oversight of Local Authority work in the prevention and early intervention space. The Chair asked SR to liaise with Local Authority colleagues on which key metrics need to be included ahead of the planned workshop. SR drew attention to the Constitutional Standards Exception Report included in the report; A&E standard and the RTT 52 week waits and fed back that both are being managed by BHRUT. The ICPB:	CJ/SR SR

	• Agreed the proposal and to receive an update of the development of a new indicator set at its July meeting. **7.3 Finance report** AK presented the report which outlined the draft financial plans for the first six months of 2021/22 based on the first allocation of money from NHSE. The second allocation for the second half of the year is expected in September 2021. The BHR ICP allocation is £616m and AK advised that the main headlines for each of the categories of spend were detailed in the report. Further detail will be presented at the July meeting. Members noted that there is an expectation that BHR will receive funding within the NEL budget that is in line with our population size, and reflects needs including levels of deprivation. The ICPB noted the report.	SR
8.0	**Development/governance**	
	8.1 Terms of reference – finance sub-group, quality & performance oversight group AB presented the ToR and explained that the groups have been set up to provide the ICPB with an enhanced level of assurance in terms of scrutiny and support in both areas. The groups will undertake the detailed work and escalate issues to the ICPB appropriately. The ICPB approved the Terms of Reference for both groups. **8.2 Framework for patient and public engagement** MH presented the proposal which aligns with the NEL CCG governance structure to avoid duplication. The 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 and the approach enables local people to shape services by working with all partners, including primary care services. A structure will need to be developed that sets out an agreed formal way of working to ensure local peoples' voices are represented at a PCN level. The BHR ICP Associate Lay Member for Patient & Public Engagement has recently been appointed and will be closely involved in the continued development of the Patient & Public Voice Committee. The committee will provide assurance that patients and the public are involved in shaping the plans being considered by the ICPB and Executive Group. It will also have a lead role in highlighting issues and concerns raised by the local community. MS asked for consideration to be given in regard to payment for individuals attending committee meetings and also consider mentoring as a means of support. The Chair gave her full support to the proposal and welcomed the proposed approach. The ICPB: • Noted and agreed the proposed approach in principle	MH

	• Agreed to establish a structure to implement the approach • Endorsed work to develop a framework for engagement for Primary Care Networks (PCNs), to be developed with PCNs and local patient representatives **8.3 Borough partnership development update** AB advised that leads from the three boroughs came together at a workshop on 19 May 2021to share the draft versions of their roadmaps and emerging key priorities. A number of areas of support / input from a NEL level were flagged at the workshop including data sharing, digital integration and estates. The roadmaps are due to be finalised at the end of May 2021 and a more detailed discussion as to how we can further support the development of Borough Partnerships at a local and NEL level is scheduled for the ICPB meeting in July. ABH commented that endorsement of the road maps needs to be undertaken locally an ICP level. The Chair agreed that we must acknowledge the differences between the three boroughs and collaborate where there are benefits across the system. The ICPB:- • Noted the approach and progress to develop roadmaps for Borough Partnership development • Agreed to receive in June/July the final Borough Partnership Roadmaps for review and endorsement **8.4 Proposed primary care governance** CJ presented the paper which outlined the proposed governance arrangements for the primary care transformation programme relating to the ICS and the governance arrangements relating to the Primary Care Commissioning Committee (PCCC) which is a delegated function from NHSE to NEL CCG. The PCCC is where decisions will be approved on items such as Local Incentive Schemes, practice mergers and closers. A BHR ICP Primary Care Management Group will sit beneath the PCCC chaired by the Associate Lay Member for Primary Care. Local decisions will be made by this group and then presented to the PCCC for final approval. This will allow local decision making about primary care in BHR to remain as close as possible to BHR. The Primary Care Transformation Board will continue in order to give local primary care colleagues the lead in how we transform and develop primary care locally. The ICPB: • Approved the governance proposal • Noted that the primary care delegated governance arrangements need to be approved by the NEL CCG PCCC.	
9.0	**Any other business**	
	9.1 Barts Health/BHRUT collaboration Further to the discussion earlier in the meeting under item 5.1, the Chair requested a report and fuller discussion on this at the next meeting in July. MB agreed and advised that by that time, recruitment of the Chair-in-common and substantive CEO will have been completed.	MC/TC/ Hannah Coffey

	ABH commented on the importance of knowing what the synergies and benefits are going to be as the focus has to be on improving outcomes for our local boroughs.	
10.0	**Questions from the public**	
	No questions from the public had been received.	
Due to conflicts of interest the next part of the meeting was held in the presence of NEL CCG (non-clinical) and Local Authority members only. All other members were excluded.		
11.0	**Phlebotomy – case for change**	
	KP as Chair of the Area Committee, took over the role as Chair of this section of the meeting. The following conflicts of interest were noted: • *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 Group which has input 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).* TW presented the report and gave an overview of the phlebotomy service that was in place prior to the pandemic which consisted of a range of providers covering approximately 53 sites and did not represent a strategically commissioned model. During the first wave of the Covid-19 pandemic, BHRUT withdrew its community phlebotomy provision and in response, the CCG, community services and primary care providers worked closely together to ensure delivery of provision in the community. The current service model was put in place as an interim solution and work to develop a new model for community phlebotomy provision has been carried out. TW gave an overview of the proposal to pilot the chosen service model. Members were advised that it has not been possible to undertake a full engagement exercise due to the pandemic, however, engagement 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 Chair commented that phlebotomy has been an area of concern across the BHR system for some time and welcomed the proposal. AK confirmed that currently it is possible to fund the proposal on a non-recurrent basis but added there is work to be done around funding going forward. TW clarified there will be 3-4 sites in each borough and the locations will be confirmed week commencing 7 June 2021. On-line booking is already available and the intention going forward is for the PCN sites to also be	

	bookable on line. Domiciliary has also been factored in. It is not yet possible to offer walk-in appointments due to social distancing. The pilot will be flexed as necessary throughout the year based on feedback. The Chair asked for an update report on the pilot in six months. The Area Committee: • Approved option 3 as set out in the options appraisal • Approved the funding to meet the gap between existing provision and the modelled requirement: £818,857 • Requested an update in six months.	TW
	Date of next meeting – 29 July 2021	

Integrated Care Partnership Board

Action ref:	Meeting date	Action required	Lead	Required by	Status
1.1 Declarations of Interest	**May 2021**	Outstanding declaration of interests forms to be submitted. Template to be re-sent to JFi.	All AMc	June May	In progress. Template sent. Awaiting return.
2.1 Integrated Care Partnership Board – Terms of Reference	**May 2021**	Patient experience to be more clearly articulated alongside outcomes.	CJ/AMK	July	**Complete** - Terms of Reference updated.
4.0 Managing director's report	**May 2021**	Further discussion on Anchor Organisations to be held at the next Integrated Executive Group (ICEG) meeting. Further discussion on the BHR system's response to the diffferent needs that are presenting as a result of the pandemic to be followed up at the System Operational Command Group (SOCG) as part of the recovery work. Borough Partnership Roadmaps and the BHR ICP priority area detailed work plans to be presented at the next meeting for approval.	CJ/EP SR CJ/EP	June June July	**Complete** - discussed at ICEG on 17 June as part of the ICP priorities discussion. **Complete** - Picked up through SOCG discussions and was also discussed at the BHR Recovery Summit. Agenda item – Borough Partnership development.
5.1 BHR ICP risk management approach	**May 2021**	All current completion dates to be reviewed. Review of emergency and business continuity plans following the pandemic to be referenced on the BHR ICP risk register. CJ to follow this up with the ICP risk lead outside of the meeting.	AMK CJ/AMK	July July	**Complete.** **Complete** - NEL CCG EPRR annual plan includes a review of all business continuity plans and will be referenced in the ICP risk register.

		Changes in governance arrangements between BHRUT and Barts Health to be added to the BHR ICP risk register. SR to work with BHRUT colegaues to agree the narrative. A performance dashboard that clearly demonstrates what the ICP is aiming to achieve and the progress being made to be presented at each ICPB meeting going forward.	SR SR	July July	**Complete** – added to the risk register. Dashboard being developed - performance data around recovery relating to key ICPB priority areas is included in the update report on the agenda.
6.3 BHR integrated sustainability plan	**May 2021**	Suggestions put forward during the discussion to be taken into account when updating the ISP.	SR/ME	July	**Complete.**
7.1 Quality and safeguarding report	**May 2021**	Consideration to be given as to how safeguarding issues will be reported to the ICPB going forward.	CJ/SR	July	Update on how safeguarding issues will be reported to the ICPB going forward is scheduled for September agenda.
7.2 Performance report	**May 2021**	SR to liaise with Local Authority colleagues on which key metrics need to be included ahead of the planned workshop.	SR	June	**Complete.**
8.2 Framework for patient and public engagement	**May 2021**	Consideration to be given in regard to payment for individuals attending committee meetings and also consider mentoring as a means of support.	MH	July	**Complete** - both proposals built into the emerging plans. Individual payments will be discussed with colleagues within BHR and across NEL to consider consistency and equity.
9.0 Any other business		The Chair requested a report on the Barts Health/BHRUT collaboration at the next meeting for discussion.	TC/MB	July	Agenda item.

11.0 Phlebotomy – case for change *(Area Committee***)**	**May 2021**	Update report on the pilot to be presented in six months.	TW	November	Scheduled on forward plan for November.

BHR Integrated Care Partnership Board

29 July 2021

Title of report	Managing Director's Report – BHR Integrated Care Partnership Update
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	The latest Integrated Care System guidance[1] and recent publication and reading of the new Health and Social Care Bill in Parliament both reinforce our approach to support the ongoing establishment and development of Borough Partnerships in Barking and Dagenham, Havering and Redbridge. 2021/22 is a key year for Borough Partnership development and the CCG is seeking to release phase 2 development funding (£100,000 per BHR Borough) following submission of the BHR Borough Partnership Development Roadmaps. As expected, the Health and Social Care Bill will seek to place Integrated Care Systems on a statutory footing, replacing Clinical Commissioning Groups. Each ICS will be required to establish an 'Integrated Care Board' - an organisation responsible for NHS functions and budgets - and an 'Integrated Care Partnership' - a statutory committee bringing together all partners to work on strategy. Clearly this has implications for our partnership which we will work through locally to

[1] Integrated Care Systems Design Framework, June 2021, NHS England

	understand in partnership with NEL ICS, including around terminology, and how we would like to configure functions and resources at each level of the system. There are also several options for the way in which delegation will flow from the ICS – this is set out in more detail in the body of this report. We have progressed a number of key elements of our identified partnership priorities since the last ICPB meeting and these are set out in more detail in the body of this report. Overall the latest guidance and Health and Care Bill are as expected and reinforce our direction of travel. It is also important that we recognise that we are still waiting confirmation of a publication date of the Green paper on adult social care.
Action Required	Members are asked to note the progress to develop the key elements of our BHR Integrated Care Partnership detailed within this report.
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 planned Health and Social Care Bill, from April 2022.
Equality Impact	Not applicable at this stage

1. Introduction

1.1 The latest Integrated Care System guidance and recent publication and reading of the new Health and Social Care Bill in Parliament both reinforce our approach to support the ongoing establishment and development of Borough Partnerships in Barking and Dagenham, Havering and Redbridge.

1.2 2021/22 is a key transition year and it is anticipated that by the end of September 2021 we will have a clearer understanding of how we would like to configure the delegation of some functions of the ICS to each level of the system, in particular Borough Partnerships. This in turn will support us to create a 'shadow form' of some of these arrangements by October 2021, in preparation for April 2022.

1.3 To achieve this, it is essential that as a Partnership we collectively; consider the options for delegation and which option we believe would work best for us; support development of our Borough Partnerships and thinking around what functions they would like to take on in the coming years; continue to take forward work on our key enabling programmes such as establishment of the BHR Health and Care Academy, ongoing development of the BHR Integrated Sustainability Plan and digital and estates programmes.

2. Progress update – key areas

Progress update since the last ICPB meeting on key partnership initiatives	
Latest ICS development guidance	The latest Integrated Care System guidance and recent publication and reading of the new Health and Social Care Bill in Parliament have implications for our partnership which we will work through locally to understand in partnership with NEL ICS, including around terminology, and how we would like to configure functions and resources at each level of the system. There are also several options for the way in which delegation will flow from the ICS, which are set out below and which we will need to consider. It would be helpful if as a partnership we could come to a consensus around which we think is the best option: An **NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners**, to jointly drive and oversee local integration. It is up to ICS to consider which option would work best for them. ▪ **consultative forum**, informing decisions by the ICS NHS body, local authorities and other partners

	▪ **committee of the ICS NHS body with delegated authority** to take decisions about the use of ICS NHS body resources9 ▪ **joint committee of the ICS NHS body and one or more statutory provider(s),** where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation ▪ **individual directors of the ICS NHS body having delegated authority**, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies ▪ **lead provider managing resources and delivery at place-level under a contract with the ICS NHS body**, having lead responsibility for delivering the agreed outcomes for the place.
Recovery and restoration of services	On the evening of Tuesday 6th July, partners from primary care, the CCG, BHRUT, NELFT and Local Authorities came together for a BHR Recovery Summit. It was a frank and open discussion in the spirit of collaboration which resulted in a number of strong actions and a better understanding between the different organisations and individuals of what we are all experiencing. Some solutions are going to take longer, such as workforce recruitment and retention and digital connectivity but others, such as the suspension of the consultant to consultant referral policy, have been enacted with immediate effect. This was an exemplar example of our partnership work at a BHR level, with partners able to have mature conversations around the key pressure in the system and how we can collectively work together to address this.
Ongoing development of our BHR Partnership	The BHR Integrated Care Executive Group, at their meeting on Thursday 15th July discussed next steps for the Organisational Development programme. A verbal update will be provided to ICPB members on next steps.
Identification of our key priorities	The BHR Integrated Care Partnership have identified a number of key priorities for 2021/22, 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** There is a specific item on the agenda providing a progress update on these key priorities.
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. Following publication of the Health and Care Bill, and as set out in this paper, we will need to consider how our form will need to evolve post April 2022 to ensure that this supports the functions that will sit at each level of the Integrated Care System.
Supporting development of our Borough Partnerships	The three BHR Borough Partnerships submitted their development Roadmaps at the end of May 2021. These were reviewed by the BHR Integrated Care Executive Group in June 2021 and endorsed. The CCG is seeking to release phase 2 development funding of £100,000 per BHR Borough Partnership to support operationalisation of their Development Roadmaps. This is subject to each Borough Partnership providing a high level outline of the anticipated spend of these monies. A follow up session to the one held on 19th May 2021 with Borough Partnerships is planned for 26th July to further discuss the implications of the latest guidance and what functions Borough Partnerships see sitting at level, alongside ongoing operationalisation of their development roadmaps.
Development of a BHR System Integrated Sustainability Plan	As partners are aware, 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 (ISP) plan has been developed 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. It is anticipated that this document will be key to informing the discussion around which functions should sit at which level of the system, and acting as a framework to support Borough partnerships as they take on more functions from the ICS post April 2022. In 2021/22 and 2022/23, the BHR ISP identifies some non-recurrent funding to support the BHR Transformation Boards. It also identifies a pot of funding to be invested in prevention over the next two years. The CCG has written to Directors of Public Health outlining this opportunity

	and seeking thoughts on how this could be spent to achieve the greatest benefit for local people.
London Vaccination Summit	On 19th July a one-of-a-kind London Summit was hosted by NEL CCG, organised by the Mayor of London, Sadiq Khan and Minister for Vaccine Deployment, Nadhim Zahawi. The summit allowed London's leading politicians, local leaders across the boroughs, businesses, faith groups and the NHS (including front line staff) to come together to discuss the remaining barriers to greater vaccination rates in the city with its young, diverse and mobile population and pockets of social and economic disadvantage.

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, and in particular consider the options for delegation that are described in the body of this report.

Emily Plane
Programme Lead, BHR System Development
July 2021

Integrated Care Partnership Board

29 July 2021

Title of report	Update on the Provider Collaboration between BHRUT and Barts Health
Author	Hannah Coffey, Director of Strategy and Partnerships, BHRUT
Presented by	Tony Chambers, Chief Executive Officer, BHRUT
Contact for further information	Hannah Coffey
Executive summary	• This paper sets out the background, process and current position of the Appreciative Inquiry process currently being undertaken under the umbrella of the NEL ICS between BHRUT and Barts Health. The process is to work through with staff and partners, the high priority areas for collaboration that will benefit the population of both Trusts and their boroughs. • This is the first stage of a process where the organisations will work more closely together and will result in three key outputs – a statement of intent, a charter for change and a document that sets out the conditions for success • This update is for discussion by members of the ICPB
Action required	For discussion
Where else has this paper been discussed?	The content of this paper has been discussed at the Collaboration Executive Group which meets every two weeks
Next steps/ onward reporting	This is a specific update for the ICPB
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The drivers of this collaboration respond to the imminent changes in legislation bought about by the new NHS white paper that include a duty to

	collaborate with NEL partners and develop local place based partnerships within the boroughs The principles of the collaboration are to work together to improve the quality and access of services for local people and respond to the significant health inequalities for our local populations.
Conflicts of interest	N/A
Equality impact	An equality impact assessment will need to be completed when the outputs of the Appreciative Inquiry (AI) are developed.

BHRUT/Barts Health Appreciative Inquiry

ICPB update pack

29 July 2021

Barts Health and BHRUT are looking to strength the collaborative working between the two organisations

Barts Health and BHRUT are examining the potential for entering into an MSA, which would outline more formal modes of collaboration between the two organisations.

Carnall Farrar (CF) have been commissioned to support this work by engaging with stakeholders, using an appreciative inquiry methodology, this involves:

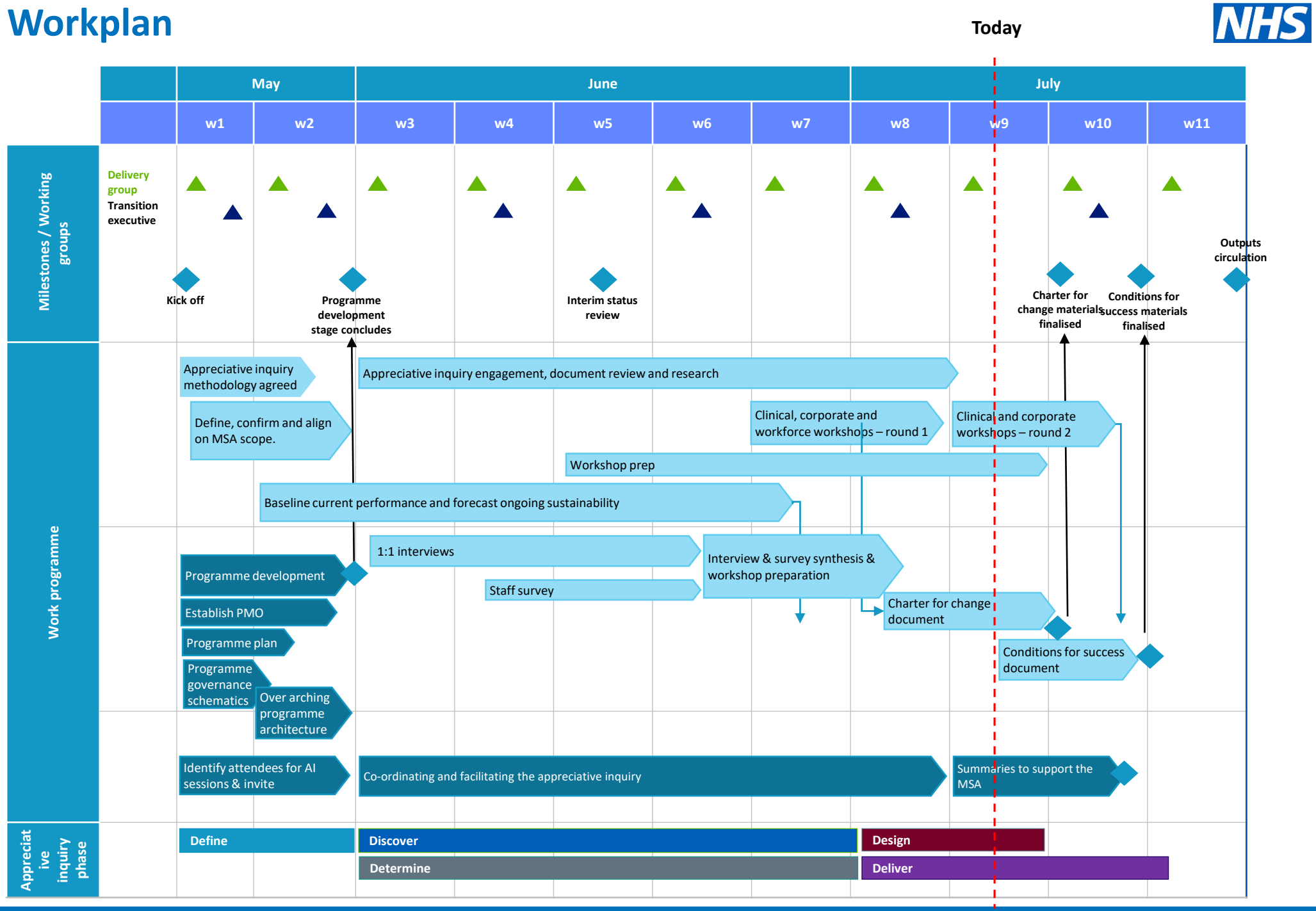
Engaging with stakeholders	Supporting alignment on

• Staff in both BHRUT and Barts Health through:
  • Leadership interviews and group discussions
  • Leadership workshops
  • Surveys
• Discussions with external stakeholders – including other providers and local authorities
	• The strengths in each organisation
	• The challenges faced individually and collectively
	• The opportunities for collaboration
	• The conditions for success required to deliver on those opportunities

The AI work between Barts Health and BHRUT is spanning four deliverables to set the scene for further collaboration

	Deliverable	Description
1	Agree appreciative inquiry methodology	• Agree the detail of the appreciative inquiry methodology, which will be used in preparing the ground for further collaboration, including: - Guiding principles which will ensure consistency of approach - Stakeholders to engage with and methods of engagement - Specific lines of inquiry (focus of analytics and engagement)
2	Charter for Change document	• A document which sets out the context for, and drivers of, deeper collaboration. Specifically, this will outline: - The challenges and opportunities that each organisation is facing and how they overlap - The priorities that have been chosen for collaboration and reasons why
3	Conditions for success document	• This document will set out the supporting arrangements that will need to be in place to achieve the domains of collaboration outlined in the charter for change • This will include quantifying the developments, changes and investments necessary to enable deeper collaboration
4	Build foundational relationships for future collaboration	• Although the documents in 1-3 will codify the outputs of the work, it is also important that the process delivers ownership of the process • The work will strengthen working relationships between the two organisations to provide the foundation for the future collaboration across services and functions

Workplan


Today
May
June
July
w1
w2
w3
w4
w5
w6
w7
w8
w9
w10
w11
Milestones / Working groups
Delivery group
Transition executive
Kick off
Programme development stage concludes
Interim status review
Charter for change materials finalised
Conditions for success materials finalised
Outputs circulation
Work programme
Appreciative inquiry methodology agreed
Appreciative inquiry engagement, document review and research
Define, confirm and align on MSA scope.
Clinical, corporate and workforce workshops – round 1
Clinical and corporate workshops – round 2
Workshop prep
Baseline current performance and forecast ongoing sustainability
1:1 interviews
Programme development
Interview & survey synthesis & workshop preparation
Staff survey
Establish PMO
Charter for change document
Programme plan
Conditions for success document
Programme governance schematics
Over arching programme architecture
Identify attendees for AI sessions & invite
Co-ordinating and facilitating the appreciative inquiry
Summaries to support the MSA
Appreciative inquiry phase
Define
Discover
Design
Determine
Deliver

We have been using an Appreciative Inquiry model which focuses on looking at the positive potential for locally led change

Define (weeks 1 – 2)

- Align on the **scope** of the Management Services Agreement
- Establish the **programme plan**, **governance** and **programme architecture**
- Align on the appreciative inquiry **methodology**

Discover (weeks 3 – 7)

Appreciate the best of what is already working:

- **Engage** through targeted one-to-one interviews and facilitated discussions
- **Survey** to understand starting point, opportunities, organisational culture and barriers
- Conduct **document review** and **research** to history of BHRUT and Barts Health
- Confirm **existing areas of collaboration** and the enabling conditions
- **Baseline** current organisational performance and **forecast** ongoing sustainability

Determine (weeks 3 – 7)

Outline what *could* be:

- **Explore** through the targeted one-to-one interviews, facilitated discussions and surveys
- **Clinical and corporate workshop 1** to identify deeper **collaboration opportunities and benefits**
- **Workforce and leadership workshop** to identify areas of collaboration and benefits
- Prep for workshops using the **working groups**
- Develop, test and refine the **charter for change**

Design (weeks 8 – 9)

Detail what *should* be – and the options to make it happen:

- **Clinical workshop 2** and **Corporate workshop 2** identify **enablers** for success to achieve the desired collaboration
- **Culture workshop** Identify **areas of challenge** and requirements to overcome them
- Research and **preparation** for workshops including 1:1 **interviews** and using the working groups

Deliver (weeks 8 – 11)

Create what *will* be – action plan:

- **Analysis** of what will be required to deliver the desired collaboration, outlining **infrastructure and investment requirements,** testing with working groups
- Leverage workshop outputs to **define actions** required
- Develop, test and refine the **conditions for success** document (week 9)
- Provide input and support development of the **management services agreement**

A **charter for change**, documenting **conditions for success** and creating a **Management Services Agreement**

A set of principles to guide the Ai approach have been agreed by both organisations

1. We want BHRUT and Barts Health to be in a position to work together more closely if they choose to do so, to deliver benefits to patients, staff and people in North-East London.
2. We want to hear views from staff at all levels across Barts Health and BHRUT to understand where we can collaborate best – both within clinical services, and corporate services.
3. We want to hear about what makes you proud, and about your ambitions for the service you are part of.
4. We will identify and capture opportunities which can help to address inequalities, while promoting diversity and inclusivity.
5. We will be honest about where there are obstacles to achieving ambitions and seek to find ways forward that work for everyone.
6. All staff own the responsibility for improving services, delivering change and working together more closely.
7. We want to build on the best of BHRUT and Barts Health, as well as build on national and international best practice.
8. Our work will be transparent and inclusive. We want to bring people together from across both organisations and the wider place-based partnerships (including local ICS boards) and will make sure everyone is clear about how the work is progressing.

The appreciative inquiry engagement has been extensive but there is more to be done, especially with external stakeholders

Engagement stream		Progress made	Next steps
Internal engagement	Interviews and group discussions	• 48 interviews originally scheduled, expanding to 84 in total • 74 have been completed • 17 are scheduled and 1 outstanding	• All interviews will be completed by 22/07 • Agree engagement plan for August onwards
	Workshops	• Corporate workshop 1 completed on 02/07 • Joint culture workshop date to be confirmed, but likely Sept'21	• Workforce workshop on 08/07 • Clinical sessions on 09/07 • Corporate workshop 2 on 16/07 • Culture sessions on 13/07 (Barts Health) and 15/07 (BHRUT)
	All staff survey	• 1,456 responses received • 489 from Barts Health • 967 from BHRUT	• Process outputs and incorporate in deliverables
	Culture survey	• 113 responses received	• Close survey on 09/07 • Process results ahead of next week's workshops (13/07 and 15/07)
External engagement	Interviews	• Healthwatch leads • NELFT CEO • Barking and Dagenham, Havering and Redbridge LA CEOs • CCG and ICS leads	• Complete target interviews by 23/07
	External survey	• Survey gone live this week – issued to exec directors of other providers, PCN leads and health leads within LAs	• Close survey 24/07 • Process outputs and incorporate into deliverables

We have used a consistent framework for the interviews and groups discussions that have taken place.

Question type	Question
What's good?	• What are you most proud of in your org/department/team/unit/partnership? • What enabled that success? • What are you keenest to hold on to as wider change takes place?
What obstructs the good?	• What is standing in the way of even stronger progress? • Probe for specific factors: - Leadership, partnership - Financial, clinical
What impact might possible change have?	• System change is likely, including as part of NEL-wide ICS development – what are the pros and cons as you see them?
How does this way forward sound to you?	• A way forward under consideration is a mutual support arrangement between the two acute trusts; what would need to happen for this to be a positive and successful move, from your perspective?

The engagement has surfaced considerable enthusiasm about the potential for collaboration between the two organisations

Theme	Description
The population similarities of the two catchment areas provide shared challenges	• Both Trusts provide services to populations that have very deprived communities, and which are beset with health inequities • The population of north east London is also very fast growing, and the catchment area of the two trusts is set to increase by 160,000 over the next ten years • Helping to resolve these inequities and accommodate this increasing population are two fundamental challenges facing both organisations
There are clear strengths within each organisation that can be built upon	• There are areas of clinical and service excellence across both Trusts • BHRUT in particular have had their elective services and diagnostic services highlighted as highly effective. • Barts Health have areas of excellence across their sites, including the MTC, cardiovascular, elective orthopaedics and are proud of their improvement trajectory over the last five years
Leaders from across both organisations are excited by the benefits that collaboration can bring	• In general the MSA is seen as an opportunity, rather than a threat amongst leadership, who are enthusiastic about both clinical and corporate potential benefits • The system responded well to the pandemic and both organisations recognise the opportunity to build something collaboratively that is mutually beneficial • Broadly, it's seen that Barts Health can help with BHRUT's non-elective performance and BHRUT can support with improving Barts Health's elective performance
There is a broad spectrum of possible collaboration which could translate into benefits for all	• There is universal recognition that there is at least some collaboration that can be undertaken to better share expertise and make use of limited resources • This ranges from suggestions about sharing knowledge and best practice through to shared standards, rotational posts, networked services, and even consolidating services in some instances

We are currently focused on producing draft deliverables and then will undertake a run of engagement on culture in September

The engagement and analysis that has been conducted in the programme so far is now being synthesised to form the **charter for change** document and the **conditions for success** document

We are still undertaking some **engagement** to further inform these documents, including some stakeholder interviews, an external stakeholder survey and a corporate workshop

These will run until **the end of July**, by which point we will have a full draft version of the charter for change and an early draft version of the conditions for success document.

In order to finalise the conditions for success document, more work is needed to be undertaken on culture and leadership. There is currently **a culture survey** that is being completed by the leadership teams in both organisations and which will be played back through **a series of workshops**.

These workshops are scheduled to conclude in **September**, when both organisations will come together to discuss the outputs of the survey and culture and leadership challenges.

Once these workshops have been completed, the outputs will allow for the **full draft** of the conditions for success document to be drafted.

Appendix: summary of engagement outputs

The Appreciative inquiry process has identified further areas of opportunity for clinical collaboration (1/2)

Emergency care

Opportunity to optimise emergency care delivery

- "ED collaboration could open channels for sharing of the workforce, allowing shared learning, innovations and culture"
- "Barts Health have identified different innovation within ED at BHRUT that Barts Health could definitely learn from. BHRUT feel there's a lot they could learn from the Barts Health ED team too"
- "Barts Health can support BHURT with ED"

Cancer

Improve cancer outcomes through collaboration and standardisation of pathways

- "There is a huge opportunity to build strong links"
- "I've been worried about cancer services in East London for some time and I do think that this gives us an opportunity to create something very positive for our patients"
- "We want to make sure that we're reducing unwarranted variation. There's an opportunity to reset the dialogue"
- "We both have a critical mass of patients so we can something genuinely collaborative"

Elective recovery

Support elective recovery across the organisations

- "BHRUT can support Barts Health with elective management"
- "Learning about how we do elective most effectively and redesigning best practice pathways"
- "Elective recovery work is a very important area"
- "There is a shared need to grasp elective recovery"

The Appreciative inquiry process has identified further areas of opportunity for clinical collaboration (2/2)

Specialised services

Building expertise in specialist services such as neurosurgery and vascular

- “Neurosurgery has scope for greater integration between the two Trusts, as neither quite has critical mass on its own”
- “BHRUT may struggle to sustain vascular surgery on its own, so 'economies of scale' could be clinically beneficial too”
- “We have good centres for neurosurgery and vascular but as a group we could be in a position where we are rivalling UCLH”

Workforce

Developing a better offer for staff

- “Sharing of workforce between BHRUT and Barts Health would be a helpful collaboration opportunity”
- “Specialised services may benefit from rotating workforce”
- “Real chance for our workforce to learn new skills and knowledge from this potential collaboration”
- “Joint posts are an opportunity, for example in renal and hepatology”

Research and clinical trials

Realising the potential for research through offering the population access to clinical trials

- “ There is absolutely scope for us to work together. Barts have the resource that would be valuable to us and we [BHRUT] have lots of patients so there is mutual benefit”
- “There is lots to be gained through research”
- “Current participation in clinical trials at BHRUT is low and this could improve significantly through collaboration”
- “Collaboration and the scale it brings can bring about research opportunities”

Work is already being undertaken across North East London on three priority programmes of corporate collaboration

- In July 2020 the **North East London Leadership Group identified 6 programmes of enquiry** (Procurement, Finance, BI & Analytics, Information Technology, Human Resources and Estates & Facilities)
- Due to the operational pressures presented by Covid, the Corporate Services programme was paused and it was agreed that **three priority programmes** would be focused on moving forward – **Procurement, Finance and BI & Analytics**

Priority programmes	Overview
Procurement	• Final transformation business case has been approved for the Commercial Procurement collaboration • Longer-term opportunities in Estates, IM&T, Clinical consumables and Continence Products have been identified. Key lines of enquiry will be further explored to understand the potential savings for NEL
Finance	• Four sub-programmes identified: Financial Intelligence, Strategic Business Intelligence, Transaction & Controls and Production • Options appraisals paper for each of the sub-programmes to be reviewed between Sept-Dec'21
Business Intelligence and Analytics	• Programme is dependent and closely linked the ICS Digital Transformation Programme • Currently focused on the data warehouse sub-programme, options appraisal is due to take place in Oct'21

Source: NEL Steering Group position paper, June 2021

The Appreciative inquiry process has identified further opportunities for deeper corporate collaboration between the Trusts

Opportunity to make more efficient use of current estate infrastructure and share expertise

Developing joint estate strategies and consolidation of expertise in areas such as clinical planning have been highlighted as potential opportunities

- "BHR are already at a similar point to Barts Health in terms of taking an estates strategy forward. I'm keen to take a piece of work forward to combine a strategy"
- "Our [BHRUT] estates strategy needs to be refreshed and Barts health are at a similar position so why don't we do a joint estates strategy piece"
- "Sharing resource between the organisations. For example, in clinical planning, will mean we don't have to go to outside organisations"
- "We can coordinate resources on PFI management"

Opportunity in transactional services and the benefit from doing things once

There is appetite to collaborate on simple transactional processes to ensure services are only done once

- "There are a lot of opportunities around transactional services. Data processing, IG, payroll are all example services"
- "Areas like recruitment, pay and rations, administration, IT to enable employees to access their records can be done at a system level"

Opportunity for joint working to share expertise and resource

Across corporate services, interviewees were keen to work together and build on individual strengths within organisations for the benefit of the system

- "Corporately, there's loads of opportunities to collaborate here"
- "We have a very nimble comms team, who are very resilient. We've got lots to offer in terms of joint working here"

Integrated Care Partnership Board

29 July 2021

Title of report	BHR ICP Risk Management
Author	Anne-Marie Keliris, Head of Governance
Presented by	Pam Dobson, Deputy Director, Corporate Services
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	In May ICPB members received a first draft of the key risks across the BHR ICP, noting further development was required. Following this meeting the NEL CCG considered the CCG's risk management strategy and policy and on 9 June the CCG's corporate objectives were agreed at the Governing Body meeting. A NEL wide risk register was considered by NEL SMT colleagues on 22 June. Further work is underway to refine the overall register and GBAF to ensure ICP/borough risks are managed appropriately locally, but that key risks of significant score or applicable across NEL are escalated to the Governing Body. The current NEL CCG key risks relate to: • Vaccine delivery • Third wave readiness and planning • Building ICS architecture for April 22 • Continued business as usual (BAU) recovery of all services • Elective recovery The BHR ICP risk register has been developed further and is attached for information along with further detail on the risk management cycle.
Action required	Note the current risks to the BHR ICP, the risk management cycle and the key risks to the NEL CCG Governing Body.

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 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	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

DRAFT sample risk register
(to be further developed)

ID no.	Date raised	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Mitigating actions		Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Close Down Status
						Likelihood	Impact	Risk Score (1-25)			Completed	Uncompleted						
BHR ICP 001_21	04/05/2021	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 Integrated Care System (ICS) and ICP from April 2022.	8	2	4	8	6	Mar-22	• Creation of a strong BHR ICP governance structure, with the ICP Board as a sub committee of North East London (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	Anne-Marie Keliris	ICPB	N		Open
BHR ICP 003_21	04/05/2021	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.	8	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	Anil Mehta	Sarah See	ICEG	N	Check if can be managed on the primary care local risk register?	Open
BHR ICP 004_21	04/05/2021	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.	16	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	Ceri Jacob / CEOs	Emily Plane	ICPB	N	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF. Agreed not to escalate - risk rating to be reviewed.	Open
BHR ICP 005_21	04/05/2021	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.	20	4	5	20	12	Mar-22		BHR Health and Social Care Academy being established to support BHR workforce to adapt to new ways of working and deliver more integrated Care.	Oliver Shanley	Kathryn Halford	ICEG	N	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF. Agreed not to escalate - risk rating to be reviewed.	Open
BHR ICP 006_21	04/05/2021	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 inaccuracies.	20	4	5	20	6	Mar-22		• BHR IT system lead and role to be identified / agreed, alongside key priorities • NEL CCG wide strategy to be developed • Scope what is currently in place • Look at how other ICS/ICPs have developed their digital infrastructure • Identify system budget	Steve Collins / Bryan Matthews	Ahmet Koray/ Umesh Gadhvi	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	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.	20	4	5	20	12	Mar-22	• A sub-group of the BHR ICP finance group has been established to start process for the development a BHR ICP financial sustainability plan using the outputs of the Transformation Boards to inform the position across the system. To allow a medium-term financial picture across the BHR and NEL system to be developed.	• Allocations received for quarters 1 and 2 of the financial year and plans are in development. • Development of a BHR Integrated Sustainability Plan to bring together a whole system view of the scale of the financial and activity challenge, including social care	Ahmet Koray	System DoFs	ICEG / ICPB	N	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF. Agreed not to escalate - risk rating to be reviewed.	Open
BHR ICP 008_21	04/05/2021	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.	20	5	4	20	12	Dec-21	Provider estate has been segregated to support cohorting of COVID, and non-COVID pathways		System CEOs	Provider estate leads	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	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. (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).	20	4	5	20	12	Dec-21		• Meeting to be convened as soon as possible linking in with the CAMHS Task and Finish group to ascertain what plans have been developed to meet future potential surges - to include representatives from the 3 LA to address issues relating to social care, delayed discharge, safeguarding and provider collaborative reps. NELFT are confirming attendees from both community and Interact/CYPHTT provision. Whipps Cross is being requested to attend to agree common approaches. TOR, actions and required outcomes for subsequent distribution and assurance. • Urgently review the services that are in place for this cohort, and what this means for developments of community services - including system reconfigurations to enable a holistic 18-25 pathway, especially with many more young people transferring to adults.	Oliver Shanley	Elaine Allegretti	SOCG / CYP Transformation Board	N	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF. Agreed not to escalate - risk rating to be reviewed.	Open
BHR ICP 010_21	04/05/2021	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 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.	16	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	N	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF. Agreed not to escalate - risk rating to be reviewed.	Open
BHR ICP 011_21	04/05/2021	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.	16	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 • BHR ICP focus on ensuring that Borough Partnerships are established	Ceri Jacob	BHR Borough directors / DASSs	ICPB	N	Score of 15 or above - to be escalated to NEL CCG corporate risk register and GBAF	Open

BHR ICP 012_21	01/06/2021	16	Support our people to thrive/ recover from the pandemic and be prepared for future waves	If there is a 3rd COVID 19 wave of infections in early autumn 2021, this could result in workforce capacity issues due to sickness / caring duties. Modelling is not clear currently however, assumptions are that it will affect more younger people (0 - 35 yrs.), and if the elderly are affected who have had the vaccine fewer people could require hospitalisation.	New	4	4	16	8	Mar-22		Surge planning workshop to be held by partners on 10th June 2021 to prepare for this surge alongside the ongoing capacity pressure of delivering the vaccination programme .	Oliver Shanley	Steve Rubery	SOCG	N		Open
BHR ICP 013_21	01/06/2021	16	High quality services for patients	The Coronavirus (CV19) Pandemic and subsequent lockdowns / reduction in face to face appointments has resulted in a backlog of elective activity which needs to urgently be addressed. On top of a backlog in many areas of elective activity that BHR was trying to address pre-pandemic. There is a risk going forward that additional peaks in covid activity alongside staff having to isolate/being unwell due to the virus, could impact on our ability to address this backlog of activity.	New	4	4	16	9	Mar-22		• BHRUT clinicians carry to out a clinical review of the backlog lists to prioritise the most urgent, to reduce the risk of clinical harm resulting from longer waiting times • Increase capacity to clear the backlog	Archna Mathur	Steve Rubery	SCOG	N		Open
BHR ICP 014_21	01/06/2021	12	High quality services for patients	If the system is not able to create the capacity to meet the sustained and significant increase in demand for MH services, there is a risk that waiting lists will grow / an increasing number of people suffering with mental health issues will present at ED. As a result of CV19 pandemic and subsequent national lockdowns, there are a number of people of all age groups presenting with mental health needs, from low level to serious mental illness (SMI). These are across all ages (with particular increases in the younger cohort) and relate to a number of different factors including joblessness, home situation, homelessness, anxiety etc.	New	3	4	12	8	Mar-22		• Transformation programme jointly with partners particularly for the SMI cohort - looking at the entire pathway for this group of people and how they can be better managed through an integrated system • Utilise national transformation funding for the community SMI programme • Crisis business case being developed with CCG and NELFT looking at specific provisions designed to meet crisis demand - for sign off by the MH Transformation Board by end August	Oliver Shanley	Jacqui Van Rossum	SCOG / MH Transformation Board	N		Open
BHR ICP 015_21	01/06/2021	12	High quality services for patients	There is a cohort of people, (esp. young people and female people) in BHR who are dealing with 'long covid' symptoms including fatigue and ongoing breathlessness. This is a new pressure on the health and care system and there is a risk that this cohort of people will not receive comprehensive care and support.	New	3	4	12	6	Jun-22	Long Covid MDT service established in the community - October 2020 to run until March 2022. Led by NELFT and primary care with input from a respiratory consultant, Physiotherapy, occupational therapy and clinical health psychologist to provide wrap around support to this cohort of people.	Identification of Long CV19 people to link to the service	Adrian Loades	Tracy Welsh	SCOG / LTC Transformation Board	N		Open

Risk grading matrix

	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
Severity	1	Insignificant	Insignificant cost increase/time slippage. Barely noticeable reduction in scope or quality	Incident was prevented or incident occurred and there was no harm	Locally resolved complaint	Loss/ interruption more than 1 hour	Short term low staffing leading to reduction in quality (less than 1 day)	Small loss <£1000	Minor recommendations	Rumours
	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	Recommendations 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/service due to lack of staff. On-going unsafe staff levels. Small error owing to insufficient training	Loss of more than 0.25% of budget. <£100,000	Reduced rating. Challenging recommendations. 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

Risk category	
Severe	
High	
Medium	
Low	

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

ID no.	Date raised	Raised by (individual/ committee/ programme)	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Mitigating actions		Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Close Down Status
							Likelihood	Impact	Risk Score (1-25)			Completed	Uncompleted						
BHR ICP 002_21	04/05/2021	TBA	8	Develop our NEL integrated care system	If the instability of senior and clinical leadership continues in the BHR system, this could affect the pace of progressing the ICS and therefore strategy development and delivery could be compromised.	8	2	4	8	6	Mar-22	agreed to the BHR ICP through the ratifed governance process of the Integrated Care Partnershipo Board • Review of BHR Health and Care Cabinet membership / ways of working complete, alongside cementing (how was this achcieved ?) 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 to ensure that there is strong clinical, CEO / executive director level (professional) leadership at each level of the partnership - complete • Revied clinical leadership across the BHR system,ensuring gaps identified and addressed to ensure 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 BHR ICP to provide resource to support development of the BHR PCN clinical directors, starting with 1-1 interviews to develop PDPs and a tailored development programme.	Ceri Jacob/ Caroline Allum	Emily Plane	ICPB	N		Closed - 19 July 2021 via BHR SMT
									0										

Risk Management report to the Integrated Care Partnership Board

29 July 2021

North East London Clinical Commissioning Group

Reporting of Risk

This slide is included as a reminder of the process for review of risks for the ICPB.

The ICPB can ask to see areas of risk from the system but it might be helpful to see all risks relating to particular areas of discussion already on the agenda.

Only high level risks for the local system will be reported to the ICPB at each meeting for review and discussion. This standard risk report will highlight any changes to risk scores, new risks or new mitigations.

Once discussions taken place at ICPB the risk will need to be updated with mitigations and actions.

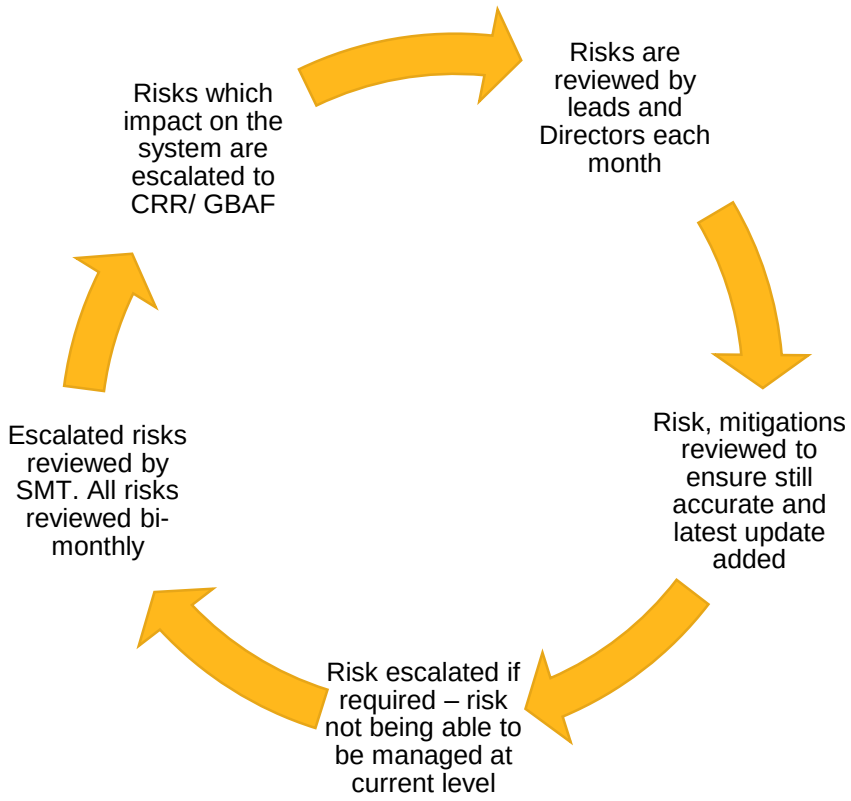
Escalation of risks will be to CCG side SMT to assess if it is an ICP issue or a CCG issue. If the risk is high, and the rest of the system need to be aware of it then it will be escalated to the ICPB as an issue to be discussed. If the risk is CCG side it will need to be escalated to the NEL corporate risk register.

All risks are discussed and reviewed as part of the day to day work within the workstreams and areas across the ICP; with the register then updated. Any areas of work which are causing concern to be escalated.

Risk Management cycle

Each month:

- Risk owners will be asked to review their risks to ensure the risk is up to date – an email reminder will be sent out to all leads
- Risks can also be taken to other groups and sub-committees for review and discussion if this will enable the risk to be more widely understood and managed
- Risks can be updated at any point following discussions with owners and at meetings
- There will be one primary owner of the risk on the register with a named NEL SMT lead included; however it is important that for NEL wide programmes (e.g. vaccine, CHC) that risk owners discuss this with their peers across NEL
- Governance team will review the registers, and update information to be sent to the NEL CCG corporate risk register or GBAF



Bi-monthly:

- NEL SMT will bring their risks to the SMT meeting for review to ensure risks are being appropriately managed and escalated across the organisation.

Integrated Care Partnership Board

29 July 2021

Title of report	Next steps for Borough Partnership Development in Barking and Dagenham, Havering and Redbridge (BHR)
Author	Emily Plane, Programme Lead, BHR System Development
Presented by	Emily Plane, Programme Lead, BHR System Development
Contact for further information	e.plane@nhs.net
Executive Summary	Borough Partnerships are a key building block of the North East London (NEL) Integrated Care System (ICS), bringing together delivery of health and care services around the needs of local people including a focus on the wider determinants of health, at a community/place-based level. In BHR, Borough Partnerships are in the first year of formal development. Each was provided with initial funding to support production of a development roadmap setting out their current arrangements and plans, and what their priorities will be over the coming months to help the Partnerships to both embed, and effect real change for local people, ahead of April 2022. Each BHR Borough Partnership has now submitted their development Roadmaps to BHR partners, and within the context of the Health and Social Care Bill publication alongside additional guidance being released on ICS development[1], we are now in a position to release phase 2 funding to support further development and operationalisation of the BHR Roadmaps. The process to release phase 2 monies to support Borough Partnership development is underway.

[1] Integrated Care Systems Design Framework, June 2021, NHS England

	This paper provides a summary of key next steps for development of the BHR Borough Partnerships.
Action Required	ICPB members are asked to: ▪ **NOTE** the detail of this paper and the next steps for development of the BHR Borough Partnerships. ▪ **CONSIDER** the operating model and implications for the Integrated Care System / Borough Partnership development of the latest ICS guidance / Health and Social Care Bill
Where else has this paper been discussed?	ICPB members will be familiar with the detail of the development of Borough Partnerships in BHR, having discussed these in detail at several previous meetings, with ICEG having endorsed the first and second phases of funding to support development of the roadmaps.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	As set out in the recent White Paper and reiterated in recent guidance, Borough Partnerships, alongside Primary Care Networks, are the foundation blocks of Integrated Care Systems. Ahead of planned legislative changes in April 2022, it is imperative that our Borough Partnerships use the time between now and then to embed themselves and seek to effect real positive change for local people. Borough Partnerships will support closer integration of services, tailored to the needs of local populations, with a strong focus on reducing inequalities and embedding prevention.
Conflicts of Interest	The phase two funding which ICEG members have endorsed the release of, will transfer to the London Borough of Barking and Dagenham, the London Borough of Havering, and the London Borough of Redbridge on behalf of their respective Boroughs. Leads from these organisations are also members of ICEG. The Borough Partnership roadmaps submitted set out clear intention for each Borough Partnership to spend the next phase of the funding on dedicated Project Management to take forward development of the Borough Partnerships and key workstreams, alongside elements of organisational development to support relationship building within the Borough Partnerships themselves. The Borough Partnership member organisations, including the Local Authorities will also be inputting resource

	into the development of the Borough Partnerships, particularly in the form of management/officer time.
Strategic Fit	This paper relates directly to all of emerging BHR System priorities.
Impact on finance, performance and quality	The CCG has identified £300,000 total to support phase two of Borough Partnership development.
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 the BHR Borough Partnerships, there is a risk that we will not be in a strong position from April 2022 when the planned legislative changes are due to take place if we do not support development of our Borough Partnerships now.
Equality Impact	Not applicable at this stage.

Borough Partnership Development in Barking and Dagenham, Havering and Redbridge

1.0 Introduction

1.1 Borough Partnerships are a key element of the North East London Integrated Care System, bringing together delivery of health and care services around the needs of local people. This will include input around the wider determinants of health, at a community/place-based level.

1.2 One of the key aspirations for the BHR Borough Partnerships, will be 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.

1.3 Further to publication of the White Paper; 'Integration and Innovation: Working together to improve health and social care for all', published on Thursday 11th February 2021, The Health and Social Care Bill has now been published. This set out plans to move to more formal partnership working as Integrated Care Systems from 2022, replacing CCG statutory bodies. This places even greater

emphasis on the importance of supporting the development and maturity of Borough Partnerships throughout 2021/22.

1.4 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.

2.0 The Borough Partnership Roadmaps

2.1 The BHR Integrated Care Partnership endorsed earlier this year the release of £15,000 per Borough (£45,000 total) to support development of Borough Partnership Roadmaps, with the intention that these would be developed and submitted to the BHR Integrated Care Partnership by the end of May 2021.

2.2 Each Borough Partnership has now submitted a roadmap setting out;

2.2.1 Membership of the Borough Partnership, which includes key partners from across health and care, including the community and voluntary sector. A key next step for each Borough Partnership is to consider how they will link with and engage local people on an ongoing basis to continually feed into and shape plans for local service transformation.

2.2.2 A clear vision setting out what the Borough Partnership aims to achieve. These all focus on pooling resources and tailoring and integrating services around the needs of local people.

2.2.3 Scope of the Borough Partnership, particularly including their key priorities for 2021/22 – a summary of the emerging priorities is set out below. The Borough Partnerships have also articulated within their roadmaps the priorities that they will focus on beyond this, and an indication of how they 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.

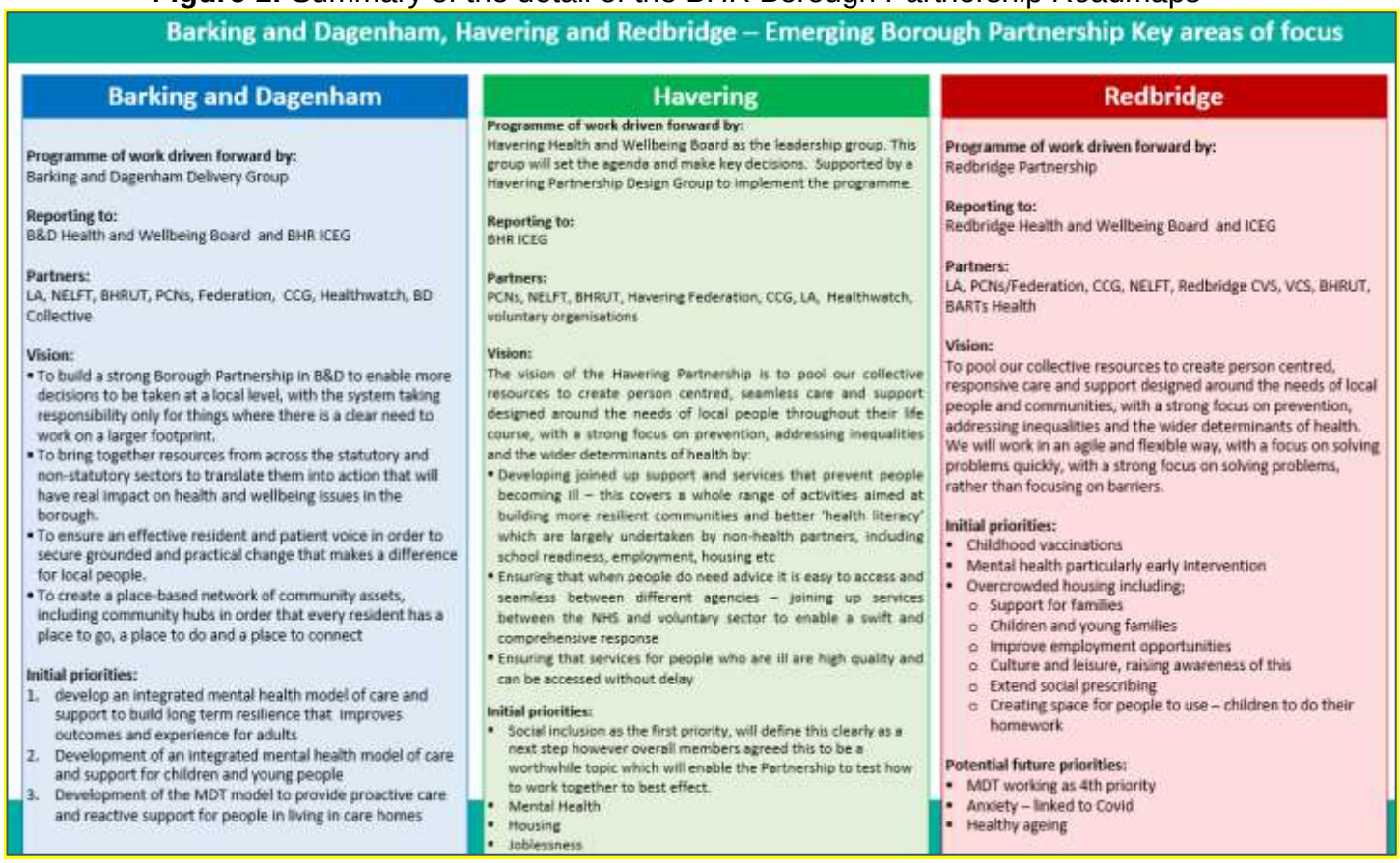
2.2.4 Timespan; each Borough Partnership's development journey to April 2022 and beyond

2.2.5 How the Borough Partnership intends to use phase two of the development fund in 2021/22. Each of the Borough Partnership roadmaps submitted articulated a clear intention for each Borough Partnership to spend the next phase of the funding on dedicated Project Management to take forward development of the Borough Partnerships and key workstreams, alongside elements of organisational development to support relationship building within the Borough Partnerships themselves. The Borough Partnership member organisations, including the Local Authorities will also be inputting resource into the development of the Borough Partnerships, particularly in the form of management/officer time.

2.2.6 The asks of the BHR ICP and NEL ICS from the Borough Partnerships to enable them to take forward their programmes of work and embed.

2.3 **Figure 1** below provides a summary of the key elements of the Borough Partnership roadmaps, including their vision; membership; emerging governance arrangements and initial areas of focus:

Figure 1: Summary of the detail of the BHR Borough Partnership Roadmaps



2.4 Members of the BHR Integrated Care Executive Group endorsed release of phase 2 funding (£100,000 per borough) at their June 2021 meeting, to support operationalisation of the Borough Partnership Roadmaps.

2.5 The CCG has written to each Local Authority (who will hold and spend these funds on behalf of their respective Borough Partnerships), asking them to confirm how the funds will be spent, ahead of transferring the monies.

2.6 A Borough Partnership Development workshop was held on 19th May with teams from across the three BHR Borough Partnerships. A follow up workshop is planned to take place on Monday 26th July to talk through the implications of the publication of the Health and Social Care Bill, and what this means for Borough Partnership development in BHR, and next steps for Borough Partnership development. There will be a further workshop in September 2021 to work though which functions of an ICS Borough Partnerships would like to take on from April 2022 and beyond.

2.7 The CCG has also written to Directors of Public Health, identifying non-recurrent funding linked to the Integrated Sustainability Plan to support prevention, and asking them to consider how this could be spent on improving outcomes for local people. This will be discussed further at the workshop on the 26th July.

3.0 Next steps

3.1 Next steps for phase 2 Borough Partnership funding in BHR include:

- 3.1.1 Local Authorities to confirm to Emily Plane, Programme Lead, BHR System Development, how is it anticipated that the phase 2 Borough Development funding will be spent
- 3.1.2 The CCG will then work with each Borough to transfer the funding over the Local Authorities on behalf of their respective Borough Partnership

3.2 Following the success of the19th May Borough Partnership development session, A follow up session is planned to take place on 26th July 2021.

3.3 By autumn 2021 the ICP wants to build a picture of the things that Borough Partnerships would want to do collectively across BHR. The Borough Partnerships have therefore been asked via the feedback on their Roadmaps to start to map this out over the coming months as part of the next phase of their development. This will be further discussed at the Borough Partnership workshop on 26th July 2021.

3.4 From a North East London (NEL) perspective, Henry Black (Acting Chief Executive, NEL CCG) agreed that NEL alongside partners, will draft a framework for Borough Partnership development, including how the Borough Partnerships and their relationship with the BHR Integrated Care Partnership are expected to evolve over time, with more resources, funding and decision making expected to transition to the Borough Partnerships as they mature. As a BHR partnership we intend to shape this as much as possible to ensure that it will meet our needs.

3.5 The CCG Borough Chairs for BHR are looking to see what additional clinical leadership support can be provided to the Borough Partnership from within the current contingent of CCG Clinical Leads.

3.6 BHRUT are keen to name leads to link in with the BHR Borough Partnerships, with specialities aligned to the key areas of focus identified. Hannah Coffey is in the process of identifying leads within the Trust and these will be confirmed shortly.

4.0 Recommendations

4.1 ICPB members are asked to:

4.1.1 **NOTE** the detail of this paper and the next steps for development of the BHR Borough Partnerships.

4.1.2 **CONSIDER** the operating model and implications for the Integrated Care System / Borough Partnership development of the latest ICS guidance / Health and Social Care Bill

BHR Integrated Care Programme Board

29 July 2021

Title of report	BHR Integrated Sustainability Plan
Author	Mark Eaton, System Recovery Adviser
Presented by	Mark Eaton
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. 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 Mental Health and Learning Disabilities. This paper provides a further update on the development of the Integrated Sustainability Plan including progress to date and next steps.
Action Required	ICPB is asked to: **AGREE** the next steps and timeline. **DISCUSS** what other evidence may be needed to add to the clinical case. **DISCUSS** how we may further represent Local Authorities within the ISP given that it makes a basic assumption that we are not seeking to have it aligned across health and care organisations.

Where else has this paper been discussed?	This paper has been discussed previously at ICEG and ICPB as well as the BHR Finance Sub-Group.
Next steps/ onward reporting	Outlined in Appendix 1.
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	ICP Priority 4 – ICP Development & Sustainability
Impact on finance, performance and quality	Outlined in the accompanying slides (Appendix 1).
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.

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BHR Integrated Sustainability Plan (ISP)

Integrated Care Programme Board (ICPB)
Presenter: Mark Eaton, System Recovery Advisor
29 July 2021

Triple Aim & Objectives for the Integrated Sustainability Plan (ISP)

The following are the proposed aim and objectives for the ISP and have been stated in various forms previously but are presented here for agreement:

Triple Aim of the ISP

The Integrated Sustainability Plan (ISP) is designed to deliver the triple aim of: improving the long term health of our population, reducing pressure on the health and care system and achieving financial sustainability.

Objectives

To deliver the triple aim we have the following objectives:

1. Improve the long term health outcomes (physical and mental health) for our population
2. Increase investment Out of Hospital (OOH) with more funding going into Prevention & Early Intervention
3. Improve support for vulnerable communities and therefore reduce the frequency of urgent needs arising
4. Deliver a reduction in pressures on our Emergency Departments
5. Reshape the casemix of elective activity within secondary care
6. Redress the historic under-investment in Mental Health and Primary Care services
7. Support all system partners to achieve financial sustainability
8. Reduce the unwarranted excess activity in acute care to zero by 2024/25
9. Achieve a recurrent reduction in overall spend by ~£35m/year by 2025/26
10. Increase recurrent investment by ~£35m/year in new models of care and OOH support by 2025/26

Progress to Date

A summary of the progress to date in developing the ISP is given below:

1. Analysis of the original drivers of the deficit to confirm these are still the main causes of system issues
2. Update of all population health metrics to confirm the current/latest available position on our outcomes
3. Agreement of the expected activity plan for 2021/22
4. Retrospective review of the impact of the first year of the previous Financial Recovery Plan
5. Reset of the areas of focus for transformation to deliver the required activity changes
6. Recasting of the financial plan until 2025/26 using ‘best available’ assumptions about finances/activity
7. Initial work on the proposed process for monitoring impact of the ISP
8. Engagement with NHS Partners and others through a variety of forums
9. Initial planning for de-risking the first two years of the ISP using a non-recurrent fund
10. Initial engagement with Transformation Boards about an indicative budget to drive the changes
11. Drafting of the initial narrative to support the ISP

Key Financial Assumptions

The table below shows the key financial assumptions built into the ISP. This excludes the additional investment required to level up Mental Health and Primary Care spend that is also considered within the financial plans for the ISP with this table focusing on reprovision and repatriation assumptions.

ANNUAL GROSS ISP REDUCTIONS	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)	TOTAL
OPD Gross Recurrent Reductions (£)	-£1,703	-£3,265	-£3,549	-£4,259	-£3,549	-£16,324
Daycase/Elective Gross Recurrent Reductions (£)	-£2,472	-£4,738	-£5,150	-£6,181	-£5,150	-£23,692
Non-Elective Gross Recurrent Reductions (£)	-£3,098	-£5,938	-£6,455	-£7,746	-£6,455	-£29,692
TOTAL	**-£7,274**	**-£13,942**	**-£15,154**	**-£18,185**	**-£15,154**	**-£69,708**
% OF SYSTEM ALLOCATION	**-0.6%**	**-1.0%**	**-1.1%**	**-1.3%**	**-1.0%**	

ISP REPROVISION (Provision is Recurrent)	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)	TOTAL
BHRUT (30%)	£1,091	£2,091	£2,273	£2,728	£2,273	£10,456
Barts (5%)	£182	£349	£379	£455	£379	£1,743
NELFT (Community Services) (15%)	£546	£1,046	£1,137	£1,364	£1,137	£5,228
Primary Care (40%)	£1,455	£2,788	£3,031	£3,637	£3,031	£13,942
Local Authority (5%)	£182	£349	£379	£455	£379	£1,743
VCS/CVS & Other (5%)	£182	£349	£379	£455	£379	£1,743
TOTAL	**£3,637**	**£6,971**	**£7,577**	**£9,092**	**£7,577**	**£34,854**

ISP REPATRIATION ASSUMPTIONS (Repatriation is Recurrent)	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)	TOTAL
BHRUT (BHR CCGs)	0.0	3,000.0	2,500.0	1,000.0	0.0	£6,500
Barts	0.0	0.0	0.0	0.0	0.0	£0
Independent Sector & Other Acute Providers	0.0	-3,600.0	-3,000.0	-1,200.0	0.0	-£7,800

Non-Recurrent Fund Proposal

The table below shows the proposed distribution of the Non-Recurrent Fund that is available to support the de-risking of the first two years of the ISP. This will provide indicative budgets for Transformation Boards, an initial Prevention Fund and funds to offset the need to remove income from acute budgets.

Work is still underway to de-risk the remaining 3 years of the ISP.

NON-RECURRENT INVESTMENT FUND	21-22 (£k)	22-23 (£k)	Narrative
Planned Care Transformation Board (ISP)	£2,022	£3,876	These funds are proposed as indicative budgets for Transformation Boards to enable them to achieve the activity changes required to deliver the ISP Triple Aim. Boards would need to submit business cases for approval for funds to be released.
Urgent Care Transformation Board (ISP)	£123	£236	
Older People Transformation Board (ISP)	£889	£1,703	
LTC Transformation Board (ISP)	£542	£1,038	
Cancer Transformation Board (ISP)	£61	£117	
Mental Health Transformation Board	MH has its own funding plan outside of the non-recurrent fund.		
Children's & Young People Transformation Board	£100	£150	The ISP recognises the need for investment to drive key outcomes hence this provision.
Prevention Investment Fund (via Borough Partnerships)	£250	£500	
BHRUT Adjustment (To Maintain Income)	£4,674	£2,658	These will appear as an adjustment to the system finances to offset the need to take funds out of acute budgets.
Barts Adjustment (To Maintain Income)	£909	£663	
Reserves	£200	£342	
TOTAL	**£9,770**	**£11,284**	

Actions Still To Undertake

The remaining actions and timeline are detailed below:

1. Develop Comms Brief and develop/enact Communications & OD Plan with all partners (July)
2. Engage partner boards with the initial & final plan (July/August and September/October)
3. Finalise “Growth Analysis” of expected growth net of transformational changes (July)
4. Incorporate additional Mental Health & Primary Care investments into financial plan (July)
5. Identify how to de-risk the impact on Acute Partners beyond the first two years (July)
6. Finalise the financial and activity plans (August)
7. Agree process for managing indicative budgets for Transformation Boards (August)
8. Finalise work on the proposed monitoring of impact (August)
9. Finalise document including supporting guidance on the plan (August)
10. Take through NEL CCG approval process (September)

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Key Metrics Supporting the ISP

The following tables and graphs supporting the clinical need for the Integrated Sustainability Plan including a review of population health data, system financial data (NHS) and other metrics. Further data such as prevalence gaps for Long Term Conditions and other metrics are not included within this pack but are available on request.

Key Population Health Metrics for BHR

The table below is drawn from the latest PHE Data 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	England	London	B&D	Havering	Redbridge		Worst 3 in London (Not in Order)		
Diabetes	Type 1 Receiving All 8 Care Processes	40.8	43.5	49.1	40.0	44.6		Newham	Enfield	Waltham Forest
	Type 2 Receiving All 8 Care Processes	54.3	57.5	68.5	58.1	65.4		Waltham Forest	Enfield	Hounslow
	Major Diabetic Limb Amputation	8.2	-	10.7	9.2	13.3		Newham	Tower Hamlets	Redbridge
COPD & Respiratory	Emergency Hospital Admissions	415.0	358.0	597.0	363.0	266.0		Southwark	Tower Hamlets	B&D
	<75 Mortality Rate Respiratory Disease	34.2	29.9	61.1	32.7	27.3		B&D	Tower Hamlets	H&F
	65+ Mortality Rate Respiratory Disease	616.1	545.5	901.7	628.1	547.6		Tower Hamlets	Lewisham	B&D
Cancer	% Diagnosed at Stage 1 and 2	55.0	56.5	54.4	55.4	60.2		Brent	City of London	Newham
MSK	% Reporting Long Term MSK Problem	18.5	13.6	15.9	19.2	14.8		Enfield	Bexley	Havering
Cardiology	CHD Admissions (All Ages)	469.8	-	523.5	395.1	542.2		Hounslow	Ealing	Hillingdon
	Heart Failure Admissions (All Ages)	171.8	-	217.9	161.3	172.4		Lambeth	Brent	City of London
	Coronary Heart Disease Mortality (<75)	37.5	-	47.7	37.7	33.4		Newham	Hackney	Tower Hamlets
	Mortality Rate 65+ Cardiovascular Disease	1044.6	994.5	1062.2	1002.4	941.1		Enfield	Hounslow	Haringey
Life Expectancy	Life Expectancy at Birth (Male)	79.8	80.9	78.1	80.1	81.5		Lambeth	B&D	Lewisham
	Life Expectancy at Birth (Female)	83.4	84.7	82.3	84.1	85.2		Islington	B&D	Greenwich
	Healthy Life Expectancy at Birth (Male)	63.4	64.2	60.1	64.2	66.5		Newham	B&D	Hackney
	Healthy Life Expectancy at Birth (Female)	63.9	64.4	62.5	65.9	62.9		Tower Hamlets	Croydon	Hillingdon
	Life Expectancy at Age 65 (Male)	19.0	19.7	17.4	18.6	20.1		Lewisham	B&D	Havering
	Life Expectancy at Age 65 (Male)	21.3	22.3	20.3	21.6	22.6		Islington	B&D	Greenwich
Deprivation	% of People 16-64 in Employment	76.2	75.1	71.1	76.4	71.2		Hackney	B&D	Redbridge
	Deprivation Score (2019)	21.7	21.8	32.8	16.8	17.2		Newham	B&D	Hackney
	Children <16 in Low Income Families	17.0	18.8	22.5	16.5	14.7		Camden	Islington	Tower Hamlets
Mental Health	Prevalence of Common MH 16+	16.9	19.3	22.4	15.9	17.7		Islington	Hackney	Newham
	Prevalence of Common MH 65+	10.2	11.3	13.8	9.9	10.8		Islington	Newham	Hackney

BHR Healthy Life Expectancy

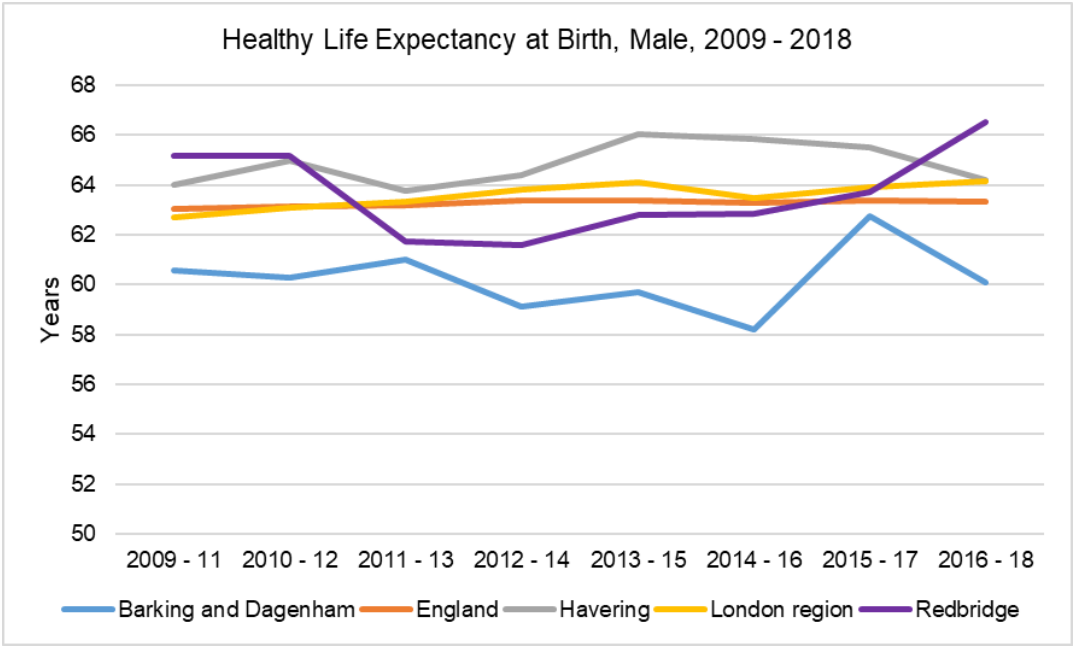
Over the period 2009 to 2018 the HLE for the BHR Boroughs have changed as follows:

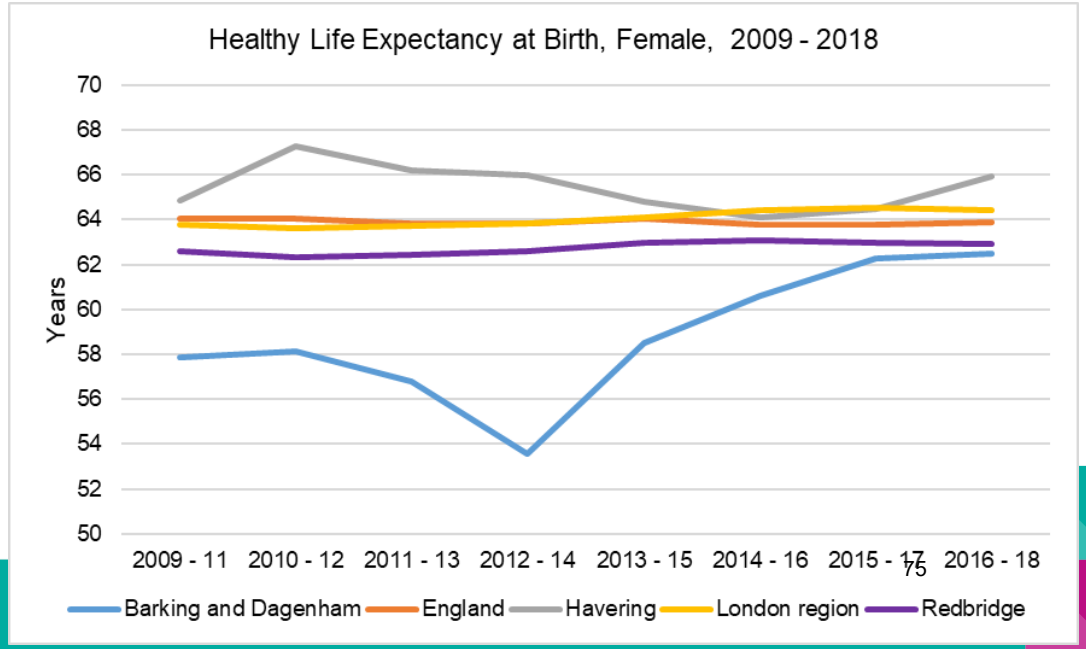
B&D – Significantly below the London Average for both males and females with the improvement in male HLE much slower than that of the London improvement trajectory.

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





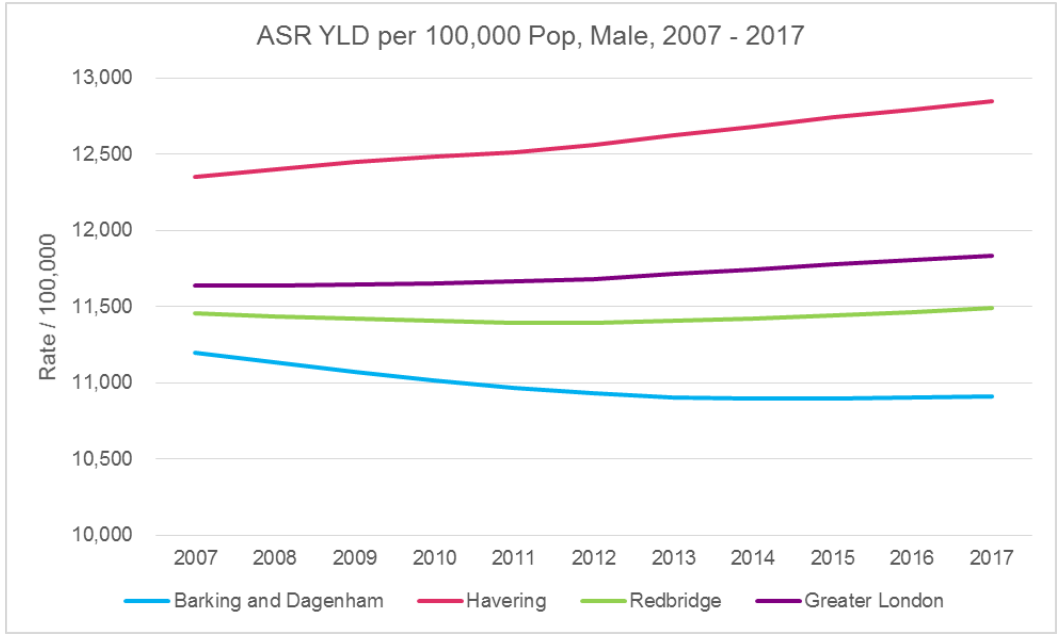
BHR Years Living with Disability

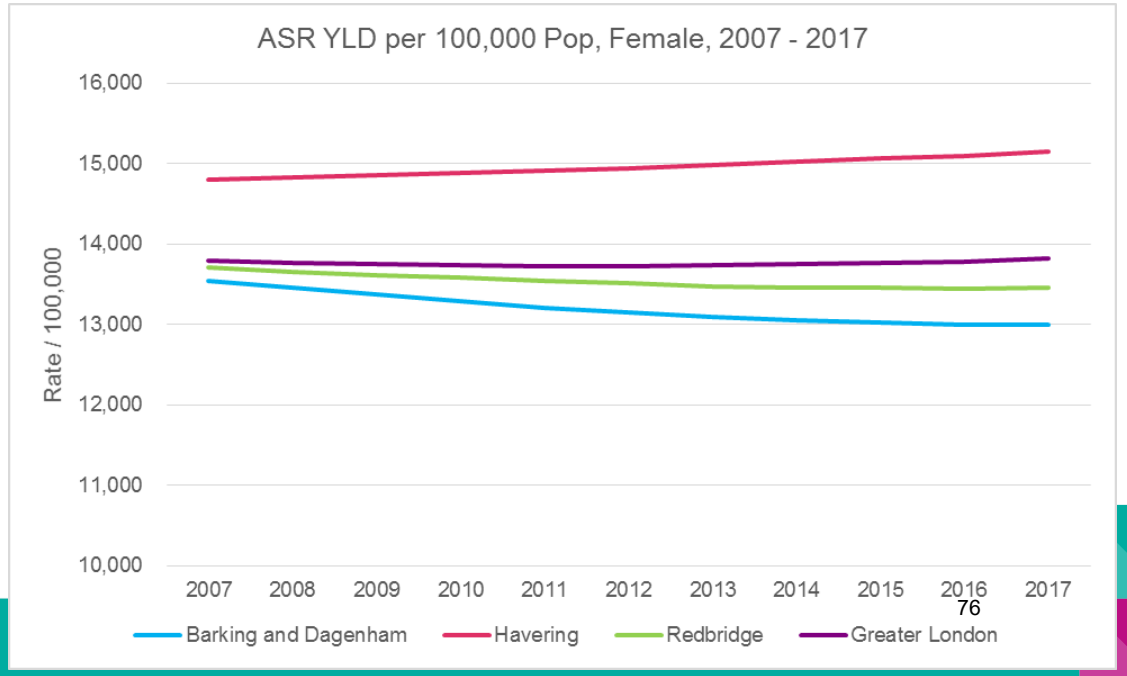
Over the period 2007 to 2017 the YLD for the BHR Boroughs have changed as follows:

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.





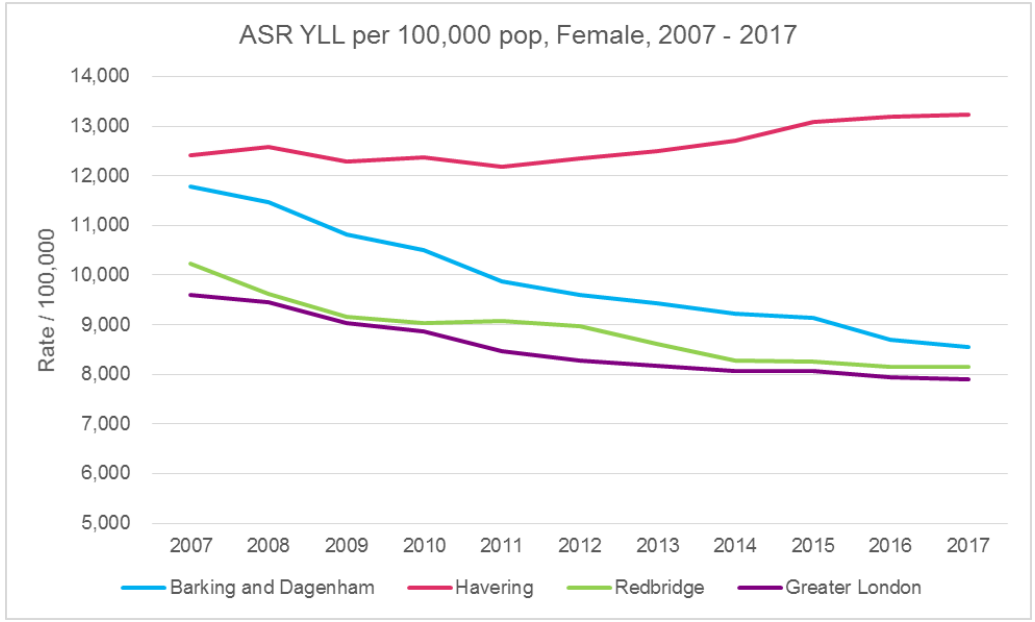
BHR Years of Life Lost

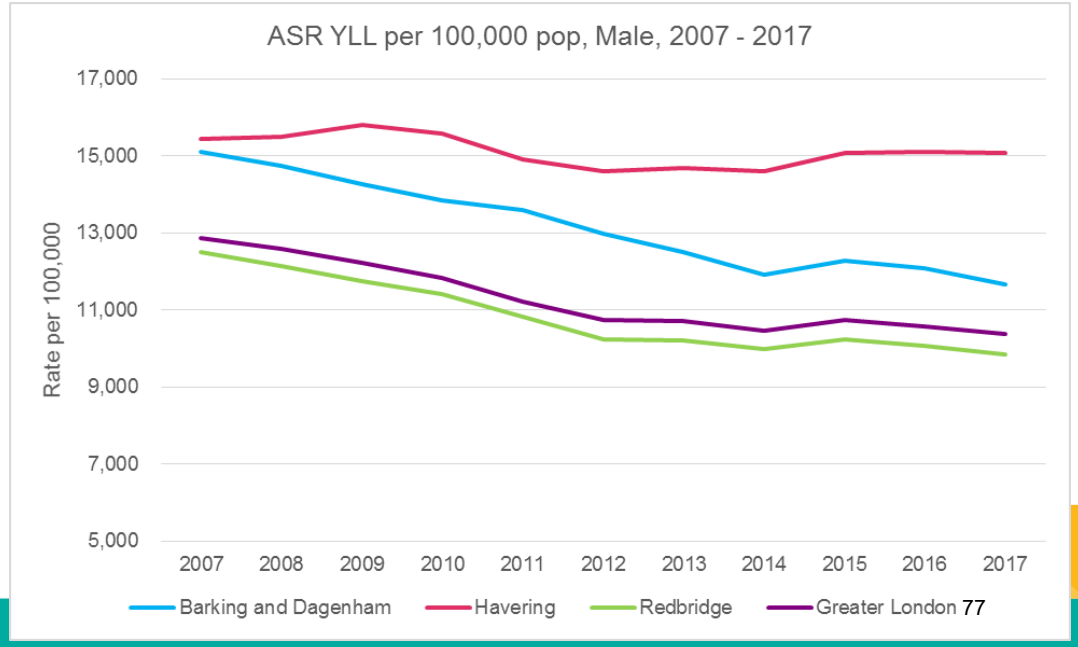
Over the period 2007 to 2017 the YLL for the BHR Boroughs have changed as follows:

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

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)

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)

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 (£)

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

Source: London data store (latest data - 2018)

% Earning Less Than London Minimum Wage

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

Employed Population (%)

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

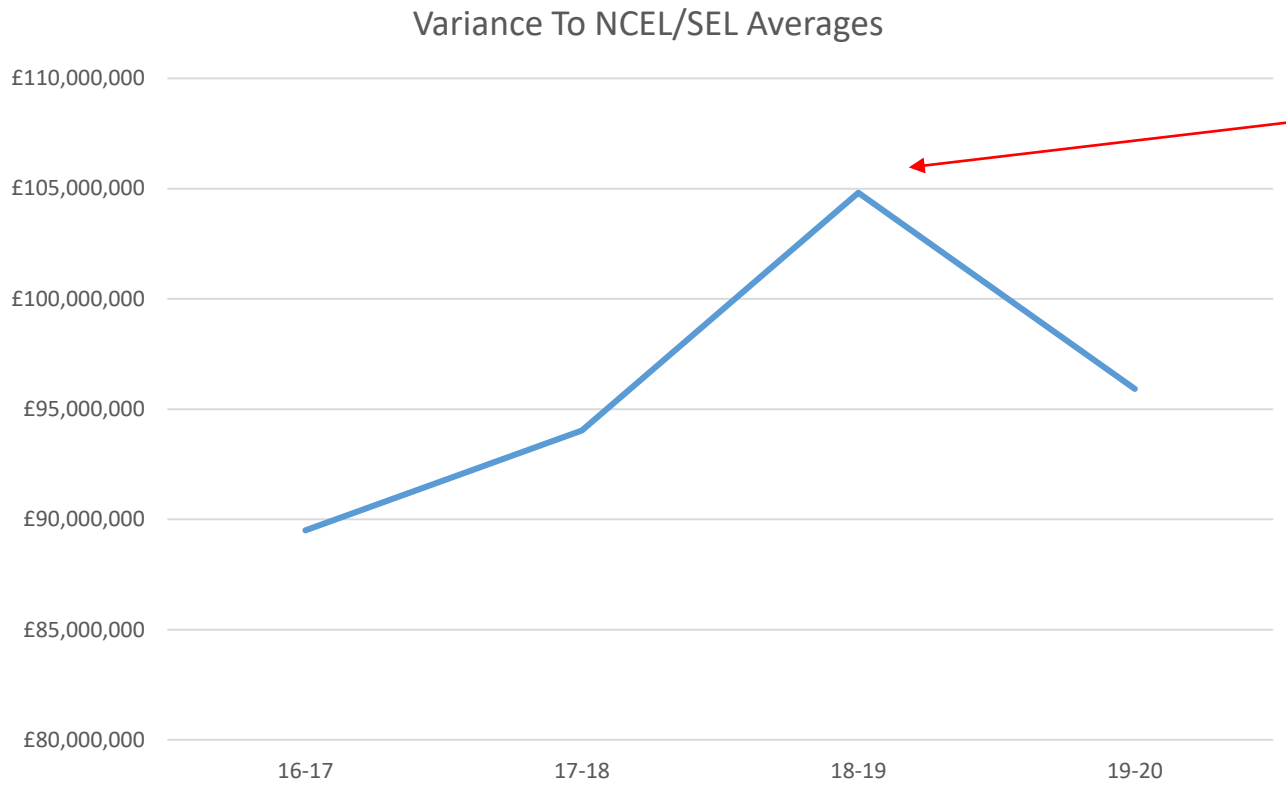
Note: These two columns will not add up to 100% for any Borough as it does not include those who are economically inactive.

Unemployment Rate %

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

Source: London data store (Latest data – Dec 2020

Financial Variance 2016/17 to 2019/20



Financial Recovery Plan Agreed

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 (Slide 1)

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 (Slide 2)

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.

Integrated Care Partnership Board

29 July 2021

Title of report	BHR Health and Care Academy update
Author	Alison Crewe, Academy Programme Lead
Presented by	Kathryn Halford SRO
Contact for further information	Alison Crewe
Executive summary	• BHR Academy – Executive Summary and the Next Steps for Future Development – A Proposal was approved by ICEG on 17th June. • Recommendation is requested from the ICP Board to support the next phase of development for the BHR Health and Care Academy which aims to deliver improvements in training, education, recruitment and retention for the benefit of our local residents.
Action required	Approve
Where else has this paper been discussed?	ICEG – 17 June BHR Academy Steering Group – June Meeting
Next steps/ onward reporting	
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The BHR Academy's plans aim to meet the wider determinants of local population health needs by offering improved employment opportunities for our local communities and thereby improved health and wellbeing outcomes to local residents.
Conflicts of interest	None
Strategic fit	ICS Development Developing Improved Workforce Planning Capabilities across BHR Partnership
Impact on finance, performance and quality	

Risks	Please state any risks to the delivery and if possible relate to the CCG BAF risks
Equality impact	Please state if an Equality Impact Assessment been completed and if there are any known implications for equalities, including the mitigations

BHR Health & Care Academy

Executive Summary

Workforce is the most critical factor to the successful delivery of high-quality health and social care. The Barking and Dagenham, Havering and Redbridge Partnership faces significant workforce challenges.

As a partnership, we collectively employ over 33,000 people, many of whom live locally; in context, nearly 1 in 20 people who live in BHR work for the NHS or a Local Authority. This number doesn't include the thousands who work for private care companies and the community and voluntary sector.

In the context of collaborative working, making best use of resource, and the need to innovatively address workforce challenges across our patch, BHR Partners are seeking to establish a Barking and Dagenham, Havering and Redbridge Health and Care Academy (BHR HCA).

This will cover the BHR Integrated Care Partnership footprint and further afield, in line with our partner organisation footprints. This is in line with the key national drivers for workforce transformation, including the aspirations of the NHS Long Term Plan, London Race Strategy, and the plans for statutory changes to formalise integration between health and care partners by 2022.

The BHR Health and Social Care Academy will build on and align the significant number of workforce initiatives already underway across the system, bringing them together, identifying and addressing key gaps, and working with the BHR Transformation Boards and Borough Partnerships to drive the workforce initiatives required to deliver their transformation programmes.

The BHR Health and Care Academy will seek to; promote education, learning and training; improve recruitment and retention; and build human resources management and leadership capability and capacity. As an Anchor organisation we aim to 'grow our own' workforce, offering careers for young people which improve health and wellbeing outcomes.

NHS Trusts and Local Authorities also have, as Anchor Organisations, a responsibility to support a greater number of local people into rewarding careers in health and care, something which, collectively through the BHR Health and Social Care Academy, we can achieve.

Introduction:
Our Shared Purpose across the BHR Partnership: Where we are now - December 2020 – June 2021

OUR VISION
INTEGRATION, CULTIVATION, MOTIVATION
GROWING, DEVELOPING AND EMPOWERING A WORLD CLASS DIVERSE BHR WORKFORCE

The BHR Health and Care Academy aims to engage proactively with communities to ensure that we meet the needs of local people, maximising the impact on narrowing inequalities, diversity and inclusion and enabling staff to act on a collective vision for enhancing community health and wellbeing.

Through the work of the Academy and promoting the employment of local people we aim to increase the health and economic circumstances of residents. This is particularly important post Covid.

The BHR Health and Care Academy will build-on and align, the significant number of workforce initiatives and programmes of work already underway across the system, bringing them together into a whole picture, identifying and addressing key gaps, and working with the BHR Transformation Boards and Borough Partnerships to drive the workforce initiatives required to deliver their transformation programmes.

An Academy Steering Group of key workforce leads and interested partners from across the BHR system and beyond, has been meeting to identify and develop core work streams of work, creating a shortlist of workforce priorities to collaboratively align at a system level and to achieve a more flexible, integrated and healthy workforce.

To maximise and embed the core values of the BHR Health and Care Academy, operational roles and responsibilities have been agreed across the ICP partners with an intent to co-ordinate the delivery of real health and wellbeing improvements for the benefit of our local communities.

BHR Health and Care Academy: Next Steps for Future Development: Sept 2021 – Apr 2023

The BHR Health and Care Academy and Steering Group membership have collectively established core programmes of work and future plans, as identified in the BHR Health and Care Academy's Next Steps for Future Development - A Proposal, which was approved by the Integrated Care Executive Group (ICEP) on 17th June 2021.

This describes the progress already made, the case for change and the benefits for the people who live and work in BHR, as well as the collective resources and structure required to make it successful.

Integrated Care Partnership Board

29 July 2021

Title of report	BHR Priority actions progress update
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	BHR Partners have identified a number of key priorities that we are collectively taking forward, framed around: - Recovering well - Addressing inequalities and prevention - Anchor Organisations - Leadership, Culture, And Leading Change A plan on a page has been developed for each of these areas, and the report at appendix 1 provides an update on progress with RAG ratings against the key actions. At the request of ICPB members, we are in the process of including key data/indicators to show the impact of the measures that we are taking. We have for this report included key headline data for 'recovering well'.
Action Required	Members are asked to note the progress to take forward our key priority areas
Where else has this paper been discussed?	This is a recurring report which will be shared with ICPB members at each meeting
Next steps/ onward reporting	N/A; this report is intended to update members of the BHR Integrated Care Partnership Board on progress of our key priority areas
What does this mean for local people?	Every element of work referenced in this report has the aim of embedding more integrated working with a view to making best use of

How does this drive change and reduce health inequalities?	resources and improving outcomes for local people. Reducing inequalities is a key priority for the BHR Partnership.
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	Capacity, in the context of transitioning to an ICS from April 2022 and establishing our Borough Partnerships, alongside continuing to deliver transformation, is an ongoing risk, which is being mitigated by bringing in additional resource where required, e.g. funding to support Borough Partnership development
Equality Impact	Not applicable at this stage

Appendices:
Appendix 1 – BHR Priority Actions progress update

Emily Plane
Programme Lead, BHR System Development
July 2021

BHR Integrated Care Partnership

Better care, better lives, together for all

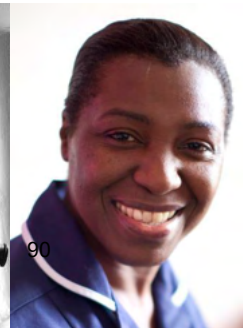
BHR Integrated Care Partnership

Key Priority Areas – PROGRESS UPDATE

Last updated: July 2021





BHR ICP Priority – RECOVERING WELL

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

Overall Objective

To 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.

SRO / Sponsor

Sponsor: Oliver Shanley
SRO: Steve Rubery
with SOCG

2021/22 Aims

- Restoration and Recovery: manage the impact of and respond to the ongoing Pandemic and vaccination programme
- Address immediate operational pressure of demand and unmet need
- Manage backlog of activity safely
- Focus on improving staff wellbeing, recognizing the long term impact of the pandemic on individuals, teams and services
- Review service changes with a view to embed those which have had a positive impact

2021/22 Key Workstreams

Restoration and Recovery

BHR Recovery and Restoration plan first draft May 2021	Complete
Review and inclusion of Social Care Provider Recovery and Restoration into the master BHR Plan June 2021	Complete
BHR Recovery Summit – 6th July 2021	Complete
BHR Recovery Summit action plan developed	Complete
Ongoing review and update of the Recovery and Restoration plan via SOCG fortnightly	Ongoing
Leads progressing actions agreed at the BHR Recovery Summit, some have already been actioned e.g. Clinician to Clinician referrals	In progress
Leads to update on key actions from the Recovery Summit at the BHR Health and Care Cabinet meeting on 12th August	In progress

Surge planning, and meeting demand and unmet need

In preparation for the BHR Recovery Summit, analysis completed on current demand across the BHR system, with action plan developed to address this	Complete
NEL Group convened to ensure a consistent approach to surge planning, feeding into the SOCG meetings	Ongoing
Ongoing Vaccination Programme delivery, including planning to roll out usual vaccination programme alongside COVID	In progress
NELFT/BHRUT/Providers planning response to anticipated surge in Children's Respiratory cases this winter	In progress
Winter planning will start shortly taking all of this into account	In progress

Staff Wellbeing

Ongoing review / discussion at SOCG on initiatives that we can collectively undertake to improve staff wellbeing	Ongoing
Individual organizations are progressing 'thank you' programmes for front line staff	In progress
BHR Health and Care Academy are working on a number of measures to improve staff wellbeing, including initiatives to improve career progression and access to training and development e.g. portfolio placement opportunities	In progress
Piece of work underway around Allied Health Professionals to seek to improve recruitment and retention	In progress

Service Changes

Service Change record collated at a BHR level, recording all of the key service changes that have taken place in recent months, including current status	Complete
Service Changes updated on a weekly basis, and reviewed monthly through SOCG meetings	Ongoing

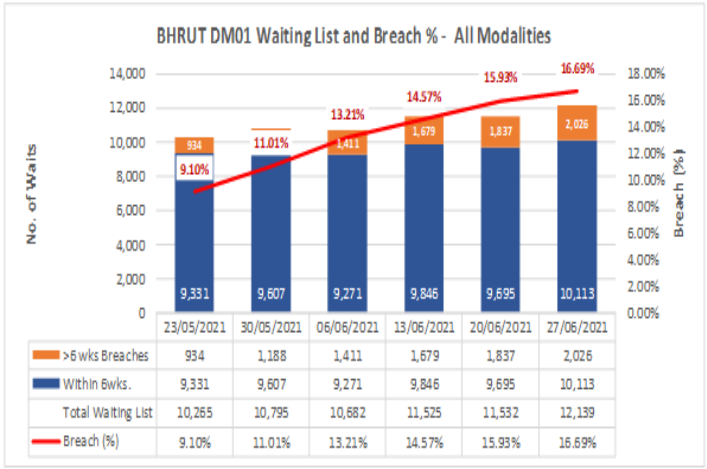
BHR ICP Priority – RECOVERING WELL

Elective Position

BHRUT overall RTT Trajectory	Apr 21	May 21	Jun 21	Trend
18 weeks + - Actual	18,963	18,168	16,814	↘
Waiting list – Actual	48,373	50,407	50,625	↑
RTT performance % - Actual	60.8%	64%	66.8%	↗
52 weeks + - Actual	1,938	1,705	1,379	↘

- The overall number of patients on the waiting list is increasing.
- However, the growth in the waiting list relates to 'new' referrals (<18 weeks).
- The level of patients waiting 18+ weeks, and 52+ weeks are seeing a week on week reduction.
- However, the level of 40 week waiters has remained consistently around c3.5k over recent weeks.
- In the last 2 weeks in June, c60% of Elective activity (Ordinary Elective and Day Cases) related to patients on the P1-4 list.
- This is an increase of 40% (up from c18%-20%) from the previous weeks.

Diagnostics



- The number of patients on the waiting list for diagnostics has been increasing over the past 3 months
- Overall, the number of patients seen within 6 weeks has increased, however, proportionately, the level of breached (>6 weeks) has also been increasing
- Improvements have been seen in:
  - Endoscopy
  - Colonoscopy
  - Flexi Sigmoidoscopy
  - Gastroscopy
- Challenges remain in Imaging Modalities which are reporting the following for the week ending 27/06/21 (unvalidated current data) :
  - MRI (31.29% breaches)
  - CT (21.26% breaches)

Referrals

- Referrals into BHRUT has been increasing since February, with the current referral rates exceeding the average monthly levels.
- GP referrals has significantly increased in June
- Referrals from other sources has exceeded the average monthly levels by c2,000, and double the 19/20 levels.
- Whilst the current level of Outpatient activity is above the NHSE Operating Plan target and currently at pre-covid levels, there is a risk that an increasing rate of referral (demand) will exceed capacity resulting in increased pressures on the growing waiting list.

BHR ICP Priority – ADDRESSING INEQUALITIES AND PREVENTION

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

Overall Objective

To develop and embed a comprehensive approach to addressing inequalities and prevention at every level of the BHR Integrated Care Partnership.

SRO / Sponsor

Sponsor: TBC
SRO: TBC
with HCC and BHR Prevention Group

2021/22 Aims

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

2021/22 Key Workstreams

Develop an approach to population health management in BHR

BHR approach will build 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.	In progress
BHR Prevention Group established, led by Usman Khan, LBBD, with a focus on: ○ Diabetes/obesity ○ Hypertension / CVD ○ Atrial Fibrillation ○ Physical and Mental Wellbeing ○ Social Isolation ○ Falls prevention ○ Dementia ○ Cancer	In progress
Borough Partnerships have submitted expressions of interest to take part in a Population Health management programme – process being led at a NEL level. Meeting towards the end of July to identify the successful areas.	In progress

Supporting key priorities from each of our Borough Partnerships

Phase 1 £25,000 funding to BP's	Complete
19th May development workshop	Complete
Submission of Roadmaps 31st May	Complete
Feedback provided to BPs – 4 June	Complete
ICEG to review/endorse 2nd phase	Complete
£100,000 Phase 2 funding release	In progress
Borough Partnerships to use £100,000 to bring in resource to take forward their development	In progress
Borough Partnerships to take forward Operationalisation of their Roadmaps	In progress
NEL to draft a framework for Borough Partnership development within ICS, with BHR input – Jul/Aug	In progress
BHRUT to name leads to join Borough Partnerships – Hannah Coffey	In progress
26th Jul – 2nd Borough Partnership development workshop	In progress
Sept/Oct – 3rd Borough Partnership Workshop to be arranged	In progress

BHR ICP Priority – ANCHOR ORGANISATIONS

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

Overall Objective

Agree a collective approach to fulfilling our social obligations as Anchor Originations to our local communities and workforce, linking with the NEL Anchor Organisations workstream.

SRO / Sponsor

Sponsor area 1: Oliver Shanley / Kathryn Halford
Sponsor/SRO area 2: Hannah Coffey/Barbara Nicholls
with BHR HCA Steering Group

2021/22 Aims

Launching the BHR Health and Care Academy, to improve recruitment and retention and increase employment opportunities for local population

Support and develop the communities we serve as 'anchor organisations', through community development and spending money locally to promote local economic development and sustainability

2021/22 Progress on Key Projects

BHR Health and Care Academy

BHR Health and Care Academy Group established – Ali Crewe	Complete
Programme Lead in place – Ali Crewe	Complete
BHR Health and Care Academy Business Case developed	Complete
BHR HCA Business Case to be reviewed and approved	Complete
Agreement of funding envelope to establish a PMO for the Academy	In progress
Establish team to drive forward the work of the Academy	In progress
Piece of work being taken forward immediately around AHPs, including a survey of all AHP staff across the system and recruitment of Project Manager	In progress
Programme of work to support development of the MSK pathway	In progress
Development of a Workforce Dashboard with clear baseline for the system and identification of gaps	In progress
Link Transformation Board requirements into the BHR Workforce Dashboard	In progress

Procurement

Pull together workshop with procurement leads, HR and contract leads to look at what we can collectively do around procurement. What areas can we collectively focus on as a first step, are there any key procurements coming up that we could do something collectively around	In progress
Barbara Nicholls to get date for workshop in the diary Directors of Strategy to brief their Procurement leads ahead of this	In progress

Long COVID

Louise Brent, Long COVID project manager to scope what further can be done around supporting people with Long Covid – Havering Public health projections suggest the numbers could be very high, likely more than we know about through e.g. the referrals to the long covid service	In progress
Barbara Nicholls to speak to Adrian Loads and Elaine Allegretti re LBR and LBBD engagement.	In progress

BHR ICP Priority – LEADERSHIP, CULTURE, AND LEADING CHANGE

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

Overall Objective

Develop and embed an comprehensive approach to developing leadership, embedding a BHR culture, and leading change

SRO / Sponsor

Sponsor: Ceri Jacob
SROs: As set out below

2021/22 Aims

- 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 partnership arrangements within the wider north east London Integrated Care System
- Develop a clear, streamlined and strong framework for decision making and mutual accountability

2021/22 Key Workstreams

BHR Integrated Sustainability Plan

Refreshed data showing the gap BHR - Secondary Care Activity – developed	Complete
Update with Principles to ICEG/ICCB May	Complete
Develop agreed Activity Plans for BHRUT for 21/22 and 22/23	Complete
Develop more detailed efficiency aspirations (activity reductions) by TB	Complete
Draft ISP for review/approval	Complete
Final ISP for Approval – June/July 2021	Complete
Comms & OD plan to Partners July	In progress
Final Plan engagement Sept/Oct	In progress
Finalise Growth Analysis of Transformation Changes July	In progress
MH + Primary Care invest incorporated	In progress
De-risk impact on acute partners 2 yr +	August
Agree process for managing indicative budgets for TBs (August)	August
Finalise work on proposed monitoring of impact	August
Take through NEL CCG approval - Sept	September

Lead: Mark Eaton/Steve Rubery

Supporting PCN Development

Engagement with PCN CDs to design an approach to development and support	Complete
NHS Elect Commissioned to undertake initial PCN interviews – end May 2021 – 10 interviews	Complete
Outputs from NHS Elect interviews reviewed and developed into a proposal for ongoing PCN Development	Complete
PCN Development session – 27th July – to review next steps for PCN development	In progress
BUDDYING: Match PCN CDs with CCG CDs for ongoing peer support	In progress
MENTORING: Match each PCN CD to a senior clinician from across BHR for dedicated mentoring sessions	In progress
BHR Heads of Primary Care to set up **regular meetings with the PCN Managers** for their respective Boroughs	In progress

Lead: Sarah See

Development of local arrangements within NEL ICS

May ICEG and ICPB OD sessions	Complete
Continued ICP development driven by Directors of Strategy	ongoing
Discuss and agree at July ICEG meeting if OD programme at BHR level is to continue and next steps	In progress
Develop a clear, streamlined and strong framework for **decision making and mutual accountability**	In progress
Continued support for development of PCNs and Borough Partnerships within wider ICP structure	In progress
Ongoing OD / building of relationships and strengthening of Borough Partnerships position within the wider Partnership structure.	In progress
BHR feeding in to and shaping proposals around the how NEL ICS will form, responding to the latest guidance and Health and Social Care Bill	In progress

Leads:
Ceri Jacob, Jacqui Van Rossum, Hannah Coffey, Barbara Nicholls

Integrated Care Partnership Board

29 July 2021

Title of report	BHR Finance Report
Author	Julia Summers, Head of Finance
Presented by	Steve Collins, Chief Finance Officer
Contact for further information	ahmet.koray@nhs.net
Executive summary	**Key issues** The CCG budgets have been set for the first six months of the financial year (H1), with a required break even position required across NEL CCG. At month 2 a full reporting cycle was undertaken and reported to NHSEI. BHR ICP and each of the ICPs in NEL CCG have reported a break-even position in the core budgets. However, a deficit has been reported against centrally held CCG budgets in relation to specific allocation arrangements in place for H1. As with 20/21 the hospital discharge pathway (HDP) will be made available post month end. The same process has also been applied to the elective recovery fund (ERF). The reporting requirement is that these elements are shown as an overspend until the allocation is received. At month 2 this resulted in a year-to-date deficit of £7.8m and a H1 forecast of £18.5m across NEL. **Recommendations** ICPB is asked to note the contents of the attached presentation, including the risks flagged. As more activity data becomes

	available further updates on performance against plan will be given to future committees.
Action required	Note
Where else has this paper been discussed?	BHR ICP Finance Sub Committee
Next steps/ onward reporting	Updates to ICPB
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	Please state if there are any conflicts of interest to manage in relation to the decision requested/issues raised? **This needs to include full details of who is conflicted, what the conflict is and how it will be managed in the meeting.**
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

1. Introduction/ Context/ Background/ Purpose of the report

The CCG has undertaken a full review of financial information at Month 2 and reported within timescales to NHSEI. Alongside reporting an updated financial plan was submitted, this will be reflected in the Month 3 financial information.

The attached presentation is intended to inform ICPB about the Month 2 financial position and the half year forecast (H1).

The paper links to the CCG corporate objective in relation to the delivery of the financial plan.

2. Key messages

The attached presentation includes a summary of the Month 2 year-to-date position and the forecast for the first six months of the financial year (H1).

The core CCG spend is reported as break even. Additionally, the CCG has incurred spend on the hospital discharge pathway and the elective recovery fund which forms part of the retrospective top up process funded by NHSEI.

NHS contracts are currently paid via a block contract. Activity based spend, such as prescribing and CHC have very limited data at Month 2. Therefore, the month 2 position has been reported as break even.

Potential risks in relation to activity based issues and investment slippage have been flagged. The reporting of risks will be further developed in future reporting periods.

3. Body of report

Included in the attached presentation.

4. Risks and mitigations

Included in the attached presentation.

5. Conclusion / Recommendations

ICPB is asked to note the content of the Month 2 finance report. Updates will be given at future committee meetings.

Attachments

Attached presentation – BHR ICPB Finance Report M2

Julia Summers
Head of Finance
1 July 2021

NHS
North East London
Clinical Commissioning Group

Month 2 Finance Overview Report 21/22

Meeting name: Integrated Care Partnership Board
Presenter: Steve Collins
Date: 29 July 2021

Finance Report Month 2

CONTENTS	
Month 2 Overview	Page 2
2020/21 H1 Budget Overview	Page 3
Month 2 and Forecast Position BHR ICP	Page 4
BHR ICP - Key issues	Page 5
Hospital Discharge Pathway and Elective Recovery Fund	Page 6
Financial Accounts metrics	Page 7
Risks and Summary	Page 8
Appendix - ICS Funds and NEL Total	Page 9

Month 2 (May 2021) Overview

- Budgets have been set for the first 6 months of the financial year (H1) across the three integrated care partnership systems for NEL CCG.
- The budgets are based on the overall NEL CCG plan submitted in April 2021, which required a break-even position to be set. A further plan update was submitted in June, and is presented as a separate paper, but this will not change the break-even requirement and will simply reset the plan to reflect the latest available information.
- At month 2 (period to the end of May 2021), BHR ICP and each of the ICPs in NEL CCG have achieved a break-even position on the core budgets, however a deficit has been reported to reflect specific allocation arrangements in place for H1.
- As with last year, funding for the Hospital Discharge Pathway (HDP) will be made available post month-end and the requirement is that these costs are shown in the CCG's books of account as an overspend until the allocation approved and received. The same approach has also been applied to the independent sector activity and cost relating to the Elective Recovery Fund (ERF). These costs are held against the central ICS budget.
- The impact of these two items is a year-to-date deficit of £7.8m and a H1 forecast deficit of £18.5m across NEL CCG. The CCG will receive the funds to cover these via a retrospective top-up from NHSE/I following review and validation. A summary across NEL is provided below, the BHR element of HDP is year-to date £2.5m, with a H1 forecast of £5m.

	YTD £'000s	Forecast £'000s
BHR ICP Planned Position	0	0
CH and TNW ICP Planned Position	0	0
HDP	(6,914)	(16,902)
ERF	(929)	(1,628)
Total Reported Position	**(7,843)**	**(18,530)**

- Activity driven areas, e.g. independent sector and continuing healthcare, have limited data at month 2. As a result, variances at month 2 have been set to break-even, but it should be noted that these areas have in the past been unpredictable and a financial risk which may again materialise as the year moves progresses.

2020/21 H1 Budget overview

- The table below presents an overview of the NEL CCG budget and ICS funds. BHR ICP core budget is £615.7m. More detail can be found on page 4.
- Of the ICS funds (£274m), £159m has been allocated across providers for their deficits (mandated) and the balance remains in the books of the CCG as a number of reserves. This will be allocated once collective agreement is reached on their use.
- ICS and SDF budgets are currently held centrally. The overspends in relation to ERF and HDP are also held centrally, rather than against individual ICPs. More detail about ICS and central budgets can be found in Appendix 1.
- At month 2, all core, ICS and SDF budgets have been assumed to be on plan.

	Budget £'000s	Forecast £'000s	Variance £'000s	Description
BHR ICP budget	615,758	615,758	0	Budgets as per BHR ICP plans
CH and TNW ICP budget	986,300	986,300	0	Budgets as per CH, TNW ICP plans
ICS Funds	274,282	274,282	0	Details below
SDF Funds	28,804	28,804	0	SDF funds for H1
Total CCG Budget	**1,905,144**	**1,905,144**	**0**	
ICS Funds				
Provider growth	8,025	8,025	0	Allocated to providers as part of the ICS plan
ICS COVID	96,904	96,904	0	Allocated to providers / CCG contingency / ICS contingency
Provider deficit	158,944	158,944	0	Allocated to providers
Provider CNST, Spec Comm & lost income	10,409	10,409	0	Allocated to providers
Total ICS Funds	**274,282**	**274,282**	**0**	

Month 2 and Forecast Position – BHR ICP

- Core BHR ICP budgets for the first two months and H1 forecast have been reported as break-even.
- Appendix 1 includes NEL CCG level information and the central ICS funds (including HDP and ERF).
- NHS providers are paid via a block contract. For activity driven spend there is limited activity data available at Month 2 and variances have been set at zero. Areas such as CHC and prescribing can be volatile so further updates will be given at Month 3

	BHR					
Area	Annual Budget £'000s	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute	314,927	104,976	104,976	0	314,927	0
Mental Health & LD	57,868	19,289	19,289	(0)	57,868	0
Community Health Services	56,705	18,902	18,901	0	56,704	0
Continuing Care	38,300	12,767	12,767	0	38,300	(0)
Other Programme Services	18,877	6,292	6,292	(0)	18,877	0
Prescribing	52,544	17,515	17,515	0	52,544	0
Primary Care	8,039	2,680	2,680	(0)	8,039	(0)
Primary Care Co Commissioning	61,018	20,339	20,339	0	61,018	0
Running Costs	7,481	2,494	2,494	0	7,481	(0)
Total Expenditure	**615,758**	**205,253**	**205,253**	**(0)**	**615,758**	**(0)**
Resource Limit	(615,758)	(205,253)	(205,253)	0	(615,758)	0
Surplus/Deficit	**0**	**0**	**0**	**(0)**	**0**	**(0)**

BHR ICP – Key issues

- At Month 2 all NHS Providers were paid via a block contract arrangement. Activity based information for areas such as CHC and prescribing was limited at Month 2 reporting. Therefore, the CCG reported a break-even position across all areas.

- Within the break-position there are some areas to note:

1. Acute – there are some emerging pressures on independent sector costs and activity which will be carefully monitored. These have been mitigated at month 2 through the use of non-recurrent measures.

2. Mental Health – the Mental Health Investment Plan (MHIS) was set for the full year. The H1 budget represents six months of this. At Month 2 it is assumed that MHIS will be achieved. Within the plan there are some potential areas of variability, for example S117 and adult placements. There is a substantial amount of investment in the NELFT contract which will require in-year monitoring to ensure any slippage is jointly agreed. Several services are due to start in the last half of the financial year which will generate a pressure moving forward into 22/23 once full recruitment is achieved. At Month 2 SDF and spending review budgets for mental health are held separately in the central ICS funds.

3. HDP – BHR share of HDP spend is £2.5m at Month 2, with a H1 forecast of £5m (more detail on the next slide). HDP is reported separately as part of the central ICS budgets.

4. CHC – at month 2 CHC is reported at break even. This will continue to be closely monitored as it is a volatile area of spend. Early indicators suggest there may be an emerging pressure around funded nursing care in Havering, due to the number of care homes and joint funded placements in Redbridge.

5. Prescribing – at month 2 there is no in-year data available for prescribing so it has been reported as break even. Further updates will be given as data is received.

6. The BHR ICP has available non recurrent transformation funds to help drive forward the sustainability plan. It is assumed at Month 2 that these funds will be fully committed in year.

Hospital Discharge Pathway and Elective Recovery Fund

Hospital Discharge Pathway (HDP)

	LA YTD £000s	CCG YTD £000s	Total YTD £000s	LA FOT £000s	CCG FOT £000s	Total FOT £000s
BHR ICP Position	2,108	425	2,533	3,720	1,276	4,996

- System budget to be held centrally by NHSEI with NEL CCG reimbursed based on actual spend. Notional budget capped at £20.491m for NEL CCG based on 2020/21 costs. Month 2 suggests NEL CCG will be within the cap.
- Scheme covers the cost over and above that normally commissioned by CCGs and Local Authorities of post-discharge recovery and support services/rehabilitation and reablement care following discharge from hospital and designated care settings.
- Work is underway across BHR and NEL to ensure all services are appropriately charged.
- BHR ICP expenditure of **£2.5m** year-to-date and a H1 forecast of **£5m**.

Elective Recovery Fund (ERF) - NEL

Organisation	Income/Allocation payable	
	Month 2 YTD £000s	H1 YTD £000s
BHRUT	231	6,241
Barts Health	4,011	16,511
Homertom	1,602	3,691
NEL CCG	929	1,628
Total	**6,773**	**28,071**

- ERF plans submitted to NHSE/I captures information from NHS and non-NHS providers - £28.1m
- At Month 2, the CCG only included non-NHS costs in its reported financial position (month 2, **£0.9m** and forecast of **£1.6m**). This is reported at a **NEL level**,
- **rather than ICP specific.**
- NHS provider costs are excluded until ERF allocations are confirmed and received.

Financial Accounts Performance Metrics

- The Better Payment Practice Code (BPPC) performance measure requires 95% or more of invoices, in terms of value and volume to be paid within 30 days of receipt of the invoice, unless there is a dispute. Performance **across NEL CCG** is shown in the table below:

	2021/22 AP2 - MAY 21		2021/22 AP1 - APR 21		2021/22 Year to date		2020/21 Outturn	
	Number	£000	Number	£000	Number	£000	Number	£000
Non-NHS Payables:								
Total Non-NHS trade invoices paid in the year	5,899	53	4,127	43	10,026	95,786	89,808	865,136
Total Non-NHS trade invoices paid within target	5,245	50	4,112	43	9,357	92,637	85,961	824,785
Percentage of non-NHS trade invoices paid within target	**89%**	**94%**	**100%**	**100%**	**93%**	**97%**	**96%**	**95%**
NHS Payables:								
Total NHS trade invoices paid in the year	154	207	282	210	436	416,882	12,449	2,407,453
Total NHS trade invoices paid within target	136	208	282	210	418	417,125	11,472	2,395,694
Percentage of NHS trade invoices paid within target	**88%**	**100%**	**100%**	**100%**	**96%**	**100%**	**92%**	**100%**
Combined non NHS and NHS:								
Total Non-NHS trade invoices paid in the year	6,053	260	4,409	252	10,462	513	102,257	3,272,589
Total Non-NHS trade invoices paid within target	5,381	257	4,394	252	9,775	510	97,433	3,220,479
Percentage of all trade invoices paid within target	**89%**	**99%**	**100%**	**100%**	**93%**	**99%**	**95%**	**98%**

- Performance for both value and number in May 2021 has been affected by the issues experienced in the first weeks of the merged CCG with the flow of invoices through budget holder accounts.

Risks and Summary

- At Month 2 BHR ICP has reported a break-even position on the core budgets.

- NHS contracts continue to be paid on a block basis and there is very little in-year activity data available for areas such as CHC and prescribing. These areas will continue to be monitored and any emerging variances to plan and emerging risks will be reported in future months.

- There may be risk with the independent sector arrangements and ERF/clearing the backlog of activity. This will be further analysed and reported next month.

- The MHIS plan has been set for the full year. There is a substantial level of investment within the MHIS plan with additional system development funds and spending review funds yet to be allocated. Mental Health will need close monitoring to ensure schemes start within planned timescales to make best use of funds. At month 2 it is assumed that mental health services will break even and MHIS will be achieved, but this may be at risk if schemes slip.

- NEL CCG has received £28.8m funding for transformation areas. Plans are being developed by transformation leads, in relation to project plans and BHR specific schemes will be reported on through the Finance Committee reports. At month 2 it is assumed that the funds are fully committed.

- As described in the budget update report, BHR ICP have identified £20m of non-recurrent resources to help drive forward the BHR system sustainability plan. The forecast outturn position assumes that all of these funds will be fully utilised within the financial year. A further update on the sustainability plan and these funds will be presented to future meetings.

Appendix 1 – ICS Funds and NEL Total

	ICS Funds/HDP/ERF - not develoved to ICPs						NEL Total					
Area	Annual Budget £'000s	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s	Annual Budget £'000s	YTD Budget £'000s	YTD Actual £'000s	YTD Variance £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute	241,737	80,579	81,508	(929)	243,365	(1,628)	1,047,478	349,159	350,088	(929)	1,049,106	(1,628)
Mental Health & LD	17,970	5,990	5,990	(0)	17,970	0	197,607	65,869	65,869	(0)	197,607	0
Community Health Services	7,628	2,543	9,276	(6,733)	23,988	(16,360)	151,245	50,415	57,148	(6,733)	167,605	(16,360)
Continuing Care	0	0	48	(48)	145	(145)	80,270	26,757	26,805	(48)	80,415	(145)
Other Programme Services	35,750	11,917	12,049	(133)	36,148	(398)	82,764	27,588	27,721	(133)	83,162	(398)
Prescribing	0	0	(0)	0	0	0	122,792	40,931	40,931	0	122,792	0
Primary Care	0	0	0	(0)	0	0	35,008	11,669	11,669	(0)	35,008	(0)
Primary Care Co Commissioning	0	0	0	0	0	0	168,749	56,250	56,250	0	168,749	0
Running Costs	0	0	(0)	0	0	0	19,230	6,410	6,410	0	19,230	(0)
Total Expenditure	**303,086**	**101,029**	**108,872**	**(7,843)**	**321,616**	**(18,530)**	**1,905,144**	**635,048**	**642,891**	**(7,843)**	**1,923,674**	**(18,530)**
Resource Limit	(303,086)	(101,029)	(101,029)	0	(303,086)	0	(1,905,144)	(635,048)	(635,048)	0	(1,905,144)	0
Surplus/Deficit	**0**	**0**	**7,843**	**(7,843)**	**18,530**	**(18,530)**	**0**	**0**	**7,843**	**(7,843)**	**18,530**	**(18,530)**

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

Agreed minutes - Integrated Care Executive Group

20 May 2021 3.30pm – 5.00pm

Via MS Teams

Members:

Oliver Shanley (OS)	Chief Executive, NELFT – Deputy Chair
Caroline Allum (CA)	Medical Director, NELFT & Health & Care Cabinet Chair
Tony Chambers (TC)	Chief Executive, BHRUT
Magda Smith (MS)	Chief Medical Officer, BHRUT
Adrian Loades (AL)	Director of People, LBR
Matthew Cole (MC)	Director of Public Health, LBBD
Craig Nikolic (CN)	Chief Operating Officer, B&D GP Federation
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation
Diane McKerracher (DM)	Interim Chief Executive, Redbridge GP Federation
Ahmet Koray (AK)	Director of Finance, BHR ICP (Rep SC)
Mark Ansell (MA)	Director of Public Health, LBH (Rep BN)

Attendees:

Hannah Coffey (HC)	Director, Strategy & Partnership, BHRUT
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Mark Eaton (ME)	BHR System Recovery Adviser
Tracy Welsh (TW)	Director of Transformation, BHR ICP
John Craig (JC)	Chief Executive, Care City
Alison Blair (AB)	Director of Transition, BHR ICP
Emily Plane (EP)	Programme Lead, BHR ICP
Sarah See (SS)	Director of Primary Care, BHR ICP
Anna McDonald (AMc)	Business Manager, BHR ICP
Wassim Fattahi-Negro (WF)	Performance & Intelligence Unit, LBBD
Carl Edmunds (CE)	ICS Deputy Director, NEL CCG (Rep ALe)
Mark Gilbey-Cross (MGC)	Deputy Nurse Director, BHR ICP
Melissa Hoskins (MH)	Head of Communications & Engagement, BHR ICP

Apologies:

Henry Black (HB)	Acting Accountable Officer, NEL CCG
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP
Chris Naylor (CN)	CEO, LBD
Barbara Nicholls (BN)	Director of Adult Services, LBH
Carrie-Anne Wade (CW)	Strategic Communications Leader, NELFT
Antek Lejk (ALe)	ICS Programme Director, NEL CCG

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	
1.1	**Declarations of conflicts of interest**	

	The register of interests was noted and the chair reminded everyone of their obligation to declare any interest they may have on any issues arising at the meeting. No additional conflicts of interest were declared.	
1.2	**Action notes from the last meeting**	
	The notes of the meeting held on 24 March 2021 were agreed as an accurate record.	
1.3	**Matters arising**	
	BHR Workforce Academy – an update on this will be presented at the next meeting together with the business case.	OS
2.0	**Transformation Boards**	
	Due to the full agenda, items 2.1 and 2.2 were covered at the same time. **2.1 Transformation Board (TB) achievements to date** TW presented the report which provided details of the key achievements of each TB to date. **2.2 Transformation Boards key priorities** The report outlined the key priorities and workplan of each of the TBs for 20/21. TW advised that following the recovery from the pandemic each TB has re-convened and they are developing their priorities for the first 6 months of 21/22. CN referred to the Primary Care TB and commented that although it sits at a NEL level it would be helpful to see the BHR impact. TW clarified that primary care is included in the 'achievements' section of the supporting slide pack and will be included in the priorities going forward. CA commented on the high number of priorities and suggested the need for them to be streamlined. UB referred to the priorities slide set and commented that it would be helpful if interdependencies were included. The Chair summarised the discussion by reiterating the need to routinely review what is having a positive impact, and areas that may not be working as well, as well as the need to identify 'read-across' the priorities giving the Mental Health TB and Children and Young People TB as examples. ICEG members noted the reports. **2.3 Phlebotomy – case for change** TW provided an overview of the effects of the pandemic on the service and the action taken to recover from the related backlog. The service in place prior to the pandemic did not represent a strategically commissioned model and as a result, work to develop a new model for community phlebotomy provision has been carried out. TW explained that approval is needed in order to implement a one-year pilot from July 2021 based on a model put forward by NELFT which will establish a community service with PCNs operating the primary care provision and BHRUT focusing on specialist tests. The risks of not proceeding with the preferred option 3 were outlined.	TW TW

	AL supported the proposal but questioned the extent of the change to residents in terms of existing phlebotomy services. TW clarified there will be some changes particularly in Redbridge but assured ICEG members that detailed communications messages are being planned, adding that patient feedback will be acted on to ensure the sites are in the right places. CN added that the communication needs to be comprehensive to both patients and clinicians. The Chair asked for an update to come back to ICEG in three months to see how the pilot is progressing. ICEG supported the proposal which will be taken to the BHR Area Committee for final approval due to the level of investment involved.	TW
3.0	**Approach to estates planning**	
	JC explained that Care City have been asked to develop an approach to infrastructural and digital planning for primary care in BHR in order to meet the needs and expectations of BHR residents and staff. Borough workshops for each of the BHR boroughs will be held and ICEG members were asked to support the proposed work, give their views on the project timeline, and also to comment on the proposed membership of the workshops to ensure the right people are invited to attend. CN commented that he would like to see an enhanced view around conflicts of interest which will help when trying to implement any recommendations. HC referred to other estates work underway in BHR and asked how this aligns to that work. AK responded that the BHR Estates Group is being re-established which JC will be attending as well as representatives from BHRUT, NELFT and the North East London Integrated Care System strategic estates function in order to develop a much wider strategy around needs are and mapping of available estate. ICEG members supported the work and will feed back on the membership of the workshops to JC via the MS Team 'chat' function which JC acknowledged. Any further comments to be fed back to JC outside of the meeting.	All
4.0	**BHR Integrated Sustainability Plan**	
	SR recapped that in 2018/19 NHS partners within BHR developed and agreed an Integrated Financial Recovery Plan (FRP) with NHSE/I which had been implemented prior to the Covid-19 pandemic. This had shown promising impact before the Covid-19 pandemic. Following on from the pandemic, an Integrated Sustainability Plan (ISP) is now being developed which builds on, and replaces the FRP, and will include plans around physical health, mental health and learning disabilities. ME asked ICEG members to discuss and agree the proposed principles outlined in the report. CN confirmed his agreement to the identified drivers of the BHR system deficit, particularly in regard to primary care. He referred to the deprivation points outlined in the report and commented that they highlight the differences in the demographics of the BHR boroughs. He commented that since the Covid-19 pandemic, and subsequent easing of lockdown, there is an increasing need to support people to access the right services and support at the right time.	

	HC articulated her support for the direction of travel and commented that the ISP is a helpful progression from the FRP. HC added that there needs to be a collective narrative for clinical and organisational ownership and accountability. HC also referred to risk and the need to consider collectively how we manage this. ME confirmed that the ISP paper will be discussed at the May Integrated Care Partnership Board (ICPB) meeting and will subsequently be taken to partners boards to ensure all partners are sighted on this. ME added that discussions are planned to ensure the ISP is closely aligned with internal organisational plans. AL commented that the principles are currently written in NHS language but the appendix refers to issues such as employment, housing, access to leisure etc and if the intention is to build those into the plan, they should be reflected in the principles. ME responded explaining that the original FRP had been submitted by NHS partners and that ICPB members will be asked if this should be a Health & Social Care integrated plan at the meeting on 27 May 2021. The planning guidance for the NHS is very focused on inequalities and it is acknowledged that addressing inequalities not only improves outcomes for local people, but ensures more efficient use of resources within a system, with a greater amount of resource focused on prevention/supporting people in the community. UB commented that the principles are reasonable and read very well but voiced her concern as to how realistic it is that it will be achieved. ME responded by explaining that in real terms the plan covers a 5-year period to close the deficit and excess spend gap, which it is approximately 2.5% per year of the total budget. After reinvestment it is a 1.25% reduction per year so whilst it is recognised that this will be challenging it is expected that this is deliverable. TC highlighted that one of the biggest challenges across NEL is the current urgent and emergency care performance and that a key driver of this is the legacy of the mis-match in funding around infrastructure, particularly in primary and community care. TC advised that SR is drafting a paper on behalf of the system in regard to the demand and capacity shortfall and suggested that SR links in with ME to ensure the content is reflected in the ISP as the risks need to be clearly defined before the ISP can be presented to the Trust Board. ME acknowledged the points being made and confirmed the aim is that none of the organisations will be disadvantaged and that in BHRUT's case, the biggest change will be to deliver more elective and less non-elective activity, which delivers better outcomes for local people, and is more cost effective for the trust. TC said it would be helpful to reflect this in the plan. HC commented that if we are asking the TBs to deliver this they need to be engaged in the discussions in addition to the system boards. CN gave his view that the TBs are the key vehicle but the driver needs to be the system groups such as ICEG who oversee everything from a system perspective. The chair summed up that the views given were on the whole supportive of the ISP on the basis that the caveats below are addressed. The ISP needs to be presented to IECG on a regular basis to ensure that the we are delivering on it:-	SR/ME SR/ME SR/ME

	• Collective ownership needed • Clinical engagement needed • Risks to be clearly defined • Reflect that this is a collaborative plan between health and social care • Needs to be clear and transparent about what it means for individual organisations so the individual boards are clear on what it means for them • Needs to be in plain succinct language to aid understanding.	
5.0	**Quality & safeguarding report**	
	MGC presented the report which provided an update on key quality and safeguarding issues across the BHR system. Future plans and priorities were also included as part of the report. The Chair thanked MGC for the full and comprehensive report but noted that it would be helpful if some of the positive work that colleagues are achieving across the BHR system could be reflected in future reports as well as the challenges that the system is facing. DM added that it would be helpful to highlight the key concerns and good practice in a summary which can be easily shared. ICEG members noted the update report.	MGC
6.0	**ICS Development update**	
	6.1 NEL ICS CE presented the update on behalf of ALe. Meetings are now in place for the Executive Group, Steering Group and the Delivery Group. The main focus of the work is around the System Delivery Plan (SDP) and a first draft is expected next week. The plan will demonstrate how we are going to implement the ICS and will help to highlight some of the gaps that will need to be addressed. The SDP will articulate how the Integrated Care Partnerships will organise themselves and what they will deliver at a local level. CN referred to the Provider Collaboration and asked for GP Federations to be added as primary care is wider than PCNs. ICEG members noted the update. **6.2 BHR ICP:** **6.2.1 ICP priorities** AB referred to the ICEG workshop held on 30 April 2021 where the four key areas of to frame our key priorities were agreed; recovering well; addressing inequalities and prevention; anchor organisations; leadership culture and leading change. The four areas will be presented in more detail at the next ICEG meeting in June. AB invited ICEG members to comment on the priorities. ICEG members noted the update and endorsed the key areas of focus. **6.2.2 Lay membership** AB advised that two CCG lay member roles are currently being recruited to. One of the roles will support patient and public involvement and champion the	CE AB/EP All

	diverse voices of all local people as we continue to build an effective and sustainable local health and care system. The second role will support the ICP's focus on quality and performance in commissioning decisions and the delivery of local services across BHR. ICEG members noted the update. **6.2.3 Framework for public engagement** MH presented the proposal for an approach to patient and public engagement to support the BHR Integrated Care Partnership (ICP). The elements will continue to be designed particularly working with the Borough Partnerships, GP Federations, and PCNs. The paper will be presented at the ICPB meeting on 27 May. ICEG members noted the report and agreed the recommendations. The Chair asked for any additional comments to be fed back to MH ahead of the ICPB meeting on 27 May. **6.2.4 Development of the BHR JSNA** MA recapped that the first edition of this was originally presented just before the pandemic. WF gave a demonstrative example of the data that the tool can provide at BHR, borough and locality level and members were advised that all the information is in the public domain. MA advised that the profiles will be refreshed following the pandemic but flagged that there is still limited access to NHS data which is an obstacle in terms of the move to population health management. MA highlighted that without access to this data, the tool will not effectively support operational service delivery transformation. ICEG members agreed that this is a very useful tool and WF shared the web link via the MS teams 'chat' facility. The Chair suggested it would be helpful at a later date in the year to set aside some more time to look at this again. **6.2.5 Proposed primary care governance** The slides presented the revised, proposed governance for the primary care transformation programme within the BHR ICP and the primary care commissioning (delegated) function within NEL CCG. For both functions, the proposed structure looks to enable the 80:20 principle with influence, design, implementation, delivery, and where possible, local decision-making within the BHR ICP whilst enabling the local system to maximise the benefits of being part of NEL to achieve economies of scale. ICEG members were asked to support the proposal. Overall final approval will be sought from the NEL Primary Care Commissioning Committee as part of the delegated authority from NHS Commissioning Board. Members endorsed the proposal.	All MA/WF
7.0	**ICP Planning & performance**	
	Due to time constraints the order of the agenda was changed at this point and members were asked to feed back any comments to the leads outside of the meeting. **7.1 NHS Operating Plan submission 2021/22**	

	SR advised the draft plan was submitted to NHS England on 6 May 2021 and the final submission will be circulated to ICEG members for sign off outside of the meeting on 1 June 2021. **7.2 Finance report** The report was noted. AK advised that further details will be provided at the next meeting. **7.3 Performance report** The report was noted and SR advised that a proposal for performance reporting within the BHR ICP and the relationship/ links into the wider North East London ICS were included in the report and asked members to send any feedback to him outside of the meeting. ICEG members supported the proposal to organise a Public Health facilitated workshop to further develop the indicators. **7.4 BHR Recovery & Restoration** The report was noted and SR advised that due to the increasing pressures in the system with duplication due to people not accessing the right services first time, a recovery summit is being organised imminently with clinical oversight by the BHR Health & Care Cabinet.	SR All SR
8.0	**Any other business**	
	The Chair reflected on the meeting and asked for some thought to be given in regard to: • reducing the number of papers which will allow time for fuller discussion • reports were too health focussed and need to be more inclusive going forward	AB
	Date of next meeting – 17 June 2021	

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

Agreed minutes - Integrated Care Executive Group

17 June 2021 at 3.30pm – 5.00pm

Via MS Teams

Members:

Ceri Jacob (CJ)-chair	Managing Director, BHR ICP
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Oliver Shanley (OS)	Chief Executive, NELFT – Deputy Chair
Caroline Allum (CA)	Medical Director, NELFT & Health & Care Cabinet Chair
Tony Chambers (TC)	Chief Executive, BHRUT
Magda Smith (MS)	Chief Medical Officer, BHRUT
Barbara Nicholls (BN)	Director of Adult Services, LBH
Adrian Loades (AL)	Director of People, LBR
Matthew Cole (MC)	Director of Public Health, LBBD
Craig Nikolic (CN)	Chief Operating Officer, B&D GP Federation
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation
Diane McKerracher (DM)	Interim Chief Executive, Redbridge GP Federation
Ahmet Koray (AK)	Director of Finance, BHR ICP (Rep SC)

Attendees:

Hannah Coffey (HC)	Director, Strategy & Partnership, BHRUT
Kathryn Halford (KH)	Chief Nurse, BHRUT
Alison Crewe (AC)	BHR Academy Programme Lead
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Mark Eaton (ME)	BHR System Recovery Adviser
John Craig (JC)	Chief Executive, Care City
Alison Blair (AB)	Director of Transition, BHR ICP
Carrie-Anne Wade (CW)	Strategic Communications Leader, NELFT
Dr Ravi Goriparthi (RG)	B&D GP Federation
Anna McDonald (AMc)	Business Manager, BHR ICP
Hanh Xuan-Tang (HX)	Deputy Director of Recovery Planning, BHR ICP
Doug Tanner (DT)	Children's Services Programme Lead, BHR ICP
Pete McDonnell (PMcD)	Older People and Frailty Lead, BHR ICP
Umesh Gadhvi (UG)	Director, Healthcare Analytics (NELFT & BHRUT) & BHR Digital Lead

Apologies:

Emily Plane (EP)	Programme Lead, BHR ICP
Tracy Welsh (TW)	Director of Transformation, BHR ICP
Elaine Allegretti (EA)	Strategic Director, Children's and Adults - LBBD
Henry Black (HB)	Acting Accountable Officer, NEL CCG
Chris Naylor (CN)	CEO, LBD

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	

1.1	**Declarations of conflicts of interest**	
	The register of interests was noted and the chair reminded everyone of their obligation to declare any interest they may have on any issues arising at the meeting. No additional conflicts of interest were declared.	
1.2	**Minutes of the last meeting**	
	The minutes of the meeting held on 20 May 2021 were agreed as a correct record.	
1.3	**Action log/matters arising**	
	1.3.1 Update on plans for workshop facilitated by Public Health – SR reported that it has not been possible to set a date for the workshop as yet due to the need for Public Health colleagues to continue to focus on the Covid-19 vaccination programme and related matters. All other actions were either on the agenda, in progress or closed.	
2.0	**ICP priorities – plans on a page**	
	AB recapped on the four key priorities that ICEG will be focussing on over the coming months; recovering well; addressing inequalities and prevention; anchor organisations; leadership culture and leading change. The sponsor and SRO for 'addressing inequalities and prevention' are still to be identified, however, in the meantime, the Health & Care Cabinet (H&CC) will be looking at this as a priority area to lead on. CJ suggested it would be helpful if the H&CC could agree the sponsor and SRO. CA agreed to follow this up and feedback to EP. AB advised that Expressions of Interest are being sought from PCNs to pilot an approach on 'population health management' and CN gave his views on this following the introductory meeting held in B&D. DM fed back on the introductory meeting held in Redbridge and advised that three PCNs in Redbridge are potentially interested. In regard to Anchor organisations, AB advised that an event is being convened by BN. ICEG members noted the ICP priorities.	CA
3.0	**Transformation Boards**	
	CJ specified that updates on the Transformation Boards (TBs) will be presented on a regular basis to ensure ICEG members are fully sighted on the areas that are being worked on as a system and what is being achieved. **3.1 Children & Young People update** DT presented the update report on behalf of EA and gave an overview of the work being undertaken in regard to the three strategic priorities identified by the TB; paediatric integrated nursing service; CYP in ED in MH crisis; ASD/ADHD. A full discussion took place and in regard to CYP in ED in MH crisis, CA advised that the escalation of mental health need in children is being seen across London and gave an overview of the productive work being undertaken London-wide in relation to bed optimisation and the 'hospital at	

	home' model. AL suggested the need for the system to adopt a broader definition of 'crisis' for young people as there is a significant number of children in crisis who are not going to ED and referred to a case he is currently dealing with as an example. CJ asked DT to take the suggestion to the C&YP TB for a discussion on how we define 'crisis'. It was acknowledged that the system's response to the broader definitions will need to be different. DT/EA to feedback on the outcome of the discussion ahead of the next ICEG meeting in July. OS informed members that the focus of the System Operational Command Group (SOCG) meeting on 24 June is on 'Emergency Mental Health Provision for C&YP'. ICEG members noted the update and thanked EA and DT for the very helpful and informative report. *Doug Tanner left the meeting.* **3.2 Older People & Frailty update** PMcD presented the update report and gave an overview of the aims, objectives and key initiatives for 2021/22. The current status of each workstream is either green or amber and in regard to 'Co-ordinate my care' there are now just under 4,000 care plans live on line. The key risk areas going forward were outlined; mobilisation of workforce; funding; possible wave 3 of the pandemic. HC acknowledged the progress being made but questioned whether this is having the impact needed in regard to the longer-term sustainability plan. HC also added that we need to ensure that the enablers and timescales are right and gave estates and the hubs as an example. CJ explained that the TBs underpin the Integrated Sustainability Plan (ISP). The reporting that was happening pre-Covid-19 in terms of the impact on activity and outcomes will be re-established. In terms of enablers, CJ recapped that the 'plans on a page' previously included an enabling requirement which needs to be added back in. PMcD assured ICEG members that the TB format of the dashboards presented pre-pandemic is being re-instated and the inputs and outcomes from the schemes and the impact on acute activity will be presented again going forward. It was agreed that the impact across the system as a whole is important. CA commented on the need to use QI measurements to ensure there are no unintended consequences and added that this should be part of all transformation. CJ referred to the very latest ICS guidance which states that transformation needs to be owned by providers and acknowledged that is already what is happening in BHR. In turn, that means that the ISP needs to be owned by Providers. The guidance also makes it clear that finance needs to be managed collectively. JC pointed out that a lot of the work Care City is undertaking could fit into the Older People & Frailty TB. He referred specifically to a business case approved six months ago for a domiciliary care pilot and voiced his concern that it had not been included in the plan. PMcD confirmed that the business case is still on the agenda and will be picked up again now that the TB has re-started again following the pandemic. PMcD to liaise with JC on this outside of the meeting. ICEG members noted the update.	DT/EA PMcD

	Pete McDonnell left the meeting. **3.3 BHR Integrated Sustainability Plan updated** ME presented the report which provided a further update on the development of the Integrated Sustainability Plan (ISP) including some of the key assumptions, outcomes and financial impacts that are expected. ICEG members were asked for views on what additional information needs to be added to the clinical case. Discussions have been held in regard to empowering TBs further and one of the proposals is for the TBs to have budgets to work with and indicative targets to meet. Business cases will be presented to ICEG/ICPB for approval as needed and delivery of the schemes will be monitored via the TBs with oversight from ICEG to enable decisions to be made about changes, expansion and/or cessation of schemes. Overall financial management of the TBs indicative budgets will be via ICEG. The key next steps were outlined in the report. CN drew attention to Table 1 in the report which provided data on public health outcomes and commented that the report did not mention if the impact of the TBs on the public health data is being looked at. He gave his view that in order for TBs to take forward credible business cases they need to be very robust and suggested that an oversight group maybe required that provides an independent view on whether the business cases are ready for approval. CJ clarified that the H&CC provides oversight alongside ICEG and that the TBs have very expert clinicians and experienced managers supporting them. They will also have finance supporting them with the business case work ups and the Finance Sub-group will oversee the business cases to ensure that what is presented to ICEG is fit for final sign-off. CN referred to the Borough Partnerships and commented that he would want to see some of the money going to the B&D Borough Partnership Board so that it can address some of the demographic needs in B&D. CJ clarified that delivery absolutely sits with the Borough Partnerships but recapped on the need to not have to negotiate the pathways three times. Funding is being allocated to primary care which will then be allocated to the Borough Partnership Boards and CJ reiterated that they need to be ready to take on the role. HC recapped on the discussion at the previous meeting about the importance of clinical colleagues taking ownership and being committed to the ISP as there will be different risks and opportunities for each organisation. HC welcomed the opportunity highlighted in the report under 'next steps' to go through the detailed planning assumptions with partners and added that the Borough Partnership Boards need to be in a position to take on the level of responsibility and accountability with the appropriate skills and suggested the need for a due diligence process to be undertaken. CJ agreed with the points made and confirmed that a discussion on undertaking a due diligence process will be held and fed back at the next meeting. ICEG members: • Discussed the following questions: ○ What additional information do we need to add to the clinical case?	CJ

	○ Is there a general agreement that we should aim to focus the work of the Transformation Boards and give them an indicative budget to work within? ○ Is there agreement on the proposed process for managing transformation as outlined in Section 5.0? ○ What questions or concerns are raised by the assumptions in Section 6.0? • Agreed the next steps outlined in Section 7.0.	
4.0	**BHR Health & care Academy proposal** – next steps for future development	
	KH presented the proposal and explained that a number of steering group and focus group meetings have been held resulting in a number of priorities that were outlined in the report. It is hoped that the launch of the academy and the programme of work will take place on 23 September 2021 but in order to fund the next stage of the development, £650k is required over the period September 2021-April 2023. The intention in the first instance is to explore potential funding sources external to BHR. If this is not possible, discussions will held with local partners about making respective contributions. The discussions will take place in July-August 2021 with the aim of having a funding plan in place by August. OS commented that this is even more important for the BHR system post Covid-19 in order to address workforce challenges and inequalities. CN commented that he would like primary care to be involved in the academy. KH responded by clarifying that this is just the start, the vision for the future is to be all inclusive. DM suggested this could be looked at from a patients' perspective in terms of looking at the training needs of the people who see the patients throughout the patient journey and KH clarified that one of the key things being looked at in regard to the patient pathway is to have an MSK pathway. ICEG members: • Supported the continued development of the workforce academy • Supported the continuing work on the priorities in the programme including the contribution of representatives from partners to this work • Noted the process for securing the funds (£650K) required for the next phase of the development (Sept 2021 – Apr 2023). *Kathryn Halford left the meeting.*	
5.0	**Borough Partnership roadmaps**	
	AB confirmed that each of the Borough partnerships have submitted their roadmaps which represent the considerable amount of work undertaken to date. The report presented to IECG members provided a summary of the key elements of the roadmaps including their vision; membership; emerging governance arrangements and initial areas of focus. AB explained that subject to endorsement by ICEG, the CCG will seek to release the next phase of funding to support partners to operationalise their roadmaps. By autumn 2021 the ICP wants to build a picture of the things that Borough Partnerships would want to do collectively across BHR and they have been asked to start to map this out over the coming months as part of the next phase of their development.	

	Henry Black, Acting Accountable Officer for NEL CCG has agreed that a framework will be drafted for Borough Partnership development, including how the Borough Partnerships and their relationship with the BHR ICP are expected to evolve over time, with more resources, funding and decision making expected to transition to the Borough Partnerships as they mature. The CCG clinical chairs for the BHR boroughs are looking to see what additional clinical leadership support can be provided to the Borough Partnerships from within the current contingent of CCG Clinical Leads. Following release of the phase two funding to support their development, Borough Partnerships will focus on developing more detailed plans for their identified key areas of focus, with a view to sharing these in July 2021. The amount of progress made so far was acknowledged and AB added that the scale of the challenge continues to be recognised. BN emphasised the burden that this has placed on local authorities and requested additional resource in regard to staff. CJ confirmed this will be forming part of the discussion at the meeting planned for 29 July being organised by AL. In addition, HC confirmed she is aligning individuals to the 'asks' and will be working with each of the Borough Partnerships on that. ICEG members:- • Noted the detail in the report and the progress to establish Borough Partnerships and their plans for development • Endorsed the release of the next phase of funding (£100,000 per Borough Partnership, £300,000 total) to support operationalisation of the Borough Partnership roadmaps, noting that this funding is from CCG budgets and is subject to the CCG approvals process following endorsement by ICEG/ICPB.	
6.0	**Digital update**	
	UG presented the update and gave an overview of the key points within BHR. With the move from seven NEL CCGs into one a single NEL CCG, there is a need to review governance arrangements for GP IT. A NEL-wide forum is needed which will bring together IT and digital leads from across all health and care partners to look at an overall digital strategy. The ELHCP Information Steering Group is well placed to adapt to this role as it has a number of key leads already in attendance and a number of the IT workstreams across NEL already feed into the group. Primary Care IT structures differ in each borough and current governance is informed by the way that finances are approved in each borough. The BHR ICP Director of Primary Care is in the process of recruiting to the post of clinical digital lead and in the meantime, there are a number of leads within the system with different remits in regard to IT and there is a need to identify an overall IT lead across the system who can bring together the various workstreams that are underway. There is also a need to review the membership and purpose of the BHR IT Strategy Group to ensure it is focusing on the right areas and is able to support the development of BHR system-wide initiatives such as the development of 'Community Based Care' with multidisciplinary teams in the community, alongside closer integrated working between health and care teams in the community, including initiatives such as Barking Riverside.	

	Discussions on PMO support have been held between UG and AB. UG explained that he is currently the BHR digital lead but the role needs to be looked at longer term. There also needs to be an ICEG sponsor for the digital programme. BN asked UG to e-mail her in regard to Havering's local authority IT/digital lead and commented in regard to population health management which local authorities want to be involved with but they are not being provided with the health data that is needed. UG confirmed that the data discovery re-vamp is going to address the issues about who can access the data. CN concurred that data sharing has been an issue and cited sharing vaccination data with LBBD as a recent example. He commented that greater focus on allowing providers to use the data for business intelligence is needed. UG assured ICEG members that based on the rules in regard to data access, creating a single data base is the direction of travel. CJ agreed to follow-up on the leadership and sponsorship matters outside of the meeting. ICEG members noted the update. A further digital update will be presented at the next meeting. *Umesh Gadhvi left the meeting.*	UG CJ UG
7.0	**ICP OD development –** next steps for April 2022	
	OS thanked AB for her leadership in this area and recapped on the three workshops held. ICEG members were asked to consider whether regular OD sessions should continue going forward and/or whether something else should take place in the Borough Partnerships. ICEG members to e-mail their views to OS outside of the meeting copying in EP and feedback on the outcome will be given at the next meeting.	All OS/EP
8.0	**BHR Health System Quality & Performance Oversight Group update**	
	The report presented by SR provided ICEG members with assurance in regards to quality and performance issues as discussed at the BHR System Quality and Performance Oversight Group (QPOG) meeting held on 3 June 2021. SR proposed that the QPOG minutes come to ICEG every month for information so that members are sighted on key quality and performance issues. CJ linked this to this to Item 7.0 and suggested one of the things to discuss at a future OD session is how we share responsibility for quality and performance issues as a system and how we understand each organisations' pressures.	SR OS/EP
9.0	**Any other business**	
	CJ advised that AB's interim role with the CCG was coming to an end and thanked AB for the invaluable help and support she provided not only to the CCG but also to system colleagues. ICEG members also expressed their thanks.	
	Date of next meeting – 15 July 2021	

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

Health and Care Cabinet

Minutes of meeting held on
Thursday 13th May 2021
(via MS Teams)

Members:

Caroline Allum (CA) - Chair	Medical Director, NELFT
Rahul Singal (RS)	Pharmacy Lead, NELFT
Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Kathryn Halford (KH)	Chief Nurse, BHRUT
Magda Smith (MS)	Medical Director, BHRUT
Matthew Cole (MC)	Director of Public Health, LBBD
Susanne Knoerr (SK)	Social Care representative, LBBD
Mark Ansell (MA)	Director of Public Health, LBH
Heather Noble (HN)	Medical Director, Whipps Cross Hospital, Barts Health
Shanika Sharma (SS)	B&D Federation

Attendees:

Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Ramneek Hara (RH)	B&D Clinical Lead, NEL CCG
Adedayo Adedeji (AAd)	B&D Federation
Siobhan Gregory (SG)	Director of Nursing, Nightingale Hospital London
Dominique Allwood (DA)	Medical Director, Nightingale Hospital London
Belinda Krishek (BK)	Chief Pharmacist BHR ICP, NEL CCG
Steve Rubery (SR)	BHR Director of Planning & Performance, NEL CCG
Sanjay Patel (SP)	Deputy Chief Pharmacist BHR ICP, NEL CCG
Mark Eaton (ME)	System Recovery Advisor
Tracy Welsh (TW)	Director of Transformation and Delivery (Planned Care and PMO) BHR ICP, NEL CCG

Apologies:

Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
John Craig (JC)	CEO – CareCity
Debbie Smith (DS)	Director of Nursing, NELFT
David Derby (DD)	Havering Federation
Jyoti Sood (JS)	HEE representative
Kate Dempsey (KD)	Social Care representative, LBH
Janaka Perera (JP)	Community pharmacy representative
Alison Blair (AB)	Director of BHR Transition, NEL CCG
Gladys Xavier (GX)	Director of Public Health, LBR
Laura Stuart Neil (LSN)	AHP Director, NELFT
Leila Hussein (LH)	Social Care representative, LBR
Norah Rao (NR)	Practice Nurse representative

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed all to the meeting and apologies were noted as listed above.	
1.1	Declaration of conflicts of interest	
	None declared.	

1.2	Minutes of the meeting held on 11 March 2021	
	Agreed	
1.3	Matters/actions arising	
	The updated actions log was noted and it was agreed to close actions 140, 160, 161 and 162.	
2.0	**BHR System Integrated Sustainability Plan**	
	Mark Eaton talked through a brief presentation on the Barking and Dagenham, Havering and Redbridge (BHR) Integrated Sustainability Plan (ISP). ME advised that in 2018/19 the BHR System agreed an Integrated Financial Recovery Plan (FRP) with Regulators. This was focused on reshaping the way in which care is delivered across BHR to improve outcomes for patients and make savings. Previous analysis showed that the main drivers of the then system deficit were a historic under-investment in prevention and early intervention driving poor outcomes and increased hospital spend. There had been indications that the approach of the FRP was making an impact and reducing the deficit as well as starting to improve outcomes. With the disruption caused by Covid there is now a need to refocus the Transformation Boards on addressing the main challenges faced across BHR. The new plan will also include a focus on MH and CYP Investments and will be an Integrated Sustainability Plan (ISP). SS asked if there has been an impact on the number of referrals since Advice and Guidance (A&G) has been available. Pre-Covid had seen a 20% decrease in referrals however since the pandemic the number of requests for A&G has reduced. It was noted that Barts Health offer A&G for all specialities. CA added that A&G has been set up for mental health however there has not been much uptake as yet and NELFT will look at advertising this more widely. ME added there is a greater focus on inequalities in the planning guidance and a need to ensure resources are aligned, including with PCNs, to tackle this. The plan will initially look at low acuity planned activity and care of frail elderly and end of life. JJ advised that primary care is stretched and that it is important that resources are moved in line with any activity shift. CA suggested a task and finish group is setup to look at these broader issues. The cabinet noted the report and agreed to receive an update quarterly. **Members of the Health and Care Cabinet noted the development of the BHR Integrated Sustainability Plan.**	
3.0	**Recovery and Restoration**	
	SR advised that as the impact of the latest lockdown and vaccination programme translates into fewer cases of COVID and hospitalisations, and following the government's announcement of a roadmap to exit the latest lockdown, BHR partners have considered plans for restoration and recovery. There is a focus on staff wellbeing, and a need to address unmet need, new needs and the elective backlog. BHRUT opened theatres and wards a lot quicker than planned and the 52 week-wait (ww) position is better than planned. BHRUT's high volume low complexity procedures position is the second best in London.	

	Re-opening of schools and services has increased demand on Local Authorities, in particular for safeguarding children and as a Partnership we are looking at ways to collectively address this. There are also a high number of children attending the emergency department (ED) that require referral to mental health services. JJ noted the increased demand across all partner organisations and that BHR CCG would be arranging a BHR recovery summit for members of the Integrated Care Partnership and should also include members of pharmacy and sexual health teams, to discuss the pathway and flow of patients, addressing the shifting of activity as well as our key risks. **Members of the BHR Health and Care Cabinet endorsed the collaborative approach to recovery and restoration for BHR.**	
4.0	**BHR Partnership Priorities**	
	The BHR ICP have undertaken a piece of work to define their priorities for 2021/22. This builds on the previous year's priorities and reflects the key areas of challenge in the system, as well as mapping and ensuring alignment with individual organisation, Transformation Board, and North East London Integrated Care System priorities. Priorities are being mapped to identify the areas that the BHR ICP can make progress on over the next 6-8 months. The emerging key priorities are arranged under four key headings; Recovering well; Addressing inequalities and prevention; Anchor Organisations; Leadership culture and leading change. It is suggested that the Health and Care Cabinet will in particular oversee the addressing health inequalities workstream. Members of the cabinet agreed with the emerging priorities and to provide the oversight of health inequalities in particular. JJ noted that it is important to include the multi-disciplinary leadership such as nurses, AHP members, professional social workers and pharmacy. EP will ensure these are included. MA agreed with the importance of prevention and occupational health management but asked how they will draw on health intelligence from health and social care to accurately understand the health needs of the population; information governance can be a barrier to this and there isn't sufficient capacity in the system currently to do this. EP advised the Borough Partnerships have fed back similar views and that this is being fed back as a key system ask to the BHR Integrated Care Partnership Board. **The report was noted and Health and Care Cabinet members endorsed the emerging priorities.**	EP
5.0	**Feedback on the learning from NELFT's involvement in setting up the Nightingale Hospital**	
	When the Nightingale Hospital London was opened DA and SG were appointed as the Medical Director and Director of Nursing. They led a multi-disciplinary team.	

	They admitted 71 patients, mainly NEL and South East London (SEL) residents. Quality metrics show that over 1,000 occupied bed days were saved from the local NHS system which in turn freed up capacity locally. Many of the patients were discharged back to their normal place of residence with improved outcomes. They took a learning system approach to the delivery of care meaning that if something needed to be addressed to improve care, they could act quickly. New role piloted called the bedside co-ordinator and a number of other innovations piloted are now being rolled out across the NHS. SG said they were very well supported by volunteers who were with them at the first stage such as the First Aid Nursing Yeomanry (FANY), the Bedside Coordinators and the Family and Liaison team. Patients fed back positive experiences from the care they received as well as benefiting from other services such as chiropody. They took a non-hierarchical approach and the experience received from the workforce was also positive. A workforce census was undertaken to understand the diversity, age profile, and previous work experience with 20% of staff not employed or in training prior to joining. NELFT are now trying to help employ some of these staff. Several have joined NELFT and are doing their Care Certificate. JJ congratulated them on the excellent work and suggested the BHR Workforce Academy should note this approach and ensure that as a system we improve access to work experience for local people, to improve recruitment and retention. KH added that BHRUT had work experience for vulnerable children and are building on this and are linking in with the West Ham Academy. RS asked if there would be an opportunity for vaccinators to do the same survey / be approached in the same way. DA advised this is being done in NWL and will share the survey if interested. The cabinet noted the update.	
6.0	**Transformation Board Operating Model – Concept Paper**	
	In the past, transformation schemes have been shared with the Health and Care Cabinet (HCC) at the point of completion, where the ability of the Cabinet to input/influence the scheme has been limited. Going forward, the intention is to change this approach and ensure that the HCC is able to offer insight and views to assist with the development of schemes from the outset. Scheme concepts will be shared with the HCC prior to further progression or development, thereby allowing HCC to input into the scheme at the earliest opportunity. HN noted that with the redevelopment of Whipps' Cross Hospital, Barts Health have been reviewing how it works to integrate care and have had similar clinical discussions on the issues, impact and outcomes for the local population. TW will share the list with HN. **The cabinet noted the report and will expect to receive scheme concept reports from the Transformation Boards at future meetings.**	

7.0	**Medicines Optimisation Transformation programme proposal**	
	BK gave a brief overview of the proposal to establish the Medicines Optimisation Transformation Programme Board, the business case of which had been approved prior to the Covid 19 pandemic. The proposal aims to embed medicines optimisation in primary care and across the interface into secondary care to improve quality, person-centred outcomes and to ensure services are as efficient as possible. The proposal has been refreshed and BK/SP are seeking endorsement from the HCC. JJ supported the concept and advised there has been a lot of interest in investment into medicines innovation. He welcomed the potential to support clinicians with development, digital, new methodologies, apps and patient empowerment. MS asked why is this not done at a NEL level, noting that there is little capacity in the local system. BK advised that there is a Medicines Pathway, Policies and Guidelines Review Group and a Medicines Optimisation Committee which will operate at NEL level. These will look at key areas such as pathway for rheumatoid arthritis. The proposed Medicines Optimisation Transformation Board will not be duplicating the work but will seek to embed innovation locally, with proposals which can be rolled out more quickly. RS raised that to implement the schemes and ensure their success there will be a need to invest - how can we ensure there is support from BHR for it to be costed like the other transformation boards. BK advised that a business plan on key areas with finance associated to each will be developed. There is an opportunity for our own Medicines Optimisation Team in BHR to look at the workstreams and start supporting them from within our own team, subject to approval for the transformation board to be established. JJ added that there is a need to ensure medicines optimisation will seek to address health inequalities. RH asked if the hospital could have a similar or joined up script-switch scheme to align with primary care and if they could arrange for patients to collect their medication at their local pharmacy rather than waiting in hospital to take their medications home. CA advised this could be part of the discussion the transformation board can take forward. **The cabinet agreed to support the proposal with a caveat that resources would be needed in the system to support this and assurance that the work undertaken would not be duplicated across NEL or London.** **BK to provide an update at a future meeting.**	
8.0	**Any other business**	
	None raised	
9.0	**Date of next meeting** 10 June 2021 at 1:30pm-3:00pm	

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

Health and Care Cabinet

Thursday 10 June 2021
(via MS Teams)

Members:

Caroline Allum (CA) – Chair	Medical Director, NELFT
Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Magda Smith (MS)	Medical Director, BHRUT
Kathryn Halford (KH)	Chief Nurse, BHRUT
Mark Ansell (MA)	Director of Public Health, LBH
Heather Noble (HN)	Medical Director, Whipps Cross Hospital, Barts Health
Shanika Sharma (SS)	B&D Federation
Debbie Smith (DS)	Director of Nursing, NELFT
David Derby (DD)	Havering Federation
Gladys Xavier (GX)	Director of Public Health, LBR
Laura Stuart Neil (LSN)	AHP Director, NELFT
Leila Hussein (LH)	Social Care representative, LBR
Shanika Sharma (SS)	B&D Federation
Jyoti Sood (JS)	HEE representative

Attendees:

Alison Blair (AB)	Director of BHR Transition, NEL CCG
Ramneek Hara (RH)	B&D Clinical Lead, NEL CCG
Keeley Chaplin (KC)	Minute taker
Wassim Fattahi-Negro (WFN)	Principal Manager, Performance & Intelligence, LBBD
Edel Casey (EC)	Consultant in Endocrinology and Metabolic Medicine, BHRUT
Louise Brent (LB)	Programme Manager – Planned Care, BHR ICP, NEL CCG
Peter McDonnell (PMcD)	Lead Commissioner Older People & Frailty, BHR ICP, NEL CCG
Meena Pawar (MP)	Senior Project Manager, BHR ICP, NEL CCG
Shujah Hameed (SH)	Clinical Lead, BHR ICP, NEL CCG
Solma Khatoon (SK)	Senior Project Manager, BHR ICP, NEL CCG
Rajesh Banka (RB)	Consultant Respiratory Physician, BHRUT
Movita Hussain (MH)	Practice Development Manager – Adults, LBH for Kate Dempsey
Anna Hawkins (AH)	Endocrine & Diabetes Clinical Lead Nurse BHRUT

Apologies:

Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Matthew Cole (MC)	Director of Public Health, LBBD
Susanne Knoerr (SK)	Social Care representative, LBBD
John Craig (JC)	CEO – CareCity
Kate Dempsey (KD)	Social Care representative, LBH
Rahul Singal (RS)	Pharmacy Lead, NELFT
Janaka Perera (JP)	Community pharmacy representative
Norah Rao (NR)	Practice Nurse representative

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed all to the meeting and apologies were noted as listed above.	

1.1	Declaration of conflicts of interest	
	None declared.	
1.2	Minutes of the meeting held on 13th May 2021	
	Agreed	
1.3	Matters/actions arising	
	The updated actions log was noted and it was agreed to close actions 159 and 163.	
2.0	**BHR Partnership Priorities; Inequalities plan on a page**	
	Further to the discussion at the May Health and Care Cabinet meeting on the key priorities of the Barking & Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership, AB presented details of further scoping of the 'plan on a page' for each priority and an overarching high-level timeline for ICP development. There is a strong emphasis on preventative care and addressing inequalities and which will build upon work already being undertaken across the partnership. Members reviewed the plan and agreed that obesity should be an initial area for the partnership to look at as this will have an impact across a wide spectrum of health and care and would greatly improve health inequalities and the prevention agenda. MA advised that it is important to look at long term solutions and could include employment opportunities and seeking contracts from local companies as these can have an impact on people's life chances and raise living standards for residents across the boroughs. It is important that this should also link in with the BHR Health and Care Academy. JS added that training should include social prescribers and primary care practitioners. Members **agreed** that a future meeting will focus on obesity to review what is already being provided in and across BHR and how they can link up. Health and Care Cabinet members **noted** the plan on a page for addressing inequalities and prevention and the high-level timeline for ICP development.	KC to add to Sept agenda
3.0	**Management of collective risks; particularly elective care**	
	MS shared slides to outline the Trust's approach to undertaking clinical harm reviews of patients on their waiting lists. Historically all patients waiting over 52 weeks had a harm review as well as a 10% sampling of patients waiting over 40 weeks. However due to Covid the waiting lists have significantly increased and the focus is now on prioritising cohorts of patients to get them treated. There is also a north east London wide group that is managing the health inequalities agenda for patients at greater risk on waiting lists. Phase 1 of this will use acute hospital coded data for patients on the list and align them with emergency attendances and admissions and deaths not due to Covid to prioritise patients into sub cohorts. The process will be the same for children and adults. This will not detract from the usual incident reporting process.	

	JJ asked if GPs have a concern that their patient is at risk of harm due to their wait, is there a process to raise this with the Trust? MS responded that they would look at developing a mechanism to alert the Trust of patients that are believed to have a high clinical risk of harm or have attended other hospitals. The cabinet **noted** the presentation given by MS.	MS
4.0	**Development of the digital BHR JSNA**	
	MA and WFN provided an overview of the current status of development of the 2021 Joint Strategic Needs Assessment (JSNA) carried out by Barking and Dagenham, Havering, and Redbridge. The revised JSNA is an interactive web-based tool that interested stakeholders and professionals can use to interrogate the data at a variety of levels, which is refreshed annually. It was a very successful collaborative approach which brought the borough intelligence groups together. This group were able to devolve into a Covid-19 working group at the start of the pandemic. The next iteration will have increased health protection data. MA added however that they have limited access to health data which would be useful to include. Members **noted** the report and praised the work that had gone into this and how useful the tool will be to all organisations. KC will circulate the link to members and to transformation boards for their information.	KC
5.0	**Transformation boards concept papers:**	
5.1	**Diabetes Early Assisted Supportive Discharge**	
	Edel Casey, the diabetes clinical lead for BHRUT, outlined the results of two pilots for a new model of care and pathway for diabetic/endocrine patients focussing on facilitating early discharge, preventing long lengths of stay and re-admission following an inpatient stay. The pilots were carried out in 2019 and then in 2020, during the Covid 19 peak. The concept paper seeks the approval for funding of an additional Diabetes Specialist Nurse (DSN) whose support for this service is fundamental to the success of this quality improvement programme. This has proved to deliver a better patient experience and increased efficiencies in bed flow through the hospital. This service also bridges the gap and eases the pressure on primary care as the patients remain under the care of the hospital. In total 194 diabetic patients were discharged with a total bed-day saving of 229 which equated to savings of £77,860. LH agreed that this is a great programme of work and asked if there is a plan to optimise this to reduce the patient's need for long-term support. EC responded that the primary objective is to facilitate discharge from hospital but that this could be looked into. The Health and Care Cabinet **approved** the concept of Diabetes Early Assisted Supportive Discharge.	
5.2	**Stroke Service Redesign**	
	DP and PMCD presented the proposal to deliver a local stroke rehabilitation and life after stroke offer that will meet national requirements. Following a public consultation in 2016/17 the CCG, NELFT and BHRUT were given a mandate to integrate two stroke rehab wards and create a system wide team of therapists. The single ward was to commence on 1 June 2020 in King	

	George Hospital (KGH) with the integrated community rehabilitation team to be in place from early 2021, however this was paused due to Covid. There are two phases to the project which are to recommence the design and mobilisation of the integrated stroke rehab ward and to develop an integrated community stroke service (ICSS) which is a national model, and will simplify the pathway for the patient incorporating rehabilitation and social care. This has been a good example of working together as an integrated system with everyone's aim to develop smoother and better pathways and increase the recovery of stroke patients. The challenge will be to know where there are gaps and to fix these as a system. The Health and Care Cabinet **approved** the concept plan for the Stroke Service Redesign. A review of the service, once up and running, will be brought back to a future cabinet meeting.	
5.3	**Tier 3 Specialist Weight Management Services**	
	SH presented the concept plan for the commissioning of a Tier 3 Specialist Weight Management Service (SWMS) as there is currently a gap in the obesity pathway. The BHR population has a very high rate of obesity and this service will support individuals with complex obesity related needs. The multi-disciplinary team will assist patients to lose weight and thereby reduce associated co-morbidities. This service will also tackle health inequalities for our deprived population as well as providing an equivalent provision across north east London. Members of the Health and Care Cabinet **approved** the concept of the Tier 3 SWMS to be taken to the next stage to develop a business case.	
5.4	**Pre and Post Rehab for Lung Cancer Operation Patients**	
	RB and RH presented the concept paper to members advising that lung cancer is the third most common cancer in the country. The proposal is to develop an enhanced pre and post rehabilitation pathway for patients undergoing curative lung cancer surgery in order to improve outcomes, reduce post-operative complications, reduce length of stay in hospital, reduce morbidity and improve functional capacity and peak oxygen consumption. This service will integrate with the existing BHRUT lung cancer pathway and will be part of a wider pulmonary rehabilitation redesign. MS added that this service will allow the BHR system to align with others. The Health and Care Cabinet **endorsed** the concept for pre and post rehabilitation for lung cancer operation patients and that the business plan should be progressed.	
6.0	**Any other business**	
	None raised	
7.0	**Date of next meeting** 8 July 2021 at 1:30pm-3:00pm	

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 1 July 2021 – 10.00 – 11.30am

Via Microsoft Teams

Minutes

Members:

Kash Pandya (KP)	Lay Member, Governance & Area Committee Chair, NEL CCG
Ahmet Koray (AK)	Director of Finance, BHR ICP
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Caron Bluestone (CB)	Lay Member, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP

Attendees:

Rob Adcock (RA)	Deputy Chief Finance Officer, BHR ICP
Andrew Ringshaw (AR)	Associate Director of Finance – Financial strategy and Planning, NELFT
Mark Eaton (ME)	BHR System Recovery Adviser
Pete McDonnell (PMc)	Lead Commissioner Older People and Frailty, BHR ICP
James Chapman (JC)	Head of Individualised Care, BHR ICP
Katie McDonald (KMc)	Corporate and Governance Administrator, BHR ICP (minute taker)

Apologies:

Ceri Jacob (CJ)	Managing Director, BHR ICP
Jane West (JW)	Chief Operating Officer, London Borough of Havering
Nick Swift (NS)	Chief Finance Officer, BHRUT
Malcom Young (MY)	Executive Director of Finance, NELFT
Philip Gregory (PG)	Finance Director, London Borough of Barking & Dagenham
Ian Ambrose (IA)	Operational Director of Finance, London Borough of Redbridge

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	
1.1	**Declarations of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict. No additional conflicts of interest were declared.	
1.2	**Actions log/ matters arising (BHR CCGs legacy)**	
	Members reviewed the BHR CCGs' Finance Committee legacy actions log and noted the actions taken. The sub-committee agreed to close all actions.	
2.0	**BHR ICP Finance Sub-committee Terms of reference**	
	KP presented the Terms of Reference (ToR) and explained the role and function of the sub-committee to members.	

	KP advised that work is underway to identify a Non-Executive Director (NED) from the Trust who can also be a member of the sub-committee. The ToR would need to be amended should the membership change. AK highlighted that the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD) are due to be amended by the NEL CCG Governing Body to allow ICP Managing Directors and Directors of Finance have a higher authorisation limit. If the SFIs and SORD are amended, then a revised ToR will be presented back to members. The Finance Sub-committee approved the Terms of Reference.	
3.0	**21/22 H1 Financial Plan Update**	
	RA presented the report, highlighting that 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. BHR ICP has identified £20m non-recurrent transformation funds to help drive forward the sustainability plan. The BHR ICP sustainability plan will identify areas for investment from the non-recurrent transformation funding and there is an expectation that the sustainability plan 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. AA queried the criteria for reclaiming Covid costs and shared concerns that this is not proportionate across London. AK agreed that there should be equal access to claims across NEL. KP suggested that a comparison of claims across NEL is made and agreed to raise this issue at a NEL-level to ensure there is fairness across the system. KP requested that the sub-committee are sighted on the full set of principles as to how the £20m transformation fund will be allocated. The Finance Sub-committee noted the report.	AK/KP AK/RA
4.0	**Month 2 Finance Overview Report 21/22**	
	RA presented the report, noting that at month 2 BHR ICP and each of the ICPs in NEL CCG have achieved a break-even position on the core budgets, however a deficit has been reported to reflect specific allocation arrangements in place for H1. As with last year, funding for the Hospital Discharge Pathway (HDP) will be made available post month-end and the requirement is that these costs are shown in the CCG's books of account as an overspend until the allocation approved and received. The same approach has also been applied to the independent sector activity and cost relating to	

	the Elective Recovery Fund (ERF). These costs are held against the central ICS budget. The impact of these two items is a year-to-date deficit of £7.8m and a H1 forecast deficit of £18.5m across NEL CCG. The CCG will receive the funds to cover these via a retrospective top-up from NHSE/I following review and validation. The BHR element of HDP is year-to date £2.5m, with a H1 forecast of £5m. The BHR ICP core budget is £615.7m. Of the ICS funds (£274m), £159m has been allocated across providers for their deficits (mandated) and the balance remains in the books of the CCG as a number of reserves. This will be allocated once collective agreement is reached on their use. ICS and SDF budgets are currently held centrally. The overspends in relation to ERF and HDP are also held centrally, rather than against individual ICPs. At month 2, all core, ICS and SDF budgets have been assumed to be on plan. KP queried whether this position is echoed across NELFT. AR confirmed that NELFT have reported a break-even position also and have risks relating to the Mental Health Investment Standard (MHIS) and workforce. KP shared concerns that a lot of resources are focussed on reducing the backlog caused as a result of Covid-19, rather than on business as usual activity, meaning that the second half of the year may prove challenging. KP noted the £274m ICS funding available and highlighted that the majority of this would go towards helping Trusts meet their deficits. A clear set of principles on how this will be allocated will be required. SR explained that planning for 2022/23 is a concern as there will be two years of less relevant data due to Covid-19 and recovery. There is no sight as to what business as usual will be next year. KP requested further updates on the key issues raised and a focus on how to return to business as usual. The Finance Sub-committee noted the report.	
5.0	**Business cases**	
5.1	Hospital discharge service	
	PMc presented the report, highlighting that a single hospital discharge co-ordination function is mandated by NHSE and supports national performance against same day discharge targets and reducing length of stay in hospital. The impact of not funding a Hospital Discharge Service (HDS) in the long term will mean poorer outcomes for patients who are ready for discharge and rehabilitation, bed pressure due to flow and capacity issues, BHR will not meet national discharge targets and are not compliant with national service model requirements and general reputational damage for the BHR system. HDS will also become part of the Single Point of Access (SPA) for discharge working across BHR, managing health and social care discharges from all hospitals. SPA will commence from the 1 August 2021, and it is anticipated that HDS is funded will integrate by Q4. AK advised that BHRUT's Finance & Investment Committee have noted an issue regarding the speed of patient discharge and at times have 60-70 patients waiting. AK queried whether the proposed investment is enough and	

	whether there is more the CCG can do to support this programme of work. PMc explained that many of the delays are due to issues with adult social services rather than the CCG. The current position could significantly worsen if the service was not in place. AA queried how this service overlaps others and whether there are working links between the HDS and Community Treatment Team (CTT). AA also highlighted the issue of delays in patient discharge due to waiting for medication. PMc confirmed that the HDS can refer to CTT directly, similarly with the intensive rehabilitation service. HDS do not refer for further diagnostics, this is for the acute service to follow up. HDS do liaise with GPs if there are any immediate concerns post-discharge from hospital (48hours) and the hospital discharge summary from acute is sent directly to the GP which includes medicines. Patients should be discharged with 7-14 days of medication. KP highlighted that proposed investment of £1.1m is outside of the ICP's Managing Director and Director of Finance's delegated limits, therefore would require approval from the BHR ICP Area Committee. KP queried whether funding is available in the budget to support the proposal. AK confirmed that funding is available. KP questioned whether the additional staffing requirements would be in place by October 2021. PMc explained that 50% of staff are already in post and that as the posts will be permanent, they should be easier to recruit to. KP requested an update in six months to establish whether there has been an impact on readmissions and requested patient feedback. The Finance Sub-committee endorsed the business case for Area Committee approval.	PMc
5.2	Single Tender Waiver for Personal Banking to Support Personal Health Budgets (PHBs)	
	JC presented the report, explaining that My Care Bank (MCB) provides a bespoke software solution to support individualised care under an existing Single Tender Waiver (STW) arrangement which ends on 31 March 2022. The solution is different to that of the remaining NEL CCG area. As such, a 6-month extension to the existing STW arrangement is required in order to align the Virtual Care Banking service across NEL CCG whilst steps to undertake a joint procurement across the wider CCG area is undertaken. Any changes in provider could cause major disruption to the service and potential interoperability. The transitioning process to a new solution would take approximately 6-12 months to embed and customise. SR advised that the STW has been presented to the NEL Procurement Group, along with a similar request from TNW ICP. STWs are not the preferred solution, however this is necessary in this particular case due to the complexities of the procurement. This STW should not be extended post-September 2022. KP echoed SR's comments and agreed that the STW should not be extended further from September.	

	The Finance Sub-Committee approved the Single Tender Waiver for personal banking to support personal health budgets of £60,000 until 30 September 2022.	
6.0	**Finance Sub-committee forward plan**	
	KP requested members' suggestions as to what should be included on the sub-committee's forward plan for the year. KP's recommendations included: • Monthly financial updates • Business cases for approval • Transformation Board deep dives AK suggested an update on the sustainability plan is presented at each meeting. The proposed forward plan will be brought to the next meeting and members should send any suggestions to KMc. The Finance Sub-committee noted the verbal update.	
7.0	**BHR Integrated Sustainability Plan**	
	ME presented the report, highlighting that in 2018/19 the NHS partners within BHR agreed an Integrated Financial Recovery Plan (FRP) with NHSE/I. Initial implementation showed almost immediate benefits. Following the need to respond to the national emergency the FRP had to be revisited and was amended to the Integrated Sustainability Plan (ISP) covering not only physical health but also Mental Health and Learning Disabilities. 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. The BHR system has access to a non-recurrent fund of ~£20m to support the de-risking of the ISP during Years 1 and 2 (21/22 and 22/23). The proposed distribution of this funding is summarised in section 6.2 of the report. The benefits of the proposal include: • For 21/22 and 22/23 the CCG would be able to provide all of the Transformation Board indicative budgets without requiring this to be taken from the Acute Contracts. • It would enable investment in the CYP Transformation Board and create a non-recurrent prevention fund (the latter managed via Borough Partnerships) • Being able to offset any additional reductions required in the BHRUT Budget in full in 21/22 and in part from 22/23. • There would be a contingency still available to deal with unexpected emergencies and events. AA noted that reallocation of funds has historically taken an extended period of time to allocate, however this non-recurring fund would enable big changes to be made quickly.	

	KP stated that there needs to be a clear set of principles for allocating money to the Transformation Boards. AR advised that NELFT has reviewed the ISP and is supportive of the proposals. KP requested that business cases brought forward by the Transformation Boards have a focus on business realisation and measuring patient outcomes and success. KP queried whether innovation funding, such as the Pilots in Primary Care (PiP) schemes, should be considered. This would support innovation and encourage engagement from the Primary Care Networks (PCNs). This in turn could also reduce the number of secondary care referrals. ME explained that there is money allocated to prevention and that an equalisation process is happening which could result in an additional £4.5m spend for this. The Primary Care Equalisation Programme aims to bring the spend in BHR up to at least the level of Tower Hamlets. Some of this will come via the re-provision assumptions built into the Integrated Sustainability Plan but on review these are insufficient to reach the Tower Hamlets average and therefore an additional investment will be required. Currently, this is being planned for. The Finance Sub-committee noted the report and approved the next steps to: • Go through the detailed planning assumptions with partners prior to a version of this paper to go to Partner Boards; • Raise awareness of the proposals with Transformation Boards; • Review the financial planning assumptions around the 'Gap' to allocation and how this needs to be spread across Primary Care, Mental Health and Acute Providers and agree how we would use the Non-Recurrent De-Risking Fund; • Align Activity and Workforce Plans for 21/22 and into 22/23; • Finalise the planning template and produce a narrative document to support the ISP; • Produce aligned aspirational plans for Transformation Boards including delegated budgets for them to invest in for at least 21/22 and 22/23; • Develop the Monitoring Process and Governance to be able to track progress and impact	
8.0	**Key messages for the BHR ICPB and NEL Finance and Performance Committee**	
	KP reminded members that the sub-committee's Terms of Reference state that the sub-committee is accountable to the CCG's Finance and Performance Committee and also reports to the BHR ICP Area Committee/ ICPB. An update report from the sub-committee Chair will be presented at these forums for noting. The key messages to feed back this month include: • Agreeing the Terms of Reference • Receiving an update on the current financial position • Receiving an update on the Integrated Sustainability Plan • Approval of business cases	

	The Finance Sub-committee noted the verbal update.	
9.0	**Any other business**	
	There was no other business to note.	
10.0	**Items for information only**	
10.1	FSPPDM actions log	
	The sub-committee noted the action log.	
	Date of next meeting – 28 July 2021	
Due to conflicts of interest involving CCG GPs, the remaining papers on the agenda were considered by a non-conflicted group of Finance Sub-committee members and recorded in a separate set of minutes.		

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

BHR Health System Quality and Performance Oversight Group
15th April 2021 by MS Teams

Minutes

Members

Dr Sarah Heyes (SH) - CHAIR	Redbridge Clinical Lead, NEL CCG
Dr Jagan John (JJ)	NEL CCG and B&D Chair
Dr Anil Mehta (AM)	Redbridge Chair, NEL CCG
Steve Rubery (SR)	Director of Planning and Performance, BHR ICP, NEL CCG
Khalil Ali (KA)	Lay Member, NEL CCG
Mark Gilbey-Cross (MGC)	Deputy Nurse Director, BHR ICP, NEL CCG
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Melody Williams (MW)	Integrated Care Director (B&D), NELFT
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT

Attendees

Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
Tracy Welsh (TW)	Director of Transformation & Delivery – planned care, BHR CCGs
John Flood (JF)	NEL Provider Performance Director, NELCSU
Hilary Shanahan (HS)	Interim Head of Quality and Clinical Governance, BHR CCGs
Doug Tanner (DT)	CYP Maternity CAMHS Commissioning Lead, BHR CCGs
Keeley Chaplin (KC)	Business Manager, Governance Team, BHR CCGs

Apologies

Caroline Allum (CA)	Medical Director, NELFT
Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Dr Atul Aggarwal (AA)	Havering Chair, Havering CCG
Jacqui van Rossum (JvR)	Executive Integrated Care Director (London), NELFT
Carol White (CW)	Integrated Care Director (Havering), NELFT
Bob Edwards (BE)	Integrated Care Director (Redbridge), NELFT
Aleks Hammerton (AH)	Acting Chief Operating Officer, BHRUT
Sue Elliott (SE)	Acting CEO, PELC

No.	Agenda item and minute
1.0	**Welcome, introductions and apologies**
	The Chair welcomed all to the virtually held meeting.

No.	Agenda item and minute
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict. There were no conflicts of interest declared pursuant to the business of this oversight group.
1.2	Minutes of the meeting held on 18 March 2021
	The minutes of the BHR Health System Quality and Performance Committee held on 18 March 2021 were duly **noted**.
1.3	Matters/actions arising
	The actions log was reviewed and the following noted: QPC ACT082 Diabetic foot care – RP advised a meeting has been held to escalate issues and the discussion is ongoing. RP will circulate a summary of actions being taken and an update report will be provided at the next meeting. The information will include a subset for Charcot Foot. **Action: RP** Members agreed to close QPC ACT090 and QPC ACT091
2.0	**Quality**
2.1	BHR System Quality and Safeguarding Report
	MGC gave an overview of quality and safeguarding issues and updates across the BHR system. A full restart of functions that were paused due to dealing with the Covid-19 pandemic has taken effect from 1 Aril 2021. An incremental approach to return to full quality requirements, in order to support colleagues across the system to recover, is being taken. However, it is noted that the team continued to monitor, review and had oversight of elements such as Serious Incidents (SI), Never Events (NE) and Regulation 28 (Prevention of Future Deaths) Reports. In BHRUT one never event was declared in March, relating to wrong-site surgery. The cancer and incidental finding task and finish group will provide a full briefing and update paper at a future meeting meeting. **Action: MGC** In NELFT there were no never events reported during the period. At the next meeting NELFT will present on the thematic reviews into community acquired pressure ulcers and the physical health needs of mental health patients. **Action: JVR** MW reported there were two SIs over the previous weekend that are currently being investigated. SH raised concerns raised by GPs with regards to inappropriate work being asked of them by some consultants and whether they should report this via GP alerts. MGC advised that the GP alert log has been refreshed as of 1 April 2021 and this will be a good way to capture themes and investigate issues. SR suggested the output from the investigations are shared with all GPs. MGC advised the team will be creating a quality and safety newsletter that will include findings and outcomes from investigations and on Regulation 28 reports. There will need to be clear communication and rebranding out to GPs to encourage the use of the alert system. JJ added there should be somewhere to record positive experience. The group **noted** the report.

No.	Agenda item and minute
2.2	BHRUT Quality Report
	LB presented an overview of the quality and safety flash report. One never event was declared in March and is under investigation and the outcome will be shared with this group. The annual self-declaration for the specialist commissioning process will not take place in 2021-22. Specialised cancer peer reviews and routine visits have also been paused and this will be reviewed again in June. Highly specialised services will be required to submit their annual outcome data for 2020/21 through the Specialist Services Quality Board (SSQD) on a voluntary basis and this is also being reviewed in June. The Trust is in the process of reintroducing patients' partners in relation to maternity scans and ante natal appointments in line with national guidance. The Trust has established a Maternity Assurance Board and will incorporate a number of workstreams, which include the ongoing action plan for the Ockenden report and governance compliance within the Maternity Division. KA advised that NEL are in the process of developing a system for the patient experience strategy and asked if BHRUT have any good practice they could share. LB advised the national patient experience framework is being presented internally in April and they could bring a report to the June meeting. **Action: LB** The group **noted** the report.
2.3	BHRUT's Board report on the Ockenden Report and Action Plan on Maternity Services
	KH presented an update on maternity services and reviews, including the Ockenden report. The action plan addresses recommendations from the Ockenden report as well as learning taken from the reports following inspections of maternity services in other Trusts. Any identified gaps have been added to the maternity improvement plan. Actions from the Ockenden report have been adapted to focus on the local diverse population in BHR to make them more relevant. The Maternity Voices Partnership has been relaunched to engage with the wider diverse population. There is a focus on multi-disciplinary team meetings and ensuring women with complex pathways have appropriate consultant overview and care. Since the report has been written it has been to the Trust's Quality Assurance Board, its Board and has been reviewed by local LAS who have agreed with the amber and green ratings given. SH congratulated BHRUT on the work and scoring achieved. SH would like this report and recommendations to be considered in any future planning for NEL such as in the redevelopment of Whipps Cross and its maternity services and planning for population growth. KH agreed. KA advised the emphasis on local demographics is commendable and asked if there is anything in the strategy on its approach to caesarean operations. KH responded that the Trust had been challenged on the high number of caesareans being undertaken but have defended this as patient choice and response to the needs of the women rather than on meeting targets. The group **noted** the update.

No.	Agenda item and minute
2.4	NELFT Quality risks and exceptions
	MW provided the group with an update on exceptions relating to Quality Governance and highlighted a few areas of interest. During January 2021, the IPC team supported the management of 20 COVID-19 outbreaks across inpatient and community services. The number of outbreaks gradually reduced with one remaining open. The community team have worked very well across the system supporting care homes and the wider system. Unfortunately, there has been an increase in safeguarding caseloads with domestic abuse remaining in the top three enquiries. KA raised the issue of the high number of open risks on the risk register and 45% of which had not been reviewed. MW advised that the actions and learning are being progressed however there is a delay in administration updating the Datix system which will close many of these down. MGC congratulated NELFT for being in the top 10 on staff surveys for the latest period. The group **noted** the report.
2.5	CYP with Mental Health Presentations and 12 Hr Waits in ED update
	DT provided a verbal update on the CAMHS crisis in ED and will provide a written report to the next meeting. Previous work undertaken had involved social care colleagues from the 3 boroughs as well as colleagues in BHRUT and Whipps Cross as large number of patients in ED with emotional or mental health crisis were looked after children (LAC) and a significant proportion of delay in discharge was finding a suitable placement especially if there was an element of self-harm involved The Provider Collaborative who now held the remit for Tier 4 CAMHS provision had submitted unilateral bids for services to affect this ED issue. It therefore seemed appropriate to deliver and 'end to end' oversight of the pathway for these CYP by combining the acute and social care representation with that for Tier 4. This has been combined into the Discharge Oversight Group (DOG) which is jointly chaired by the BHR CYP Programme Lead (DT) and Dr Rafik Refaat from ELFT and the Provider Collaborative The DOG had its first meeting on 6th April and established its system priorities and revised Terms of Reference. This group will now be the assurance vehicle for this risk with a revised outcomes framework supported by a robust dataset SH asked if there has seen a reduction in ED since children returned to school? MW advised there has been a reduction in numbers presenting in ED but there has been a large increase in referrals through the community CAMHS service which is now back to pre Covid figures and in some areas above pre-Covid level. SH advised of the difficulties faced by GPs in getting help for children who are struggling until they reach crisis point and asked if there is a strategy especially going into next winter. MW responded that there is a NEL CAMHS steering group that reports to the mental health transformation board and thousands of children go through CAMHS service every year but there may be some individual cases where their needs will not be

No.	Agenda item and minute
	met through this service. The next phase of investment was top sliced out of mental health transformation and there was a significant proportion ringfenced for mental health schools' team. In BHR there are only two teams and are vastly under represented. This is a significant factor and will have a share of the investment to invest with two opening in Havering and two in Redbridge later on this year. The work is not about waiting until children are so unwell to go to the GP but the focus is on intervention work in schools. SH thanked DT and MW and noted that this is an ideal opportunity to do something differently and this should be explored. MW agreed that this is. The group **noted** the verbal update.
3.0	**Performance**
3.1	System performance report
	SR advised that due to the timing of the meeting the data presented is largely the same as the previous meeting. Due to the issues regarding receipt of data in time for the meeting, the scheduling of the meeting will be moved to the first week of the month from June. BHRUT have restarted their elective activity and are ahead of plan. The 52 week waits has not increased to the level predicted they could get to. The 2ww cancer performance has stayed strong but there has been a slight dip on the 62-day performance which was mostly due to challenges of surgery during the pandemic with little green theatre capacity and the need to arrange alternative care through the independent sector. A&E performance has started to improve. It is difficult to compare over the last two years due to the pandemic as well as using a different delivery model. There has been slightly improved performance across the system over the last two months, the variation is less and is much more stable. The group **noted** the update.
3.2	BHRUT performance challenges and recovery
3.3	RP advised that the 52ww numbers have been coming down over the last four weeks, and though the Trust had predicted 3000 at the end of March it was less at approximately 2600. There has been a significant increase in A&E attendances in March compared to February. There have been much larger numbers of 2ww patients which is now in excess of pre Covid levels. In March the Trust saw the highest number of 2ww patients since July 2019. The 62-day performance was affected due to a change in surgery eg the move out to independent sector which caused delays in January and then repatriating it back in house when that contract ended. This will continue to cause breaches but the Trust is focusing on the clinically heightened priority patients and ensuring available theatre capacity is devoted to treating them first. Cancer performance is impacted by pathways across other providers eg Barts with gynaecology. Patients are being treated in other ways whilst they await surgery eg hormones until they are seen.

No.	Agenda item and minute
	The Trust is experiencing significant pressure on attendances by patients concerned with post AZ vaccination worries since the adverse publicity regarding it. SH noted that this has also added pressure on GPs too. SH asked what the conversion rate is on 2ww patients being referred in. RP advised they are monitoring this but there has not been any evidence of inappropriate referrals in but is more likely unmet need. The group **noted** the report.
3.4	NELFT performance challenges and recovery
	JH gave an overview of the NELFT integrated performance report. JH noted that in the CAMHS service there may have been a drop in referrals by 25% but they still had over 6000 contacts and are now back up to normal levels and patients had consistent contacts throughout. For children's access the targets were met in some areas but due to some variables and abilities, others were not met. The system has changed and rather than requiring two contacts there is now only one needed. Safeguarding compliance is an improving picture and MGC is involved in this. The group **noted** the report.
4.0	**Any other business**
4.1	NEL Chief Nurse MGC reported that Diane Jones has been appointed as the NEL chief nurse and will be joining in July with Vanessa Lodge continuing to cover in the meantime.
4.2	Independent sector monitoring SH queried the lack of quality assurance on the independent sector. SR advised that during the last year the independent sector had been commissioned by NHS England and therefore the contractual meetings with the CCG had paused. These will now return and will be included in future reports.
5.0	**For noting**
5.1	Draft terms of reference
	Comments on the draft terms of reference were requested by end of April. The final draft will then be presented to the May ICPB.
6.0	**Date of next meeting** 3 June 2021

BHR Integrated Care Partnership
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BHR Health System Quality and Performance Oversight Group
3rd June 2021 by MS Teams

Minutes

Members

Dr Sarah Heyes (SH) - CHAIR	Redbridge Clinical Lead, NEL CCG
Steve Rubery (SR)	Director of Planning and Performance, BHR ICP, NEL CCG
Dr Anil Mehta (AM)	Redbridge Chair, NEL CCG
Mark Gilbey-Cross (MGC)	Deputy Nurse Director, BHR ICP, NEL CCG
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT
Sue Elliott (SE)	Director of Nursing, Quality and Governance, PELC

Attendees

Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
Tracy Welsh (TW)	Director of Transformation, BHR ICP, NEL CCG
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG
Olu Omotayo (OO)	Assistant Director of Planning and Performance (BHR) NELCSU
Hilary Shanahan (HS)	Interim Head of Quality and Clinical Governance, BHR ICP, NEL CCG
Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Bob Edwards (BE)	Integrated Care Director (Redbridge), NELFT
Ben Conway (BC)	Acting Deputy Chief Operating Officer and Director of Performance Analytics, BHRUT
Chloe Jackson (ChJ)	Nurse Fellow, BHRUT
Ramneek Hara (RH)	Deputy Chair – B&D CCG, NEL CCG
Karina Christensen (KC)	Deputy Director of Contracts, NELCSU
Jeremy Kidd (JK)	Deputy Director of Delivery (Planned Care), BHR ICP, NELCCG
Helen Mason (HM)	Director of Operations, PELC
Keeley Chaplin (KLC)	(Minute taker) Governance Team, BHR ICP, NEL CCGs

Apologies

Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Aleks Hammerton (AH)	Acting Chief Operating Officer, BHRUT
John Flood (JF)	NEL Provider Performance Director, NELCSU
Carol White (CW)	Integrated Care Director (Havering), NELFT
Jacqui van Rossum (JvR)	Executive Integrated Care Director (London), NELFT
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT

No.	Agenda item and minute
1.0	**Welcome, introductions and apologies**
	The Chair welcomed all to the virtually held meeting. Apologies were noted as above.

No.	Agenda item and minute
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict. There were no conflicts of interest declared pursuant to the business of this oversight group.
1.2	Minutes of the meeting held on 15th April 2021
	The minutes of the BHR Health System Quality and Performance Committee held on 15th April 2021 were duly **noted and approved**.
1.3	Matters/actions arising
	The actions log was reviewed and **noted**. Members agreed to close QPC ACT082 and QPOG ACT003
2.0	**Performance**
2.1	System performance report
	OO provided an overview of the system performance report highlighting the following: • BHRUT achieved the 2ww Cancer Standard for the eighth consecutive month in March with performance of 96.03% against the 93% standard and trajectory, however challenges persist in Breast and Gynaecology against the Trust's aspiration of 7 days. • Overall BHRUT achieved 6 out of the 8 waiting standards. Key challenges are within the 62-day standard for Gynaecology, Urology, Upper and Lower GI pathways which was mainly due to the reduction in theatre availability due to Covid. The Trust are working with the CCG, independent sector and the NEL Cancer Alliance to bring back within the target. • In diagnostics the Trust saw an improvement in performance with 93.03% being achieved against the 99% target. • RTT performance saw a slight improvement of 61.41% in March against the 92% standard. The RTT PTL was 1,287 below the agreed Phase 3 trajectory in March 2021. • A&E performance is stable. • The updated operating plan has been submitted for the sector and future reports will include tracking against submission. • Barts Health are consistently achieving the cancer standards. • To reduce the PTL list BHRUT have increased capacity to see more patients face to face and have increased theatre schedules. The Trust are holding 'perfect' weeks which has a focus on specific specialties such as 'Bones week' which increased outpatient appointments for diagnostics and joint surgery. RH raised queries relating to performance for access to CYPMH access and Serious Mental Illness (SMI) physical health checks. SM and RH will discuss the reporting methods for these targets separately. **Action: SM** RH asked if NELFT classify the initial triage appointment for IAPT as the first appointment or if it is the first therapy appointment. **Action: NELFT** The group **noted** the update.
2.2	BHRUT performance challenges and recovery
	BC briefed members on BHRUT's performance noting the following: • They were pleased to maintain the 2ww standard thought-out the pandemic • Forecast for the number of patients waiting over 52 weeks in May is 1700 which is in line with the increase in face to face appointments and the theatre restart.

No.	Agenda item and minute
	• Biggest risk for RTT continues to be the pain service and maintaining theatre capacity for these patients is a priority. • Diagnostics continues to improve but there is a risk as MRI capacity in the independent sector is reduced. • The Emergency Department has seen a sharp increase in type 1 in May. A multi-agency front door walk-though has been scheduled to look at processes and suggest improvements. • The Queens Frailty Unit opened on 7 May and there has been some improvement in performance for patients over 75 treated within 4 hours and are now looking to expand the unit is one of the priorities. SH asked if this has been communicated to GPs. MS will ensure this has been communicated. Focus has been patients from ambulances and will check communication on direct referral. SH added that PCNS are working with LAS and sharing patient information on EMIS and that it would work well if they could share. • RH noted that there had previously been an issue with the resolution of MRI scans taken in the private sector differing from those taken in BHRUT and that when contracting out to the independent sector quality of the scans should be a consideration. SH added that if scans are undertaken elsewhere it should be available on the national spine. MGC will raise this at the next radiology meeting. **Action MGC**. The oversight group **noted** the update.
2.3	NELFT performance challenges and recovery
	JH presented the May NELFT performance report. • As consultation methods moved to remote as a result of the Covid the number of DNA rates dropped. • The CYP mental health target was met in Havering but was missed in Barking & Dagenham and Redbridge. The number of contacts has been renegotiated and will include an open contact in future. • There has been an increase in under 18-week waiters • The performance for Early Intervention Psychosis (EIP) has good progress with just one dip in March 2020. • received treatment within 4 weeks. • The Did Not Attend (DNA) rate has reduced *MS left the meeting.* BE clarified that people can do the online IAPT therapy module (self-cloud) and if at the end they still want a face to face they can do. The online offer is broadening, enhanced coming onstream in the next couple of months. SH asked if there is an opportunity for the eating disorders team to provide a GP educational session especially as there is an increase in numbers. BE will liaise with MGC to arrange this. **Action: BE** The group **noted** the update report.
3.0	**Quality**
3.1	BHR System Quality and Safeguarding Report
	MGC provided an overview of quality and safeguarding issues and risks across the BHR system.

No.	Agenda item and minute
	• The final meeting of the Cancer and Incidental Findings Task & Finish Group is expected to be held in July and a full oversight and closure briefing will be presented to the Quality & Performance Oversight Group of August 2021 • Since the last reporting period, no Never Events have been declared by BHRUT or NELFT. • There have been two Regulation 28 Reports issued to BHRUT and two to NELFT since the previous report. • An independent audit into the quality of Independent Health Assessments (IHAs) has been delayed but NELFT have commissioned an independent deep-dive review into IHA's with the purpose of developing a training needs analysis for LAC professionals. • A complex and robust action plan has been developed following a number of SIs at the mental health inpatient unit, with a number of actions already completed. A summary of concerns and details of actions taken/planned will be presented at the next meeting. • Details of BHR practice CQC ratings are included within the report and support is given to practices where concerns have been identified. • SH asked for clarity regarding nursing home patients that are on Mirtazapine needing to have Deprivation of Liberty Safeguards (DoLS) documented in their notes. **Action: MGC to provide a summary for circulation to GP colleagues** • SH noted the coroner's reports as being particularly harsh. MGC advised that there is a potential increase in Regulation 28 reports relating to services paused due to Covid. It has been agreed that if any BHR providers are issued with a Regulation 28 as a result of a pause in service they should be forwarded to MGC who will help to co-ordinate a response and will discuss further with the coroner. • RH raised concerns relating to the NG tube incident at the Royal London and if there is related data available from other hospitals. MGC advised that previously a review of never events relating to NG tubes at BHRUT had been undertaken and was benchmarked across London and BHRUT appeared to be an outlier at the time. Some concerns were found on the procurement but mitigations were put in place. The group noted the report and agreed the actions being taken to date to mitigate the identified risks.
3.2	InHealth Endoscopy SI
	KC gave an overview of the SI raised by InHealth who had discovered a list of 26 patients on an obsolete queue of patients which had not been transferred over to the default triage queue. Out of 26 affected patients 19 are BHR patients. Commissioners have raised concerns regarding the delay in reporting this to the commissioners. A remedial action plan has been agreed and the CCG is working with the provider to expedite the review and assessment of affected patients. One patient has died since their initial referral and the coroner is being contacted to identify whether the delay in treatment impacted on the cause of death. InHealth are required to complete the full SI investigation and has agreed to share the full Root Cause Analysis (RCA) with commissioners upon completion MGC has notified the quality and nurse leads at other CCGs that have patients on this list so they can chase up any outstanding information from their relevant GPs. The Quality and Performance Oversight Group noted the briefing and that an update report will be presented at the next meeting.

No.	Agenda item and minute
3.3	BHRUT Quality Report
	LB presented the BHRUT quality and safety integrated report as at April 2021. Key highlights include: • A review of nosocomial deaths is being undertaken for definite healthcare-associated COVID-19 infections (identified on 15+ days of admission). The initial stage of the process includes triangulation of data using incidents, complaints, PALS, patient experience surveys which will be followed by the Structured Judgement Reviews (SJR) if it fulfils the SI criteria. • There had been an increase in the number of deaths of patients with learning disabilities. During the to March 2021 there were 40 reported deaths which is a significant increase on the previous year. BHRUT Data is being reviewed and will be compared to national data via the Learning Disabilities Mortality Review (LeDeR) programme to identify learning and implement recommendations. MGC noted that the highest number of deaths were recorded in March to June 2020 and was a similar picture nationally. • A review of the National Patient Experience Framework has been undertaken which supports NHS Trusts and Foundation Trusts to achieve good and outstanding ratings in their CQC inspections. The Trust has undertaken a baseline assessment against the Improvement Framework. The Patient Experience Team are now exploring the areas it wishes to progress during 2021/22. • There has been an increase in the number of paediatric patients attending ED with mental health needs. This remains an ongoing concern. The group **noted** the update report.
3.4	NELFT Quality risks and exceptions
	BE presented the NELFT annual quality governance report. • In 2019, following receipt of the CQC provider quality report, an improvement plan to mitigate the 22 must do risks identified was developed. However, Covid-19 had a major impact on the completion of this plan. They have now closed 15 with plans in place to close the remaining six. Internal audit has monitored and provided assurance on these risks. • The Serious incidents team have achieved accreditation for their serious incidents processes. The Trust is now one of four organisations in the UK to have received this accreditation to date. • The patient experience review has been completed and is now being implemented. They have over 20 patient involvement representatives. The team is working with Sunflowers Court with the development and embedding of the See, Think, Act (STA) Relational Security project across the inpatient wards. • There has been a sharp increase in inquests being requested when cases delayed due to Covid resume. There are 77 open inquests currently. The group **noted** the update report.
3.5	NELFT BHR CCGS Physical Healthcare Serious Incidents in Mental Health Inpatients Units Thematic Review
	SS briefed members on the thematic review which focused on 9 incidents that took place in 2018/19 relating to deteriorating physical health in a mental health inpatient setting. One of those settings is not in NELFT but in a residential mental health home. Eight for review (one not submitted at time of review). The key themes were identified and action plans developed. The actions have since been closed but a review to ensure they were embedded and if any further actions are needed.

No.	Agenda item and minute
	The staff induction protocol has been reviewed and audits undertaken. Development programmes for staff with a focus on physical health is now in place and are recruiting a Physical health nurse consultant/strategic lead. A rotational nurse programme has commenced with BHRUT. HS and MGC has reviewed the update against the thematic review and noted there is a lot of excellent work being undertaken in particular the work with BHRUT. HS will discuss the detail further with NELFT and an update report will come to a future meeting. The group **noted** the report on the review.
3.6	PELC Integrated Quality and Performance report
	SE provided a brief update on quality. There were no SIs reported in March 2021 and one open SI with actions for PELC completed but it remains open for the police investigation to be completed. The 2021/22 audit plan was agreed at the Combined Audit and Medicines Management Committee meeting in February 2021, subject to any relevant additions. An assessment of the audit plan for 2020/21 confirms that most of the audits have been completed and reports and action plans discussed at the relevant committees and with staff. This audit highlighted that some clinicians were failing to document clearly whether a patient had capacity when making clinical decisions and management plans. All staff have been reminded to ask and record this and IT are looking at adding a prompt in the system to record if the patient has capacity. A new patient survey feedback form has been created which can be accessed using a QR code. HM updated members on PELC's Performance. Due to significant and sudden increased demand, performance has been challenged, but surges have been well managed. Utilisation has been higher and only 30% or less are streamed into ED but this is then a challenge to manage patients in the designated areas at the hospital. Abuse towards staff is an issue mainly due to redirecting patients from the service. Rota adjustments are now being made ready for the end of national lock-down and likely further increase in demand. Members agreed that there should be zero tolerance for abuse of staff and CJ will look at what can be done at a local level to impower staff. **Action CJ** KH asked if PELC are getting 100% fill rates for these posts. SE advised they are working closely with BHRUT looking at the 4 hour waits and what can be done to reduce the length of queue. A clinical navigator walks the queue to ensure anyone that needs urgent care will be prioritised. The group **noted** the integrated quality and performance report.
3.7	PELC CQC inspection report update
	SE advised that CQC visited PELC twice over 4 weeks. They used two frameworks - acute for well-led and primary care for service delivery which culminated in one report which has now been published and is available online.

No.	Agenda item and minute
	Key issues raised as concerns and are working on these at pace. PELC are in regular conversations with both CCG and CQC colleagues who are assured on the actions that have been taken so far. Non-audited accounts will be uploaded onto the FCA website by the date specified. The comprehensive action plan will be shared with the CCG. The group **noted** the verbal update.
3.8	Diabetic Foot Care MDT
	JK advised that following an SI report into a critical event in 2017 relating to a delay to treatment for a suspected Charcot Arthropathy a Diabetic Foot MDT service was commissioned from BHRUT in 2019. Following concerns raised by the Trust and commissioners around the availability of clinicians to input into the MDT as a result of Covid related pressures, a roundtable was convened in May 2021 and actions have been agreed to address the staffing challenges. The Trust have informed the CCG that appointments are now available in one week which is an improvement but longer than 48 hours NICE recommendation. In addition, to improve diabetic foot outcomes in BHR, and to reduce pressure on the MDT the CCG, in partnership with BHRUT and NELFT, are in the process of working to commission a Community Diabetic Foot Protection Service. The aim is to manage medium and high-risk diabetic foot in the community and prevent deterioration to the extent that referral to the MDFT is required. It is anticipated that the proposed service will function as a single point of access for all suspected diabetic foot related referrals. SH congratulated all on the work that has been done across the organisations and asked for details of an equivalent pathway at Whipps Cross Hospital through Barts Health. JK will bring this to a future meeting. The group **noted** the update report.
4.0	**Any other business**
	None.
5.0	**Date of next meeting**
	1 July 2021
6.0	**Items for information only**
6.1	Minutes of the Area Prescribing sub-Committee
	The minutes of the BHR Area Prescribing sub-committee held on 16 March 2021 was duly noted.
6.2	Minutes of the Integrated Safeguarding Assurance Board
	The minutes of the BHR integrated safeguarding assurance board held on 28 April 2021 were noted.