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

Barking and Dagenham, Havering and Redbridge
Integrated Care Partnership Board

26 May 2022

1:00pm – 2:30pm

via Microsoft Teams

AGENDA

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1:00	Chair	Verbal	Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meeting held on 31 March 2022			Attached	Approve
1.3.	Actions/matters arising			Attached	Note
2.0	**Managing Director's report**	1:05	Ceri Jacob	Attached	Note
3.0	**JSNA update**	1:15	Mark Ansell	Attached	Note
4.0	**Transformation**	1:40			
4.1.	BHR Transformation programme key progress and achievements		Tracy Rubery / Han Xuan-Tang	Attached	Note
5.0	**BHR ICP performance**	1:55			
5.1.	Finance report		Henry Black	Verbal	Note
6.0	**Any other business**	2:05	All	Verbal	Discuss
7.0	**Items for information**	2:10			
7.1.	Confirmation of Area Committee approval: • Discharge to Assess (D2A) STW • Wheelchair Service STW		Kash Pandya	Verbal	Note
7.2.	Minutes of relevant forums: • Integrated Care Executive Group • BHR Health & Care Cabinet • BHR Quality & Performance Oversight Group • BHR Integrated Care Partnership Finance Sub-Committee		Chair	Attached	Note

	Item	Time	Lead	Attached/ verbal	Action required
8.0	**Questions from the public**	2:20	Chair	Verbal	Discuss
9.0	**Close**	**2:30**			

Glossary of terms and abbreviations

Term	Explanation
BH	Barts Health NHS Trust
BP	Borough Partnership
BHR	Barking and Dagenham, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
C&H	City and Hackney
CAMHS	Children and Young People Mental Health Services
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CHC	Continuing Healthcare
DoH	Department of Health
ELFT	East London NHS Foundation Trust
GBAF	Governing Body Assurance Framework
HUH	Homerton University Hospital NHS Foundation Trust
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
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
PELC	Partnership of East London Co-operatives
PHE	Public Health England
PBP	Place Based Partnership
PPGs	Patient Participation Groups
PPI	Patient and Public Involvement
PTL	Patient Tracking List
RTT	Referral to Treatment
TNW	Tower Hamlets, Newham and Waltham Forest
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
WX	Whipps Cross Hospital

- Declared Interests as at 19/05/2022

Name	Position/Relationship with CCG	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Andrew Blake-Herbert	Chief Executive; London Borough of Havering	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	London Borough of Havering	Employed as Chief Executive	2021-05-01		Declarations to be made at the beginning of meetings
Anil Mehta	Redbridge Clinical Chair	BHR ICP Health and Care Cabinet BHR ICP Primary Care Management Group BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC)	Financial Interest	Fullwell Cross Medical Centre	GP Partner	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Metropolitan Police	Forensic Medical Examiner	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	NHSE	GP Appraiser	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Healthbridge Direct	Shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Fouress Enterprise Ltd	Director	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Prescon	Ad-hoc screening work	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	The Cleaning Company	Sister-in-law is owner	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Healthwise Ltd (non-trading)	Director	2009-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GMC	Associate	2019-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NEL CCG	Registered as a patient at a GP practice in NEL.	2000-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Redbridge Health and Wellbeing Board	Vice Chair	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Anglia Ruskin University Medical School	Lecturer	2019-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	QMUL	GP Tutor	2021-01-01		Declarations to be made at the beginning of meetings

Anju Gupta	Clinical director	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Sponsorship	UCLP	I am participating in a clinical reference group led by UCLP. An unrestricted and unconditional grant from Astra Zeneca and boehringer	2022-03-25		
			Financial Interest	NELFT	GP SI diabetes	2010-02-01		Declarations to be made at the beginning of meetings
			Financial Interest	Health education England	GP trainer	2017-11-01		Declarations to be made at the beginning of meetings
			Financial Interest	PCN	member	2018-04-03		Declarations to be made at the beginning of meetings
			Financial Interest	Federation	Member	2017-04-01		Declarations to be made at the beginning of meetings
			Financial Interest	Principal	Abbey medical centre	2016-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Clinical champion	DUK	2020-11-01		Declarations to be made at the beginning of meetings
			Sponsorship	oviva	invited to and attended HSJ partnership awards re B&D - Oviva partnership re diabetes structured education ; winner of the HSJ partnership awards in PROJECTS impacting inequalities in healthcare and outcomes	2022-03-24	2022-03-24	
			Financial Interest	Maylands Healthcare	GP Partner	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Maylands Healthcare Ltd	Director and shareholder in on-site pharmacy	2013-01-01		Declarations to be made at the beginning of meetings

Atul Aggarwal	Havering Clinical Chair	BHR ICP Finance Sub-committee BHR ICP Health and Care Cabinet BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body	Financial Interest	Essex Medicare LLP	Part-owner (which owns Westland Clinic, Hornchurch. Space rented out to: · Inhealth (Diagnostics) · Nuffield Health (Brentwood) · Communitas Clinics (Dermatology and gynaecology)	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Havering Health Ltd	Shareholder. GP partner at Maylands Surgery (Dr joti) is a Director	2014-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Parkview Dental Practice	Sister is NHS Dentist within Havering she is an associate and does not own the business	1996-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Westlands Clinic (Langton Dental) who has an outsourced contract with BHRUT for oral surgery)	Spouse is dentist	2018-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking, Dagenham and Havering LMC	Co-opted member	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Havering and Wellbeing Board	Member	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Anglia Ruskin University Medical School	Lecturer	2019-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	NEL CCG	Registered as a patient at a GP practice in NEL.	1990-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica LTD	Partner at Surgery who is director or company - I am a shareholder	2021-10-31		Declarations to be made at the beginning of meetings
Barbara Nicholls	Director of Adult Social Care & Health, Havering Council	BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Non-Financial Professional Interest	Association of Directors of Adult Social Services (ADASS)	Professional membership	2016-01-01		Declarations to be made at the beginning of meetings

DR R HARA	Clinical lead	BHR ICP Health and Care Cabinet BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	At Alban's Surgery	GP principal.	2016-05-01		
			Financial Interest	Together first federation	Member practice	2014-05-01		
			Financial Interest	Network East one	Practice is member of the PCN	2019-05-01		
			Financial Interest	London deanery	GP trainer for GP registrar	2013-07-11		
			Financial Interest	Barts and Queen Mary's University (Barts and the London) – Undergraduate Tutor	Tutor for medical student.	2016-10-18		
			Financial Interest	Nhse GP Appraiser	GP Appraiser for professional development personal and colleagues.	2016-12-01		
			Indirect Interest	Medimmune (Astra zeneca)	Spouse is a medical director	2011-04-01		
			Non-Financial Personal Interest	Redbridge surgery	I am registered patient	1996-07-01		
			Financial Interest	Aris Private limited	Director, company not trading.	2019-09-01		
Emily Plane	Programme Lead - BHR System Development	BHR ICP Health and Care Cabinet BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Non-Financial Personal Interest	The Greenwood Practice	I am a registered patient of The Greenwood GP Practice, Gubbins Lane, Harold Wood, in Havering.	0021-04-01		
Henry Black	Acting Accountable Officer	NEL CCG Governing Body BHR Integrated Care Partnership Board (ICPB)/ Area Committee BHR Integrated Care Executive Group (ICEG) TNW ICP Area Committee/ Delivery Group	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Tower Hamlets GP Care Group	Daughter is Social Prescriber	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Clinical Commissioners	Board Member	2018-01-01	2021-07-31	Declarations to be made at the beginning of meetings

Jagan John	NEL CCG Chair	BHR ICP Health and Care Cabinet BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Governing Body NEL CCG Quality Committee NEL CCG Remuneration Committee	Financial Interest	Parkstone Holdings Ltd	Director	2020-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	2020-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	2020-05-01		Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and Shareholder	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifieth Ltd)	Director and Shareholder	2020-10-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Aurora Medcare (previously known as King Edward Medical Group)	Other GPs are family members	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	2020-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Personalised Care – Healthy London Partnerships and NHS England London Region	Clinical Lead	2017-05-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust – Barking and Dagenham Community Cardiology Service	GPWSI in Cardiology	2011-08-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking and Dagenham Health and Wellbeing Board	Deputy Chair	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is share holder	2021-10-31		Declarations to be made at the beginning of meetings
Jason Frost	Councillor; London Borough of Havering; Cabinet Member for Health & Adult Care Services; Chair of Havering Health & Wellbeing Board	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indirect Interest	Local care provider which receives CHC patients	Mother is employed as a registered nurse	2021-04-01		Declarations to be made at the beginning of meetings

Kash Pandya	Lay Member Governance and Audit Chair	BHR ICP Finance Sub-committee BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Audit & Risk Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC)	Financial Interest	Southend-on-Sea Borough Council	Independent Audit Committee Member	2016-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Essex Police, Fire and Crime Commissioner's Audit Committee	Independent Audit Committee Member	2021-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	University of Essex	Independent Audit Committee Member	2014-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Brentwood Citizen's Advice Bureau	General Advisor	2009-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Metro Bank	Son is Procurement Manager	2019-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Accenture	Son is a Legal Director	2017-01-01		Declarations to be made at the beginning of meetings
Narendra Teotia	Clinical Director; Barking & Dagenham North Primary Care Network	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	Together First CIC (B&D GP Federation)	Shareholder	2014-01-01		Declarations to be made at the beginning of meetings
Rt Hon Jacqui Smith	Member of Integrated Care Partnership Board	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	Barking, Havering & Redbridge University Hospitals Trust	Chair in common with Barts Health NHS Trust	2021-10-01		Declarations to be made at the beginning of meetings
			Financial Interest	Sandwell Children's Trust	Chair	2021-10-01		Declarations to be made at the beginning of meetings
			Financial Interest	Jacqui Smith Advisory Limited	Director	2021-10-01		Declarations to be made at the beginning of meetings
			Financial Interest	Dalgety Limited	Non-Executive Director	2021-10-01		Declarations to be made at the beginning of meetings
			Financial Interest	Global Partners Governance	Associate	2021-10-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Jo Cox Foundation	Chair	2021-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Kings Fund	Trustee	2021-10-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	The Precious Trust	Chair	2021-10-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UCL Partners	Director	2021-10-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barts Charity	Trustee	2021-10-01		Declarations to be made at the beginning of meetings

Sangeetha Pazhanisami	GP; PCN Clinical Director	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	Clayhall Group Practice	GP Partner	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Healthbridge Direct	Shareholder			Declarations to be made at the beginning of meetings
			Financial Interest	NHS England	GP Appraiser			Declarations to be made at the beginning of meetings
Steve Collins	Acting Chief Finance Officer	TNW Finance & Performance Sub-committee TNW ICP Area Committee/ Delivery Group C&H Finance and Performance Subcommittee C&H Integrated Care Partnership Board (ICPB) BHR ICP Finance Sub-committee BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Audit & Risk Committee NEL CCG Finance & Performance Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Remuneration Committee	Non-Financial Professional Interest	Trisett Limited (business support service)	Director	2003-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Sevenoaks Primary School	Chair of Governors	2002-01-01	2021-01-01	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Hope Church Sevenoaks	Chair of Trustees	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Fegans (charity)	Wife is Chair of Trustees	2017-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	PwC	Daughter is Senior Associate	2019-01-01		Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 19/05/2022

Name	Position/Relationship with CCG	Committees	Declared Interest
Caroline Allum	Executive Medical Director, NELFT Chair of BHR ICP Health & Care Cabinet	BHR Integrated Care Partnership Board (ICPB)/ Area Committee BHR Integrated Care Executive Group (ICEG) BHR ICP Health and Care Cabinet	Indicated No Conflicts To Declare.
Ceri Jacob	Managing Director; BHR ICP	BHR ICP Finance Sub-committee BHR ICP Primary Care Management Group BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Governing Body NEL CCG Primary Care Commissioning Committee (PCCC) NEL CCG Quality Committee	Indicated No Conflicts To Declare.
Ahmet Koray	Director of Finance; BHR ICP	BHR ICP Finance Sub-committee BHR ICP Primary Care Management Group BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee NEL CCG Audit & Risk Committee NEL CCG Finance & Performance Committee	Indicated No Conflicts To Declare.
Adrian Loades	Corporate Director of People; London Borough of Redbridge	BHR Integrated Care Partnership Board (ICPB)/ Area Committee BHR Integrated Care Executive Group (ICEG)	Indicated No Conflicts To Declare.
Maureen Worby	Councillor and Cabinet Member for Social Care and Health Integration Chair of BHR ICPB/ Area Committee	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indicated No Conflicts To Declare.
Jacqueline Van Rossum	BHR ICP member	TNW ICP Area Committee/ Delivery Group TNW Quality, Safety and Improvement Sub- committee BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indicated No Conflicts To Declare.
Matthew Trainer	BHR ICPB member	BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indicated No Conflicts To Declare.
Ikenna Obianwa	Programme Manager	BHR ICP Finance Sub-committee BHR ICP Health and Care Cabinet BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indicated No Conflicts To Declare.

Historic declarations

Name	Position/Relationship with CCG	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To
Jayam Dalal *Historic*	ASSOCIATE LAY MEMBER FOR PATIENT AND PUBLIC ENGAGEMENT - BHR	BHR ICP Primary Care Management Group BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Non-Financial Professional Interest	TRADING ARM OF THE THIRD AGE LIMITED	Trustee of TATTL, which is the trading arm of the U3A [University of Third Age]	2021-02-01	Left organization 31/3/22
			Financial Interest	RESIDENTIAL PROPERTY - FIRST TIER TRIBUNAL, PROPERTY CHAMBER	Lay Member	2000-03-01	
			Financial Interest	ETHICAL STANDARDS COMMISSIONER SCOTLAND	Independent Advisor	2015-10-01	

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

Draft minutes – BHR Integrated Care Partnership Board

31 March 2022

1.00pm – 2.30pm
Via MS Teams

Members:

Cllr Maureen Worby (MW)	ICPB **Chair** (LB BD)
Kash Pandya (KP)	Lay Member, Governance & Area Committee Chair, NEL CCG
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Rt Hon Jacqui Smith (JS)	Joint Chair, BHRUT & Barts Health
Matthew Trainer (MT)	Chief Executive, BHRUT
Joe Fielder (JFi)	Chair, NELFT
Andrew Blake-Herbert (ABH)	Chief Executive, LB Havering
Dr Jagan John (JJ)	NEL CCG Chair and B&D Clinical Chair
Dr Anil Mehta (AMe)	Redbridge Clinical Chair, NEL CCG
Adrian Loades (ALo)	Corporate Director of People, LB Redbridge
Cllr Mark Santos (MS)	LB Redbridge
Cllr Jason Frost (JFr)	LB Havering

Attendees:

Tracy Rubery (TR)	Director of Transformation, BHR ICP
Caron Bluestone (CB)	Associate Lay Member, BHR ICP
Dr Rami Hara (RH)	Deputy B&D Clinical Chair, NEL CCG
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Keeley Chaplin (KC)	Governance Officer, NEL CCG
Emily Plane (EP)	Programme Lead, BHR ICP
Nassib Gungoo (NG)	Project Officer, NEL CCG
Selina Douglas (SD)	Executive Director of Partnerships, NELFT
Helen McKenna (HK)	Chief of Staff, BHRUT and Barts Health
Justin Daniels (JuD)	Acting Medical Director, BHRUT
Sultan Taylor (ST)	Non-Executive Director, NELFT
Sarah See (SS)	Director, Primary Care Transformation, BHR ICP

Apologies:

Magda Smith (MSm)	Chief Medical Officer, BHRUT
Henry Black (HB)	Acting Accountable Officer, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
Dr Caroline Allum (CA)	Executive Medical Director, NELFT
Jacqui Van Rossum (JVR)	Acting CEO, NELFT
Claire Symonds (CS)	Acting CEO, LB BD
Dr Narendra Teotia (NT)	PCN Clinical Director, B&D
Dr Sangeetha Pazhanisami (SP)	PCN Clinical Director, Redbridge
Dr Gurmeet Singh (GS)	PCN Clinical Director, Havering
Dr Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Ahmet Koray (AK)	Interim Director of Finance, BHR ICP
Jayam Dalal (JD)	Associate Lay Member, BHR ICP

		Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies received were noted. The chair extended gratitude and thanks to Magda Smith, Joe Fielder, Claire Symonds and Steve Rubery for their contributions to this Committee as this will be their last meeting before moving on to other roles and organisations.	
1.1	**Declarations of conflicts of interest**	
	The chair reminded everyone of their obligation to declare any interest they may have on any issues arising at the meeting. Additional conflicts of interest were declared by: • Steve Rubery declared that he will be joining PELC (provider organisation) as Chief Executive with effect from 1 May. There are no conflicts arising regarding the items on the agenda. • Sultan Taylor is a Non-Executive Director at NELFT. There are no conflicts arising regarding the items on the agenda. The register of interests was noted.	
1.2	**Minutes of the last meeting**	
	The notes of the meeting held on 27 January 2022 were agreed as an accurate record.	
1.3	**Actions/matters arising**	
	ICPB members noted the actions taken since the last meeting.	
2.0	**Managing director's report**	
	Steve Rubery presented the progress report on behalf of Ceri Jacob, which covered the following areas: • Key points from the recent White Paper - Health and social care integration: joining up care for people, places and populations, published February 2022. A proposal has been prepared by the NEL team which attempts to translate the requirements into what's needed at a Place Based Partnership (PbP) level in terms of leadership and governance. This will be presented to the PbPs for discussion. It includes an accountable lead at a PbP level, a Director lead for the PbP, and a system clinical and care lead for each PbP. • Update on work to progress the Transformation Cycle within NEL ICS work. Workshops are taking place to drive the process forward and shape the system. This will all be brought together at a workshop in April with key ICS workstreams including finance, quality etc. • A proposal on the future of the BHR joint commissioning board will be presented to the next meeting. • Development of the clinical and care leadership model for the North East London ICS and our BHR PbP. Each PbP has submitted its model to North East London (NEL). These will be reviewed and a workshop will be held in April to further develop the proposals. Each PbP will have a discussion on quality and how this is forming at NEL level.	

		Action
	• The Provider Collaboratives are also keen to engage with PbPs so that they can collectively shape how these are forming and the relationships with the PbPs • The proposed terms of reference for the Integrated Care Executive Group (ICEG) post July 2022 is currently going back to each BHR PbP for review and endorsement Discussion points included: • Work will be undertaken at place-based levels however should not lose sight that work will still be undertaken at BHR and NEL level where this is appropriate. • Waltham Forest will form part of outer North East London • Financial modelling and governance will be challenging, in particular with block contracts and breaking down to place-based level. It was suggested that a roadmap on how to break down the two largest contracts should be developed, if this is possible. Discussions are ongoing regarding the apportionment of system development funding and weightings. • Outer NEL has been historically underfunded compared with inner NEL and the challenge will be levelling up and ensure that funding is leveraged to outer NEL based on need. • Priority to primary care in respect of workforce, funding and capacity planning as this is the first point of contact for patients. • NELFT have a sustainable plan for workforce and are looking at ways to attract and retain local staff. The BHR Health and Care Academy is an excellent source to innovatively address workforce challenges across BHR. Members of the ICPB: • Noted progress to develop our BHR Place Based Partnership and ongoing multi borough collaboration.	
3.0	**Risk Management Policy and Process**	
	Steve Rubery presented the revised risk management policy and process which has been undertaken following an internal audit recommendation to review and strengthen the policy. The following was highlighted: • A new corporate risk register (CRR) has been produced and risk leads have been asked to review their current risks to ensure that all risks have the appropriate rating, mitigations and target rating. • The NEL CRR was reviewed by the Audit and Risk Committee on 23 March and recommendations for further review were made and will be taken forward. • A further report will be presented in May. • Once the registers are finalised then training for committee members will be considered. Members of the ICPB: • Noted the revised risk management policy and process.	

		Action
4.0	**Transformation**	
4.1	**Primary Care Development Update**	
	Sarah See provided an update on primary care development which includes the Winter Access Fund and GP access, planning for the Covid-19 spring booster campaign, population health management, supporting resilience in general practice and PCN CD development. The key aim of all of the projects or programmes of work is to improve access to a high quality of service, with a key focus on reducing health inequalities for a diverse population. Support is being provided to PCNs including: • budget management • ensuring sufficient estate to deliver care, particularly for ARRS roles (PCN estates capacity plans now completed) • Business Intelligence data management • PCN managers plan – learning same QI programme • workforce – working with the BHR Health and Care Academy and training hubs and working with NELFT to provide education and training. The LIS equalisation programme continues with Safeguarding scheme now live, and finalisation of the Duty Doctor and Phlebotomy schemes. The roll out of the spring booster and 5-11 year olds vaccination campaign has commenced and will run until May 2022. Members thanked Sarah See and the primary care team for the update and noted the vast range of work undertaken.	
5.0	**BHR ICP Performance**	
5.1	**BHR priority actions progress update**	
	Steve Rubery provided an update on progress on BHR's priority actions: • Recovering well • Addressing inequalities and prevention • Anchor Organisations • Leadership, Culture, And Leading Change The report provided a focus on recovering well and provides detail on the elective position, diagnostics and referrals. The waiting lists for elective is increasing however the number of referrals into the trust have increased significantly from an average of 650 to 1000 referrals per week. The number of patients waiting over 52-weeks has increased. The number of very long waits has remained stable. For diagnostics, the proportion of patients with over 6-week breaches have improved significantly with 20% of patients breached compared to 30% at the end of January. BHRUT's radiology department are working on scanning and reporting to help improve the waiting lists, however a high proportion of staff are off sick and demand is increasing with more patients seeking medical help.	

		Action
	Specialist advice and guidance in the Trust has been very successful, however there are some surgical specialities that are not yet providing this service which could improve the quality of Advice and Guidance (A&G) referrals. Collaboration with Barts Health has started and is making progress with the offer of capacity/mutual aid where available. Theatre productivity and driving efficiencies is an area that could be considered. Members noted the progress to take forward the partnership priorities.	
5.2	**Finance report**	
	The CCG has submitted a H2 plan to NHSEI and budgets have been set for the full financial year across the three integrated care partnerships. At month 11, BHR ICP and each of the ICPs in NEL CCG have reported a break-even position across core budgets. However, delivery of the position has been reliant on the use of non-recurrent opportunities totalling £8.1m. The draft Operating Plan for 2022/23 was submitted on 17 March 2022. This showed a system deficit of £99.5m, with £36.7m being the CCG share. The plan includes sustaining services into 22/23 and looks at affordability and some of the levelling up agenda. The CCG and providers will work together to close the financial planning gap before the final submission. The CCG is facing a number of inflationary price pressures that have been built into the plan. The submitted system deficit in the draft plan is £99.5m and indications from the treasury is that systems should close this by developing a plan that achieves year-end balance. It is likely pressures will persist for the next 2-3 years. Members asked if there has been an assessment on the impact of the increase in fuel bills and other costs across the system as this will affect all services including primary, community and voluntary services and will impact workforce in terms of costs to travel and the cost of living. BHRUT and NELFT have begun to look at this with staff networks and unions and it was agreed that this is something that should be discussed collaboratively and reported on at the next meeting. **Action: CJ agreed to raise this at the SOCG on how to progress this discussion.** Members noted the update provided and contents of the report.	CJ
6.0	**Any other business**	
6.1	**Population growth in NEL** Following a visit from the Secretary of State to Barking Hospital it was highlighted that Barking and Dagenham and Newham have the highest growth of residents in London with 300k in NEL. All public services may be affected with this increase and it was suggested a group could meet to discuss Local Plans. It could also consider how to approach the government for additional support due to these specific and special circumstances.	JJ

		Action
	Action: JJ is meeting with Sharon Morrow to link into work already being progressed.	
7.0	**Items for information**	
7.1	**BHR Area Committee approvals**	
	ICPB members were advised that the following items received Area Committee approval since February 2022: • Urgent Care Response, CTT expansion - business case • Diabetic foot protection - business case • Beam Park - strategic outline business case • Ilford Exchange - strategic outline business case	
7.2	**Minutes of relevant fora:**	
	The minutes of the following meetings were noted: • BHR Integrated Care Executive Group – 20 January and 17 February 2022 • BHR Health & Care Cabinet – 9 December 2021 and 10 February 2022 • BHR Quality & Performance Oversight Group – 2 December 2021 and 3 February 2022 • BHR ICP Finance Sub-Committee – 25 November 2021 and 27 January 2022	
7.3	**ICPB effectiveness survey results**	
	The chair thanked members that had responded to the recent survey and the summary was presented to the committee for information. The analysis will be included in the NEL CCG's annual report.	
8.0	**Questions from the public**	
	None raised	
	Date of next meeting – 26 May 2022	

Integrated Care Partnership Board – open actions

Action ref:	Meeting date	Action required	Lead	Required by	Status
5.2 Finance report	**31 Mar 2022**	BHRUT and NELFT have begun to look at the impact of the increase in cost of living with staff networks and unions and it was agreed this should be discussed collaboratively and reported on at the next meeting.		May 2022	**CJ raised this at the SOCG meeting as this has reps from across the ICP and will update at the May meeting**
6.1 Population growth in NEL	**31 Mar 2022**	Barking and Dagenham and Newham have the highest growth of residents in London with 300k in NEL. All public services may be affected with this increase and it was suggested a group could meet to discuss Local Plans. It could also consider how to approach the government for additional support due to these specific and special circumstances.		May 2022	There is a NEL group that is being convened to look at this, particularly in relation to population growth in B&D and Newham **JJ and Sharon Morrow have discussed this from a B&D perspective to shape how best to take this forward.**

BHR Integrated Care Partnership Board

26 May 2022

Title of report	Managing Director's Report – BHR Integrated Care Partnership Update
Author	Emily Plane, Head of Strategy and System Development, BHR
Presented by	Ceri Jacob Managing Director, BHR Integrated Care Partnership
Contact for further information	e.plane@nhs.net
Executive Summary	This paper sets out progress on the BHR approach to further developing our local partnership within the wider context of the developing North East London Integrated Care System (ICS). It provides an update on: - Our proposal to continue the BHR Joint Commissioning Board as part of our continued multi borough working post July 2022 - Update on progress on the Transformation Cycle work which aims to illustrate what functions will be led by which parts of the system; adopting a population health based approach to how our ICS service areas will be led, planned and delivered - Development of the clinical and care leadership model for the North East London ICS and our BHR Place Based Partnerships – next steps - Ongoing development of our Place Based Partnerships and local partnership priorities
Action Required	ICPB members are asked to: ▪ **NOTE AND COMMENT** on the detail of this paper and the next steps to further develop our

	local partnership/multi place based collaboration within the wider context of the developing North East London Integrated Care System
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 1 July 2022.
Equality Impact	Not applicable at this stage

1. Introduction

1.1 The latest Operating Plan guidance (December 2021) and Health and Social Care Bill, alongside the more recent (February 2022) White Paper on integration reinforce the importance of establishing Place based Partnerships within each North East London Borough.

1.2 The months leading up to and beyond 1 July 2022 form part of a key transition period and it is essential that we collectively support development of our Place Based Partnerships and thinking around what functions they will take on in the coming years; consider how the emerging Place based Partnerships will interact and work with the Provider Alliances that are also in development, continue to progress multi borough working where it makes sense to do so (for example around the BHR Integrated Sustainability plan and associated transformation programmes) and develop our proposed clinical and care leadership models (which will operate in partnership with the North East London Clinical and Care Leadership Model and emerging Provider Collaboratives and Clinical Networks).

1.3 The Health and Care Act 2022 has now completed the parliamentary process and received Royal Assent. This is a key step on the journey towards establishing Integrated Care Systems on a statutory footing, which will take place on 1 July 2022 as communicated in the NHS 2022/23 priorities and operational planning guidance, and enabling more collaborative ways of working across the health and care system.

1.4 The next phase of system development will continue, and builds on the evolution of local partnerships and collaborative ways of working over several years, with the first ICSs created in 2018, emerging from Sustainability and Transformation Partnerships. The vision for greater integration was laid out in the Five Year Forward View and further cemented by the NHS Long Term Plan in 2019.

1.5 ICB leaders are now preparing for the implementation of statutory ICS arrangements on 1 July 2022 in line with the ICS establishment guidance previously set out by NHS England.

1.6 This paper sets out progress on the BHR approach to further developing our local partnerships within this context.

Progress update – key areas

Progress update since the last ICPB meeting on key partnership initiatives	
Our BHR vision for the arrangements to support collaboration at a Multi Place Based level and proposal to continue the BHR Joint	As ICPB members have discussed and agreed, the three BHR Place Based Partnerships will continue to collaborate around the following key areas at a BHR level; ▪ Oversight and delivery of the BHR Integrated Sustainability Plan, and associated Transformation Boards which include: o Children and Young People Transformation Board o Long Term Conditions Transformation Board o Older People/ Frailty Transformation Board o Unplanned Care Transformation Board ▪ Delivery of key collaborative work such as the BHR Health and Care Academy ▪ This will be reviewed on a six monthly basis

Commissioning Board	▪ Post July 2022 it is proposed that the BHR Integrated Care Executive Group (ICEG) meeting continues for a period of time (subject to a review of the terms of reference and wider governance arrangements), with a key role around overseeing the BHR element of the multiborough collaboration work, and delivery of key areas. This arrangement will be kept under ongoing review, and it is important to note that this is a committee in common – the group as a unit will have no decision making authority other than that which its members have vested in them as key members of their respective Place based Partnerships. ▪ Alongside this, a proposal for the future of the BHR Joint Commissioning Board has been developed based on discussion with key partners from across health and care in Barking and Dagenham, Havering and Redbridge during February/March 2022. ▪ There is consensus that at least initially, the BHR Joint Commissioning Board should continue, noting that this will need to work alongside strong discussion at Place Based Partnership level. ▪ There is also consensus that there is benefit from continuing to develop a Better Care Fund plan at a Barking and Dagenham, Havering and Redbridge level. ▪ It is proposed that BHR JCB meetings are every two months going forward. ▪ Individual Place Based Partnerships may wish to have a local group or forum to discuss borough specific opportunities around joint commissioning between the NHS and Local Authority; this should be considered as part of the development of their respective local governance arrangements. ▪ Local Authorities are now required to develop market position statements alongside a market sustainability plan; the BHR JCB may be a useful place to achieve economies of scale around the development of these and ensure alignment. ▪ It is proposed that the BHR ICEG group identifies key opportunities for Joint Commissioning, highlighting those they consider priorities, which the BHR JCB can focus on for 2022/2023. ▪ We need to ensure that the structures that are put in place to support this don't create duplication of discussion across the system. ▪ The current JCB is not a committee and this approach will remain for the proposed continued B&D, Havering and Redbridge JCB; it will be authorised within the limits of delegated authority for its members (which are received through their respective organisation's own financial scheme of delegation to: for each commissioning partner of the ICB and Local Authority, to deploy agreed resources within the pooled fund(s) in accordance with required outcomes within the Better Care Fund Plan, having regard to the consequences of any movement in funding between schemes, workplans or areas within each local area. It is therefore proposed that this meeting is referred to a group going forward, rather than a board. ▪ B&D, Havering and Redbridge partners to consider the resource required (through the process/consideration of the resource required to support the ICB/Place Based Partnerships), to properly resource the BHR JCB to fulfil its role, including access to data and reporting and consideration of backfill of officer time to undertake the agreed joint commissioning arrangements – partners have been clear through the development of this proposal that there are significant opportunities around joint commissioning that have not been possible to progress due to lack of capacity. ▪ This position should be reviewed on a six monthly basis in line with the review of arrangements for the BHR Integrated Care Executive Group which will oversee agreed ongoing areas of multi borough collaboration, from 1 July 2022. ▪ Draft terms of reference incorporating these proposals, for the refreshed Joint Commissioning Board, have been drafted and are out for comment with ICEG and B&D, Havering and Redbridge Place based Partnership members.

Update on the Transformation Cycle work within NEL ICS	Ceri Jacob, Managing Director, BHR ICP and Siobhan Harper, Director of ICP Transition for TNW, have been leading a process with partners from across the NEL system around the Transformation Cycle, adopting a population health based approach to how our ICS work service areas will be led, planned and delivered. Through this process, it is hoped that partners will have a better understanding of what functions will sit at each level of the system post July 2022. A set of principles have been developed by partners, and emerging functions for Place Based Partnerships have been articulated including: ▪ Developing a local plan ▪ Integrating health, social care and the voluntary sector on the ground ▪ Demand management ▪ Supporting equity of access ▪ Resident, patient and community engagement ▪ Embedding clinical and care professional leadership ▪ Local service design ▪ Gathering of local data insight and intelligence across partners including local authorities and VCSE A number of workshops have taken place to drive this process forward, culminating in a workshop in April with partners to bring together a number of the key pieces of work to shape the NEL Integrated Care System. The output paper summarising the discussion can be found at **appendix 1.** This is being socialised with each Place based Partnership in NEL for consideration and review. ▪
Clinical and Care Leadership model for NEL and our Place Based Partnerships	▪ Development of proposals for the clinical and care leadership model for the North East London ICS and our BHR Place Based Partnerships continues to progress. ▪ Current Clinical Leads have been written to setting out the implications of the extension of the CCG until the end of June 2022. ▪ We have been informed that the North East London team are considering a further delay to the recruitment to the Place based Partnership Clinical and Care Leadership models to allow time to recruit to the Clinical Director post that is critical to the Clinical and Care Leadership models within each Borough and who will have a key role in overseeing the transition to the new model. Each Place based Partnership is being asked to consider and articulate any risks that may be associated with such a delay. ▪ Place based Partnerships are also being asked to prepare for recruitment to the Clinical Director role imminently. Diane Jones, NEL Chief Nurse will sit on the recruitment panel, alongside local leads from each Place based Partnership. ▪ The NEL team have confirmed a baseline allocation of £498,000 for each place for clinical and care professional leadership. From a BHR perspective: - Our approach will need to take into account our proposal around ongoing multi borough collaboration

	- Each Place Based Partnership in BHR has set out their initial proposal for their Clinical and Care Leadership model, and is in the process of refining this.
Ongoing development of our BHR Place Based Partnerships	- Our BHR Place Based Partnerships continue to develop and progress. - BHR Place Based Partnership development sessions continue, with two sessions planned in June 2022, with a focus on: o June session 1: Finance and Contracting o June session 2: Green Social Prescribing, preparation for the creation of the ICB from 1 July and an update on the Population Health Management Pilots that are in development in B&D and Redbridge - At the May BHR PbP joint development session, partners were given the opportunity to meet the new PbP Quality leads, and agree a way forward to develop joint working at a PbP level. Partners also received updates on the development of Community and Primary Care collaboratives in NEL, and discussed how the PbPs can work with these emerging collaboratives. - BHR Partners continue to utilise dedicated time at the Joint Commissioning Board meetings to discuss Place Based Partnership development in the context of the NEL Integrated Care System.

2. Risks and mitigations

2.1 A full risk register for our BHR Integrated Care Partnership has been developed, capturing our key risks; this feeds up into the North East London Integrated Care System Risk Register. This will be discussed in more detail under agenda item 3.

2.2 One of the key overall risks for 2022/23 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the 'integration and innovation' White Paper from July 2022.

3. Recommendations

3.1 Members of the BHR Integrated Care Partnership Board are asked to note and comment on the progress to develop our Barking and Dagenham, Havering and Redbridge Place Based Partnerships, and ongoing multi borough collaboration, within the wider context of the North East London Integrated Care System, detailed within this report.

Emily Plane
Head of Strategy and System Development, Barking & Dagenham, Havering and Redbridge
May 2022

Appendices
Appendix 1 – Transformation Cycle Proposal

North East London Health & Care Partnership

Collaborating to deliver better care across the North East London integrated care system

How place-based partnerships, provider collaboratives, and the Integrated Care Board can work together to deliver service transformation in North East London

April 2022

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Introduction

The purpose of our integrated care system is to 'work with and for all the people of North East London (NEL) to create meaningful transformation and improvements in health, wellbeing and equity'.

Our ability to achieve this will depend on how the main component parts of the integrated care system – place-based partnerships, provider collaboratives, and the Integrated Care Board (ICB) – work together to support residents to achieve the health and wellbeing outcomes that matter most to them.

This requires us to improve our understanding of how the ICB is able to work with and through provider collaboratives and place-based partnerships in order to carry out its statutory responsibilities. Primarily, the ICB is expected to play an oversight and direction setting role, taking on a convening and coordination role only when this is required and agreed by the Integrated Care System (ICS) partners. The majority of service transformation areas will be driven through the provider collaboratives and place-based partnerships and this is reflected in the final output principles and recommendations.

This paper sets out the process and outputs from a project designed to work out how we should do this, involving partners from across North East London. Our integrated care system is complex and it will take time to learn how its many parts best work together. This paper is intended to provide a creative, ambitious, and sensible starting point for 1 July 2022– a starting point that will iterate and evolve as we test it in practice.

In this spirit, the proposal set out here should be viewed as a kick-off point rather than a blue-print for the future. This work will iterate and change over time. The precise timelines for regular review and evaluation are currently under discussion.

Objectives

The starting point for this work is the central ICS ambition to improve outcomes, quality, value and equity for the entire population of NEL.

In supporting this aim, the key objective of this work was **to determine how service transformation and improvement will be led, planned, and delivered across place-based partnerships, provider collaboratives and NEL-wide teams working within the Integrated Care Board (ICB)**.

Achieving this objective required us to answer two questions:

- How will all partners work together to deliver improvements to population health across NEL?
- Which partners are best placed to take on coordinating and supporting roles for improving different types of care?

We know that there are currently communities in NEL who are underserved and not thriving. This work will enable us to maximise the opportunities presented by multi-level organisation working across the ICS to deliver the triple aim for *all* our residents.

Process

Over the past three months, this work has benefitted from engagement from partners across North East London, including local authorities, trusts, and NEL's places.

The approach to this work has been 'both and' as opposed to 'either or'. By this we mean that this work is not about dividing up service transformation areas and deciding that work should *either* be undertaken at place *or* collaborative *or* ICB.

Instead, for every area of service transformation it was vital we understand how places, collaboratives *and* the ICB will all work together and play their part in order to succeed. There will be different responsibilities and functions undertaken in each part of the system and one partner will be the most natural choice to lead on coordinating the system plan for that particular service transformation area.

For example, in order to deliver the ICB's statutory responsibilities for mental health there will be some functions associated with the programme that can only be delivered at scale through the collaborative and some that can only be delivered at place. As a result, it makes sense for the Mental Health Learning Disability and Autism Alliance to lead on coordinating the system's plan for mental health.

It is only by understanding how places, collaboratives and the ICB will work together that we can take an effective, population based approach to service transformation. The different parts of the system also need to be able to hold each other to account and foster a productive, creative tension that maintains momentum and supports continued learning and innovation.

Genuine collaborative working arrangements across partners are required to realise the ambitions of the triple aim and achieve our system purpose: **working with and for all the people of North East London to create meaningful improvements in health, wellbeing and equity.**

In February, workshops tested four different service transformation scenarios –services for children with a learning disability, urgent community response, adults' mental health, and planned care – and explored how partners would work together to deliver them.

Following these workshops, additional discussions, and the rich feedback received on the workshop outputs, this paper has been created as the draft output of this work.

It applies the conclusions drawn from the four scenarios to create an overall proposition for how the parts of NEL's integrated care system best collaborate to deliver improvements to care.

A third workshop in April reviewed and revised this paper ahead of it being socialised more widely, including with forums such as the ICS strategy group. There will also be engagement and then formal sign-off with the ICS executive management team.

Outputs

The outputs from this process are:

- a set of proposed key behaviours and organisational culture commitments for how partners will work together to deliver service transformation for the people of North East London;
- a set of principles which define how place-based partnerships, provider collaboratives, and the ICB each contribute to strategy, planning and delivery for service transformation; and
- applying these principles, a set of recommendations across all service transformation areas.

Contents

This paper comprises:

- **Part one** – which defines what we set out to achieve and the iterative process designed to accomplish this, based on both the workshops and accompanying engagement; and
- **Part two** – which contains the final outputs and recommendations, taking each transformation service area in turn, applying the framework principles and offering a proposal for how they should delivered from 1 July 2022.

Get in touch

We welcome all feedback. Please send your responses to:

- Ceri Jacob – cerijacob@nhs.net;
- Siobhan Harper – siobhanharper@nhs.net; and
- Eli Bond – elanor.bond@nhs.net.

PART ONE

1.1

Purpose

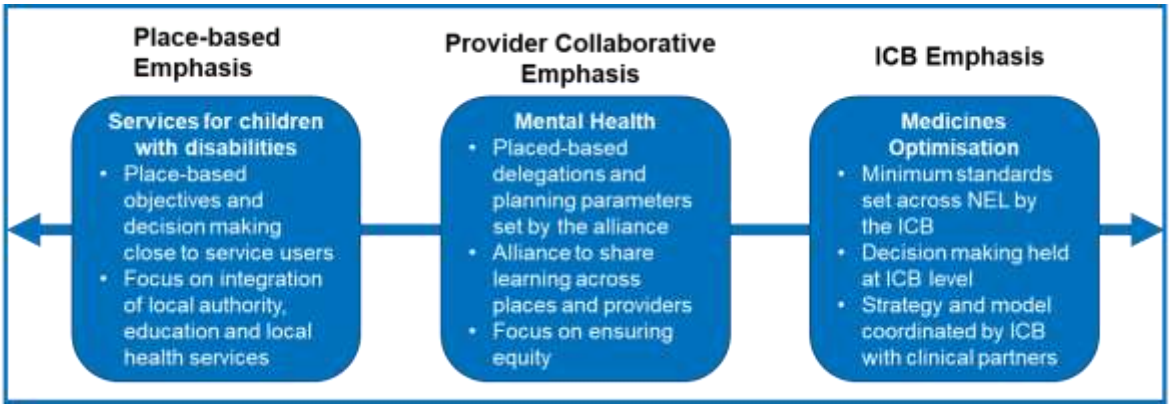
The key purpose of this work was to improve outcomes for the entire population of NEL by determining how different ICS service transformation areas can best be led, planned, and delivered across place-based partnerships, provider collaboratives, and NEL-wide ICB teams.

For all service transformation areas, there will need to be close collaboration across all parts of the system to achieve the best possible outcomes for residents.

At the same time, the balance of input and the role of place-based partnerships, provider collaboratives, and the ICB will differ depending on the needs of different types of service transformation.

This work therefore set out to establish principles for where a particular part of the system should act as a coordinating partner for particular service transformation areas.

The below diagram gives examples of how the emphasis might differ across different areas.



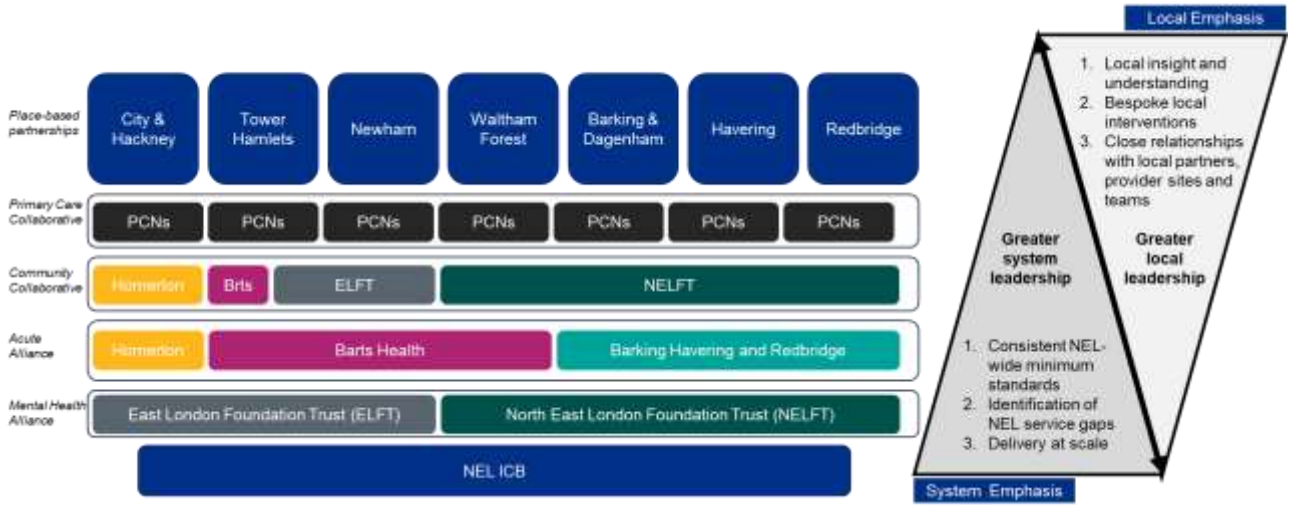
Note: these examples are not final conclusions for these areas but simply demonstrate how logic could be applied

Participants in the workshops agreed that determining where strategy, planning and delivery should sit depends on factors such as:

- the amount of local input and community insight needed to deliver a high-quality service;
- whether minimum or core standards have already been set by NHS England and how specialised the service transformation area is;
- whether services are bespoke for each place or whether there is (or should be) a shared model across NEL;
- the current levels of unwarranted variation across services, programmes or populations;
- whether there are existing service gaps that would benefit from a common approach; and
- the potential benefits of delivery at scale.

The diagram below highlights some key considerations and interdependencies that were factored-in when deciding on the balance between local and system emphasis.

The diagram shows a simplified overview and consequently we have not named all of the partners within each place.



Overall, this work aims to provide the following:

1 **a clear answer to the question of which parts of the system will coordinate and support service transformation in each area**, so that responsibilities are clearly defined and all the necessary infrastructure can be put in place to allow the ICB to carry out its statutory duties safely and efficiently; and

2 within this, **a detailed understanding of the different functions and responsibilities allocated to each component of the system** so that, working together, the system can deliver impactful service transformation that directly benefits the residents of North East London.

Scope

The areas covered by this work is:

Service and transformation areas

- Mental health
  - CAMHS
  - Adult Services
- Learning disabilities and autism
- Babies, children and young people
- Maternity
- Cancer
- Community Based Care
- CHC
- End of life care
- Medicines optimisation
- Primary Care
- Homelessness
- Planned Care
  - Acute
  - Long term conditions
- Prevention
- Personalisation
- Testing and vaccination
- Urgent and emergency care

Given the complexity of the task, the following elements were designated out of scope to ensure suitable focus during the workshop (though the outputs will inform work in each of these areas):

- the clinical and care professional leadership model;
- specific staffing arrangements for ICB teams;
- the accountability model across difference parts of the system; and
- the delegation of budgets within the ICS.

A note on budgets

Whilst this work will inform the discussions taking place on the ICS's financial framework, the financial model underpinning each service transformation area is outside the scope of this work. Acting as the coordinating partner for a service transformation area is not dependent on receiving a budget for that area. Equally, being listed in this paper as a prospective coordinating partner for a service transformation area is not a suggestion that a budget should follow.

There is, therefore, a critical distinction between leading the coordination of the system around a particular transformation area and holding a budget.

Engagement on the ICS's financial framework is ongoing over April and May 2022.

1.2

The process

In answering the question of how place-based partnerships, provider collaboratives, and ICB teams should work together to deliver service transformation, two workshops tested scenarios in the four areas listed above.

This paper has been drafted following those two workshop discussions and was also subject to review at a third and final workshop.

The conclusions drawn from the four scenarios were used to build a set of broader principles to be applied to the remaining service transformation areas, without the group needing to go through each one in turn.

These principles not only inform how partners work together but also how coordinating and supporting roles should be devised, helping to inform the wider ICS operating model.

The workshops also developed a set of proposed behaviours and cultural commitments for how partners can grow stronger and more trusting relationships across the ICS, building on NEL's strong history of partnership working.

Using the transformation cycle (included in the appendix) as a starting point, the project team created an eight-step framework to help work through the different elements of strategy, design, and delivery involved in each service transformation area:

#	1	2	3	4	5	6	7	8
Category	Delivery	Governance	Delivery	Governance	Delivery	Governance	Delivery	Governance
Stage	Develop strategy and standards	Decision making - agreeing the strategy and scope of work	Analyse population health information	Prioritise service/ programme needs and challenges	Service / programme design	Service / programme sign-off	Implement care model or change model	Review impact / monitor performance
Decision Making in the ICS	**Who will develop the strategy, priorities and minimum standards?**	**Where are decisions made about the services strategy and scope of work?**	**Who should carry out the BIA?**	**Where will the prioritisation (based on the BIA) be agreed?**	**Who will design the programme (CCP leaders/programme leads)?**	**Where is the service or programme signed-off**	**Who is responsible for delivery?**	**Where is the impact of the service / programme reviewed and assured?**
Supporting considerations	• Given answers to the above, where does it make sense for the funding for this area to sit?		• How will the individuals working on this be resourced? E.g. PbP teams / central ICB teams / combination		• How will collaboration and appropriate input from across the ICS be ensured where it's required?		• What processes need to be in place to maintain appropriate assurance and learning across the system?	

With the framework as a guide, it was easier to delve into the details of which partners are best placed to undertake coordinating and supporting responsibilities for different service areas.

Working group

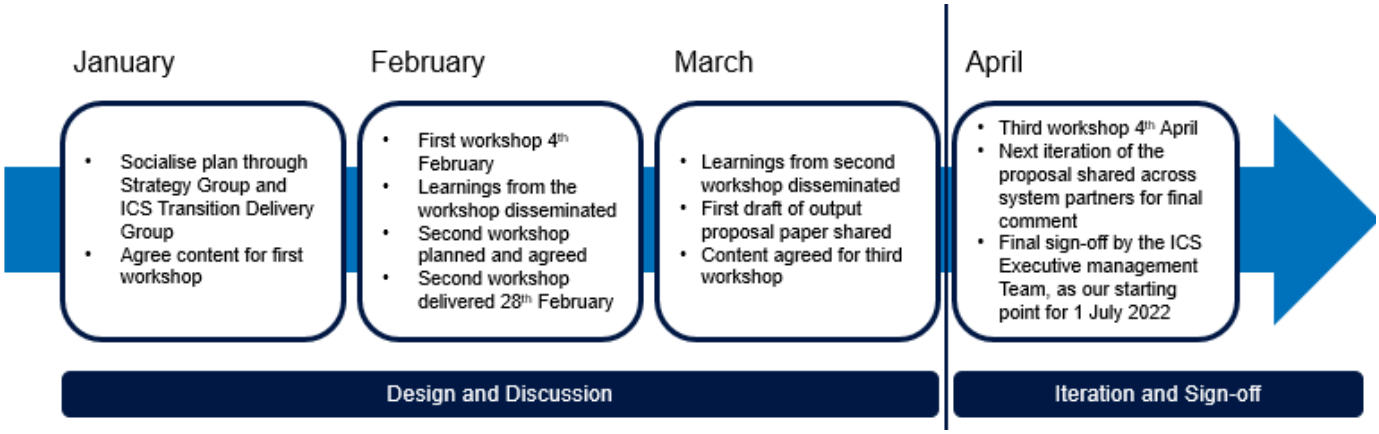
A working group with broad representation across our place-based partnerships, provider collaboratives, and CCG colleagues led this work. Each member was also charged with ensuring that the developing outputs were shared widely across other system partners.

Name	Role	Organisation
NHS trusts / provider collaboratives		
Lee Basso	Acting Director of Strategic Development	BHRUT
Selina Douglas	Executive Director of Partnerships	NELFT
Richard Fradgley	Executive Director of Integrated Care	ELFT
Ann Hepworth	Director of Strategy & Partnerships	BHRUT
Caroline O'Donnell	Director of Strategy and Partnerships	NELFT
Catherine Pelley	Director of System Development	Homerton Healthcare
Mark Turner	Interim Group Director, Strategy and Planning	Barts Health Trust
Morag Harvey	Deputy Director of Planned Care	Acute Provider Collaborative (Employed by Barts)
Claire Hogg	Director of Planned Care	
Place-based partnerships		

Colin Ansell	Corporate Director of Adults and Health	Newham
Dan Burningham	Mental Health Programme Director	City and Hackney
Heather Flinders	Strategic Director, Families	Waltham Forest
Nina Griffith	Director of Delivery Development	City and Hackney
Sandra Husbands	Director of Public Health,	Hackney
Anil Mehta	Clinical Chair	Redbridge
Mark Rickets	Clinical Chair (and NEL primary care CRO)	City and Hackney
John Rooke	Delivery Director	Newham
NEL CCG		
Steve Beales	Assistant Director of ICS Implementation	NEL CCG
Simon Hall	Director of Transformation	NEL CCG
Siobhan Harper	Director of Transition – TNW	NEL CCG
Ceri Jacob	Managing Director – BHR	NEL CCG
Hilary Ross	Director of Strategic Programmes	NEL CCG
Tracy Rubery	Director of Transformation – BHR	NEL CCG
Rachael Tomlinson	Finance Lead	NEL CCG

Timelines

The work is taking place over four main stages:



1.3

The workshops

Both workshops involved in-depth discussion about the scenarios, using the framework shown above as a rough guide. Comments and recommendations were recorded on a virtual jamboard template. The online jamboards can be found here.

The four scenario areas explored were:

- services for children with a learning disability;
- ageing well – urgent community response;
- adults' mental health; and
- planned care.

These four service transformation areas were chosen in order to highlight how partners will need to play different roles in the improvement of different types of care.

For example, group members felt that the Mental Health, Learning Disability and Autism Alliance would play a more prominent coordination role in decision-making on adults' mental health than it would for services for children with a learning disability. This is because there is a strong drive to achieving equity of provision across North East London for adults' mental health, requiring coordination at scale through the collaborative. For services for children with a learning disability on the other hand, the coordinating role more naturally sits with each place-based partnership due to the close alignment required between the local services provided by councils and other partners.

Functions and responsibilities

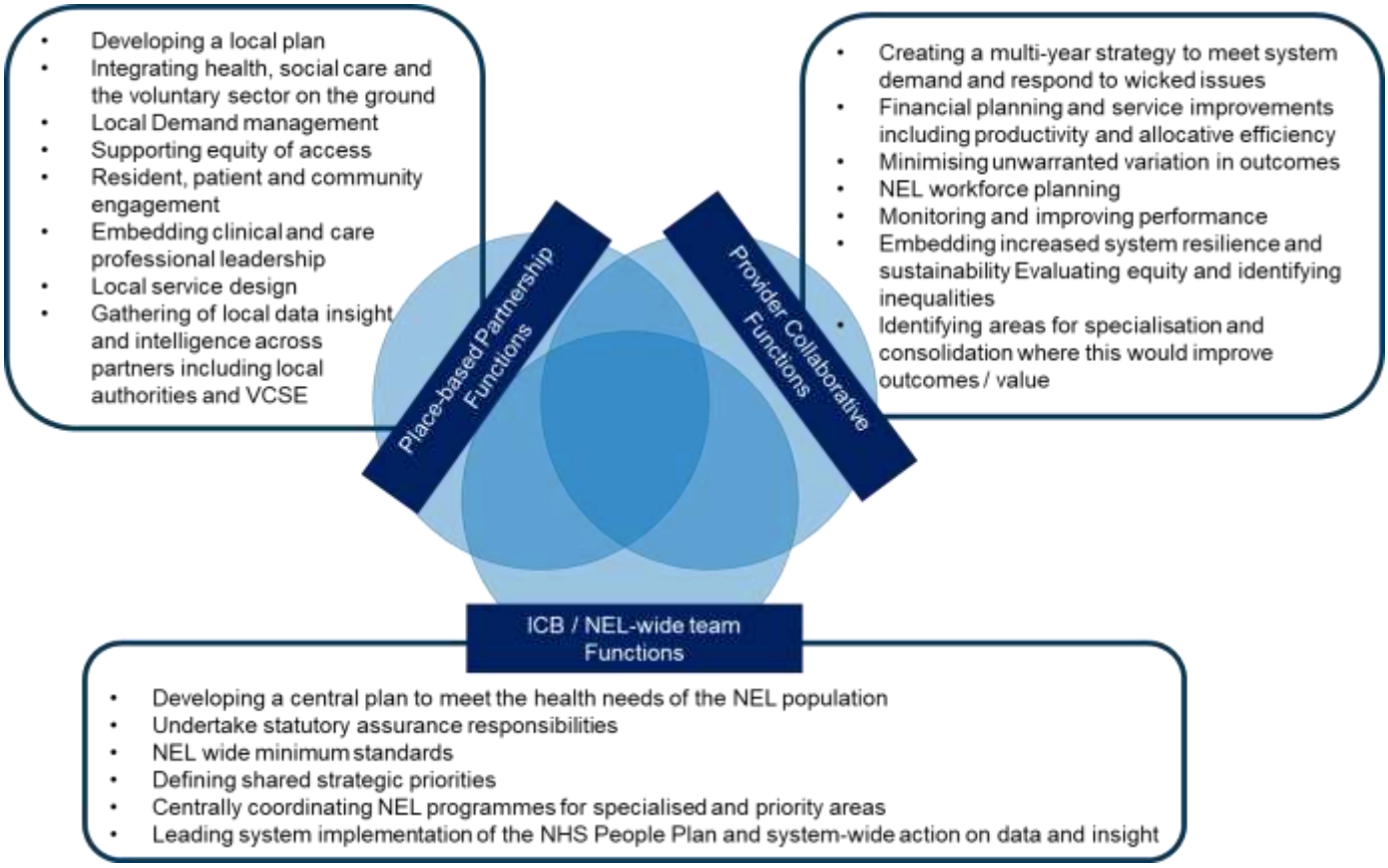
In order to ensure a population-based approach, it was useful to remind ourselves of the over-arching expectations for the contributions made by each part of the system.

Whilst not intended to be a comprehensive list, the diagram below identifies some of the critical functions and responsibilities that will sit in each part of the system.

By understanding their individual responsibilities and priorities it is easier to see where joint working and collaboration will be most important, as well as where different areas of service transformation will have different emphasis between places, collaboratives and the ICB.

The majority of work will be delivered through the provider collaboratives and the place-based partnerships with the ICB playing a unifying, prioritising role at the centre of the system and ensuring statutory responsibilities are met.

This collaboration is not just between places, collaboratives and the ICB, but will sometimes need to be between different places or different collaboratives too. For example, the primary care collaborative and the community care collaborative will need to work together on service transformation areas such as long term conditions and ageing well. Given the multiple overlaps, it is most accurate to display this as a Venn diagram.



This is based on:

- the national ICS design framework;
- *Thriving Places: guidance on the development of place-based partnerships as part of statutory integrated care systems*
- *Working together at scale: guidance on provider collaboratives*
- *Health and social care integration: joining up care for people, places and populations* (the integration white paper); and
- engagement across North East London as we have developed our local ICS design.

Defining coordinating and supporting partner roles

The diagram above sets out how partners' roles and responsibilities overlap, showing the need for close collaboration in all areas of service transformation and helping us with both:

- Understanding how all three system components work together and;
- establishing which components are best placed to lead and support the coordination of the system around a particular service improvement area

The above diagram also provides some examples of where there are responsibilities best led by a particular part of the system. This helped to inform the framework principles which, once applied, were used to decide the most appropriate coordinating and supporting partners for each service transformation area.

The distinction between the two roles can be best understood as below:

- Coordinating partner: the part of the system best placed to lead the development of a shared plan for that area of service transformation
- Supporting partner: parts of the system with significant responsibilities for that area of service transformation which will be central to making the plan a success

The working group members felt that this was a useful distinction whilst accepting that it is an imperfect one. The roles of coordinating partners and supporting partners will develop further in partnership as this work progresses. Once roles and responsibilities become more clearly defined, clarity on the coordinating and supporting partner roles will be part of evaluating and iterating this work going forward.

1.4

Reaching recommendations on each service transformation area

The workshops provided the opportunity for detailed and deliberative discussions, taking the conclusions drawn from the four scenarios to build principles then to be applied consistently across all service transformation areas.

The tables below show the four worked-up scenarios that participants developed through the workshops. These describe the coordinating partner and supporting partner roles, alongside the functions and responsibilities undertaken by each partner, how partners will need to work together, and the relevant decision-making forums.

These detailed examples formed the basis of the three key outputs for this work: the behavioural and cultural commitments, the framework principles and the recommendations for each service transformation area. Applying the framework principles to the functions and responsibilities undertaken by each part of the system helps us to build up a complex, interdependent picture for each area whilst also identifying the partner best placed to lead the coordination of the system around a shared plan.

Services for children with a learning disability	**Place-based Partnerships**	**Provider Collaboratives**	**ICB teams**
	Coordinating Partner	Supporting Partner	Supporting Partner
Relevant Functions	• Demand management • Ensuring equity of access	• Minimising unwarranted variation in outcomes • Embedding increased system resilience and sustainability	• Statutory assurance responsibilities • Setting and monitoring ICS minimum standards • Defining shared system priorities
Service Transformation Area Responsibilities	• Individual Place-based strategies set locally with the exception of some specialist areas held centrally at NEL • Each place will monitor progress against local priorities and processes e.g. local SEND inspections • Place-based committees will bring together local insight to prioritise work for their populations	• The role of the provider collaborative in this service transformation area requires further discussion and will evolve over time	• Minimum standards set at NEL following national frameworks where these exist. • A NEL-wide assurance process will then assess progress against minimum standards and ICS aims • Some specialist areas led centrally at NEL where there is clear benefit to a single approach
Working together and engaging partners in our work	• The PbP and will need toe ensure a collaborative process with inputs gathered at place from across a broad range of partners including LA, education, etc. as well as the collaborative and the ICB	• Working closely with places, the ICB and clinical networks to understand opportunities and challenges in delivery, including highlighting areas of inequality	• ICB will work with places and the collaborative to monitor progress against national standards and to understand opportunities where centralisation offers a benefit
Decision Making Forums	• Place-based Partnerships	• Mental Health Learning Disability and Autism Alliance	• ICB Board and committees

Ageing well – urgent community response	Place-based Partnerships	Provider Collaboratives	ICB teams
	Coordinating Partner	Supporting Partner	Supporting Partner
Relevant Functions	• Demand management • Ensuring equity of access	• Embedding increased system resilience and sustainability • Evaluating equity and identifying inequalities	• Statutory assurance responsibilities • Defining shared system priorities • Developing a central plan to meet the health needs of the NEL population
Service Transformation Area Responsibilities	• Delivery of the service will be the responsibility of each place • Places will agree local delivery models following central NEL strategy • Places will work closely with their local community providers to design, plan and implement the service transformation required to deliver the standards etc.	• Strategy set in close collaboration with Community Collaborative (currently in its infancy)	• Minimum standards set at NEL following national frameworks and London objectives • Monitoring of overall standards and whether objectives are being met takes place at NEL • Ensuring equity and identifying inequalities across NEL
Working together and engaging partners in our work	• This needs to be a collaborative process with inputs gathered at place from across a broad range of partners and it should include health needs and existing capacity against that need. This will be collated at NEL level to inform NHSE returns.	• The Community Collaborative is currently in its infancy, however it is expected to gain increased responsibilities from the ICB as it matures	• System priorities and allocation of transformation funding based on population need set by NEL and the Community Collaborative following engagement with PbP to understand specific needs and local variation across models
Decision Making Forums	• Place-based Partnerships	• Community Collaborative	• ICB Board and committees

Mental Health	Place-based Partnerships	Provider Collaboratives	ICB teams
	Supporting Partner	Coordinating Partner	Supporting Partner
Relevant Functions	• Demand management • Equity of access • Local service design • Patient engagement	• Multi-year strategy • Minimising unwarranted variation • Improving and monitoring outcomes • Ensuring equity and identifying inequalities across NEL	• Statutory assurance responsibilities
Service Transformation Area Responsibilities	• Place-based mental health partnerships will develop and deliver plans within the parameters set by the alliance • Detailed design and delivery of mental health services based on population needs and local priorities and resources • The two MH providers will bring together councils, GP, VCS and acute trust partners together with service users, carers and citizens to develop and deliver these plans as partners	• The Alliance, operating as a joint committee of the ICB, ELFT and NELFT, will carry the delegation from the ICB and set place-based budgets and a planning framework - noting that NHSE is fairly prescriptive about how the money will be spent • 'Commissioning' integrated into Alliance to join-up transformation • Reviewing place-based plans to identify unwarranted variation	• Central NEL programmes might be necessary for more specialised areas of mental health that benefit from being coordinated centrally • The joint committee will carry accountability back to the ICB and NHS England for delivery of the Long Term Plan
Working together and engaging partners in our work	• Place-based partnerships will work closely with the Alliance and seek their support to solve wicked issues that can't be solved individually at place e.g. workforce	• The Alliance will feed their work into the ICB, place-based partnerships and clinical networks across the ICS	• ICB will integrate Alliance priorities and plans into wider ICS strategy • ICS will work closely with Alliance to deliver identified specialised programmes where identified
Decision Making Forums	• Place-based Partnerships	• Mental Health, Learning Disabilities and Autism Alliance joint committee	• ICB Board and committees

Planned Care	Place-based Partnerships	Provider Collaboratives	ICB teams
	Supporting Partner	Coordinating Partner	Supporting Partners
Relevant Functions	• Local engagement across GPs, patients and wider place partners • Demand management • Ensuring equity of access	• Defining shared system priorities • Addressing unwarranted variation in outcomes & access • Improving and monitoring outcomes	• Statutory assurance responsibilities • Setting and monitoring ICS minimum standards • Identifying health inequalities and inequity across NEL
Service Transformation Area Responsibilities	• Local demand and pathway management with warranted variation in models to best match local need • Engagement with wider partners e.g. GPs having confidence in the model and being able to direct patients optimally • Local development of culturally competent services / access etc.	• Acute Provider Collaborative design planned care strategy and clinical model working with Clinical Networks • Acute Provider Collaborative to monitor improvement and identify priorities and risks of inequity • Centrally coordinating NEL planned care programme	• Minimum standards for planned care set by the ICB • Monitoring of overall standards and whether objectives are being met takes place at NEL
Working together and engaging partners in our work	• Working closely with clinical leads, acute partners and the Acute Alliance to understand the place-based end of the pathway and successfully engage partners on how to convey patients through it effectively	• Working closely with places, the ICB and clinical networks to understand opportunities and challenges in delivery, including highlighting areas of inequality & inequity	• Supporting provider teams to deliver on NEL-wide minimum standards with their place-based partners • Close working with the Acute Alliance to better understand the reality of challenges on the ground and emerging priorities as the work progresses
Decision Making Forums	• Place-based Partnerships	• NEL Planned Care Recovery and Transformation Board • Acute Provider Collaborative	

Teams will be asked to work-up these templates for the remaining service transformation areas to help build a richer picture of how places, collaboratives and the ICB will work together and to test our initial assumptions around coordinating and supporting partners.

A full set of these templates will form an important resource as we continue to develop our understanding of service transformation beyond the 1 July.

PART TWO

2.1

Outputs and recommendations

From these discussions and subsequent feedback, the three key outputs are:

1. a set of key behaviours and cultural commitments for how partners will work together to deliver service transformation for the people of North East London;
2. a set of framework principles which define how place-based partnerships, provider collaboratives, and the ICB each contribute to strategy, planning and delivery for our service transformation areas; and
3. a set of recommendations, applying these principles and suggesting initial coordinating and supporting partner arrangements for each service transformation area.

Output 1: Behaviours and cultural commitments

The workshop discussions highlighted the need for partners to work closely together in a timely, meaningful and transparent way.

Every area of service transformation within the ICS will be dependent on the three main components of the system working together to deliver the best possible outcomes for every person who lives in North East London.

The following list represents a set of nine key behaviours and cultural expectations for how partners want to work together to deliver impactful, high-quality service transformation:

1. Partners are committed to treating each other with respect, being clear and kind to each other and about each other both in private and in public
2. Partners are focussed on building relationships, ensuring different parts of the system can work together effectively and are involved in the right conversations with each other at the right time;
3. Partners are committed to genuine co-creation, securing leadership and engagement from partners across the system, including citizens, carers and experts by experience;
4. Partners operate with openness and transparency, employing an open book policy to help share insight and learning and build trust;
5. Every system partner feels able to ask for what they need and can expect support and engagement from other parts of the system when they do so;
6. All partners commit to taking a population-based approach, leaving behind old silos and divisions in favour of a broader, whole-system approach that maximises our collective potential when solving local challenges;
7. Discussions begin with the outcomes, focussed on achieving the triple aim and working together to spot opportunities for quality improvement;
8. Partners utilise a broad range of data insight and intelligence, learning from each other by sharing information beyond organisational boundaries and benefitting from a consistent single version of the truth;

9. Partners are committed to QI by default and implementing learning organisations across North East London
10. Consideration of inequalities and achieving equity of provision is central to all that we do and is always taken into account when determining financial value; and
11. Clinical and care professional leadership is embedded throughout all partners' work, ensuring the clinical and care professional voice is at the heart of service transformation.
12. Partners commit to protecting, supporting and building our north east London workforce, working to build meaningful, joyful and productive careers where every member of staff can thrive and reach their professional goals

These principles have been shared with other ICS work taking place in parallel including work on organisational development and the ICS operating model to ensure alignment and to avoid duplication.

Output 2: Framework principles

Each workshop explored two different service transformation areas, discussing questions such as where minimum standards should be set, how data insight is gathered, and how new care models should be designed.

As participants worked through the examples, general principles emerged. These principles provide a framework that we can apply to determine which partners should coordinate and support each service transformation area.

The six key framework principles are:

1. Decision making should take place as close to the person as possible, in accordance with the ICS principle of subsidiarity
2. Where a service transformation area has significant overlap with local authority responsibilities, each individual place should lead development of strategy and plans, taking into account implications for other place-based partnerships or providers;
3. Where a service transformation area is predominantly delivered by a group of providers, the relevant provider collaborative should lead development of strategy and plans, taking into account implications for place-based partnerships and providers;
4. Where a service is delivered across all seven places, some system-wide coordination maybe required or requested by the ICB to ensure that NEL delivers on its duties to achieve greater equity, taking into account implications for individual place-based partnerships and providers;
5. Working at a NEL system level, either through a provider collaborative or coordinated by the ICB, is necessary to achieve the best outcomes with residents where:
    a. variation in outcomes is unwarranted and working together will help to reduce variation and share best practices;
    b. working at scale offers opportunities to solve complex, intractable problems; or,
    c. the service is highly specialised and low volume;

6. Partners will build on what we have learned from the pandemic about operating in a high-trust environment, ensuring all partners have the freedom and information required to do the right thing for our residents; and
7. As well as delivering on national targets, place-based insight must enable NEL ICS to give emphasis to the priorities that matter most to our populations and address their specific needs.

Through application of these principles, we have developed a third output outlining recommendations for the coordinating and supporting partners for each service transformation area.

These recommendations are suggested as a logical starting point for the system to work from on 1 July 2022. As we test these arrangements in practice and as our place-based partnerships and provider collaboratives grow in maturity, there is likely to be significant iteration. We should embrace this as demonstrating a learning system in action.

Output 3: Recommendations for each service transformation area

The table below applies the seven framework principles to each system transformation area to form an initial recommendation for coordinating and supporting partners from 1 July 2022.

There are a number of areas of overlap between the service transformation areas listed, e.g. between BCYP and LD autism, where it will be important for partners to ensure a successful collaborative interface between areas, particularly where there are different coordinating partners.

Where a provider collaborative is identified as a supporting partner and highlighted in green this indicates that there is an ambition that the collaborative will develop its role in this area over time.

Whilst the table will continue to iterate, what is already clear is that in the majority of cases the coordinating partner is the provider collaborative or the place-based partnership with ICB teams leading the coordinating of only the few specialised areas where this makes the most sense.

Service transformation area	Place-based partnerships	Provider collaboratives	ICB teams
BCYP	Coordinating partner	Supporting partner	Supporting partner
Cancer	Supporting partner	Coordinating partner	Supporting partner
CHC	Supporting partner	Supporting Partner	Coordinating partner
Community-based care: Ageing well, COVID, rapid response, virtual wards, discharge, OOH, neighbourhood development etc.	Coordinating partner	Supporting partner	Supporting partner
End of life care	Coordinating partner	Supporting partner	Supporting partner

Homelessness	Coordinating partner	Supporting partner	Supporting partner
LD and autism	Coordinating partner	Supporting partner	Supporting partner
Maternity	Supporting partner	Coordinating partner	Supporting partner
Medicines optimisation	Supporting partner	Supporting partner	Coordinating partner
Mental Health	Supporting partner	Coordinating partner	Supporting partner
• CAMHS	Supporting partner	Coordinating partner	Supporting partner
• Adult	Supporting partner	Coordinating partner	Supporting partner
Personalisation	Coordinating partner	Supporting partner	Supporting partner
Planned care	Supporting partner	Coordinating partner	Supporting partner
• Acute	Supporting partner	Coordinating partner	Supporting partner
• LTCs	Coordinating partner	Supporting partner	Supporting partner
Primary care development	Supporting partner	Coordinating partner	Supporting partner
Primary Prevention	Coordinating partner	Supporting partner	
Secondary Prevention	Supporting partner	Supporting partner	Coordinating partner
Testing and vax	Supporting partner	Supporting partner	Coordinating partner
U&EC	Coordinating partner	Supporting partner	Supporting partner

2.2

Next steps and sign-off

This paper is the culmination of two workshops, multiple additional discussions, and extensive feedback. The paper was reviewed at a further workshop on 4 April 2022 and additional input and suggestions have been incorporated since.

Further feedback from across the system will enable the outputs to iterate ahead of a sign-off process.

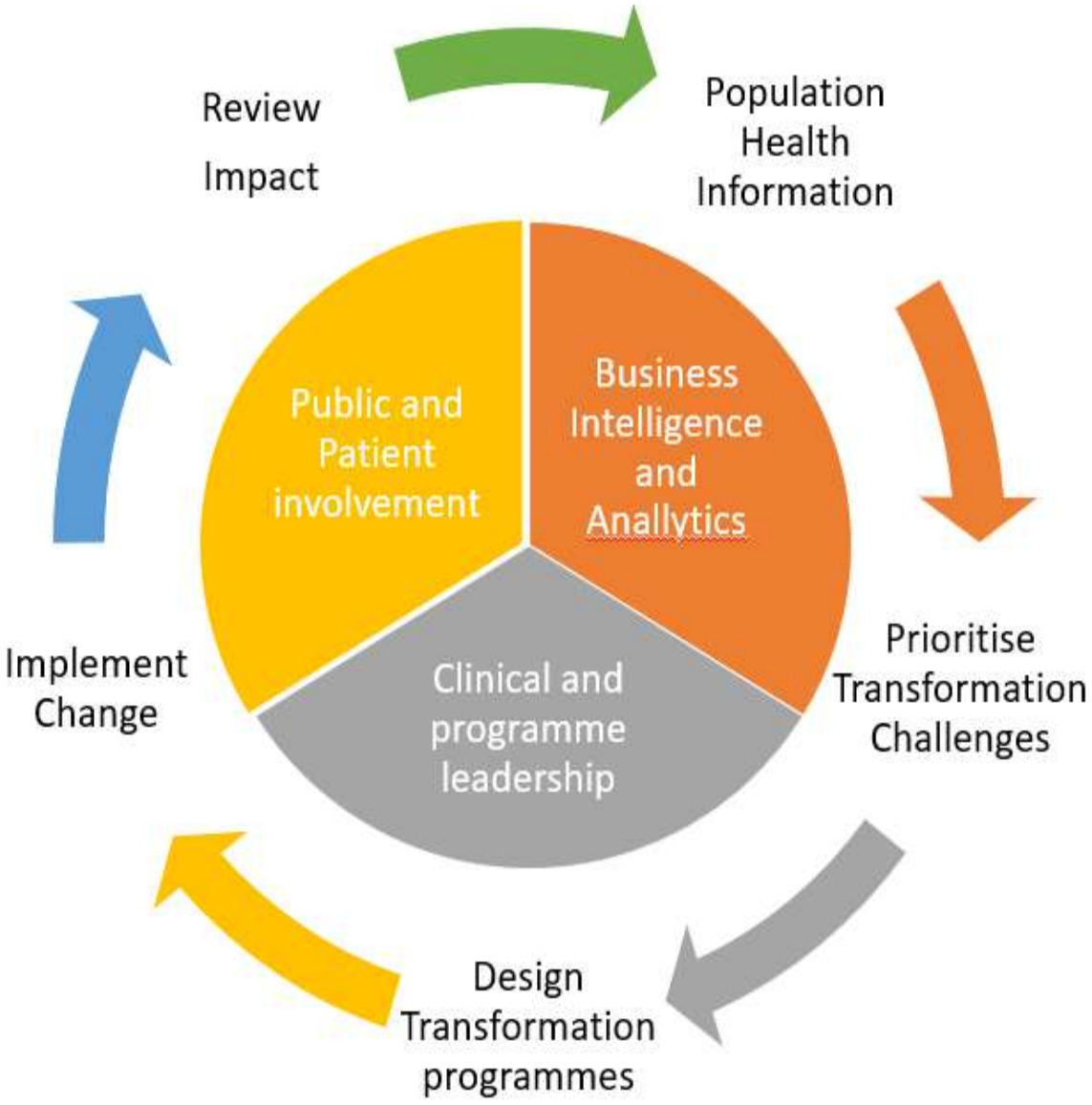
The next steps for development and sign-off of this work are:

1. Following the 4 April workshop, a further version of the paper will be shared with place-based partnerships, provider collaboratives, and CCG colleagues, plus the ICS Executive Management Team, ICS Transition Oversight Group, and ICS Strategy Group – all for final comments;
2. Through May there are plans for a further two engagement sessions, one bringing together our place-based partnerships and another bringing together all of the provider collaboratives - these sessions will help to form a shared understanding of the roles of places and collaboratives in this work and the expectations of coordinating and supporting partners for different areas of transformation;

3. final sign-off by the ICS Executive management Team, as our starting point for 1 July 2022;
4. in parallel there will be further engagement with teams across the ICS to test live examples and build the additional level of detail shown in the four worked-up scenarios, thereby allowing us to begin to embed this in our ways of working; and
5. work with the governance, finance, quality, and assurance teams to ensure that the outputs of this work are reflected in the technical design of the ICS.

APPENDIX

The Transformation Cycle



BHR Integrated Care Partnership Board

26 May 2022

Title of report	Update on BHR JSNA 2022
Author	Mark Ansell, Director of Public Health, LB Havering
Presented by	Mark Ansell
Contact for further information	Mark.Ansell@havering.gov.uk
Executive summary	Key issues • A refreshed BHR wide JSNA is close to completion and the complementary data visualisation tool has been further developed. • The JSNA has fostered collaboration between Local Authorities and encourages partners to adopt a population health management approach. • As development of the ICS proceeds, is the ICPB in a position to advise Health and Wellbeing Boards as to how the JSNA might be further developed so that the needs of residents in BHR are still better understood by borough partnerships, but also provider collaboratives and the NEL ICS as a whole. Recommendations • Note the report and consider the draft Executive Summary and Recommendations provided as appendices. • Suggest amendments to the current approach that might add value given the ongoing development of the ICS.
Action required	Note / Discuss
Where else has this paper been discussed?	Agreed by the 3 BHR DsPH
Next steps/ onward reporting	Borough specific versions of the BHR JSNA will be presented to the Health and Wellbeing Boards of each of the three boroughs in June - July.

What does this mean for local people? **How does this drive change and reduce health inequalities?**	Health and Wellbeing Boards must produce a JSNA. It provides relevant decision makers with an assessment of the health and social care needs of local residents and recommendations as to how outcomes can be improved, including the reduction of inequalities. Councils and CCGs must have due regard to the JSNA and Joint Health and Wellbeing Strategy agreed by Borough Health and Wellbeing Boards.
Conflicts of interest	None identified
Strategic fit	The BHR JSNA supports the shift to a population health management approach
Impact on finance, performance and quality	None arising directly from this paper (A good JSNA should lead to better informed decision making and hence improvements regarding finance, performance and quality)
Risks	None identified (Partners to Health and Wellbeing Boards would be failing to meet a statutory requirement if a JSNA was not published)
Equality impact	None arising directly from this paper (A good JSNA will identify significant inequalities and suggest opportunities to reduce them)

1. Introduction

The Health and Social Care Act 2012 introduced duties and powers for Health and Wellbeing Boards (HWBs) in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the H&WB.

JSNAs are assessments of the current and future health and social care needs of the local community that might be met by the local authority, CCGs, the NHS or VCS; alone or together. JSNAs are produced by the H&WB and are unique to each top tier local authority area. The JSNA provides a single, agreed view of priorities at place level and provide crucial insight to shape the Joint Health and Wellbeing Strategy of the borough. Health and care partners must have regard to the JSNA and JHWS.

H&WBs can agree to work together and the three BHR H&WBs collaborated on a JSNA for the first time in 2020 and also commissioned an online tool to enable users to explore the data themselves.

A refresh, using a very similar approach is nearly ready for publication.

Given the ongoing development of the ICS, now would be an opportune time to consider if / how the current collaboration needs to develop to ensure the needs of residents are best understood by all partners.

Key messages

- A refreshed BHR wide JSNA is close to completion and the complementary data visualisation tool has been further developed.
- The JSNA enables Local Authorities to share the workload and avoid duplication of effort and encourages partners to adopt a population health management approach.
- But before undertaking further development, H&WBs will wish to understand if / how the current approach needs be adapted to ensure that the needs of residents in BHR are still better understood by borough partnerships, but also provider collaboratives and the NEL ICS as a whole, whilst making best use of limited capacity in public health teams.

2. Body of report

BHR JSNA 2020

In 2019, the Directors of Public Health in Havering, Barking and Dagenham and Redbridge agreed, on behalf of their respective H&WBBs, to develop a Joint Strategic Needs Assessment for the BHR area. The first iteration, published in 2020, provided a unique JSNA for each borough but to a common format and based on the same underlying datasets. In addition, a standalone summary highlighted the challenges common to all three areas.

The JSNA was structured under 4 pillars underpinning population health outcomes:-

- The wider determinants to health
- Behaviours and lifestyle
- Communities and places
- Integrated health and care services

The section about health and care services was developed through the various BHR wide Transformation Boards.

The three boroughs also jointly commissioned an online tool called Local Insight that when fully configured would allow professionals and public to interrogate and interact with the data referred to in the JSNA and download pre-populated analytical reports or specific data sets.

Overall, the 2020 JSNA was well received: -

- Undertaking the JSNA together allowed for pooling of resources and avoided some duplication of effort. In addition, in future, it was anticipated that the data sets available via the online tool would largely be in the public domain, hence when fully functional, they would update automatically when new data was released.
- Having a common approach also aided partners working across borough boundaries to understand the needs of the whole of the population they serve whilst the borough specific versions emphasised the very marked differences between the three boroughs and within boroughs themselves using small area data.
- Working with transformation boards enabled the identification of more specific priorities than previous JSNA products.

BHR JSNA 2022

The pandemic slowed delivery of the next edition and limited engagement with new stakeholders e.g. PCNs. As a result, the 2022 edition is very similar to its predecessor in form and content. Efforts have been made to highlight the impacts of the pandemic as they are currently understood.

A draft of the BHR wide JSNA summary and a list of recommendations made is attached as Appendix 1.

All three boroughs are now looking to finalise the borough specific versions of the JSNA for consideration and adoption by their respective H&WBs in the summer.

The JSNA will also be shared with each of the borough partnerships, both to inform their thinking regarding priorities for action but also to seek feedback as to how the JSNA can be improved.

A considerably larger number of datasets, organised under the 4 pillars scheme, are now available via the Local Insight tool.

Future development of the BHR JSNA

The rationale for a BHR JSNA was twofold:-

- Firstly, it was a means of making the best of limited public health analytical capacity and it continues to deliver in this respect.
- And secondly, a common approach assisted transformation boards that were leading much of the redesign of health and care services across BHR.

However, the production of the detailed borough specific versions of the JSNA has proved very time consuming at a time when PH teams would wish to also contribute to the practical application of population health management.

NB. The JSNA is based on aggregate data that are in the public domain. This allows for a wider variety of comparators to be used and for trends to be mapped in a consistent fashion over time. As such, the JSNA can be used to identify the overall needs of population and high-level priorities for action e.g. to be addressed in the Joint Health and Wellbeing Strategies of each borough. However, none of the underlying data is available at the level of individual patient / resident and development of the JSNA is happening separate to thinking about the intelligence needed to underpin operational aspects of population health management.

A less burdensome approach would be to drop publication of detailed borough editions of the JSNA but continue to produce the summary document, illustrated with infographics capturing key statistics and a set of recommendations agreed with the various transformation boards whilst further enhancing the online platform. This would continue to provide an overview of the needs of the three boroughs and recommendations for action, with supporting data sets that could be explored and downloaded as desired but significantly reduce the effort entailed.

Given the increasing clarity about the ICS, is it possible for the ICPB to advise H&WBBs if the suggested alternative approach might adequately meet its needs and thereby allow PH teams to redirect their limited capacity to supporting their respective borough partnerships and the development of population health management.

Risks and mitigations

None identified - Partners to Health and Wellbeing Boards would be failing to meet a statutory requirement if a JSNA was not published at all.

Conclusion / Recommendations

Members are asked to consider

- the attached JSNA Summary document and recommendations and use them to inform their decision making over the coming year
- if they are in a position to advise H&WBBs if / how the JSNA might change to best support decision making within the ICS and make best use of limited PHI capacity.

Attachments

Draft Executive Summary of the 2022 BHR JSNA

Draft Recommendations of 2022 BHR JSNA

See also BHR online insight tool: https://bhrjsna.communityinsight.org/map/

End

Mark Ansell, DPH, LB Havering 05/05/22

BHR JSNA 2022

Executive Summary

Introduction

The BHR JSNA 2022 provides a single view of the challenges facing the partners represented at the Barking, Havering and Redbridge Integrated Care Partnership if they are to improve the health and wellbeing of people resident in the three boroughs and their experience of the health and social care system post pandemic.

The differences between the three boroughs e.g. in terms of population structure, diversity, levels of disadvantage etc. are marked. These differences are explored in the detail of the JSNA[1]. Nonetheless, the major challenges faced by the health and social care system are similar in all three boroughs and these overarching issues are highlighted in the Executive Summary.

Since publication of the 1st edition of the BHR JSNA in 2020, further progress has been made in establishing Integrated Care Systems (ICS) charged with implementing population health management[2] (PHM) - providing intelligence led, high quality health and social care services but also proactively addressing the factors that pre-dispose to ill health at the level of the individual resident and cause health inequalities between groups and communities at population level.

The BHR JSNA is consistent with PHM, describing the factors shaping health outcomes for the population in terms of the 'four pillars of population health'[3], shown in the chart below with an estimate of their relative impact on health outcomes (%)[4].

Population health outcomes			
The wider determinants of health (40%)	The places and communities we live in (10%)	Our health behaviours and lifestyles (30%)	Integrated health and care services (20%)

[1] A variety of datasets relevant to each of the four pillars are available at https://bhrjsna.communityinsight.org/. The site allows users to explore the data through interactive maps and download reports and individual datasets.
[2] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/
[3] Kings Fund 2018 A vision for population health – towards a healthier future https://www.kingsfund.org.uk/publications/vision-population-health
[4] https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

The population of BHR

All things being equal, the size and age structure of the population served are the most direct drivers of need for health and care services.

The population of all three BHR boroughs has grown in recent years to 778K[5]. Further **significant growth** (another 120K) is predicted over the next 20 years, more than half of it in Barking and Dagenham; but all three boroughs have areas identified for large-scale redevelopment i.e. in addition to Barking Riverside in LBBD; Rainham and Romford in LBH and Ilford in LBR.

The type and quantity of health and care services varies with age and is generally higher in the early years and very much higher in old age. LBBD and LBH are very different from one another in terms of age structure, with LBR somewhere in between. LBBD is relatively young (32% aged 0-19) compared to LBH (24%). LBH has a much higher proportion of older people (23% aged 60 and above) compared to LBBD (13%). The populations of all three boroughs are projected to age; the **very elderly** cohort, with the most complex health and social care needs will see the greatest growth.

The pandemic illustrated the need for culturally appropriate services, developed through co-design with the communities served and action on racism and discrimination. The three boroughs are very different to one another in terms of ethnic composition. As is the case for London as a whole, a majority of Redbridge (67%) and Barking and Dagenham (55%) residents are from **ethnic minority groups.** Havering (19%) is more similar to England as a whole (15%) in this regard but is become more diverse, particularly its younger residents.

Current health outcomes of BHR residents

Life expectancy in Havering and Redbridge is similar to the national average but is significantly lower in Barking and Dagenham. In common with England as a whole, improvement in life expectancy in BHR has **stalled in recent years and actually declined during the pandemic.**

The additional years of life that have been gained over the last couple of decades are often **marred by physical and mental ill-health and a degree of dependency** on health and care services.

Moreover, there are marked **inequalities** in health outcomes between communities and population groups reflecting a direct causal association between increasing disadvantage and poorer health outcomes.

[5] Current population estimates based on the 2011 census will be superseded by data from the 2021 census to be released in the coming year.

Overall, existing models of treatment and care are failing to deliver further improvements in health outcomes or narrow health inequalities and are struggling to cope with the demands of a growing and ageing population, with much more to come. **Population health management (PHM)** with its focus on prevention and early intervention to address the causes of ill health rather than just responding to problems when they become severe enough for patients to seek care, is essential if we are to improve outcomes and ensure the long-term financial viability of health and care services.

Achieving better health and narrowing inequalities.

It is implicit from our model of population health that for future generations to have equal opportunity to enjoy a long and healthy life, action is needed to ensure that they:

- are born into loving families with the means to adequately support them through childhood and that they enter school ready to learn;
- are encouraged to aim high and achieve the best they can in education; to attain the qualifications and skills that will equip them for later life
- gain good employment that pays enough to enable them to fully participate in their community
- have secure, affordable housing that adapts to their needs as they change through life
- live in places / communities that:
    - make healthier choices the easy and obvious choice
    - minimise the risk posed by communicable disease and environmental threats to health
    - are safe and feel safe
    - offer support and encouragement throughout life but particularly in times of need, including periods of poor physical and mental health and later in old age
- have access to high quality health and social care services, appropriate and proportionate to their needs

Pillar 1: The wider determinants of health

Addressing the wider determinants of health e.g. by improving income, employment opportunities, educational attainment, high quality affordable housing etc. will have the greatest impact on physical and mental health of an individual and the population as a whole in the long term. Inequalities regarding the wider determinants of health are the underlying cause of the great majority of health inequalities.

Barking and Dagenham ranked 22nd most deprived out of 312 local authorities in England, Redbridge 173rd and Havering 180th. 54% of LBBD residents live in areas ranked in the **most deprived quintile**[6] in England. The figure for Havering and Redbridge is 7.6% and 3.3% respectively.

Health and care providers can **directly improve the life chances** of local residents e.g. by **creating routes into employment** for people who struggle to gain a foothold in the job market due to lack of formal qualifications; physical and learning disabilities; long term or recurrent physical and mental health problems or criminal justice issues. Similarly, they can work together to **assist individuals with complex problems** to remain in safe, secure housing and avoid the catastrophic consequences of street **homelessness**.

Health and care agencies can also work to ensure that more of their budgets are spent locally e.g. by recruiting more staff locally particularly from disadvantaged areas and communities, and by procuring more goods and services from local small to medium enterprises. In so doing, they act as **'anchor institutions'** at the centre of the local community and economy.

What is increasingly described as a cost of living crisis will push more residents into poverty. Those on low incomes, who spend a greater proportion of their income on food and heating, will be hit hardest. As it is, nearly 1 in 5 residents in Barking and Dagenham are **income deprived** and more than 1 in 10 in both Redbridge and Havering. Statutory partners must work together to do all they can to support families through what will be a still more difficult period e.g. ensure families are in receipt of all benefits available; target any discretionary funding or discounts to those in most need and enable communities, by working with community and voluntary sector partners, to assist fellow residents.

[6] Communities in the most deprived quintile are identified as a priority in Core20plus5 – NHSE's approach to tackling health inequalities https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Pillar 2: The places and communities we live in

Supporting and enabling communities to remedy their own problems can mitigate inequalities to some degree and assist residents who statutory services may otherwise fail to engage or effectively support. Programmes such as local area coordination may help engage the most vulnerable residents and assist them to develop solutions to their problems. Social prescribers can sign post a wider group to resources and support available in the community. Statutory services need to work with voluntary and community sector partners to grow community capacity and ensure that statutory services are appropriate and accessible.

The physical environment in which we live also affects our health in many ways.

Access to green space benefits physical and mental health. Good public transport provides access to jobs, retail and leisure opportunities and health and care services. Conversely, car usage reduces physical activity and increases **air pollution**, which causes significant harm to health. Partners in the ICS should seek to minimise their direct contribution to air pollution and encourage residents to use public transport when accessing services, or better still, walk or cycle, choosing routes that minimise their exposure to pollutants. However, the poor public transport infrastructure in parts of BHR is likely to result in continuing reliance on the private car and partners should also consider how to encourage a switch to electric vehicles. Action to reduce air pollution is consistent with the overwhelming priority to avoid catastrophic **climate change**. Partners in the ICS should hold each other to account for the delivery of ambitious plans in this regard.

The **regeneration** underway or planned in all three boroughs is a significant opportunity to improve the health of current and future residents. The incorporation of **health impact assessment** into the planning process (and many other decision making processes) can ensure that health benefit is maximised. Through regeneration we must aim to create healthy communities, with all the necessary facilities, as well as much needed high quality, affordable housing. Regeneration can also provide well paid, high skilled jobs for local people while construction proceeds.

Regeneration may also provide an opportunity to tackle some of the problems facing the health and social care system e.g. by improving the quality of local primary care facilities or offering key worker housing to attract hard to recruit health and social care professionals to live and work in BHR.

Pillar 3: Lifestyles and behaviours

Lifestyles and behaviours have a huge impact on health outcomes – second only to the wider determinants.

Most of us will have a least one behaviour that increases our risk of ill health e.g. 2/3rds of adults are overweight or obese, and a quarter are obese; 2/5th of adults drink at levels that put them at higher risk of alcohol-related harm.

Some individuals will have multiple risks that compound one another and have a profound impact on physical and mental health over the life course. Lifestyle related **risk factors cluster in disadvantaged communities** and amongst vulnerable groups and hence are the immediate cause of a significant proportion of health inequalities.

In the case of alcohol and drug dependency, the harm caused extends to affect family and the wider community.

Smoking has become far less common, but 1 in 10 adults continue to smoke. The prevalence of smoking is higher in disadvantaged communities and specific population groups (e.g. people with SMI) where **smoking cessation support** should be focused. The majority of smokers wish to quit but most try without **pharmaceutical aids and behavioural support**, which together can triple the likelihood of a successful quit attempt. More recently, **vaping** has helped many more people to stop smoking and partners should actively encourage this trend for those who are not ready to quit outright.

As the example of smoking cessation demonstrates, input from **lifestyle support** services does not guarantee success. Many individuals will make multiple attempts to change behaviour before they succeed, and some will subsequently relapse. Nonetheless, there is robust evidence that the right support provided in the right way increases rates of success, and is **very cost effective**, in part due to the massive cost to the public purse caused by behaviour related risks to health.

In working with residents to promote healthier lifestyles and behaviours we must also recognise that our day-to-day decisions are shaped by how and where we live. The best example of this being **obesity**. For an increasingly high proportion of residents, obesity begins in childhood and will continue throughout life, greatly increasing their lifetime risk of a range of conditions including diabetes, CVD, cancers and MSK problems. Obesity will not be solved by simple advice to eat more healthily or weight management services, although both have their place. We need to employ **a whole system approach** using all the levers available to assist residents to get a better balance between calories consumed and energy expended.

Pillar 4: The integrated health and social care system

The last of the four pillars underpinning good population health outcomes is a high quality, **integrated health and social care system** that provides easily accessible and effective care, proportionate to the needs of the population. The pandemic has demonstrated the value of **designing services with the community served** and that outreach via the VCS or other trusted intermediaries may be necessary to overcome barriers to access and meet the greater needs of disadvantaged communities and vulnerable groups. The following commentary about the health and care is structured around the various transformation boards guiding the development of services for BHR residents.

Pillar 4: Antenatal and maternity services

Fertility rates in all three BHR boroughs are above the national average, markedly so in Redbridge and Barking and Dagenham. Some local women delivery in maternity units elsewhere in inner northeast London. Due to these flows, it makes sense that **maternity services** are planned across the NEL footprint. The East London Local Maternity System (ELLMS) priorities are to provide women with personalisation, safety and choice, and access to specialist care whenever needed.

Women with **complex pregnancies** who would benefit from delivery on hospital labour wards have become more common because of social disadvantage, increasing levels of maternal obesity and gestational diabetes. Mid-wife led care options are expanding so there is enough hospital capacity for higher risk mothers.

Tragically, a small proportion of pregnancies will end in **stillbirth or neonatal death**. Work is underway to minimise such events and the BHR patch is on track to halve stillbirth, neonatal and maternal deaths and brain injury by 2025. This includes action to increase the proportion of women who book for antenatal care early in their pregnancy, which is particularly low in Barking and Dagenham and Redbridge and further action to reduce the proportion of women who smoke in pregnancy.

The experience of childbirth is a uniquely personal event with potentially long-term impacts on mother and baby and their developing relationship. Feedback from women attending Queens pre-pandemic was similar to the national average. But face to face contact with midwives was much reduced during the pandemic, as were opportunities for participation by partners.

Pregnant women are at significantly higher risk of poor outcomes from COVID-19. Evidence regarding the safety and effectiveness of covid vaccination in reducing that risk is compelling. However, a significant proportion of pregnant women remain **unvaccinated**.

Pillar 4: Health and care for children and young people

Barking and Dagenham and Redbridge are young boroughs. Havering has an older demographic. Nonetheless, Havering has seen a significant increase in children and young people numbers recently. Therefore, **the capacity of health and care services for children and young people is an issue** in all three boroughs.

Happily, **most children are born in good health**. Nonetheless, maternity and health visiting services offer essential support to all parents at a time that inevitably brings new and sometimes significant challenges. Provision in the community, alongside other family-orientated services provided by Councils and the VCS, can help introduce new parents to the full range of support available.

Health visitors provide a series of checks through the early years and are ideally placed to identify those families that are struggling, enabling **early intervention** to avoid problems escalating e.g. by identifying a child who is at risk of not being school ready.

All children at some point will experience ill health. In most cases, it is relatively mild and self-limiting. However, young children in BHR are **more likely to attend A&E** than the national average. Understanding why this is and developing an effective response should be a priority.

Vaccines are safe and effective. Anti-vaccination messages to the contrary during the pandemic are unhelpful but uptake of childhood vaccination has been falling for some time. Better systems to remind parents and greater choice of venue and timing would increase uptake.

A number of long-term physical health conditions can begin in childhood. **Asthma** is the most common. Effective management can minimise day-to-day distress and inconvenience associated with poorly controlled asthma, minimising the frequency of severe attacks and preventing deaths. However, young people have died from asthma in all three boroughs in recent years and the system has developed a detailed improvement plan to remedy identified weaknesses.

While 90% of diabetes cases are type 1, type 2 diabetes is increasing in prevalence due to **increases in childhood obesity**.

The mental health of children and young people is a significant and growing concern. **CAMHS** capacity is increasing significantly in response but even so, only a minority of the 1 in 10 children and young people with a diagnosable condition will be under the care of specialist services at any point in time. Further effort is needed to improve the capability of GPs to support them and engage services commissioned by schools to make the most of overall capacity and ensure that cases are escalated when needed. In addition, there is a need to build the resilience of our children and

young people and give their parents, teachers, social workers etc. the skills and knowledge to identify and help them cope with mental health problems.

Successful **transition** from children's to adult services is crucial to accommodate the changing needs of young people over time. Moreover, their eligibility for services and the team providing their care is also likely to change. Thorough and early planning is essential.

A proportion of children are born with or develop significant and lifelong problems. More than 1 in 10 children with Special Education Needs and Disability (**SEND**) may need support from health, social care and education professionals to learn. The most common type of need is mild to moderate learning disability followed by speech, language and communication needs. The needs of a growing cohort of children are captured in an **Education, Health and Care Plan** (EHCP). Autistic Spectrum Disorder is the most common primary need identified in EHCPs. Development and delivery EHCPs can involve contributions from schools, children's social care and NHS services (e.g. therapies, community paediatrics, CAMHs etc.). Changes in legislation have combined to significantly increase demand (and parental dissatisfaction) and put pressure on services and budgets. Some children with particular needs have to be bussed long distances, at great expense, to specialist provision or in exceptional cases are in residential placements out of borough. Cooperation across the ICS is needed to grow capacity as a whole and fill gaps in some specialist provision, allowing support to be provided closer to home and at lower cost.

Safeguarding must be a priority for all partners. Early identification and intervention protects the child in the short term and reduces the likelihood of poor outcomes in later life associated with multiple Adverse Childhood Experiences. In most circumstances, it remains in the best interest of the child that they remain under the care of their parents with additional support. However, for some CYP, the best option is that they be taken into care. All **looked after children** (LAC) will have had complex and difficult childhoods; many will have mental health problems; often coupled with poor educational attainment; their long-term life chances are significantly poorer than the norm. Support to LAC from all partners should extend beyond timely access to excellent treatment and care to include support with housing and opportunities to gain employment e.g. in health and social care services.

Exposure to Adverse Childhood Experiences **(ACEs)** increases the risk of a range of negative outcomes in later life. Conversely, creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help children reach their full potential. To this end, the needs of the child should be central to the thinking of all agencies working with families affected by serious mental illness, substance misuse, domestic violence, suicide, criminality, homelessness etc.

The experience of poverty in childhood has significant and long lasting effects and is associated with poorer outcomes in all aspects of life including health. The proportion of children affected by income deprivation is highest in LBBD but many

thousands of children are affected in all three boroughs. All partners in the ICS should redouble their efforts to increase participation in schemes designed to support families on low income e.g. Healthy Start, free early years provision and free school meals, which is far from complete.

Children and young people have been hard hit by the pandemic, or rather the steps taken to protect more vulnerable sections of the community from COVID-19, as children were at low risk of serious illness themselves.

Although there was provision for the children of key workers and vulnerable families, most children were unable to attend preschool or school for extensive periods. Despite the best efforts of teachers and parents, it is likely that learning was affected, with disadvantaged children being most affected, further increasing existing inequalities in learning achievement.

Lockdowns also deprived children of social interaction and may have increased exposure to ACEs in the home e.g. domestic violence. Such factors, coupled with anxiety regarding the pandemic itself may account for reported lower mental wellbeing and higher rates of referral into CAMHs.

Disruption to education and health visiting may have delayed the identification of children at risk of abuse and neglect. Impacts on social care may have affected the protection offered to known vulnerable children. These factors, together with the additional pressures on households during lockdown, may explain the increase in the number and / or severity of presentations reported by children's social care.

Delays in diagnosis and treatment during the pandemic, resulting in prolonged suffering and poorer outcomes are a recurrent theme in the health and care chapter of the JSNA. The potential for harm may be particularly acute in childhood if delayed intervention prolongs and exacerbates impacts on a child's development and learning with potentially life-long impacts.

Pillar 4: Adult mental health services

One in four adults experience mental illness and the total harm to health is comparable to that caused by cancers or CVD. Hence, it is right that the NHS is now committed to giving mental health **parity of esteem** with physical health.

As with physical ill health; the burden of mental ill health shows marked inequalities and there are significant opportunities to prevent mental illness throughout the life course e.g. by reducing exposure to ACEs. The impact of the **wider determinants** on mental health is particularly marked. Factors like debt, unemployment, homelessness, relationship breakdown and social isolation predispose to mental illness. Action to address the wider determinants can aid recovery but people with mental health issues, particularly serious mental illness are much less likely to be have stable accommodation or be in work. A coordinated, proactive approach on the part of multiple agencies is necessary.

People in the criminal justice system and street homeless have particularly complex problems often including concurrent mental illness and drug & alcohol dependency.

A relatively small number of patients live with **serious mental illness**. Priorities for action include a timely and effective response to **crisis** and action to reduce the **gap in life expectancy** between people with SMI and the population as a whole.

A far bigger number of people are living with a common mental health condition. The ongoing development of **IAPT** has greatly increased the provision of talking therapies but further work is needed to increase uptake, especially among groups who are less likely to seek help, and achieve outcomes comparable to the best.

At the same time; action is needed to increase the capacity and capability of **primary care** to better support the bulk of people living with mental health problems. This includes promoting mental wellbeing, identifying those groups at greater risk of poor mental health and less likely to seek help, and promoting better physical health of patients living with serious mental health.

Alongside improvements in care, action is needed within **communities** to tackle stigma; build resilience and improve awareness of effective self-help options. It is important to increase public understanding of mental health; when and how to seek help, and how to recognise and intervene when others experience a mental health problem. This includes a greater awareness amongst frontline staff/volunteers in both clinical and non-clinical settings who maybe in contact with individuals experiencing unemployment, debt, homelessness and relationship breakdown.

Despite concerns about a risk in suicide during the pandemic, early indications from real time suicide surveillance systems have not shown a significant increase in suicides comparing pre and post lockdown periods. However, periods of financial recession are known to impact suicide which is a concern in the current climate of increasing costs and in the event of an economic downturn.

Pillar 4: Cancer services

Cancer, with cardiovascular disease, remains the **big killer.** Cancers account for a quarter of all years of life lost.

1 in 2 people will be diagnosed with cancer in their lifetime. More than 3200 people in BHR are diagnosed each year. 46% of cases are in Havering due to its older age profile. More than half of all cases are cancer of the breast, prostate, lung or bowel.

Just under 4 in 10 cases are caused by avoidable risk factors like smoking, obesity and alcohol and hence are **essentially preventable**.

Survival has increased steadily in all three BHR boroughs but lags behind the national average.

Early detection remains the key to improving survival. But about 1 in 5 cases of cancer in BHR are first diagnosed during an emergency presentation when disease is more likely to have progressed and hence prognosis is poorer. Only about 50% of cases are identified at stage 1 and 2 (early); a long way from the ambition stated in the NHS Long Term Plan of 75% by 2028.

Participation in cancer **screening programmes** is incomplete and displays a clear social gradient contributing to health inequalities.

Further effort is needed to increase participation in screening programmes and raise public and professional awareness of the early signs and symptoms of cancer and increase.

Additional capacity, dependent on both more equipment and professional staff, is needed to facilitate timely diagnosis and subsequent treatment.

As survival improves – and the incidence of disease increases with population ageing, more people are **living with and beyond cancer**; sometimes with significant ongoing health problems associated with treatments received.

Disruption to screening programmes during the pandemic and public anxiety about attending health care services despite suspicious signs and symptoms is likely to lead to more late diagnoses and poorer survival.

Pillar 4: Long term conditions

As previously stated, life expectancy has increased in recent decades, but most of the additional years of life gained are marred by some degree of ill health or disability. Much of it due to a variety of long term conditions (LTCs) including cardiovascular disease (CVD), diabetes, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) and musculo-skeletal (MSK) conditions.

Many people are at increased risk of CVD due to a combination of **lifestyle** (e.g. smoking, obesity, alcohol use) and **physiological risks factors** (e.g. high blood pressure and cholesterol levels). As with many LTCs, the prevalence of CVD demonstrates a strong social gradient and very clear **inequalities.**

Treatment and / or lifestyle change can significantly reduce that risk and **prevent potentially life changing heart attacks and strokes**. However, many people will experience few or no obvious symptoms and as a result disease remains undetected and untreated until they experience an event that may kill or cause permanent disability. The proportion of undiagnosed cases tends to be higher in disadvantaged communities further exacerbating health inequalities.

CVD is representative of a number of LTCs that show significant **under diagnosis**.

All adults aged 40-74 should be invited for an **NHS Health Check** once every 5 years to assess their risk of CVD until and unless a problem is detected. It's estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Uptake varies considerably but can be improved by adopting a more robust invite process and providing checks at convenient times and locations.

Some communities and population groups are less likely to make time for such a check but may be engaged through opportunistic community or work based interventions.

Some risk factors are common to several LTCs. As a result, someone with one LTC is more likely to develop another and GPs should regularly check patients being treated for one condition for others.

As well as under diagnosis, there is strong evidence that a proportion of people with a known LTC **miss out on interventions** that would reduce their risk of disease progression. Further improvement in the management of common LTCs is necessary to maximise the benefits. This includes **pharmaceutical treatment** but also participation in **lifestyle change programmes** commissioned by local government and the NHS.

A small but growing proportion of residents live with several LTCs, also known as **multi-morbidity.** Individuals affected by multi-morbidity are also at substantially increased risk of poor mental health. Existing services struggle to meet their complex needs and as a result they frequently attend A&E and/or have unplanned hospital admissions. Although small in number, a disproportionate amount of resource is expended achieving less than satisfactory outcomes.

The diagnosis and management of LTCs was significantly disrupted during the pandemic. Residents put off seeking help due to fear of infection; access to general practice was curtailed, face-to-face appointments were done virtually and diagnostic investigations delayed. Pending a successful recovery, it is likely that residents will experience otherwise avoidable harm.

It seems increasingly likely that another legacy of the pandemic will effectively be a new LTC in the form of **long COVID**. Symptoms vary widely, including fatigue, shortness of breath, muscle ache and difficulty concentrating. In addition, extended absence of work may increase the risk of unemployment, debt, relationship problems etc. ONS estimated 1.9% of the population self-reported long COVID in October 2021 (before the recent and largest wave of infection associated with the omicron variant). Most individuals can self manage but a dedicated service has been established at King Georges Hospital to assess and provide a programme of physical and psychological therapy for those with greater needs. Prior hospitalisation with acute COVID-19 has been linked to a higher risk of severe and prolonged symptoms and subsequent diagnosis of new and significant health problems including respiratory disease, diabetes, CVD, CKD and liver disease.

Pillar 4: Older people and frailty services

Older people experience more ill health and have greater need for health and social care than other age groups. Consequently, ongoing population ageing will pose a growing challenge to health and social care services.

Greater focus on **prevention** is needed at every stage of the life, including in old age, to improve quality of life for older residents and delay the point at which ill-health results in significant loss of independence and reliance on health and care services. Prevention in old age can take many forms.

Older people are at very much higher risk of serious illness and death because of COVID-19. Vaccination reduces that risk, but immunity wanes quickly and boosters are needed when the incidence of coronavirus infection is high to minimise harm and pressure on the health and care system. As we slowly move out of the pandemic, the frequency of boosters is still linked to successive waves of infection but in time these will settle and **COVID vaccination** may be offered in advance of winter when other respiratory illnesses peak.

Pre-pandemic, death rates were 20% higher amongst residents aged 85 and above during winter. The bulk of **excess winter deaths** are from dementia, CVD and respiratory conditions, some linked to flu. Pre-pandemic, uptake of **seasonal flu** vaccination by BHR residents aged 65 and above was below the national target and had been in slow decline. In addition to further efforts to maximise uptake of vaccination, the wider partnership should work together to identify and support residents vulnerable to cold weather due to poor housing and low income particularly given the recent huge increase in energy costs which can only add to the 1 in 10 households affected by **fuel poverty**.

People can feel lonely at any stage of life, but that the experience is most severe among older people. Action to **tackle social isolation** improves wellbeing and reduces the burden on health and social care services and as such is cost-effective.

An **early diagnosis of dementia** helps someone to benefit from available treatments, make the best of their abilities and live independently for longer. However, between a ⅓ and a ½ of BHR residents with dementia are undiagnosed.

A ⅓ of people over 65, and ½ of people over 80, fall at least once a year. Falls are the number one precipitating factor for loss of independence and admission into long-term care. **A comprehensive approach to falls** includes action to prevent falls; detect and manage osteoporosis; and to support residents after a fragility fracture.

Falls, social isolation and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of **frailty**. Frailty is a particular state of health experienced by a significant minority of older people (25-50% of those 85 and older) such that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing. A **comprehensive approach to frailty** includes prevention as described above but also the systematic identification and ongoing targeted support to people living with moderate frailty by community based multidisciplinary teams, to limit further progression and able to respond urgently to crises to prevent unwarranted hospital admissions.

The mental health of older people is as important at physical health but may be over looked. **Depression** is the commonest mental health condition, with higher rates among care home residents and after bereavement. Many people with dementia are also depressed but may struggle to express themselves making diagnosis more difficult. It is important that people are able to access mental health services appropriate for their needs, irrespective of age. Use of **IAPT** appears particularly low.

Hospital admission can lead to a rapid decline in physical abilities, equivalent to a year's additional age for each day of admission. Such deterioration can very quickly make a return home impossible. There is strong evidence that **reablement** services after admission can improve function, independence and the likelihood of a successful return home.

Research suggests that most people would prefer to stay in their own home rather than to move into residential care. **Domiciliary care** enables some residents with very significant care needs to remain at home. Nonetheless, **residential care** homes provide an essential service for some of our most vulnerable residents. Whilst in care, they remain vulnerable individuals often with complex multi-morbidity and frailty requiring ongoing assessment and proactive management to minimise crises and avoid hospital admission. Adoption of the **enhanced health in care homes** model is designed to ensure that all care home residents receive consistently high quality, proactive care.

Few people would choose to die in hospital and yet more than half of all older people in BHR do so. The proportion of people dying in hospital in all three boroughs are significantly higher (worse) than England average. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. Care Home Support, rapid response team and 24-hour support line are being implemented and the palliative care capacity is increased to improve the quality of the **end-of-life care**.

The protection afforded to residents of care homes will be a key consideration for the review of the national response to the pandemic. It's clear from local experience that care home management and staff worked unceasingly to protect residents while continuing to meet their care needs. Nonetheless there were outbreaks and some residents became seriously ill and died before the roll out of vaccination. In addition, measures enacted to protect against the spread of infection, as set out in national guidance, served to separate residents from loved ones for long periods. The families affected suffered themselves and report residents deteriorated more rapidly as a consequence.

While enhanced **infection, prevention and control measures** are still in place, some of the most intrusive elements of guidance to care homes have been relaxed. Cases of infection amongst staff and residents continue but rarely result in serious illness while vaccination continues to provide effective protection.

Care homes will continue to be high risk settings with regard to COVID-19 for several years to come; requiring ongoing support from UKHSA and local authorities, and not least from NHS partners providing **booster vaccinations** and timely access to **antivirals** for those eligible. The pandemic has demonstrated that **care homes and domicillary care are essential elements of the health and care system** and neglect of any one part has consequences for the whole.

BHRUHT is often full to capacity, with long waits in A&E, ambulances queueing and

Pillar 4: Urgent and unplanned Care

patients unable to be admitted until someone else is discharged. Whereas previously this would have only happened in the depths of winter, it has become a regular occurrence year round.

Work is underway under the auspices of the BHR Urgent and Emergency Care Transformation Board to create alternatives to A&E attendance. Further action will be needed to ensure that patients and clinicians use these new services as intended.

Perhaps more importantly, the JSNA identifies many opportunities to avoid the crises that trigger attendances at A&E and the need for unplanned hospital admissions. For example, by tackling the risk factors for disease; through better identification and management of long term conditions to prevent disease progression; and by better coordinated and intensive support of a relatively small number of patients with very complex problems that make disproportionate use of services.

Pillar 4: Planned (non-urgent) Care

A huge variety of care is provided on a planned basis, including diagnostic investigations, specialist assessment and then treatment, including surgery, much of it traditionally provided in acute hospitals through outpatient clinics.

The number of people waiting for care and the duration of that wait was growing before the pandemic hit and has grown greatly since as services stopped entirely and then returned with reduced capacity.

The BHR Planned Care Transformation Board aims to ensure that patients are seen in the right place, at the right time, by the right healthcare professional, saving patients' time, improving their experience of care and ensuring clinical time and resources are utilised effectively to reduce waste in the system.

- Closer working between hospital consultants and GPs, and improved access to diagnostic tests will increase the scope for managing patients in primary care.
- Alternatives to traditional hospital based services are being developed.
- Digital options will reduce the need to travel to hospital and improve sharing of information between clinician and patient.
- Where appropriate, routine appointments to confirm nothing is wrong will be replaced with the opportunity for the patient to initiate follow up when they have concerns.
- Improved information and support will leave patients better informed and more able to self-care.

Just as COVID-19 has exacerbated existing inequalities in other parts of life, access to elective treatment fell further in the most socioeconomically deprived areas of England between January 2020 and July 2021 than in less deprived areas. Hence plans for the recovery of planned care need to consider and provide for the greater need for care in disadvantaged communities.

Population Health Management

There is a recurrent theme through the JSNA and particularly the section regarding integrated health and care. A different approach is required to the organisation and delivery of health and social care.

We need to make better use of information to inform how we plan and deliver services for the population as a whole as well as the clinical management of individual patients. Stratification of the population by life stage and complexity of need will improve the planning and delivery of services for specific patient cohorts:

- **People who are generally well** who will benefit from primary prevention interventions to maintain good health; with more intensive support where people are currently well but at risk of developing LTCs.

- **People with long term conditions**; who in addition to the primary prevention interventions above, will benefit from early identification and treatment of LTCs, personalised care planning, self-management support, medicine management and secondary prevention services.
- **Older people with complex needs or frailty**; who in addition to the interventions above this cohort would benefit from a case management approach offering integrated, holistic, personalised, co-ordinated care with a high degree of continuity.

In each case, the precise interventions and delivery mechanisms will vary through the life course and in response to social factors.

The NHS Long Term sets out a very clear path for regarding the care of people with the most complex needs. It pledges to end the distinction between primary care and community services. Rather it envisages a new model, delivered within **localities** by general practices acting together as **Primary Care Networks (PCNs), with community teams, social care, hospitals and the voluntary sector working together** to help people with the most complex needs, to stay well, better manage their own conditions and live independently at home for longer.

At times of crisis, a new NHS offer of **urgent community response and recovery support** will act as a single point of access for people requiring urgent care in the community; provide support within two hours of a crisis and a two-day referral for **reablement** care after discharge.

Residents in care homes, some of the most vulnerable patients will benefit from guaranteed NHS support providing timely access to out of hours support and end of life care when needed.

The extension of **personalisation** from social care to health care services will see the whole package of care brought together in a care and support plan reflecting the needs and assets, values, goals and preferences of the individual.

Development of personalised care plans is an opportunity to reset the relationship between professional and client focusing less on deficits and what they need by way of services and more on what they can do and the **assets** available to them including family and wider social networks. The role of health and social care being to provide any additional support and / or aids necessary, for a limited period, to return them to their former level of functioning and independence.

Developing the multidisciplinary and multiagency team necessary to deliver this new model of care for complex patients; involving non-professional peer support and voluntary sector input in addition to professional and statutory health and care staff will be an immediate and significant challenge for emerging locality teams.

But better management of complex patients will not of itself improve health outcomes and achieve a sustainable balance between the needs of a growing and ageing population and the capacity and capability of local health and social care services.

Greater capacity will be needed in the community if the far bigger group of residents with or at risk of a LTCs are all to be identified and thereafter managed in line with best practice. More can be made of **community pharmacy**. The introduction of **new professional groups** e.g. clinical pharmacists and physician assistants to complement GPs and practice nurses will help. As will better coordination and collaboration between practices working within PCNs; facilitated by improvements to **premises** and **IT**.

Innovative methods will be needed to identify residents who are at risk of disease who currently don't engage with general practice. The use of wearable technology will enable people to better understand and take more control over the management of their health.

Equally, health professionals and public will need to recognise the impact of personal circumstances and place on health and look beyond health care for more effective ways of improving wellbeing. Strong links between general practice, other statutory services such as housing and the Department of Work Pensions, the community and voluntary sector within the locality should be an essential element of locality working. The development of an effective **social prescribing** function; whereby patients are actively encouraged to access other forms of support will maximise the likelihood of success e.g. with 1:1 support from a care navigator. Partners and the community itself will also need to consider the assets available relative to needs and how any gaps may be filled[7]. Approaches such as **local area coordination** are needed to strengthen the capacity of communities to identify and support our most vulnerable residents and hence reduce pressure on statutory services.

The switch to a more **preventative** approach will not be achieved by health and social care services alone. Currently many thousands of residents miss potentially lifesaving interventions such as immunisation and cancer screening or turn down the opportunity to have a NHS health check. Others will delay seeking help when they notice changes to their body that subsequently turn out to early signs of cancer.

We can and must seek to improve knowledge and awareness e.g. the 'be clear on cancer' campaign and remove any barriers to engagement by offering screening and health checks out of working hours or in the workplace.

However, people's decisions about engagement with health services and more widely regarding behaviours that impact on health are not made in isolation but rather are shaped by the place which they live; prevailing cultural norms, their previous experiences and aspirations for the future. A focus solely on the health and social care is not enough. We come back to the message underpinning this JSNA – that we cannot achieve significant improvement in health outcomes and a reduction in health inequalities without **tackling all four pillars of the population health model**.

[7] The current JSNA currently describes the need for health and social care services at BHR and borough level. Data are provided at locality level and in the coming year, Public Health Services intend to work with developing locality teams to identify priorities for each.

Although not the lead agency, the health and social care system should give equal priority to the direct contribution it can make to tackling the wider determinants of health, throughout the life course e.g. by minimising exposure to and the harm caused by adverse childhood experiences; improving income and aspiration by creating apprenticeship opportunities for CYP in disadvantaged communities; helping people with physical and mental health problems into work or a secure home and reducing social isolation amongst older people.

No.	Recommendation
Improving health outcomes and reducing inequalities	
1	All partners should participate in borough level H&WBs and take the opportunity to ensure there are robust plans in place regarding all four pillars that give adequate priority to health improvement and reduction of health inequalities.
2	All partners within the developing integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.
3	Plans regarding integrated health and social care services (pillar 4) should give the same priority to • mental health as physical health and • conditions resulting in ill health and disability as for conditions causing premature death.
4	Plans for the recovery of health services after the pandemic e.g. reducing waiting lists are essential but must not detract from the commitment to adopt a population health management approach that seeks to prevent ill health and pre-empt crises by the timely, proactive offer of support, care and effective treatments to an empowered and informed population.
5	To reduce potential inequities in access to local services, partners must ensure that cultural competence is integral to the development of future services to meet the changing needs of the population.
Pillar 1: The wider determinants of health	
6	Levels of disadvantage vary greatly from borough to borough and within boroughs. After size and age structure of the population served, disadvantage is the most important factor affecting need for health and care services in general, but particularly preventative services. Commissioners and providers must work together to ensure that the range and capacity of services reflects the distribution of need.
7	Partners must consider the needs of digitally excluded communities whenever they seek to improve access to services by digital means.
8	Councils, NHS providers and the VCS should work together to promote existing support mechanisms to low income households particularly those with children e.g. food banks, free school meals, school holiday meal scheme, Healthy Start scheme, free childcare and early years education, fuel poverty grants and schemes etc.
9	Councils, NHS providers and the VCS should work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure a job.

No.	Recommendation
10	As employers, all partners should consider the impact of working from home on any existing workplace health offer and work together to spread best practice to local businesses.
11	Partners must work together to mitigate the worst harms of street homelessness and proactively engage those affected with the aim of ultimately enabling them to maintain suitable permanent accommodation.
12	The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.
13	Health and care professionals should consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore that patients / residents might benefit from social prescribing in addition to or instead of the tradition medical response.
14	Partners should strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function to local assets. Residents with more complex needs may require more intensive and / or prolonged support e.g. local area coordination.
15	Encourage councils, NHS providers, colleges etc. to become 'anchor institutions' within the BHR patch maximising the contribution they make to the local community over and above the direct provision of services.
16	Encourage all partners to adopt a Health in All Policies approach that takes into consideration health and wellbeing impacts in all decision-making including on the social determinants of health to maximise the wellbeing of residents.
17	Strengthen community resilience through continued partnership with the VSC. This includes building upon and mapping existing VCS capabilities, identifying gaps in community support and providing opportunities for skills development.
Pillar 2: The places and communities we live in	
18	Partners should collaborate to reduce greenhouse emissions and mitigate the harms caused, ensuring that climate change is considered in every policy and decision made.
19	Partners should collaborate to reduce air pollution, risks and health inequalities and ensure the impact on air pollution is considered in every relevant decision.
20	Partners should collaborate to raise public understanding and awareness of current local levels of air pollution – the 'air pollution forecast' and encourage residents to adjust their behaviour accordingly, taking into account any health problems that might put them or their family at particular risk.
21	Partners should ensure that health and social care services are as accessible as possible by public and active transport options and encourage staff and users to leave their car at home when using public services as far as this is practicable.

No.	Recommendation
22	Local Authorities to work with partners to expand the active transport infrastructure in the borough. The health and social care system to advise residents of the health benefits of active travel whenever the opportunity arises.
23	All partners to facilitate the shift to electric vehicles including their own fleet.
24	Councils to make use of the powers available to create a healthier offer on our high streets, prioritising disadvantaged areas with the unhealthiest offer, and taking into consideration the views of the local community.
25	Local Authorities should ensure that plans and policies shaping regeneration and housing growth e.g. borough level Local Plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.
26	The plans shaping regeneration and housing growth should also explicitly address the needs of residents with specific health and care issues e.g. relating to frailty, mental illness, physical and learning disabilities etc. to promote independence and wellbeing
27	The 3 BHR boroughs, working with developers, should put in place processes to share learning from the healthy new town project at Barking Riverside.
28	Local authorities and provider organisations should collectively consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.
29	Building on regeneration plans in the three boroughs; the partners should develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.
30	Health and Social Care Partners should be active participants in borough level Community Safety Partnerships and contribute to the delivery of agreed plans and strategies e.g. regarding Violence Against Women and Girls, and the harm caused by serious violence and drug and alcohol misuse
31	Partners, working with the community, should agree how best to go about strengthening social networks and community capacity, prioritising areas with new housing developments, high population churn and significant disadvantage.
Pillar 3: lifestyle and behaviours	
32	Ensure that smokers who wish to quit can access face-to-face counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.
33	Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g. people with mental health problems.
34	NHS partners to begin to provide smoking cessation support to identified priority patient groups including pregnant women, inpatients and patients with severe mental illness in consultation with local authority partners to ensure continuity of support.

No.	Recommendation
35	Actively promote e-cigarettes to smokers as an effective quitting aid and a safer alternative to continued smoking.
36	All partners to contribute towards the aspiration of a smoke free society by 2030 e.g. by continuing the de-normalisation of smoking in public spaces and homes; minimising the recruitment of new smokers through work with schools, rigorous enforcement of age-related sales regulations and minimising access to cheap smuggled or counterfeit tobacco.
37	Actively promote existing food and financial support mechanisms to low income households and households with children e.g. free school meals, school holiday meal scheme, Healthy Start scheme, food banks etc.
38	Ensure that there is a comprehensive whole system approach to tackling obesity (and in so doing improve diet and levels if physical activity) across BHR as a whole with additional efforts aimed at supporting groups known to have higher prevalence of obesity.
39	Partners should work to: • reduce the proportion of the population that drink at levels that increase their risk of ill health • increase participation in drug and alcohol treatment, particularly the latter, with additional efforts aimed at supporting those who are more socially deprived • improve the offer to people with drink and drug dependency and additional mental health problems • effectively support people with drink and drug problems who are street homeless • reduce and prevent harm to children and families arising from parental drink and drug problems.
40	Partners to work together to encourage healthy attitudes and behaviours regarding sex and relationships, supported by an accessible, effective and seamless health and care services offer that enables informed choice and minimises harm to health and wellbeing.
Pillar 4: Integrated health and care services – antenatal and maternity services	
41	The East London Local Maternity System (ELLMS) to enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led continuity of carer initially prioritising those identified as most vulnerable and high risk.
42	ELLMS to strengthen personalised care and choice; increase the proportion of women with a personalised care plan, initially prioritising disadvantaged and vulnerable women whilst offering all women information and choice on place of birth.
43	ELLMS to continuously improve maternal safety including by full implementation of the second version of the Saving Babies' Lives Care Bundle and work with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths, and intrapartum brain injury by 2025.
44	ELLMS to improve access to domestic violence support to all women accessing maternity services through the introduction of an early support and referral scheme for identified victims

No.	Recommendation
45	Partners to work together to improve the quality of postnatal care for all women including enhanced support to vulnerable women (e.g. perinatal mental health, drug and substance misuse) and focusing on infant feeding.
Pillar 4: Integrated health and care services – children and young people	
46	The children and young people (CYP) population is more diverse than the population as a whole and becoming still more diverse. All partners should ensure that consideration of cultural competence and language is integral to the development of all services and particularly services for CYP.
47	Partners should consider a rolling programme of reviews to ensure that the capacity of universal services e.g. health visiting, community paediatrics, therapies, Speech and Language etc. within BHR is adequate given the scale and pace of growth in the CYP population in recent years.
48	Lessons learned through the Child Death Review process should be shared with the Maternity and CYP Transformation boards, to inform their respective work plans.
49	Partners should ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g. via regular contacts with health professionals including midwifery, health visiting and with general practice and Local Authority Early Help teams/Children's Centres.
50	Work with providers common to the patch to recover from the impacts of Covid and improve delivery of mandated early years checks as a priority.
51	Providers of the 0-19 Healthy Child Programme (0-19 HCP) should ensure that anonymised aggregate data gathered at the 2 year check using the ASQ3 are available to inform health service planning and delivery of interventions to improve school readiness including timely assessment and care from relevant specialist health care services.
52	Increase joint assessments at 2 – 2 ½ years by early years settings and health visitors. Health Visitor teams (part of 0-19 HCP) are recommended to implement a failsafe follow up procedure to capture all children eligible for the 2 year check.
53	Schools, 0-19 HCP and Early Years Foundation Stage providers to work together to improve the percentage of children achieving at least the expected level across all learning goals, and a good level of development. Consider an additional focus on the gender difference in school readiness.
54	Consider how health visiting, children centres and other early years providers can work together to strengthen the ability of parents to manage minor childhood illness and injury (and their confidence to do so).
55	As part of a comprehensive approach to building greater aspiration, educational achievement and employment particularly in disadvantaged and / or otherwise vulnerable groups; consider the potential contribution of health and social care providers e.g. outreach to schools and career fairs; workplace experience; apprenticeships; career paths from less skilled lower paid roles into better paid, professional health and social care roles etc.

No.	Recommendation
56	As part of a wider whole systems approach to tackling obesity, partners should consider the need for Tier 2 and Tier 3 weight management services for CYP
57	Encourage and support early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the Health Early Years London / Healthy Schools London scheme or similar.
58	Partners to work with schools to provide better support to pupils at risk of exclusion.
59	Ensure that programmes to improve digital connectivity are supported by associated education and awareness of the health impacts of cyberbullying and screen addiction.
60	Put in place processes to share learning from joint working between the Early Intervention Foundation and LBBD. Ensure that multi-agency working around Emotional Wellbeing and Mental Health (including family interventions and targeted support for vulnerable cohorts) are taken forward.
61	Capitalise on relationships built through the Borough Partnerships to embed a public health approach to tackling serious youth violence focusing on adverse childhood experiences and addressing risk factors for gateways to youth crime.
62	Review the delivery of childhood immunisation in BHR with the aim of increasing uptake to levels necessary to achieve herd immunity.
63	Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.
64	CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews to better direct resources and options on pan-BHR commissioning to facilitate best use of scarce clinical resources and closer to home wherever possible.
65	CYP and MH transformation Boards should work to: - • Increase CAMHS capacity and strengthen links with other providers • Develop the capacity and capability of professionals in universal services including health visiting, school nursing general practice and schools to support children with mental health problems and their families • Support children and their families to be more resilient
66	ICS partners to i) consider how best to report attendances for self-harm in CYP; ii) ensure that NICE guidance for psychosocial assessment after hospital attendance for self harm is implemented
67	CYP Transformation Board, and Borough Partners to prioritise and consider how best to implement plans developed to improve asthma care in BHR.

No.	Recommendation
Pillar 4: Integrated health and care services – adult mental health	
68	Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.
69	Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience e.g. by making use of 'Every Mind Matters' resources and self-help aids giving particular consideration to groups who appear less likely to seek help e.g. LGBT and BAME residents and older people.
70	Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.
71	Improve understanding of public perceptions of Talking Therapies and how it be can promoted and delivered to maximise participation and successful completion and thereafter improve the promotion and delivery of Talking Therapies based on this insight.
72	Develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.
73	Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.
74	Improve and increase joint working between mental health services and drug and alcohol services, to improve outcomes for patients with co-occurring substance/alcohol misuse and mental health conditions.
75	Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.
76	Review arrangements for those in contact with the criminal justice system, including ex-prisoners and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements
77	MH services should audit readmissions to identify the underlying causes of readmission and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).

No.	Recommendation
78	Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.
79	Review the management of patients in crisis ensuring there is adequate place of safety provision given population growth and increasing complexity of needs. Investigate where interventions might have previously prevented escalation to crisis and use the lessons learned to improve mental healthcare
80	Improve the management of physical health of patients with SMI; ensure all get an annual health check and improve effectiveness of support available to assist with lifestyle change – starting with smoking.
81	Ensure there are comprehensive plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.
82	Monitor suicides in real time to identify and respond to trends.
Pillar 4: Integrated health and care services – cancer	
83	Continue to work to increase uptake of cervical screening by offering extended hours in general practice and bowel screening with the roll out of FIT testing for diagnosing colorectal cancer and breast screening.
84	To undertake an audit to assess the impact of Covid-19 on Cancer screening and service delivery including emergency presentations post-pandemic
85	Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.
86	Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)
87	Implement the national optimal cancer pathways
88	Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways for prostrate, breast and bowel cancer patients.
89	Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.

No.	Recommendation
Pillar 4: Integrated health and care services – long term conditions	
90	Partners should review the current service delivery model and approach to increasing the offer and uptake of NHS health checks in each borough and develop a robust action plan for improvements in uptake, particularly among those at greatest risk of poor health. Key opportunities to explore should include the accessibility of Health Checks appointments by time and geography, the role of PCNs and exploring the potential for delivery of workplace-based programmes.
91	Partners should review the care pathway and provision of support for patients found to be at high risk of LTCs following an NHS Health Check (or other identification route) to ensure that treatment and behaviour change support is effective, high quality and in line with best practice guidelines. This should include reviewing whether behaviour change support is culturally appropriate for each borough's communities, with a focus on contributing to reductions in health inequalities by ethnicity and deprivation.
92	Partners should review the local approach to maximising participation in the National Diabetes Prevention Programme and develop an action plan for improved uptake and outcomes. This should include actions to ensure that the NDPP is culturally appropriate for the different communities of BHR to reduce inequalities by ethnicity and deprivation.
93	Partners should explore opportunities to expand the target populations for preventative interventions, including the NDPP and Health Checks programmes, beyond the statutory minimum to enable more effective early intervention, prevent ill health and reduce inequality. This should include developing actions to increase uptake by under-served populations e.g. such as homeless residents.
94	Partners to review the processes for analysis and reporting of key local data on preventative interventions to include both the Health Check and National Diabetes Prevention programmes. There should be a focus on improving the granularity of data, both by geography (in particular by Primary Care Networks) and inequalities by ethnicity, deprivation and age, as well as regular reporting of data on invitation, uptake and outcomes.
95	Partners should review current levels of preventable mortality and surgical procedures linked to LTCs e.g. lower limb amputation, to understand in detail differences across the three boroughs. A robust action plan should be developed to reduce these negative outcomes.
96	Partners should conduct a review of the current provision of prevention and care to those with multiple conditions and develop a robust action plan for improving local care pathways across all three boroughs to reduce levels of preventable ill health, morbidity and mortality.
97	Regular reviews of patients with LTCs to consider mental and well as physical health. Partners to consider how best to support the mental health needs of patients with LTCs.

No.	Recommendation
98	Borough partnerships should work with primary care clinicians and directly with the public to raise awareness of long Covid, opportunities for self-care and appropriate referral for specialist assessment
99	Consider commissioning of further services for those with long Covid, based on learning from newly commissioned services in BHRUT. These should include dedicated support services and self-management, for example mobile apps, community exercise programmes and peer support groups.
Pillar 4: Integrated health and care services – older people and frailty	
100	Contact and support older people in receiving both flu vaccine and covid vaccine as recommended. Also review coverage of pneumococcal and zoster vaccine.
101	Maintain efforts to further increase the completeness of dementia diagnosis, and improve access to information and support for patients and their families
102	Refer older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitations services.
103	Ensure the BHR Falls prevention pathway is consistent with national guidance and equitably implemented according to need.
104	Ensure that the BHR Older People and Frailty Prevention offer currently under development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions.
105	Ensure that patients at risk of frailty are systematically identified, using a population health management approach; effectively supported by the local partners to stay well; or to receive urgent additional help in times of crisis.
106	Ensure that there is a systematic approach of reviewing patients with multi-morbidity and frailty that includes a medication review to maximise the benefits of medications and minimise side effects.
107	Regular review of older people should consider their mental health as well as physical health and functioning.
108	Further improve the reablement offer in all three boroughs to maximise the proportion of patients who return home and stay home after admission to hospital.
109	Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.
110	Strengthen end of life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.

No.	Recommendation
Pillar 4: Integrated health and care services – planned care	
111	Support implementation of plans developed by the BHR Planned Care Transformation Board to: - • Increase the capacity and capability to effectively manage patients in primary care e.g. by use of 'advice and guidance' and improved access to investigations • Extend patient initiated follow up to reduce unnecessary appointments • Increase capacity and range of treatment options including community minor surgery and MSK exercise on referral • Improve emotional and wellbeing support to patients throughout treatment journey including for self-care.
Pillar 4: Integrated health and care services – urgent and emergency care	
112	Support plans developed by the BHR Urgent Care Transformation Board, specifically:- • encourage clinicians and patients to make appropriate use of alternatives to ED referral and attendance, including self care • support residents to stay well longer and ensure they receive effective preventative and / or primary treatment to minimise the need for urgent and emergency care

BHR Integrated Care Partnership Board

26th May 2022

Title of report	BHR Transformation Board 21/22 Key Progress and Achievements to Date
Author	Hanh Xuan-Tang, Deputy Director of Recovery Planning
Presented by	Tracy Rubery, Director of Transformation
Contact for further information	Hanh.Xuan-Tang1@nhs.net 07736 117771
Executive summary	In November-21, a paper was provided to ICPB highlighting the key achievements of each of the Transformation Boards against their 21/22 priorities. The paper also provided an update on some of the key impacts that the Transformation Boards have made on the BHR system. The report in November focused on the first part of the year (to September-21) This paper provides a further update and progress on the work of the Transformation Boards in latter part of 21/22, an overview of the programs of work delivered throughout 21/22 and the impact of transformation schemes which were implemented previously.
Action required	The BHR ICPB are asked to: **NOTE** the achievements of the Transformation Boards in 21/22, in relation to the delivery of transformation schemes in 21/22, and the impact that that this has had in terms of reducing activity in Secondary Care through the provision of alternative services through transformation.

Where else has this paper been discussed?	N/A
Next steps/ onward reporting	An update report will be provided in 6 months reflecting on the delivery and impact of the Transformation Boards in 22/23.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The role of the Transformation Boards is to develop and deliver service transformation to improve the outcomes of our population, tackling inequalities and inequities and in turn, deliver efficiencies and savings by reducing the burden on the Acute Hospitals. This will ensure that we can sustainably deliver our commitments into the future. Through Transformation, we will: • Bring Care Closer to Home • Support our population to start well, live well and age well • Tackle inequalities
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	ICP Priority 4 – ICP Development & Sustainability
Impact on finance, performance and quality	Not applicable – will be part of individual schemes delivered under each Transformation Board
Risks	There is a risk that if schemes do not deliver as planned, the financial sustainability may exceed the time frames set out in the Integrated Sustainability Plan
Equality impact	Not applicable – will be part of individual schemes Business Cases

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

NHS
North East London
Clinical Commissioning Group

BHR Transformation Board 21/22 Key Progress and Achievements to Date

Meeting name: Integrated Care Partnership Board
Presenter: Tracy Rubery – Director of Transformation (NEL CCG)/ Hanh Xuan-Tang – Deputy Director of Recovery and Planning
Date: 26th May 2022

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

OLDER PEOPLE

- Additional investments have been made to enhance the Community Treatment Team service offer to include **Advanced Care Practitioners** (senior pharmacists and nurses) who will help undertake medication usage reviews for patients in the community, to help avoid presentations to A&E and associated admissions relating to medication compliance and adverse reaction events. The service launched in March 2022. Over the first 12 months of the service it is estimated that 384 emergency admissions and A&E attendances will be avoided, saving £182k.
- New pilots have been implemented to operate alongside the **Single Point of Access Discharge** service to support the discharge of patients from hospital. The **Home First** service went live in October 2021. This service provides a therapist who meets the patient and their family within one hour of discharge to complete a needs assessment at the property, equipment is provided the same day and community support within 1 week. Over the first 12 months of the service, it is estimated the scheme will save 11,232 bed days.
- Additionally, the **Discharge to Assess Pilot** was also launched in October 2021. The service block books nursing home beds where patients can be discharged to. The service also provides wrap-around physio and occupational therapy support so that patients can continue their rehab outside of a hospital setting. The services is forecast to save 1,064 bed days in the first year.
- The **Out Of Hours End of Life Rapid Response Team** service launched in April 2022. The service provides out-of-hours palliative care to patients in their last weeks of life to help them stay at home where this is their wish, and support patients and their families to receive improved end-of-life care and support. The service is expected to prevent 365 emergency admissions and A&E attendances each year.

CANCER

- **Targeted Lung Health Check (TLHC)** is a new pilot, initially being rolled out in Barking & Dagenham and Tower Hamlets based on data showing the areas with the highest smoking rates in north east London. Invites will be sent to people aged 55-74 who are, or have been, smokers. This will be a free MOT of the lungs for those most at risk of developing lung cancer. The pilot is part of the NHS Long Term Plan ambition that by 2028, 75% of all cancers are diagnosed at an early stage.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

PLANNED CARE

- The Planned Care Board is now led at a North East London (NEL) level, and as such, the BHR Planned Care Board has been stood down.
- The **Musculoskeletal (MSK) New Model of Care** project has procured an **Electronic Referral Tool** (Vantage Rego) that will direct GPs referrals to the appropriate sub-specialty and automatically load the correct test/investigation generating pathways efficiency in primary and secondary care settings, and therefore releasing valuable clinical time and reducing same specialty consultant to consultant referrals. The **MSK Exercise on Referral (EoR)** is now live in all 3 boroughs providing alternative treatment to clinical intervention to over 3,000 patients with chronic pain each year. The physiotherapy backlog of 4,500 patients is being progressed and on target to be cleared by July 2022.
- A **special project (T3000)** to reduce Appointment Slot Issues (ASI) waiting list to first outpatients appointments has been completed and the triaging of 6 specialties referrals has saved 10% of Follow Ups (323) with patients returned to their GPs with advice in just one month. The project successfully exceeded the target of triaging 3,000 appointments in one month. As a result, the Trust is working to embed triage as business as usual either via ASI referrals or Referral Assessment Services to surgical specialties. Additional investments has also been made to support BHRUT with additional triage capacity.
- The **Community Minor Surgery** service is due to be launched imminently, prioritising BHRUT waiting list and inter-practice referrals. The launch has been delayed due to the winter wave of Covid and prioritisation of the vaccination booster programme. The service plans to deliver over 2,000 additional minor surgery procedures each year in a Primary Care setting, and therefore reduce the burden on Acute services and support the clearance of the current Elective backlog post Covid. The service is also aimed at reducing waiting times for patients and facilitate access to treatment closer to home.

LONG TERM CONDITIONS

- The **Non-Invasive Ventilation (NIV)** Service, which went live in April 22, has been put in place for the management of chronic hypercapnic respiratory failure (CHRF) due to chronic obstructive pulmonary disease (COPD) and obesity hypoventilation syndrome (OHS). Previously the service was only available through Tertiary institutions however will now be delivered locally by BHRUT to patients at home. The current cohort of patients is 44 with COPD and 11 with OHS. It is planned that this service will reduce 57 emergency admissions in 2022/23.
- **The Lipid Transformation Pathway Pilot** - The implementation of the medicine optimisation pilot in September 21 in Redbridge is aimed at ensuring people with dyslipidaemia, a risk factor for stroke, is managed appropriately and put on the correct course of medication for example statins. The pilot aims to reduce both attendances and admissions of high risk patients. The pilot has delivered as of January 2022 some very positive results with 10 out of 42 GP practice systems already been accessed which has led to 315 high risk patient records being reviewed. More significantly this has resulted in:
    - 177 patients having their lipid management medication optimised
    - 67 Review diagnosis
    - 50 Incorrect coding being corrected for patient records /no Cardio Vascular Disease (CVD)
    - 21 Exceptional reporting (haemorrhagic strokes, embolic/cryptogenic stroke, non-atherosclerotic Myocardial Infarction (MI) or palliative)

As this is currently a pilot, a full review and evaluation will be undertaken after 10 months (August 22), with a view that if successful, a business case is developed to support the rollout of a service across BHR.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

URGENT AND EMERGENCY CARE

- The **Same Day Emergency Care (SDEC)** service was successfully launched in July 2021 with 10 patient spaces. As of March 2022 the unit is now accepting direct referrals from 111 as part of an abscess pathway. The SDEC unit is contributing to a forecast of 268 less emergency admissions for conditions treatable by the SDEC unit when comparing 2021/22 with 2019/20, saving the BHR System £502k.
- A business case for a **Physician Response Unit (PRU)** has been approved, however, given a change in financial requirements, a revised Business Case is currently being finalised and is expected to be approved this month. The PRU has an expected launch date of July 2022. The PRU is a rapid response vehicle staffed by a senior Emergency Medicine doctor and Emergency Ambulance Crew, the vehicle is equipped extensively enabling the delivery of definitive emergency care on scene between 8am and 11pm Monday to Friday. The PRU scheme, which already operates in Tower Hamlets, Newham and Waltham Forest, is expected to prevent 910 A&E attendances over the first 12 months of operation as ambulance crews would otherwise have had to convey these patients to the hospital for emergency care. These avoided A&E attendances will save the BHR system £433k.
- A number of winter initiatives were launched to support with winter pressures including the creation of additional capacity in the **Intensive Rehab Service** in November 2021, this ran until the end of April 2022. The service provided intensive rehab to a patient in the community following hospital discharge for up 21 days. This allows patients to be discharged sooner from the hospital and receive their care in the community. The service is estimated to have generated capacity for c500 new assessments and c2700 follow up appointments in a community setting over this period. This will be evaluated as part of a wider piece of work.

CHILDREN AND YOUNG PEOPLE (CYP)

- An integrated **Autism Spectrum Disorder (ASD) NICE compliant pre and post diagnostic pathway** has been developed across BHR. Stage one of the service is in progress with the recruitment of clinical staff currently underway. The service is aimed at reducing waiting times for assessment and diagnosis with a plan to provide over 2,000 assessments and diagnostics per year.
- The integrated **Paediatric Hospital at Home** pathway and **Paediatric Continence service** are currently going through the final stages of clinical governance approval. The redesign of the services will meet the needs of Children and Young People utilising the ‘team within a team’ approach, working from borough bases and linked to PCNs, nurseries, schools, colleges and families hubs. The expectation is that 1,396 short stay admissions will be avoided each year focusing on prevention, early detection and treatment in the community.
- A collaboration between the CYP Transformation Board and BHR Workforce Academy has resulted in the successful delivery of a workforce workshop in September 21. The workshop identified short and long term solutions to address the shortage in the workforce affecting children across BHR and the Board has, for the first time, access to BHR wide invaluable workforce information via the newly developed workforce dashboard. An additional Business Intelligence resource has also been recruited following the Star Chamber process, and is due to start in May.

BHR Transformation Board 21/22 Scheme Overview (March-22)

LTC Diabetes – out of hospital management
Ageing Well - Community catheter clinics
Social Care In Emergency Department

Musculoskeletal (MSK) e-Referral Tool
Albumin to Creatinine ratio (ACR)Testing from Home/ACR Diabetes
ACR Hypertension
Physician Response Unit (PRU)
Domiciliary Care Pilot

Concept Schemes

Business Case

Mobilisation

Simple Wound Care
Diabetes Assisted Discharge
Tier 3 Weight Mgt
Stroke Rehab- Service Review
Ageing Well - Hospice End of Life Service (RRT 24hr helpline and Nurse)
Ageing Well - Hospice End of Life Service (Care Home End Of Life (EOL) Nurse Specialist)
Point of Care Testing (POCT)
Hospital at Home
LTC Continence Pathway
Autism Spectrum Disorder (ASD)Attention Deficit Hyperactivity Disorder (ADHD) Service (Adults)
Autism Spectrum Disorder (ASD)Attention Deficit Hyperactivity Disorder (ADHD) Service (Childrens)

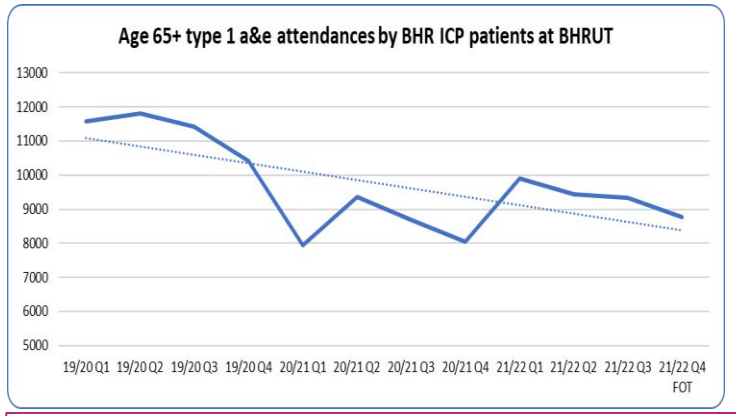
Red schemes – denotes progress to next stage of process from previous month
Blue Schemes – New schemes added in since previous reporting month

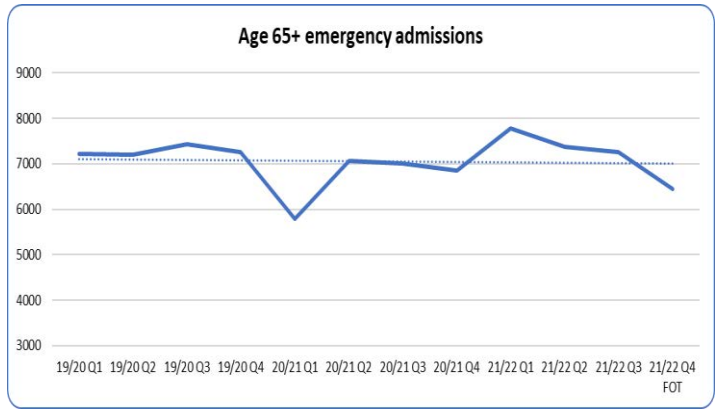
Live Schemes

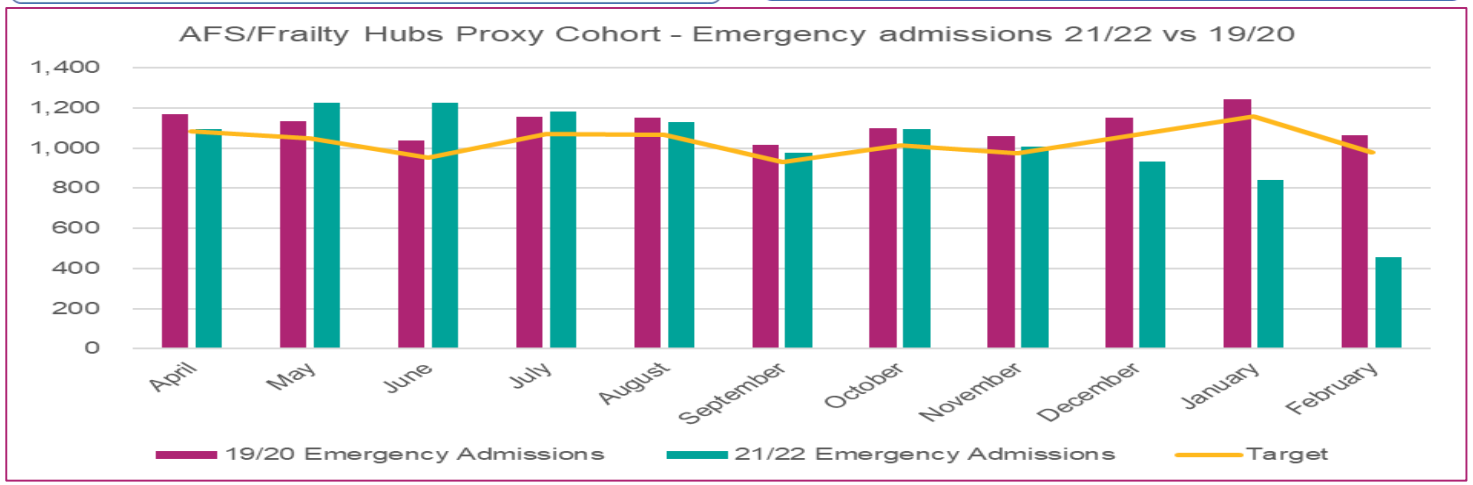
Queens Frailty Hub Service (AFS)
Falls Programme Line - Strength & Balance Service
Local Area Coordination – Havering/Redbridge
Reduce attendances for High Intensity Users (HIU)
Develop Same Day Emergency Care (SDEC) Pathways
Advice & Guidance (A&G)
Consultant 2 Consultant (C2C) referral reduction - Triage/Rapid Access Service (RAS)
Musculoskeletal- (MSK) New Model Of Care-EOR
Musculoskeletal (MSK) New Model Of Care-Primary Care MSK Team
Patient Initiated Follow Up (PIFU)
Urology-gynae pathway
Children Asthma Local Incentive Scheme (LIS)
Long Term Condition (LTC) LIS - Atrial Fibrillation
Long Term Condition (LTC) LIS - Diabetes Injectables
LTC LIS Group 2 (COPD/Asthma)
Diabetes 8 Care Processes
v Chronic Kidney Disease (CKD) Pilot
Pilot HALO (Hospital Ambulance Liaison Officer)
Atrial Fibrillation (AF) Case Finding-Havering
Complex Wound care Programme/Dressings and Lymphedema
Ageing Well - Discharge to assess pilot
Hospital Discharge Service
Ageing Well - Urgent Care 2-hour response (UCR)
Duty Doctor
Expansion of Community Falls Service
Community Complex Dementia – Havering
Alternative Care Pathway (ACP) Pharmacist in the Community Treatment Team (CTT)
Ageing Well - Out Of Hours (OOH) - End of life rapid response team
Winter schemes x10
Weekend Nursing Home Discharges Service
LIPIDs Management
Local Non-Invasive NIV Service
LITC LIS – Respiratory
Marie Curie - Night Sitting Service
Electrocardiogram (ECG) LIS
Community Minor Surgery
Evidence Based Interventions (EBI) Wave 2

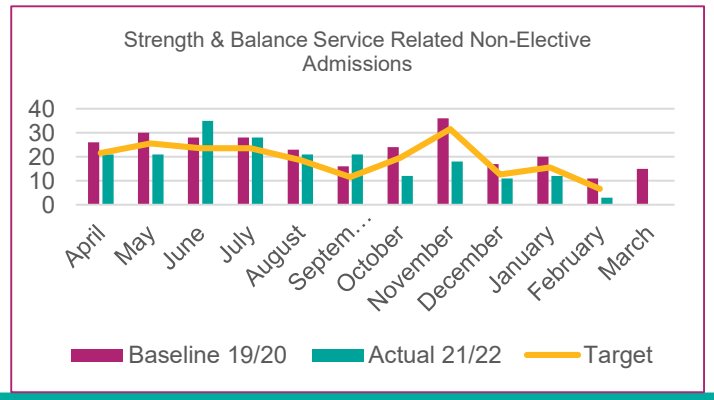
Impact of Transformation

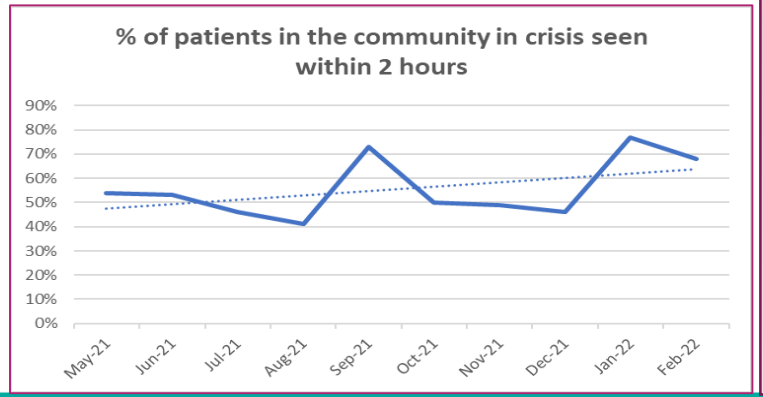
Older People Transformation Board Impact Achievements







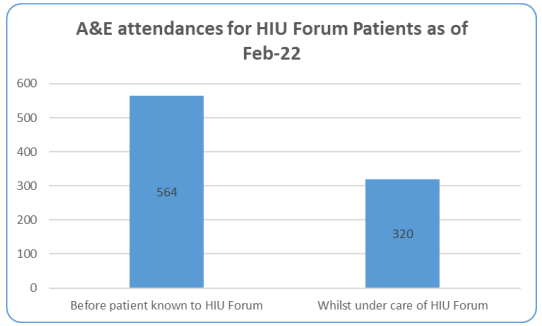


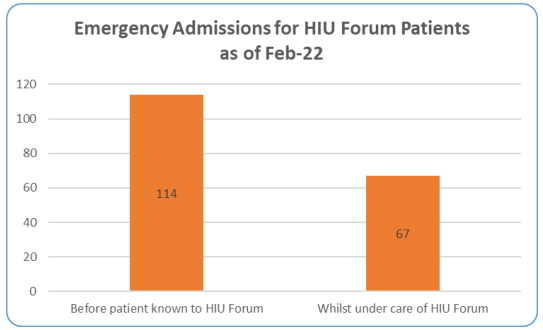


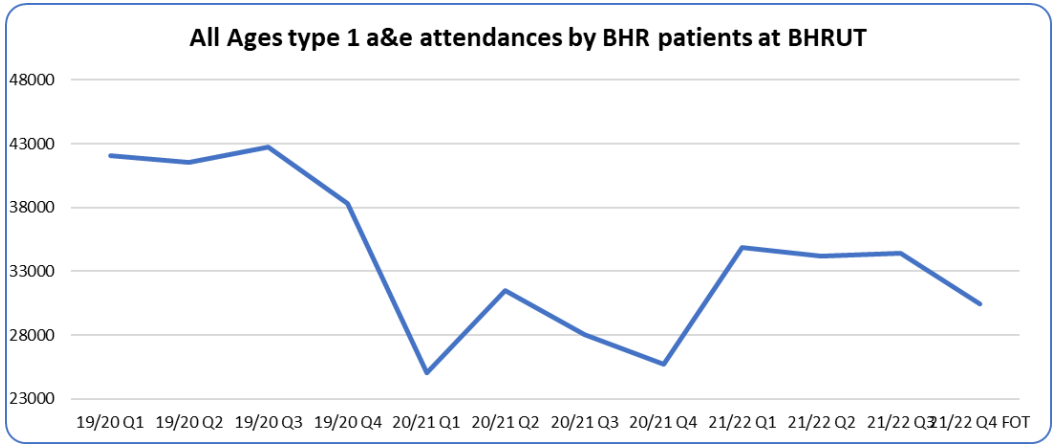
Key Notes

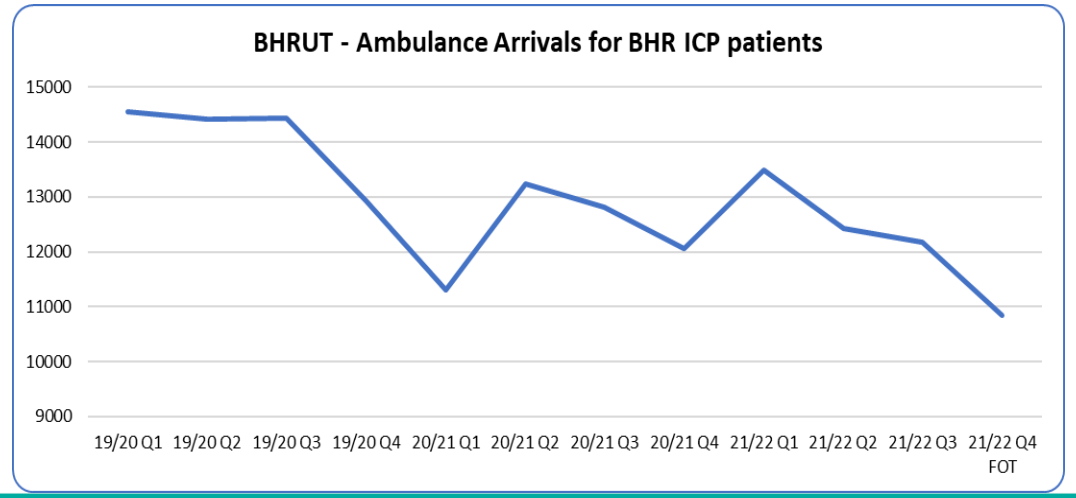
- Due to the impact of Covid, the 2020/21 position has been skewed and therefore, the 2021/22 position has been compared to the 2019/20 pre-Covid levels.
- Pre-covid (19/20), A&E attendances were 6% below the previous year levels (45.2k attendances in 19/20 compared to 48.2k in 18/19. The 21/22 forecasted position is showing a further 17% reduction on 19/20 levels (37.4k attendances in 21/22).
- The 2021/22 level of emergency admissions, for patients aged 65+, is currently 1% (232 attendances) lower than the comparable period in 19/20.
- The Queen's Frailty Unit, which was launched in May 21 ,incorporating the previous 'ED Front Door' and 'Home is Best' services, is starting to impact on the admission rates through a more dedicated and integrated Frailty service aimed at assessing and supporting patients to be cared for in an appropriate setting where an admission is not required. As of January 2022, there were 32% (405) less admissions for the conditions identified as treatable by the Frailty Unit than in January 19.
- The Falls Strength and Balance service was impacted during Covid due to social distancing measures and the move to virtual sessions. However, despite a spike in June 21, the 21/22 position as of January 2022 shows a 22% reduction in falls for this cohort equating to 56 less falls by January 22 compared to the same period in 19/20.
- The NELFT Community Treatment Team (CTT) began expansion in August 2021, as of February 2022 all additional substantive posts have been recruited to. The CTT supports the delivery of the National 2 Hour Community Crisis Response Standard. As of February 2022, 68% of patients in crisis in the community are seen within 2 hours, this is up from 41% in August 2021. Based on February 2022 data, the service is forecast to provide a reduction in emergency admissions of 910 and A&E attendances by 772, providing the BHR System with savings of £1.9m

Urgent & Emergency Care Transformation Board Impact Achievements









High Intensity User Forum & Open Dialogue service

The High Intensity User Forum is a multi-disciplinary team, consisting of London Ambulance Service, BHRUT, NELFT, Police, Social Care, patient GPs and others who provide direct care for the patients. They devise care plans and support options for patients who are identified as 'complex high intensity users' to prevent them from utilising urgent and emergency care services when not required, and directing them to more appropriate services to support the needs of the patient.

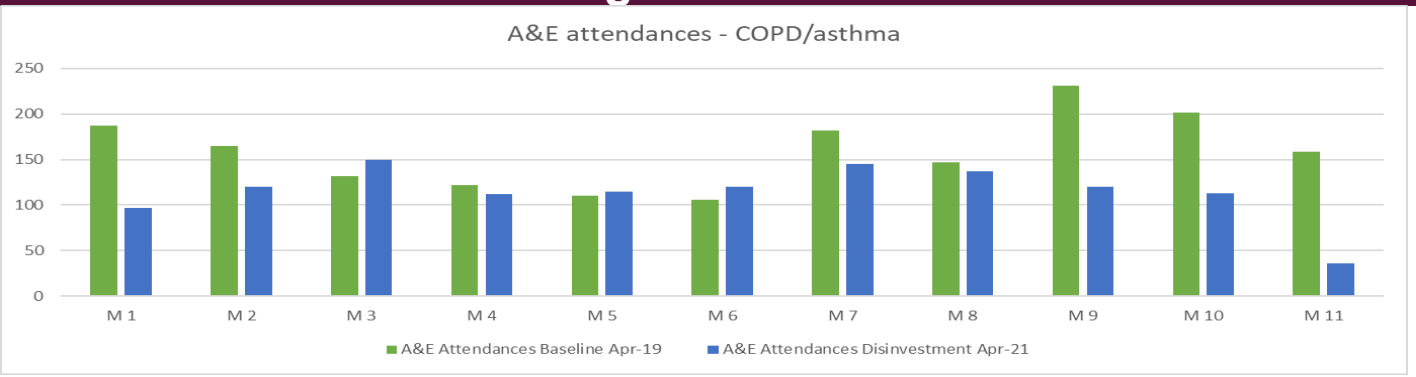
In 21/22 (as of February 2022), the service has delivered a reduction in emergency admissions of 41% (47 less admissions) and a reduction in A&E attendances by 43% (244 less attendances).

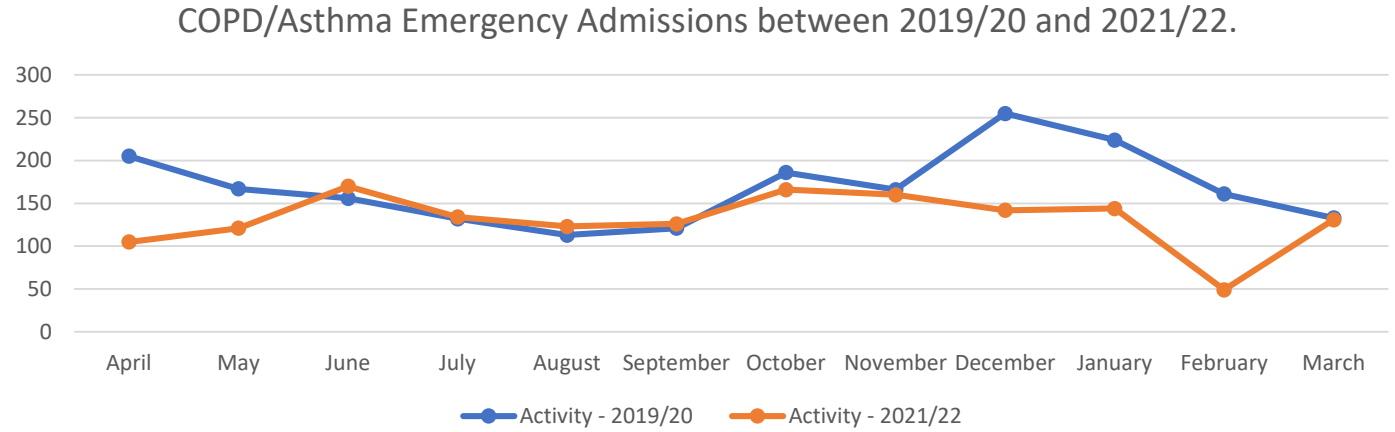
Type 1 A&E Attendances, relating to BHR patients of all ages at BHRUT, continue to show an overall downward trend with a 19% reduction (30,767 less) in A&E attendances in 2021/22 when compared to 2019/20, despite the post covid surge in 21/22. A significant contributor to this shift has been the successful implementation of 4 UTCs across BHR and the ongoing work to increase utilisation of alternative care pathways so that the emergency department is not the first port of call for patients when clinically safe to utilise alternative services.

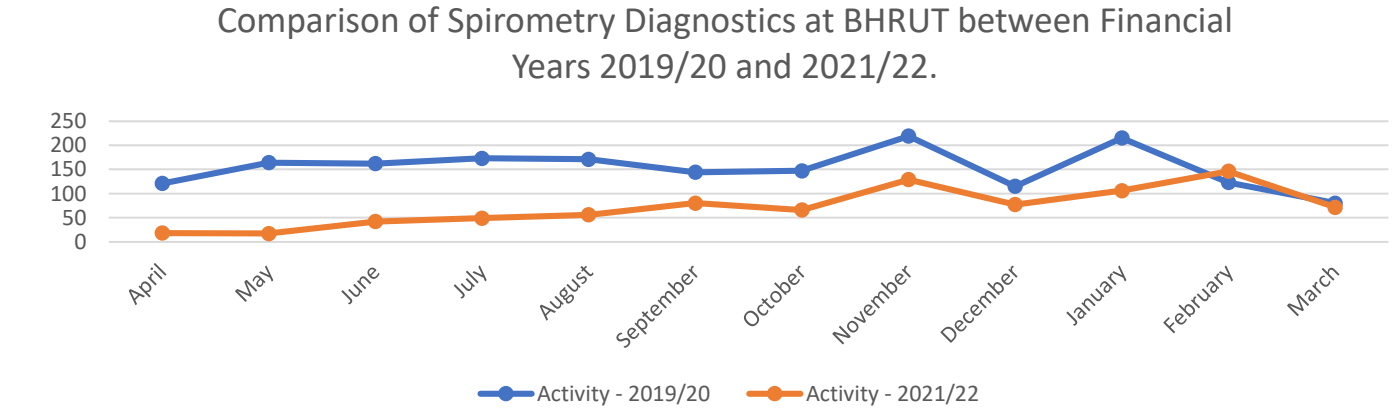
A significant amount of work has been undertaken to ensure alternative care pathways are increasingly available, such as Community Treatment Teams including an increase in capacity for the 2hour response team, Urgent Treatment Centres, Crisis Centres and Frailty Units. As a result, ambulance crews are now able to take an increasing number of patients to these alternative services. The impact of this can be seen in the reduction of ambulance arrivals at BHRUT, when comparing 2021/22 with 2019/20, this shows a 13% reduction (7,397 less conveyances).

Over the winter period, LAS recruited paramedics (HALO – Hospital Ambulance Liaison Officers) who review ambulance arrivals, 7 days a week throughout winter and guide/educate their ambulance crew colleagues with regards to the alternatives available for suitable patients. Through doing this, the HALO service is forecast to have prevented 1005 unnecessary A&E attendances between October 2021 and March 2022, saving the BHR system £183k.

Long Term Conditions Transformation Board Impact Achievements



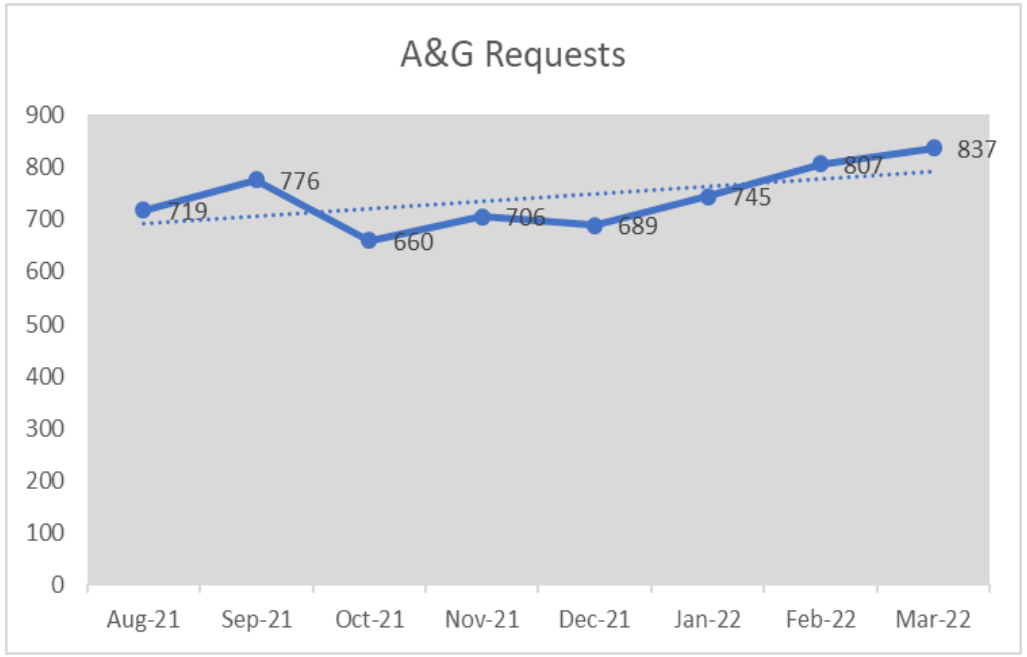




Key Notes

- The LTC COPD and Asthma LIS was implemented prior to Covid, with the purpose of shifting routine spirometry tests, for diagnosis of COPD/asthma, from an Acute setting into Primary Care, and to support patients through the development of care plans to better manage their condition and reduce presentations to Secondary Care. The LIS has now been extended into 22/23 and we envisage to see similar positive impacts.
- Since April 2021, there have been 570 less respiratory related A&E attendances compared to the same period in 2019/20 which is a significant reduction.
- COPD and asthma related emergency admissions remain on a downward trajectory, and despite a post-Covid surge in admissions in August and September 2021, at Quarter 4, admissions remain below the 2019/20 position with a combined total of 579 less admissions.
- Over 80% of high risk COPD/asthma patients have received their review and a personalised action plans with (5583 reviews completed)
- The shift in setting for the delivery of routine Spirometry testing, has resulted in 57% less spirometry activity (reduction of 1048 tests between April 21 to February 21) taking place in secondary care. As the Tests are performed in an Outpatient setting, this has resulted in the freeing up of outpatient appointments at BHRUT.
- Currently the majority of routine spirometry tests for diagnosis of COPD/ asthma is taking place within primary care. The aims is that by the end of 22/23, all spirometry diagnostic testing for COPD/Asthma will be undertaken out of hospital.

Planned Care Transformation Board Impact Achievements

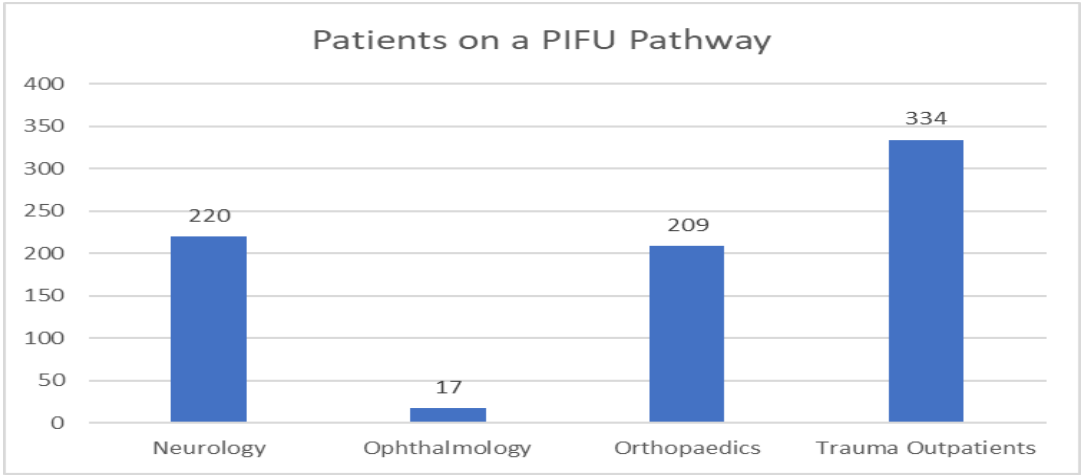


Key notes

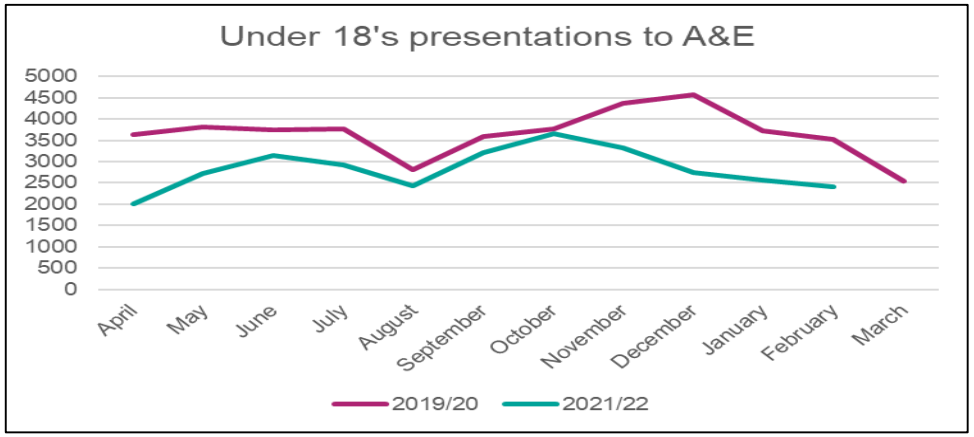
- The Advice & Guidance (A&G) requests are on the upward trajectory with a target to increase to 16 A&G per 100 first Outpatient appointments by March 2023.
- Covid-19 significantly impacted waiting times for patients, creating a huge backlog of patients sitting on the ASI waiting list, waiting for their first outpatient appointment. This cohort of patients needed to be addressed as a priority, to ensure they were on the correct pathway for the correct sub-specialty and ensure that the patient is seen by the right clinician first time, where clinically indicated. The T3000 project initiated by BHRUT aimed at triaging 3,000 patients on the ASI list waiting for a 1st Outpatient appointment in General Surgery, Colorectal, Vascular, Urology, ENT and Orthopaedics in February 2022. The Trust triaged 3,254 patients with an average of 10% of patients returned to referrer with advice. The medium to long term plan now is to investigate digital solutions to undertake triage effectively to free up clinical time.
- Following the successful pilot of the Patient Initiated Follow Up (PIFU) in early 2021, the service has been implemented in an additional 3 specialties. Plans are in place to expand the service to a further 4 specialties - gynaecology, urology, cardiology and dermatology. The target is to move 5% of all outpatients attendances to PIFU by March 2023.

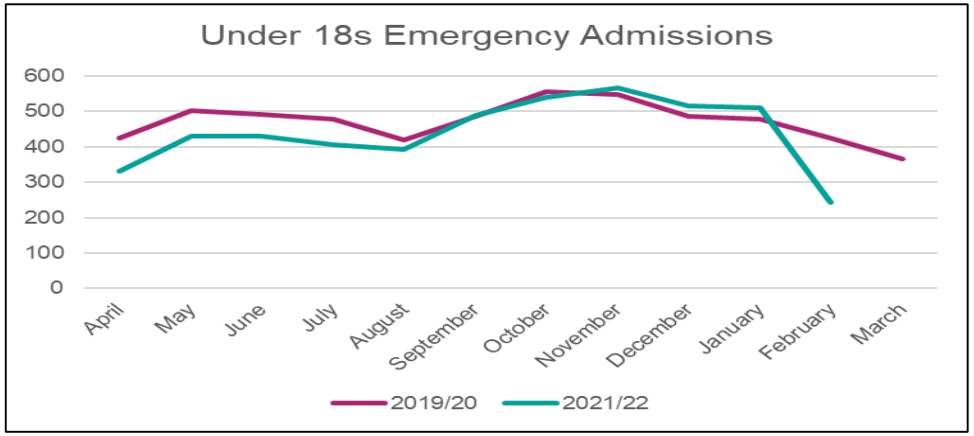
T3000 Project

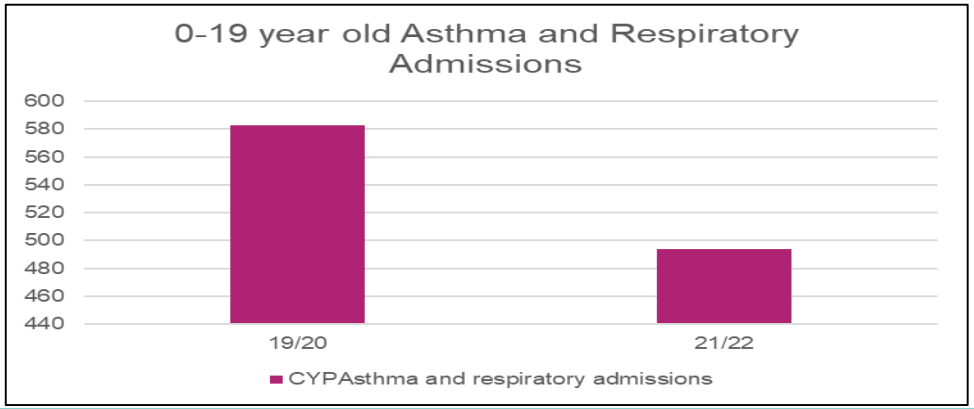
Specialty	Accept and Refer/Book Later	Return To Referrer With Advice	Grand Total	% Return to Referrer with Advice
Vascular	175	91	266	34%
Urology	595	75	670	11%
ENT	56	6	62	10%
General Surgery	870	91	961	9%
Colorectal	332	28	360	8%
Orthopaedics	903	32	935	3%
Total	**2931**	**323**	**3254**	**10%**



Children and Young People Transformation Board Impact Achievements



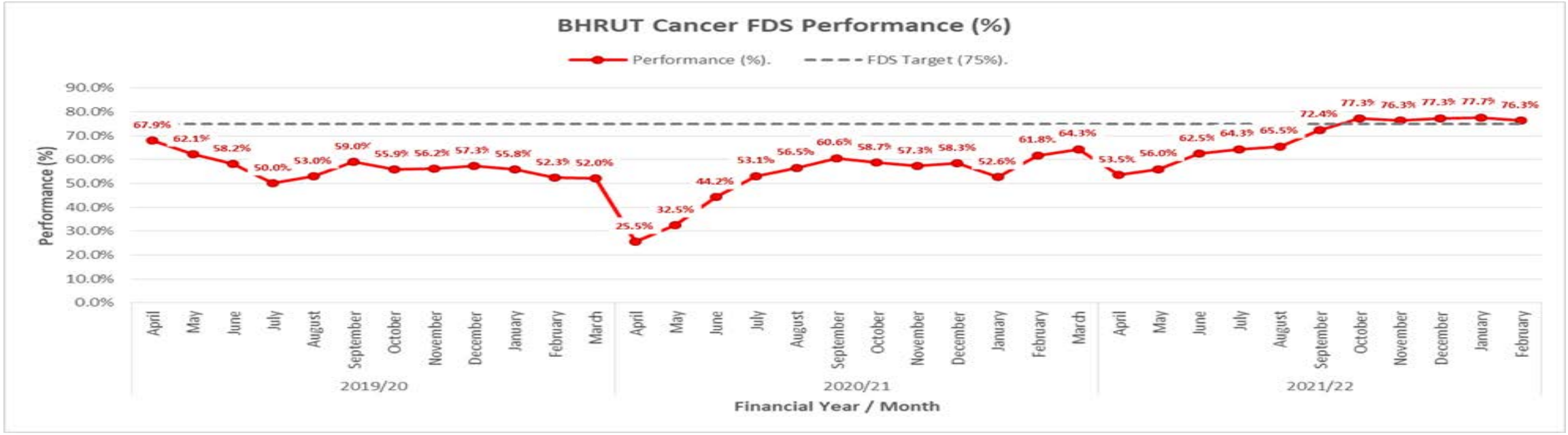




Key notes

- Type 1 A&E Attendances, relating to BHR patients under 19 years old at BHRUT, continue to show an overall downward trend with a 25% reduction (10,143 less) in A&E attendances in 2021/22 when compared to the same period 2019/20, despite the post covid surge in 21/22. A significant contributor to this shift has been the successful implementation of 4 UTCs across BHR and the ongoing work to increase utilisation of alternative care pathways so that the emergency department is not the first port of call for children and their families when clinically safe to utilise alternative services.
- Correspondingly, the number of emergency admissions relating to 0-19 year olds have also reduced by 8% at BHRUT (444 less admissions) when compared to the same period in 19/20. This is despite a surge in activity during the winter months caused by the Respiratory Syncytial Virus (RSV).
- The reduction in admissions, in part, is driven by the implementation of the Sustainable Asthmas LIS, which was implemented in 19/20 in response to the Regulation 28, and focuses on providing education and support to children and their families to help manage the Asthma condition through the implementation of Care Plans.
- The LIS also funded the recruitment of 3 Asthma specialist nurses in BHR, which has contributed to the reduction of hospital admissions for respiratory conditions by 15% (494 less admissions) in 21/22 in comparison with 19/20.

Cancer Transformation Board Impact Achievements



Key notes

The latest results from NHS England/Improvement show that North East London is the top performing cancer alliance out of 21 across England when it comes to achieving the Faster Diagnosis Standard for cancer patients. Significant work has been undertaken by the Trust to improve the Faster Diagnosis compliance including:

- Dedicated clinical review clinics established with consultant time to sign patient off pathway
- Local process agreed with Primary Care on endoscopy sign off process to support FDS delivery
- Increased Clinic capacity to reduce median waits
- Clinical triage team booking directly onto Endoscopy list
- Increased Radiology scanning capacity to support delivery of FDS.
- Resource allocated to support Gynae and Urology specifically.

This work has resulted in the current performance being back to pre-Covid levels and achieving the 75% target since October 2021. The latest published information for 28 Day FDS shows a performance of 76.3% in February 2022 against the 75% Target.

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

Minutes - Integrated Care Executive Group

17 March 2022 at 3.30pm – 4.30pm
Via MS Teams

Members:

Ceri Jacob (CJ)	Managing Director, BHR ICP – chair
Craig Nikolic (CN)	Chief Operating Officer, B&D GP Federation
Diane McKerracher (DMc)	Interim CEO, HealthBridge Direct (for Ross Arnold)
Barbara Nicholls (BN)	Director of Adult Services, LBH
Jacqui Van Rossum (JVR)	Chief Executive (Acting), NELFT
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Adrian Loades (AL)	Director of People, LBR
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation

Attendees:

Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Debbie Harris (DH)	Governance Officer, BHR ICP – note taker
Emily Plane (EP)	Head of Strategy and System Development, BHR ICP
Dr Ravi Goriparthi (RG)	B&D PCN Clinical Director
John Craig (JC)	Chief Executive, Care City
Hanh Xuan- Tang (HXT)	Deputy Director of Recovery Planning (for Tracy Rubery)

In Attendance:

Nassib Gungoo (NG)	Project Officer, Transformation, BHR ICP

Apologies/not present:

Henry Black (HB)	Acting Accountable Officer
Claire Symonds (CS)	Interim Chief Executive, LBBD
Carrie-Anne Wade (CW)	Strategic Communications Leader, NELFT
Melissa Hoskins (MH)	Associate Director – Communications and Engagement (BHR and TNW), NEL CCG
Ross Arnold (RA)	Chief Executive, Redbridge GP Federation
Matthew Trainer (MT)	Chief Executive, BHRUT
Dr Magda Smith (MS)	Chief Medical Officer, BHRUT & Health & Care Cabinet Chair
Ahmet Koray (AK)	Director of Finance, BHR ICP
Dr Caroline Allum (CA)	Medical Director, NELFT
Ann Hepworth (AH)	Director, Strategy & Partnership, BHRUT
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Matthew Cole (MC)	Director of Public Health, LBBD

Item		Action
1.0	**Welcome, introductions and apologies**	
	The chair welcomed everyone to the meeting and apologies for absence were noted.	

Item		Action
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 items discussed at the meeting. Diane McKerracher advised she will note any DoI should they arise in her role as Interim CEO for Redbridge Healthbridge Direct. No further conflicts of interest were declared.	
1.2	**Minutes of the last meeting**	
	The minutes of the meeting held on 17th February 2022 were agreed as an accurate record. One member requested clarification on how the agreed areas of ongoing BHR collaboration will operate, and how this will link to place based work. The proposals were developed through discussion with each organisation in BHR and each Place Based Partnership. It was noted the proposals for ongoing collaboration will be reviewed on a six monthly basis from July 2022 to ensure that they remain appropriate within the context of the wider evolving system. ICEG will not be a decision-making committee, and key decisions will be shared back with Place based Partnerships for endorsement as required. The Chair clarified to members that decision making is not being delegated from the Place based Partnerships to ICEG. CJ, as chair, offered to attend partnership committee meetings to talk this through with members if helpful.	
1.3	**Action log/matters arising**	
	The actions log was noted and updated accordingly.	
2.0	**Transformation Board updates**	
2.1	**Key milestones**	
	HXT took members through the key highlights in the attached paper. Due to a technical issue with the data last month the attached paper did not include the ISP impact element as the forecast was unable to be updated. The ISP impact position remains the same as reported in January. Therefore, the paper provides the following: • An overview of the current status of each scheme • An update of the progress of schemes against the key milestones of each of the Transformation Boards. Reference was made to the Duty Doctor scheme that went live in March, the current contract is in place until the middle of April and there was a question around if the ICS will extend it beyond this. The Chair will follow up with the Primary Care team and report back. A query was raised that some areas are still flagged as red although progress has started - should they be amber if they have started. Advice was that these were initially Rag rated against the	**Action:** UB to email CJ with a deadline date for the Duty Dr scheme to be extended

Item		Action
	original “Go live” date and where this has been missed, the flag will remain as red. It was agreed this needs to be explicit. JC asked for a more in-depth discussion on the Domiciliary Care Pilot outside of the meeting. HXT to arrange a call with JC. ICEG members: • Noted the update	**Action:** HXT to arrange a call with JC to discuss the Dom Pilot
3.0	**ICS development**	
3.1	**Transformation Cycle**	
	CJ verbally updated members on the progress of the transformation cycle workshops with partners, through which process we are aiming to practically articulate how the system will work together going forward. Work is underway to develop Provider Collaboratives. Thought then needs to be on how these will all start to work together, becoming self-managed, and how they will interact with the Place based Partnerships. It was noted that we need to avoid duplication in the system where possible, particularly around transformation. The work that is being led from a transformation cycle perspective is seeking to address this and prevent duplication. Two workshops have taken place with a final paper being written to take into the final workshop in April. The aim is to come up with a set of principles to apply to this work. This is subject to change as we move into the ICS but feelings from the system were that we needed a framework as a guide. The Place Based Partnerships are also being brought together along with the relevant Collaboratives around real scenarios to test how they can work together in practice. CJ advised she will share this paper towards the end of next week and advised members they can join the final workshop. The final paper will be brought back through the ICEG at a later meeting. ICEG members: • Noted the update	**Action:** CJ to share the Transformation Cycle paper towards the end of next week **Action:** CJ to bring back final Transformation Cycle paper to a future mtg
3.2	**Redbridge Place Based Partnership development update**	
	AL verbally updated members on Redbridge Place Based Partnership development highlighting the below: - A Steering Group has been established to shape priorities and development of the Place Based Partnership Board. - Redbridge have been progressing sessions that focus on specific areas of development - Recent agenda items have been: developing a score card for the partnership based on the Public Health outcomes framework to enable us to hold ourselves to account, clinical leadership models, finance arrangements, updates from Whipps regarding the Hospital redevelopment, updates on population health management, Voluntary Sector presentation on the role of the VCS and a presentation of the Housing Strategy.	

Item		Action
	The Steering Group met today with discussions on the Clinical Leadership model, importance of Clinical leadership, retention and development of clinical staff in the Borough. A need to be inclusive in clinical leadership and extend the roles to other professions. Finance discussions took place around fair share and how to lobby for as a Borough Partnership for funding. It is felt that further conversations need to take place re governance, particularly on how the Place Based Committee and Partnership will operate going forward. Reference was made to the Health and Wellbeing Board and how this will work with the Place Based Partnership. It was confirmed that Cllr Mark Santos sits on the Place Based Partnership Board and as part of the Governance conversation there's a need to map through the relationship between these two committees. It was suggested to AL that he has a conversation on governance with Brown-Jacobson, the external lawyers as it was noted that a similar discussion in Havering has been helpful. The group noted that until the functions that will come into the Place Based Partnerships are fully clear, it is difficult to plan, with a need for some practical examples. It was noted that the Transformation Cycle approach mentioned earlier in the meeting seeks to take this approach, to map functions at each level of the system based on practical examples. CJ suggested she pull out the functions page from the Transformation Cycle paper and circulate to members. Confirmation was given to the Place Based Partnerships that another £100k has been agreed for them to continue their ongoing development from April 2022 for the 2022-23 year. As per the guidance plans for each Place Based Partnership need to be ready by April 2023. A discussion took place on how monies can be spent, reference was made to the Financial paper that came to the last meeting and how financial flows in the system will operate in practice, in a way that ensures that each part of the system is responsible for the right budgets to deliver improved outcomes for local people and patients. The subject of where deficits will fall also took place wondering if they will be shared out across the patch. This is being worked through, and there is a delicate balance to be achieved between ensuring parity of funding, and not adversely impacting an area by reducing funding significantly. Reference was made to the difference of funding allocation between Outer and Inner NEL. The Chair suggested a dedicated discussion with herself, Steve C, Ahmet Koray and the Local Authority DAS's outside of the meeting to discuss this in more detail. The group asked when it will be clear what resources will be transferring to Place Based Partnerships. There is a process that is	**Action:** CJ to set up a call to have a dedicated discussion around funding allocation with

Item		Action
	underway to map this through, and we should be able to share early indication of this from early April 2022. ICEG members: • Noted the update	the LA DAS's, CJ, SC & AK
4.0	**ICP planning and performance**	
	SR talked members through the attached paper advising he was going to focus on the Recovering Well element (slides 3 & 4), the deep dive for today's meeting. A more up to date pack has been produced since the shared pack with the below highlights: - Elective position, waiting lists continue to rise at BHRUT. Last set of validated data shows the waiting list has risen to 52,618 which is just under the trajectory for December, however the unvalidated data for January suggests a further increase to 55,796 which brings us close to the trajectory that stan at 51, 855. This brings pressure on the agreed trajectories in relation to quarter two. - The 18-week backlog is also deteriorating with January data suggesting just over 20,500 patients waiting, substantially over the no of 17,600 in the earlier paper shared this morning. - RTT still around the 67% mark - 52-week marker is going in the right direction, being slightly above the trajectory figure with 877 patients waiting more than 52 weeks at BHRUT. - Diagnostics continues to be challenged at 58.43% against 99% standard. - Referrals still remain stable currently. ICEG members: • Noted the update	
5.0	**Any other business**	
	None noted	
6.0	**Items of information**	
6.1	The minutes of the BHR Quality & Performance Oversight Group held on 3rd February 2022 was noted.	
6.2	The draft agenda for the March BHR ICPB was noted.	
	Date of next meeting – 21 April 2022	

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

Health and Care Cabinet

Thursday 10 March 2022
(via MS Teams)

Members:

Magda Smith (MS) – Chair	Chief Medical Officer, BHRUT
Debbie Smith (DS)	Director of Nursing, NELFT
Caroline Allum (CA)	Medical Director, NELFT
Gladys Xavier (GX)	Director of Public Health, LBR
Dalveer Johal (DJ)	Pharmacy Services Manager
Susanne Knoerr (SK)	Social Care representative, LBBD
Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Jyoti Sood (JS)	HEE representative

Attendees:

Tha Han (TH)	Public Health Consultant, LBH
Uzma Haque (UH)	B&D Clinical Lead, NEL CCG
Debbie Harris (DH)	Minute taker, BHR ICP, NEL CCG
Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Nassib Gungoo (NG)	Project Officer, Transformation
Ali Crewe (AC)	BHR Health and Care Academy Director
Sven Bunn (SB)	Life Sciences Programme Director
Masud Khan (MS)	GP Registrar, LBR

Apologies:

Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
John Peters (JP)	Acting Medical Director (Whipps Cross), Barts Health
Mark Ansell (MA)	Director of Public Health, LBH
John Craig (JC)	CEO, Care City
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG
Kate Dempsey (KD)	Social Care representative, LBH
Remi Odejinmi (RO)	Director for Equality, Diversity and Inclusion
Hanorah Rao (HR)	Practice Nurse representative
David Derby (DD)	Havering GP Federation
Ahmed Soliman (AS)	Deputy Medical Director (Quality Improvement and Clinical Outcomes) and Consultant Emergency Physician, BHRUT

1.0		Action
	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 10 February 2022**	
	The minutes of the last meeting were **agreed**.	
1.3	**Matters/actions arising**	
	Action 174: MS asked for this to be added as an agenda item at the April meeting. Action 188: CA advised a meeting has been arranged for Monday 14 March. CA to update at the next meeting.	

2.0	**Life Sciences / BHR Health and Care Academy**	
	SB presented a paper that provides a summary of the work being under taken by the Bart's Life Sciences programme which will seek to address the health needs of the local population, reducing health inequalities and improving outcomes through the use of technology and life sciences. Reference was made to the linking up with Public Health and the NEL Population Health programmes as these are already well-established and this would fit well with that discussion. There was an offer of help with Data science capability and capacity. A concern was raised that, from an ICS point of view, this seems heavily focussed on Inner North east London. Outer North east London have heard of the Life Sciences project but haven't seen any projects in the system or had the opportunity to link in with these yet. It was agreed that this has been geographically focused but that attending today's meeting is part of the first steps to extend and set up links locally with areas to work together on e.g. Skills and training, Digital projects across the whole of the ICS. A request was made for SB to link in with Dr Victoria Tzortziou who is the research lead for the ICS. A question was asked on how involved the Life Sciences project is with all of the different NEL networks. Life Sciences are currently working with two main networks but are open to engage with others. SB referred to slide 4 in the pack that lists the networks they are working closely with. CA advised that NELFT are the leading researchers for Mental Health across NEL and would be keen to work with SB and his team around this. Ali Crewe also joined the meeting and provided members with an overview of the BHR Health and Care Academy and the opportunity to link these pieces of work. AC advised that the Academy has been up and running for two years; the focus is on 'growing our own' workforce, addressing our recruitment and retention challenges, increasing access to careers in health and care, and developing a dashboard of in-depth health and care workforce data so that we have a better understanding of our key challenges and how to address them. To meet the needs of out of hospital care, particularly for Primary Care and Social Care, a short to medium term plan is in place to look at working collectively as a system on AHP workforce needs looking at the supply chain, the volume, the gap and the shortages across the system to create a more meaningful workforce supply chain. BHR is one of the largest under doctored areas, and Life Sciences may be able to help us attract more opportunities into outer London. For many years a tried and tested approach to workforce strategic development has taken place with us all competing for the same workforce so to make this more meaningful we are collectively working on a range of workstreams, AHPs, therapists. MSKs.	**Action:** GX to contact SB outside of the mtg **Action:** SB to contact VT as research lead for the ICS

	The first ever ICS digital dashboard (including health and care data) has been created that gives a total view of the whole system workforce across Health and Social Care. There is a need to work with Primary Care to upload their data to realise the benefits. The approach has been to collectively agree to share data into this single dashboard which will inform our education and training platform and working with our innovation partners. Developing of an approach to apprenticeships, known associates, enablement champions and career ambassadors. We recently placed a successful bid to join the Mayors Academy programme by the Mayor of London which aims to offer 750 new careers entry level roles in Health. SB mentioned that digital skills has been identified as a gap. It was agreed that working at scale is the way forward, working across organisational boundaries with the dashboard providing the evidence place for the system to make these decisions. MS mentioned that she felt Health Education England are thinking differently re education and training on how and what is being commissioned asking if they are linked into this work? It was confirmed that the training hubs are the vehicle to promote this education and training. **Members of the HCC**: Noted the two updates	
3.0	**Transformation boards concept plans:**	
	GX talked members through the attached paper. Public Health Directors meet fortnightly and have discovered that there is more access to data across inner NEL than outer NEL, and there is an ask for data to be available across the patch equally. This will be developed and brought back to the April DPH prevention meeting. The Chair felt, from an HCC perspective, that the data sharing issue should be escalated to the ICPB to support Public Health colleagues in the ambition to get this data sharing issue resolved to ensure equity for BHR. **Members of the HCC**: noted the update	**Action:** Data Sharing issued to be escalated up to ICPB.
4.0	**Effectiveness Survey**	
	The Chair thanked members for taking place in the Effectiveness Survey. The Survey highlighted what has gone well and not so well in the past year. **Members of the HCC:** noted the update	

5.0	**Any other business**	
	MS advised she is moving onto her new role at Barts Health early April. Her replacement was interviewed yesterday with her deputy acting up in the interim. MS will contact relevant members of the group to discuss them taking on the role of Chair until her replacement is in post.	**Action:** MS to contact relevant HCC members to discuss chairing the mtg
6.0	**Date of next meeting – 14 April 2022**	
	14 April 2022 at 1:30pm-3:00pm	

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

BHR Health System Quality and Performance Oversight Group
3 March 2022 by MS Teams

Minutes

Members

Dr Sarah Heyes (SH) - CHAIR	Redbridge Clinical Lead, NEL CCG
Mark Gilbey-Cross (MGC)	Director of Nursing, NEL CCG
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Carol White (CW)	Director of Operations for London, NELFT
Omar Hashmi (OH)	Joint Medical Director, PELC
Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT
Caron Bluestone (CB)	Associate Lay Member for Quality, Performance & Finance, BHR ICP, NEL CCG
Debbie Smith (DS)	Director of Nursing / Patient Experience, NELFT
Dr Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG

Attendees

Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
John Flood (JF)	NEL Provider Performance Director, NELCSU
Ben Conway (BC)	Acting Deputy COO & Director of Performance Analytics, BHRUT
Dr Ramneek Hara (RH)	Deputy Barking & Dagenham Chair, NEL CCG
Hilary Shanahan (HS)	Interim Head of Quality & Clinical Governance, BHR ICP
Ahmed Soliman (AS)	Deputy Medical Director of Quality Improvement and Clinical Outcomes, BHRUT
Melody Williams (MW)	Integrated Care Director B&D and Barnet Integrated Care Director, ARD NELFT
Joseph Lindo (JL)	Integrated Care Director ARD
JoAnne Young (JY for JHa)	Interim Head of Performance
Russell Perera (RP)	PELC, Non-Executive Director
Mark Elverstone (ME)	Performance Manager, NELFT
Debbie Harris (DH)	Governance Team, BHR ICP, NEL CCG (minute taker)
Jennifer Muiru (JM)	Governance Team, BHR ICP, NEL CCG

Apologies

Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Steve Rubery (SR)	Director of Planning and Performance, BHR ICP, NEL CCG
Tracy Rubery (TR)	Director of Transformation, BHR ICP, NEL CCG
Bob Edwards (BE)	Redbridge Integrated Care Director
Dr Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Diane Jones (DJ)	Director of Nursing & Quality, NEL CCG
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT
Pauline Goffin (PG)	Director of Mental Health, Learning Disabilities and Autism
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Sheryl Saunders (ShS)	Head of Governance and Streaming, PELC
Aleksandra Hammerton (AH)	Acting Chief Operating Officer, BHRUT

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.
1.1	**Declaration of conflicts of interest**
	The Chair reminded members of their obligation to declare any interest they may have on issues arising at the meeting which might conflict. None were noted.
1.2	**Minutes of the last meeting**
	The minutes of the BHR Health System Quality and Performance Oversight Group held on 3 February 2022 were duly **noted and approved**.
1.3	**Matters/actions arising**
	The actions log was reviewed and further discussed as follows: 035 – noted that many of the SPA forms have changed with the need to ensure that old forms are taken away to avoid duplication. SH's understanding was that some comm's was to be issued. CW advised that this related to the 0 – 19 forms for Redbridge, she has taken this action in general back through the SPA Steering Group which is a system wide meeting. SH mentioned that her practice learnt today, that the phlebotomy email address had changed but this had not been communicated out to practices. CW agreed to pick up this issue. **Action: CW** 033 – MGC advised that he received a response in relation to this action but there have been some subsequence concerns highlighted, one of these being Discharge, this will be picked up under AOB. Members **noted** the update and agreed to close Action no's – ACT018, ACT022, ACT033, ACT034, ACT036, ACT037, ACT038, ACT039, ACT040
2.0	**Deep Dive – NELFT** CW talked members through the attached presentation and the following issues were raised: • CB asked, in relation to the staffing risk, has there been linkage with the BHR Academy? - CW advised yes there has been. • CB asked if people in crisis turn up at ED are they then diverted to ACAT? - CW replied by advising that if someone arrives at ED and its clear there is a MH issue ED staff will trigger the psychiatric liaison team referral with a response of up to 4 hours maximum. If they then require a physical intervention they may remain in ED but with a support from psychiatric liaison or referred out to the ACAT team and into the MH crisis system. • SH asked how NELFT interact with schools given children are now back at school, schools often know the children better than their GP. MW replied by advising there are a couple of different key areas: In all CAMHS services there are a network of "star workers", these are non-qualified clinical roles. These are the interface between the school cluster arrangements in each area and the CAMHS teams. If a school has a service they commission eg: counselling there is then a network through the "star workers". The CAMHS services have offered out a range of training programmes. During lockdown Hot Clinics were arranged for direct access to schools, SENCO and Child protection leads to be able to discuss and highlight particular children before a formal CAMHS referral. There are also Mental Health Support Teams (MHSTs) with Redbridge's facilitated by the Local Authority not NELFT. Barking and Dagenham and Havering have gone live in January this year. This rollout will allow 60/65% coverage of schools.

No.	Agenda item and minute
	This will not cover all schools so to mitigate these gaps we are looking at the current workforce eg: “Star workers” and how we can transform their roles to interlink with schools that don’t have an MHST. • SH asked if schools can refer directly and not have to go via the GP? MW replied by advising yes this has always been the case, you can self-refer as a parent, carer or a young person. • SH asked if this service also covers private schools along with state schools? MW advised that in terms of MHSTs these are state schools, in the case of a child accessing the CAMHS service it would depend on their area of GP residency. • SH mentioned the criteria of CAMHS stating that some referrals come back advising that the child has not meet the criteria asking for sight of the criteria. MW advised that NELFT work to the Thrive model with the CAMHS team aligning them to the correct pathway. In many cases there is self-help material that parents, carers and the young person’s themselves can utilise but doesn’t need a full clinical pathway team to pick up this referral. In this case there is a brief intervention pathway but this may mean they do not enter formally onto another clinical pathway. Reference was made to the letters that come back to GPs and the lack of information on why the patient didn’t meet the criteria. **Action:** CW to take back the quality of narrative issue of the GP letters • CB asked if patients are able to work with the self-help, having concerns that patients won’t be put onto a formal pathway? MW confirmed this would be part of the clinical pathway with the team arranging follow up calls to ensure engagement, was it beneficial, supportive and where there are now. • AM made the point that he feels PCNs are not utilising the expertise of mental health workers. • SH asked about the interface between adult and children’s services and what is happening to resolve this? CW advised on the current process: - Formalised transition between CAMHS and Adult services begins at 17/17 ½ depending on complex needs, though not every CYP will meet the criteria for Adult services - In the current set up for provision there will always be some cases where a child doesn’t meet the criteria but has ongoing concerns and venerability – this is recognised Nationally. - Previous CQIN between CAMHS and Adult MH services pre Covid. Under the current long-term plan for 18 to 25 there are some interim transition support workers across BHR working with these young people transferring to Adult services. - A piece of co-production work has been commissioned with at scale who are undertaking research to help to inform future commissioning to meet the needs of 18 – 25-year olds. There is also a NEL 16 – 25 group run by ELFT and NELFT working with Local Authorities’ and other sectors to plan review elements of the Looked After Children (LAC). - Funding is in place to develop this service • MGC advised that, with the support of NELFT, colleagues within Children’s Commissioning and Quality & Safeguarding team are looking at a review of the processes, across Redbridge in particular, it is hoped this will be concluded by the end of March. • MGC referred back to the inpatients elements and made these comments: - MGC referred back to the internal mock CQC inspections that are being conducted around the ongoing work and asked for any documentation around the themes and trends to be shared - MGC asked for assurance that Oxehealth has not become a replacement for staff to physically assessing patients as appropriate. JL

No.	Agenda item and minute
	replied by confirming that Oxehealth has not replaced observational Obs, it's a support mechanism. - MGC asked SS to share the Restricted Intervention Law details with him that has recently changed. **Action:** SS to share details of the new Restricted Intervention Law details with MGC • SH mentioned GP training advising she is in favour of Silver Cloud. As GPs we need to promote this service. SH suggested having some time set aside at a PLE teaching event to discuss this further. • SH brought up the issue of Eating Disorders understanding that patients have to be quite severe before they are excepted into the service. SH asked if some teaching related to MH services could be provided so GPs could help NELFT. MW replied by advising that Healthy London Partnerships have recently issued some free training, which is open to Health Professionals, across disciplines co-ordinated by HLP with specific eating disorder modules. MW also mentioned that there is a tender process in place to increase the hospital at home and intensive community support element. CB asked if there is a separate pathway for Children's eating disorder? It was confirmed that its an all age Eating Disorder Service with direct referral in though younger patients will be picked up through the triage stages and moved to EDS if is better than the CAHMS pathway. SH thanked NELFT for their update. CW advised she is happy to take any questions on the data pack and for members to contact her. Members noted the update
3.0	**Assurance**
3.1	**BHRUT Clinical harm process**
	MS talked members through the attached paper and the following issues were raised: • SH asked, in phase one, why was it chosen to look at patients that had already died opposed to those living and still waiting? MS replied by advising if, for example, to identify if of those that had died there wasn't another reason for them dying but their referral related reason these would move to a P2 category immediately. The categorisation of risk of delay was nationally set and locally implemented. MS advised that this process does not negate the normal harm process and would expect incident reporting. • CB referred to the pressure on the system around mental health and choosing to ignore any harm done by these delays and the following impact. MS replied by advising that the data is limited with a need to go back to the ICS, Public Health, Primary Care Leaders to triangulate the data for these patients with other information systems. Members noted the update
3.2	**Broadcare SI** MGC provided members with an update on a serious incident declared by the CCG following issues from the transfer of Health Analytics to Broadcare, an electronic information system used by the Continuing Health Care team. The investigation outlined a number of governance and process issues that related to the procurement of the Broadcare system. Due to personnel changes within the CCG there was no follow up of this SI report being published so MGC will now pull together a related action plan. MGC offered to bring back an update on the action to a future meeting. **Action MGC to bring a further update to a future meeting.**

No.	Agenda item and minute
	Members noted the update
3.3	**Patient death following AZ vaccine SI** MGC updated members on an SI discussed at the last meeting regarding a 26-year-old gentleman from Redbridge who died not long after receiving an Astra Zeneca (AZ) vaccine. The attached report is a compilation of the SI investigations from BHRUT, PELC, Tower Hamlets GP Care Group and London Ambulance Service. It was found that this gentleman's death was untimely as the guidance from NICE, that made the connection between headache symptoms and AZ was published on the day/day after this gentleman died. This case is subject to a coroner's inquest taking place next month. MS provided assurance that BHRUT had promoted this to their clinician's making them aware of the association. MS sought assurance from other partners around the table that this is also the case to which they agree it had. Members noted the update
4.0	**Performance**
4.1	System Performance Report
	JF provided updates by exception on performance against constitutional standards highlighting the following: • Continuing slow growth in the list of patients in elective care • Issue with 104 week wait • 52 week still significant • Recovery in diagnostic performance • Cancer – 2 week standard now met but 62 day still a challenge. 28-day standard has been met for 3 consecutive months • 4 Hour wait in ED remains challenged with some improvement in Ambulance turnovers • Some anomaly in Mental Health figures from NELFT - **Action:** JF to pick up with CW Members noted the update
4.2	**BHRUT Performance Challenges and recovery**
	BC presented the BHRUT integrated performance report highlighting the following: • Since ARC went operational there has been over 2800 hours of LAS time been released back out • FDS wait performance achieved in December though some risk around the breast pathway so looking to secure some IS capacity • Blip in RTT recovery due to staffing issues though plans in place to for the coming months. Members noted the report.
4.3	**NELFT Performance Challenges and Recovery**
	JY presented the NELFT operational performance report and provided the following key points: • CPA review within the last 12 months. Minimal decrease in January though still above the 90%. • Access and Assessments continue at 100%

No.	Agenda item and minute
	• Restrictive Interventions plan in place to manage violence and aggression with a trial on body camera's to be worn on Mental Health wards. • LAC has dropped since April but this can be due to when the paper work is received from the Local Authorities and the updating of Clinical systems. MW advised that Jacqui Himbury has been commissioned to undertake a deep dive around this pathway. SH asked for an update on LAC to come back to a future meeting after the deep dive has taken place. **ACTION**: DH to follow up with JH/JY on a suitable meeting to bring this report back to Members noted the update
4.4	**PELC Performance report**
	OH presented the PELC performance report which forms part of the integrated quality report noting the following: • 64 open incidents as of January with 79 closed in the month • Oct/Dec 1300 audit cases for the 1% quality assurance audit • Minor updates regarding NICE for COVID • 8 new complaints with a total of 56 being investigated, trying to keep on top of the backlog. • 14 risks none of which are high risks. 10 amber and others low risk • 4-hour target at Queens and King George Urgent Care at 96% with an average of 71% of utilisation. Similar no's at Barking and Harold Wood with nearly 98% of utilisation. SH raised the issue of Barking and Queen's UTC's being Red and what is happening with this? OH advised this was from a previous inspection from around 6/9 months ago and we now have no "inadequate" but 3 areas that require improvement. Still awaiting Queen's CQC report to be released which will be combined with a NEL wide CQC review. SH mentioned the Clinical Guardian programme and audit saying what a good idea this is and asked for a more in-depth discussion to come back to a future meeting. **Action: PELC to bring back a more in-depth discussion on the Clinical Guardian programme to a future meeting** The Group **noted** the content of the report.
5.0	**Quality**
5.1	**BHR System Quality and Safeguarding Report**
	MGC provided an overview of quality and safeguarding issues and risks across the BHR system highlighting: • BHRUT no Never Events since the last reporting period • No Regulation 28 (Prevention of Future Deat) Reports • MS stated that the 4-hour target is unacceptable with a focus from the Executive team. Through Jan/Feb running a version of perfect week to facilitate flow through the hospital. As we see a lower no of patients with Covid we are trying to free up some space to get an emergency care service up and running. This will be piloted at Queen's over the coming weeks to see the impact of taking patients away from ED. • MGC asked MW to provide him with a copy of the overarching LAC Improvement programme. **Action:** MW Members noted the update

No.	Agenda item and minute
5.2	**BHRUT Quality report**
	LB presented the group with their Board report to provide assurance on their most up to date Quality and Safety data and highlighted the following: • Continued focus on C.diff's with alert out to GPs – SH interjected that this alert has not gone out to GPs – **Action:** LB to follow up on the status of this alert • Maternity capacity risk was previously at 25, which is the highest it can be, has reduced to 20 after mitigation actions where put in place, this is being monitored by the Division. This will stay under constant review. • Still awaiting a date for ED CQC inspection. CB mentioned that she had given LB's name to the BHR Academy re linking up on Refuge Aid. Members noted the update
5.3	**NELFT Quality Report**
	SS advised anything more to add following the Deep Dive in section 2 Members noted the update
5.4	**PELC Quality Report**
	See 4.4
6.0	**Effectiveness survey**
	SH reminder members that the Effectiveness survey is something we are contractually obliged to do each year to look at what did we do well and not so well. SH felt there were some positive comments with an open dialogue and appreciation of each other's needs. There is still room for improvement, it would be nice to have Barts Health in attendance and as MS is moving to Barts shortly in her new role as Deputy Group Chief Medical Officer, she will add this to her list of jobs once in post. MGC advised, from a quality perspective, that the Quality Directorate has undergone a re structure with a single Quality Directorate for NEL led by Diane Jones as Chief Nurse, this includes Quality and Safeguarding. In MGC's new role he holds responsibility for all of Quality with 2 Associate Director roles for Safeguarding Adults and Safeguarding Children. In additional there is a Director of Quality Development which is Chetan Vyas who will work on the overarching NEL Quality Strategy. There are some continuing discussions on what local governance will look like in relation to this meeting. Initial thoughts are, though still need to be clarified, that each Borough Place Based Partnerships may have their own Quality and Performance forum which will link back through the governance process internally then into Heads of Quality, back through MGC and then to NEL Quality and Safety Committee. AM and SH shared concerns that BHR will be de-qualified going forward. MGC replied by advising that from a quality and safeguarding perspective, which has been align across NEL, BHR now has a Quality Lead for each Place Based Partnership, a Designated Nurse for Safeguarding Adults, a Designated Nurse for Safeguarding Children and Designated Nurse for looked after Children.
7.0	**AOB**
7.1	Clinical safety concerns SH advised that a colleague has identified quite a number of specific events that have been shared re: failed discharges and safety issues. MGC updated members following discussions he had earlier that morning: The first concern was around a Sepsis patient, details regarding the second patient have been forwarded to BHRUT colleagues who are taking through their internal

No.	Agenda item and minute
	investigation process. Further emails have also been received relating to another two inappropriate discharges from one GP in particular. MGC advised that KH has requested for a Task and Finish Group to be set up with appropriate colleagues around the table to look at these issues. MS suggested the conversation also includes an overhaul on GP alerts but not for this to detract from the Discharge issues. MGC advised that some internal discussion have taken place around GP alerts with an options paper being pulled together. A second meeting is taking place on 4 March with a plan to transfer all GP service alerts for NEL into a single NEL GP service process with appropriate staff to manage it effectively. This will be reviewed in the future also looking at a reversed GP service alert. Providers can then send in areas on concern. **Action:** MGC to arrange for someone to present a review of the GP alert service at a future meeting. **Action:** SH made a request to MS that AS is part of the Task and Finish Group given his role in A&E role and Deputy Medical Director role. **Action:** SH asked MGC to email Mary Burtenshaw given their concerns, explain what has been discussed today copy SH in and advise on timelines. SH noted that this was Dr Magda Smith's last meeting, wished her well in her new role and thanked her for her contributions to the QPOG.
8.0	**Items for information**
8.1	Integrated Safeguarding Assurance Board – minutes noted
8.2	BHR IPC Area Prescribing Committee – minutes noted
9.0	**Date of next meeting**
	7 April 2022

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 24th February 2022 – 11.00am – 12.30pm

Via Microsoft Teams

Minutes

Members:

Kash Pandya (KP)	Lay Member, Governance and Audit Chair, NEL CCG
Caron Bluestone (CB)	Lay Member, BHR ICP
Jane West (JW)	Chief Operating Officer, London Borough of Havering
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Rob Adcock (RA)	Deputy Chief Finance Officer, BHR ICP
Michael Gilham (MG)	Director of Finance, BHRUT
Philip Gregory (PG)	Finance Director, London Borough of Barking & Dagenham
Ahmet Koray (AK)	Director of Finance, BHR ICP
Ian Ambrose (IM)	Director of Finance, London Borough of Redbridge

Attendees:

Tracy Rubery (TR)	Director of Transformation, BHR ICP
Pete McDonnell (PMc)	Lead Commissioner for Older People and Frailty, BHR ICP
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP
Belinda Krishek (BK)	Chief Pharmacist, BHR ICP
Sanjay Patel (SP)	Deputy Chief Pharmacist, BHR ICP
Barbara Nicholls (BN)	Director of Adult Social Services, London Borough of Havering
Melanie Porter-Turner (MPT)	Senior Commissioning Manager, BHR ICP
Wajid Qureshi (WQ)	Lead Directorate Pharmacist, BHR, NELFT
Carla Morgan (CM)	Senior programme manager – urgent care and cancer, BHR ICP
Muna Ahmed (MA)	Governance Manager, NEL CCG

Apologies:

Ceri Jacob (CJ)	Managing Director, BHR ICP
Nick Swift (NS)	Chief Finance Officer, BHRUT
Anil Mehta (AM)	GP
Malcolm Young (MY)	Executive Director of Finance, NELFT

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting and apologies were noted. It was noted that any business cases with a value of over £250k will be sent to Ceri Jacob, after the meeting, for approval.
1.1	**Declarations of conflicts of interest**
	The Chair reminded members of their obligation to declare any interests they may have on any issues arising at the meeting which might conflict.

	No additional conflicts of interest were declared.
1.2	**Minutes of the meeting held on 27 January 2022**
	The minutes of the meeting were agreed as an accurate record.
1.3	**Actions log/matters arising**
	ACT013 – MHIS Update - AK confirmed that the LD/Autism is not part of the mental health investment standard. Close.
2.0	**Month 10 Finance Overview Report 21/22 and Operating Plan Update**
	Rob Adcock presented the item. RA reported a similar position to previous months, of a breakeven position. Pressures for BHR are in the independent sector, elective recovery and CHC – high cost packages. The forecast outturn includes the various investments approved by the sub-committee, i.e. MHIS, SDF and the non-recurrent transformation funds. Discussions across NEL CCG and all NHS organisations resulted in potential movements in provider forecast outturns and these were managed in the ICP to enable a breakeven position. This means that the additional elective recovery costs at BHRUT will be funded from the ICP. <u>2022/23 planning update</u> The CCG has received the financial framework and planning guidance. The draft submission of the operating plan is due on 17th March and is a system wide plan (includes provider plans). RA stated that any CCG baseline increases have been negated by a reduction in system wide Covid funds and is therefore a flat cash funding position for 22/23. There is growth in the delegated co-commissioning funds, which is a separate allocation. The contractual agreement regarding co-commissioning is currently unknown. The system has been allocated £66m of Elective Recovery Funding (ERF) to deliver 104% of costed activity, compared to 2019/20. RA is expecting final guidance on ERF for 2022/23. The final submission of the operating plan will be on 28th April 2022. AK commented that 2022/23 will be challenging and that we will need to see the savings from the transformation work. For 2022/23, KP is concerned about the underlying deficit and reliance on non-recurrent funding. RA confirmed that the national allocations have included assumptions on inflation and that we are expecting inflation-related pressures. CB queried whether there is alignment across the system when including the cost of inflation. AK stated that there is some alignment across health because we use a set of business rules. MG stated that they are expecting inflationary pressures, particularly in utilities and large contracts. MG added that BHRUT will keep the inflationary pressures separate from other pressures.

	JW commented that London Borough of Havering (LBH) have included wages inflation in the care home sector, the increase in national insurance and an increase in demand. The Finance Sub-Committee noted the month 10 finance report and Operating Plan Update.
3.0	**Provider Update**
3.1	London Borough of Havering Update (inc. hospital discharges)
	Jane West and Barbara Nicholls presented the item. JW highlighted the financial challenges for Havering. The current overspend projection is £10m and the reserve is £18m. There is pressure in the adult social care budget and children. A lot of growth has been built in for 2022/23 and the council is proposing a 2.99% council tax increase. BN highlighted the overspend for adult social care is £13.5m in 2022/23. For 21/22, the overspend is £5-6m. The council has undertaken modelled of the growth of demographics and transitions from children's services. The modelling for the provider market need was £5.1m and preparation for the liberty protection safeguards was included, which is now delayed. The forecast growth for 22/23 is £20m, driven by post Covid activity, for example, the number of people not known to adult services requiring a care home placement has quadrupled, increased activity across the services and higher-cost care packages. The level of need for existing users has also increased. There are some mitigations to reduce the overspend to £10m. The Cabinet has agreed that the plan needs to go to full council. The mitigation considerations include review of high cost packages and how discharge to assess is funded in 22/23. KP queried whether there are similar issues in Barking & Dagenham and Redbridge. IA confirmed that it is a similar picture in Redbridge, with growth of c.£12m which they are looking to mitigate through various initiatives, such as package reviews. There is also pressure in children's services. BN confirmed the adults budget includes the cost of inflation. CB suggested re-purposing the underspend in the mental health investment standard for children's services, to prevent future costs. AK explained that the MHIS is for mental health related costs and the responsibility for this is with NELFT. There was a discussion about the underspend across the NEL system and re-distributing funds to alleviate pressures in the system and levelling up. AK stated he is looking to provide support to the 3 local authorities and noted that support with discharges also benefits health. AK added that an equalisation project will be undertaken in the future.

	The Finance Sub-Committee noted the update from the London Borough of Havering on Adult Social Care Services.
3.2	BHRUT planning finance update – full year impact and investments
	Michael Gilham presented the item. MG highlighted that there has been a significant cost increase, due to the pandemic. Of the expenditure, £70m is business as usual, inflation and business cases. MG is working with AK and RA on the planning assumption of £35m to support service development, of which £25m will support the non-elective pathway. There is currently a pause on the development of the business cases due to more work required on the pathway, as the impact of the frailty unit has not been established. It was noted that there are opportunities for other sources of funding. The starting financial position for BHRUT will be a deficit of £116m. The internal improvement focus is predominantly on workforce by reducing bank and agency costs by £20m. The Trust is expecting to receive £20m from the elective recovery fund (ERF). The current theatre utilisation is at 60% and the aim is to reach 80%. Challenges are around infection prevention control and aligning workforce for theatres. An investment of £45m has been allocated for improvement work. The overall aim is to return to the deficit in line with 2019/20 figures. Work is still in progress on the affordability. KP queried whether the plans include the transformation work that may come out of the sustainability plan. MG explained that the activity assumes a growth in non-elective activity. CB queried what the plan is to reduce the workforce budget by £20m. CB also asked whether the booking system for theatres is fit for purpose. MG stated that there is a programme for workforce and that they are working collaboratively with Barts and Homerton, as there is an opportunity to reduce the enhanced rates which will be around £6m. Other initiatives include reviewing high earners and converting agency to bank staff and bank staff to substantive staff. MG confirmed that in addition to reviewing the pathway for theatres, the digital support will also be reviewed and updated to support clinicians and optimise utilisation. AA asked whether there is any national funding available for recovery and whether advice and guidance is helping to reduce long waiters. MG stated that the ambition is to reduce the waiting list to a sustainable level, in 2 years. The modelling indicates the Trust needs to do 118% of outpatient activity to reach the target. Approximately 6% is via A&G and is part of the elective recovery programme. MG noted that the Trust receives 9% of the London capital and have 20% of the population. This has been raised and is being taken forward. The Finance Sub-Committee noted the BHRUT planning finance update.

4.0	**Deep Dive**
4.1	Prescribing Deep Dive
	Dr Belinda Krishek and Sanjay Patel presented the paper. BK provided an overview stating that pre-pandemic from 2016/17 to 2019/20 the medicines management team (MMT) efficiency workplan delivered a prescribing saving of £22.16m. Since 2017/18 to date, the MMT is forecast to help BHR deliver a prescribing underspend of £10.84m against budget despite cost pressures from elevated medicines prices from supply issues and increasing volume of prescribing. During the Covid-19 pandemic, the MMT developed workstreams to ensure residents stayed safe. Some of the work included: - Medication reviews in care homes. - Increased electronic prescribing from 77% to over 95%. - Dedicated workforce supported the Covid vaccination programme. - Commissioned end of life support. The team consists of 9 WTE pharmacists, 1 pharmacy technician, 2 administrators and a data analyst. The team works across BHR and has excellent working relationships with GP practices, Clinical Directors, PCNs, NELFT, BHRUT and colleagues across NEL. BK felt the team has clear governance and a successful Area Prescribing Committee and a Medicines Safety and Governance Group. The team is also working closely with TNW and C&H and leading on many areas across NEL. KP commented that he has always been impressed with the work the MMT has carried out, over the years. AA thanked the MMT for all their work during the pandemic and on the Covid vaccinations, as well as maintaining quality of care. AA enquired what the projections for next year will be and whether prescribing is likely to increase in primary care. SP responded to say that in the current year, there will be an underspend. For next year, any savings target and efficiencies will be considered against any growth. For 2022-23, a cost increase of 2.5% is anticipated and will work on what the growth may be and mitigations, such as rebates. The focus is on ensuring the budget is spent correctly to achieve the right outcomes for patients. The finance will be tracked throughout the year. BK informed the Committee about their integration with Barts Health on anti-coagulation. AA advised the finance team to not set a target on savings for the MMT, as AA is expecting an increase in prescribing. CB queried what percentage of the savings are attributed to negotiating cheaper prices for drugs and reducing the volume of prescriptions. CB also enquired what is happening with prescription wastage and what is the biggest challenge for the MMT. Regarding wastage, SP stated that the move towards digital prescribing and increased electronic prescriptions will enable local pharmacists to make any changes quickly and is less burden on GP practices. BK stated that the team has rich data and will be carrying out a deep dive on prescriptions where abnormally high quantities of medicines have been prescribed for patients. BK

	added that drug prices are negotiated nationally and that drug tariff prices are set internationally. Rebates are also received from pharmaceutical companies, as a discount. The price of the drug does not change. SP felt the challenge for the team has been balancing business as usual with the vaccination programme. BK added that going forward, the challenge is the integration work, as we move to a NEL ICS. KP concurred with BK's point and would not like to lose the benefits that the local team has delivered. BK thanked Steve Rubery for his leadership and support. The Finance Sub-Committee noted the deep dive on Prescribing.
5.0	**Business cases for investment**
5.1	BHR Older People and Frailty Transformation plan refresh
	Sharon Morrow presented the item. Older People and Frailty Transformation Board decided to re-set the programme for the next 2 years, in order to learn from the work progressed during Covid. As a system, they would like to develop an approach to manage demand, that prevents escalation of need and supports improvement in outcomes and finances. A proposal was taken to ICEG, to adopt an end to end delivery approach to focus on priority areas that will have the highest impact on the system (health and care). There are 2 phases – 1) analysis and planning and 2) design and implementation. For phase 1, SM is looking to procure external support for analysis and planning, for 14 weeks, and will include stakeholder engagement across the 3 boroughs and staff, gap analysis around internal capabilities and maximise digital opportunities. The request is for £660k for a 14 week project, from the Ageing Well budget. The End to End delivery approach is aligned to other systems who have implemented it, i.e. Essex who have delivered £26m in savings. The supplier will be procured from the framework through a competition process and will look to extend support into phase 2, if required. The risk of not conducting this work is that the costs for this cohort will continue to increase. AK confirmed the funding would come from the Ageing Well SDF funding. AK supports the proposal, subject to a proper procurement process to ensure value for money. CB queried how this work fits in with older people and frailty work being carried out by the transformation board in urgent care and whether this will be an overarching review of everything. CB was concerned about duplication of work. SM confirmed there was a transformation plan for 2 years which has run out and this would will build on that and do more on prevention. The proposal was developed by a task and finish group reporting into the older people's board and consisted of clinicians and senior managers.

	KP felt that £660k is a lot of money and asked SM to draw on good practice from across NEL and share learning. SM stated that they will align with other boroughs in NEL via the NEL Community Based Care Group which is co-ordinating Ageing Well activities across NEL. KP requested an update report in 6-9 months time, to whichever committee is in place then. The Finance Sub-Committee approved £660k from the Ageing Well fund for external support on the BHR Older People and Frailty Transformation plan refresh. **Post meeting update: Ceri Jacob approved the business case via email.**
5.2	Advanced Clinical Practice (ACP) Pharmacist and Nurse in the Community Treatment Team (CTT)
	Pete McDonnell stated that this business case has been brought back following the Sub-Committee's request for assurance that there will be no duplication and overlap of pharmacy roles. Wajid Qureshi highlighted that the ACP CTT pharmacist role is an acute role to carry out a medical review in order to stabilise the patient and may include medicines optimisation. If, any follow on structured medicines review (SMR) is required, the GP will be informed via a letter, who will then arrange the SMR follow up with a PCN pharmacist. Therefore, there is no duplication. The patient will remain with the CTT team if more interventions are required, before the patient is discharged to the GP. WQ noted that PCN clinical pharmacists use risk stratification tools to prioritise which patients will benefit from an SMR. WQ assured the Sub-Committee that they are all working collaboratively, in order to ensure patients do not get admitted into hospital. It is forecast that there will be a reduction in 96 non-elective patients and 672 A&E admissions MP-T stated that this is already being piloted by NELFT. It will be monitored closely and will also reduce frequent flyers to A&E. AA raised concern that there could be a potential for GP workload to increase if a high volume of referrals is made back to the GP, to follow up and take further action. WQ responded that the reduction in A&E admissions will result in reduced workload for GPs. Also, the acute management will stay with the ACP CTT pharmacist and they will not ask GPs to undertake that work. WQ added that they are also working collaboratively with the PCN pharmacists to explore the role and how it will impact them once the patient has been transferred. KP requested an update on the service in 12 months to review the savings and reductions and the impact on GPs and PCN pharmacists. The Finance Sub-Committee approved the request for the Advanced Clinical Practice (ACP) Pharmacist and Nurse in the Community Treatment Team (CTT). **Post meeting update: Ceri Jacob approved the business case via email.**

5.3	Simple Wound care
	Tracy Rubery presented the item. The proposal is to implement an 18 month pilot starting April 2022 for simple wound care, similar to the successful model in phlebotomy. It will be a mixed model with Partnership of East London Cooperatives (PELC), NELFT and Primary Care provision across BHR which will provide a 7 day a week service and provide a reporting system, so that patients can book online and amend appointments. The data can be pulled off the system. TR highlighted current issues in Havering, as wound care flows into the urgent treatment centre (UTC), which is not commissioned to provide wound care. The plan is for NELFT to cover the larger sites and weekends. Primary care will have the option to provide care during the weekdays. On a short term, PELC will set up dedicated clinics to take patients out of the UTCs and book them in, until the community model is established and people are aware of where to refer patients. The funding requested is £290k for 2 financial years. AA supports the proposal and raised care for housebound patients and the frail. TR explained that it will be the same approach as phlebotomy, whereby NELFT will provide a domiciliary service. AK confirmed funding is available. The Finance Sub-Committee approved the business case for the Simple Wound Care service. **Post meeting update: Ceri Jacob approved the business case via email.**
5.4	Discharge Hub
	Kirsty Boettcher presented the item. KB stated that this scheme came out of the Urgent Care Recovery Summit in July 2021. It is a service for patients going to the emergency department (ED) and the consultant may identify that the patient needs a diagnostic which is not urgent. Therefore, the consultant will refer into the discharge hub, for the diagnostic to be arranged and the patient will be discharged from ED. The hub will receive the results of the diagnostic and feedback to the patient and GP. The benefits are reduced admissions, improve 4 hour performance, an improved patient pathway and an improvement in primary care capacity. The service is for ED patients and those on discharge and will help to reduce length of stay. The hub is forecast to take on 10-15 patients a day and this will be monitored closely. The financial request is £404k for 12 months. KB is working through the staffing to reduce it and looking to provide an integrated service, as there are currently 2 services. CB encouraged KB to have the IT in place to support the hub and communications between services. KB stated that BHRUT have improved their IT and there is the integrated record between primary and secondary care.

	AA supported the business case. AA asked KB to ensure the patients are aware that they have been referred to a virtual hub and have the contact details. Also, to ensure letters to GPs explicitly state they are from the virtual hub. AK confirmed funding is in place. KP raised concern about the potential need for additional funding for staffing. KB stated that 2 nurses have been recruited already and will bring back an update to a future meeting. The Finance Sub-Committee approved the business case for the Discharge Hub. **Post meeting update: Ceri Jacob approved the business case.**
5.5	Bridging Service for UCR 2 Hour Response
	Carla Morgan presented the item. CB stated that the service bridges the gap in ED and frailty units between patients identified for discharge and having a care package in place. Staff will be provided by NELFT and will manage, on average, 6 patients a day. Staff required will be at Band 3 and 4 and will provide a 'settle in' service. The investment required is £351k from the Ageing Well budget for a year, as a pilot. The service will be for 6 patients a day, for up to 72 hours. It is forecast that the service will save 6 beds a day. The Finance Sub-Committee approved the Bridging Service. **Post meeting update: Ceri Jacob approved the business case via email.**
5.6	Long Covid 2022/23
	The Finance Sub-Committee noted the Long Covid 2022/23 business case which was approved by the Sub-Committee, outside of the meeting. The Chair asked members to send any questions through to him and MA.
5.7	CHC AQP Prices 2022/23
	The Finance Sub-Committee noted CHC AQP Prices for 2022/23 which were agreed by the NEL F&P Committee on 23rd February 2022. The Chair asked members to send any questions through to him and MA.
6.0	**Key messages for the BHR ICPB and NEL Finance and Performance Committee**
	Key messages will be picked up outside of the meeting.
7.0	**Any other business**
	1. AK informed the Sub-Committee that Jane West is leaving LBH and thanked Jane for all her support and contributions to the Finance Sub-Committee.

8.0	**Items for information only**
8.1	Sub-committee forward plan
	The sub-committee noted the forward plan.
8.2	FSPPDM actions log
	The sub-committee noted the action log.
9.0	**Date of next meeting – Thursday 31st March 2022**

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 31st March 2022 – 11.00am – 12.30pm

Via Microsoft Teams

Minutes

Members:

Kash Pandya (KP)	Lay Member, Governance and Audit Chair, NEL CCG
Caron Bluestone (CB)	Lay Member, BHR ICP
Dave McNamara (DMcN)	Director of Finance (Interim), London Borough of Havering
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Rob Adcock (RA)	Deputy Chief Finance Officer, BHR ICP
Michael Gilham (MG)	Director of Finance, BHRUT
Philip Gregory (PG)	Finance Director, London Borough of Barking & Dagenham
Anil Mehta (AM)	GP

Attendees:

Tracy Rubery (TR)	Director of Transformation, BHR ICP
Julian Buckton (JB)	Programme Manager, PMO, BHR ICP
Pete McDonnell (PMcD)	Lead Commissioner for Older People and Frailty, BHR ICP
Louise Brent (LB)	Programme Manager, BHR ICP
Kirsty Boettcher (KB)	Deputy Director of Transformation, BHR ICP
Muna Ahmed (MA)	Governance Manager (interim), NEL CCG

Apologies:

Ceri Jacob (CJ)	Managing Director, BHR ICP
Nick Swift (NS)	Chief Finance Officer, BHRUT
Malcolm Young (MY)	Executive Director of Finance, NELFT
Ahmet Koray (AK)	Director of Finance, BHR ICP
Ian Ambrose (IM)	Director of Finance, London Borough of Redbridge

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting and apologies were noted. The Chair introduced Dave McNamara, who has replaced Jane West, as the interim Director of Finance at London Borough of Havering (LBH). It was noted that Ceri Jacob and Ahmet Koray have approved the business cases, prior to going on leave.
1.1	**Declarations of conflicts of interest**
	The Chair reminded members of their obligation to declare any interests they may have on any issues arising at the meeting which might conflict.

	No additional conflicts of interest were declared.
1.2	**Minutes of the meeting held on 24 February 2022**
	The minutes of the meeting were agreed as an accurate record.
1.3	**Actions log/matters arising**
	ACT010 - Proposal to Extend BHR's Community Ophthalmology Service (Evolutio) AK requested Jeremy Kidd to provide further analysis on how the pathways compare between independent providers and the NHS and what the differences are. In AK's absence, TR confirmed that JK has provided the information to AK. AK to review the information and decide whether a paper is required for the Sub-Committee.
1.4	**Committee Effectiveness Survey**
	KP presented the paper and stated that the results will inform the development of any new ICP meetings. The Finance Sub-Committee noted the results of the committee effectiveness survey.
2.0	**Month 11 Finance Overview Report 21/22 and Operating Plan Update**
	Rob Adcock presented the report. RA reported a similar position to previous months which is a breakeven position. RA highlighted that the financial position assumes that all the transformation SDF funding will be spent by the end of the financial year. There is continued pressure in CHC from high-cost packages and one to one packages. There will financial pressure in 2022/23. Operating plan The system plan was submitted on 17th March which included the provider positions and the CCG/ICB position for 2022/23. There is a system deficit of £99.5m of which £36.7m is in the CCG/ICB and the remaining is within the provider positions. The deficit is driven by inflation pressures above funding, particularly in acute on utilities and PFI contracts. In the CCG, the deficit is driven by the cost increases in CHC package rates. The BHR ICP position for 2022/23 includes a number of investments, for example, the Integrated Sustainability Plan (ISP) investments and capacity changes in BHRUT within critical care. The CCG plan includes an efficiency target in CHC, prescribing and corporate costs. The position across London is a deficit position. The NEL deficit of £99m is the second smallest deficit in London. The Elective Recovery Fund (ERF) plan is for £66.5m, to drive elective recovery and deliver over 104%, based on 2019/20 activity. The ERF will fund providers and the independent sector contract. The risk around the ERF funding is that NHSE/I will claw back the ERF, if we do not deliver the elective recovery targets. There will be a lot of work to do from now until the final submission. The national team is keen to understand our position, above the funding inflation pressures. The updated plan will be brought to future meetings. MG stated that the BHRUT deficit from the £99m is £12m, of which half is attributed to inflationary pressures and the other half is service developments and ED staffing model. MG felt that at this stage, we do not have a good understanding of the level of risk within

	the plan and the chief finance officers are working on this. BHRUT has set a higher rate of savings of 4-5%, compared to other Trusts, who are around 2-3%. Therefore, the level of risk is higher in BHRUT. CB noted the significant risk in the plan on the inflation assumption of 2.8% and cautioned that we are already seeing inflation at 5% and that the situation is likely to worsen. CB is sceptical that efficiencies can be made in CHC and prescribing, due to growing population and covid. AA queried why we are aiming for 4-5% in efficiencies which is higher than other Trusts and will put added pressure on staff. MG stated the reasons are - 1) Money, as BHRUT needs to stay within levels to pay staff and suppliers. 2) Affordability of rates for staff – currently tackling high earners which is unaffordable and causing inequality, as there is a big disparity between high and low earners. Regarding elective recovery, MG informed all that BHRUT is currently using 60% of capacity in theatres and the aim is to reach 80%. There are opportunities at King George's, which is a high volume, low complexity hub, to drive more activity through it. There are also a number of process issues that are key drivers to increasing the activity, such as pre-operation assessment and scheduling. It will require good process management and some will need digital solutions. DMcN stated that for LBH, the main concern is adult social care and discharges from hospital to care homes. Funding is significantly constrained. For LB Barking and Dagenham, PG stated that the pressure in Barking is in children's services, as B&D have a smaller elderly adult population. KP raised concern about starting a new organisation with a deficit of £99m and noted that half of the deficit is attributable to price rises and inflation. RA relayed that the CFOs will be carrying out deep dive work on the financial pressures. KP noted that a deep dive on hospital discharges is due to come to the Sub-Committee soon and will be useful. The Finance Sub-Committee noted the month 11 finance report and Operating Plan Update.
3.0	**BHR transformation board update - Report on end of year schemes**
	Julian Buckton presented the paper and stated that the paper reflects where we will end in 2021/22, subject to month 2 data in May. JB highlighted: - £13.6m has been invested in Transformational services in 21/22, either as 'new monies' (including Ageing Well and Non-Recurrent funding), or via existing budgeted funds. - The forecast Savings/Reductions in activity total £8.9m. However, this is non-cash releasing due to the current 'block' contract arrangements. - Of the £13.6m investment, some services are not expected to deliver savings, which totalled £4.9m. These include Winter Pressures (UEC Transformation Board £3.1m); Supporting Discharges (Older People and Frailty Transformation Board

	£1m); and nationally mandated Long Covid Support (LTC Transformation Board £0.8m). - The data from January 2022, for Older People and Frailty, the Acute Frailty Service (AFS) indicates that the unit is not seeing as many patients as planned (currently seeing 23%, against a plan of 70%), resulting in a further reduction of c£500k. this is due to issues with flow within the unit, caused by winter and Covid. An audit has been undertaken. JB noted that this service is a pilot and work will be carried out to understand the issues. - Long term conditions – the outturn for the Diabetes programme has been downgraded by c£530k, due to the national suspension of local incentive schemes (LIS), to focus on the Covid response. Only a third of patients received all the Diabetes 8 Care processes. AA flagged that AA and Matthew Henry are conducting a piece of work to identify patients with LTCs who have either not been seen, missed off, or are newly diagnosed. The outcome will be a high number of patients who will need to be seen. There will be a financial risk and it is unknown at this stage, where the funding will sit, i.e. primary care, acute, community or pharmacy. AA added that the work will be carried out in Barking & Dagenham first. TR stated that Jeremy Kidd is linked into the LTC Transformation Board and the work AA mentioned will be picked up via that process. TR added that this report is the year end position and the work AA is doing is noted as a piece of work in progress, for reporting in 2022/23. JB commented that a similar piece of work is being mapped across Havering and Redbridge. KP stated that the transformation plans for 2022/23 will need to be updated. KP noted that the AFS is not delivering and queried whether we need to consider the issues in more detail. SR explained that the AFS is not delivering due to other pressures on beds in BHRUT. SR noted that Covid has impacted progress with the plans and the need to work through delivery of transformation schemes, in the new environment with Covid. TR concurred with SR and added that the transformation team approach will be to continue with plans. The LISs have been impacted by Covid. The transformation team is developing a schedule of reviews, for the schemes, to present at this Sub-Committee. A review has been completed on the AFS and the Trust has agreed to extend the pilot until September 2022. TR will bring the evaluation report to a future meeting and will be added to the forward planner. RA commented that we need to understand the impact of the transformation schemes, across the whole pathway and the impact on providers. Going forward, as an ICB, this will be imperative and will need to be a focus. The Finance Sub-Committee noted the Transformation Board update.
4.0	**Provider Update**
4.1	London Borough of Redbridge Update – deferred to April

5.0	**Deep Dive**
5.1	Better Care Fund Update
	Pete McDonnell presented the item. PMcD provided some background information and informed the Sub-Committee that the Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires CCGs and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006). BCF plans are signed off at Joint Commissioning Boards (JCB) and final sign off at HWBs. The plans are monitored at the JCB, on a regular basis. The 4 main elements to the budget are: - Minimum CCG allocation contribution – for out of hospital services i.e. discharges and reducing admissions and support for carers. - Disabled Facilities Grant (DFG) paid directly to Local Authorities (LAs) - for home adaptations and technologies to support people to live independently at home. - Winter Pressures (WP) - Improved Better Care Fund (iBCF) paid directly to LAs for Social Care Funding – meet social care needs; reducing pressures in the NHS; supporting more people to be discharged from hospital and support the social care provider market. In 2021/22, the focus was on: - Hospital Discharge Planning & Support: Ensuring effective discharge & increasing patient independence - Targeted Out-of-Hospital Care: Supporting people with higher care needs in the community - Community Wellbeing, Care & Support: Prevention & early intervention for low level care & support needs. - Integration, market stabilisation and Covid recovery. Regarding metrics, reporting is on discharge (14 and 21 days length of stay) and re-admissions related to residential care. The CCG's minimum contribution to social care increased by 5.3% since last year (in line with previous years) and can go above it, if needed. The budget is between £30-35m pooled budget, per borough and is monitored at the JCB. The BCF Executive Group, chaired by Sharon Morrow, brings all the commissioners together to review the budget, before it goes to the JCB. PMcD highlighted some of the initiatives funded by the BCF: - Community Health Services. - Locality multi-disciplinary and integrated case management teams across the community, integrated care and mental health. - The Single Point of Access (SPA) that coordinates hospital discharge and the Community Health and Assessment Team (CHAT) of social workers within the local authority that supports discharge and assessment. - Home First discharge process to facilitate same day and next day discharge. - Crisis intervention packages for the first six weeks of an individual leaving hospital. - Carers services.

	PMcD noted that the BCF plans have been signed off by NHSE in January 2022 and the borough HWBs. The Finance Sub-Committee is requested to delegate authority to the Managing Director and Director of Finance, to sign the variation which includes the updated BCF plan and revised finance schedules, on behalf of the CCG. A quarterly BCF update will be provided to the Sub-Committee. KP requested a dashboard on the BCF, to clearly see progress against delivery, for a future meeting. RA confirmed the BCF update is in line with the finance paper. RA also thanked PMcD for all his work on getting the BCF to this point. The Finance Sub-Committee approved the requested to delegate authority to the Managing Director and Director of Finance, to sign the variation, which includes the updated BCF plan and revised finance schedules, on behalf of the CCG.
6.0	**Business cases for investment**
6.1	Ageing Well - Discharge to assess pilot
	Pete McDonnell presented the item. PMcD stated that there are 28 beds, across 3 nursing homes. The business case supports a wrap around therapy team that will go into the 3 homes, to support patients from hospital, on the discharge to assess scheme, for up to 6 weeks. The outcomes include: - 266 discharges per annum - Reduces length of stay by 4 days - Length of stay 5.5 weeks - Over 1,000 bed days saved per annum - 23% patients returned home - 25% reduction in nursing home placements The request is for the Sub-Committee to fund the pilot for £237k in 21/22 (H2) and £475k from April 2022. AA queried whether this will help BHRUT. MG stated that any extra capacity in the hospital is welcome. CB commented that training staff to become enablers is positive for the workforce. CB questioned what the beds were used for previously and raised concern about duplicity of care. PMcD explained that previously, the beds were spot purchased. PMcD clarified that there is no duplicity of care, as the carers would be in the homes and the enabling aspect is that they are linked in with the therapy team and will provide therapy support when the team is not there, i.e. evenings and weekends. DMcN stated that LBH would welcome additional funding, into the system. DMcN queried what contact the therapy team will have with social workers, to agree the care and work in partnership, to ensure better outcomes for patients. PMcD assured the Sub-Committee that the senior therapist will link in with social services, particularly for flow out of the nursing home beds and into their homes without care; home with a care package or residential care.

	CB queried what the support costs are used for. PMcD confirmed that the support costs cover various elements, such as IT, travel, estates, and supports the 2 teams. RA confirmed funding is available from the Ageing Well fund. PMcD also confirmed the staff are already in place. The Finance Sub-Committee approved the funding for the Physiotherapy and Occupational Therapy teams, for the Ageing Well Discharge to Assess pilot.
6.2	Integrated Sustainability Plan (ISP) Domiciliary Care Pilot (Digital)
	Pete McDonnell stated that the business case requests non-recurrent funding of £100k to pilot digital health monitoring of adults with long term conditions (LTCs) and Frailty. Training will be provided to domiciliary care agencies, to train their domiciliary care workers to carry out observations, i.e. take blood pressure readings and report back electronically, to a health professional. The pilot includes: • Project organisation & training • Research organisation • Gadgets and on-line systems • Backfill and extended time payments Of the £100k funding, £30k will be spent on the project and the majority of the funding will go into backfilling and paying for extra carer time. It will be piloted with 2-3 agencies, across the boroughs. AA queried where the information will go. PMcD stated that this will be defined through the project. CB asked whether the information will go on to the patient's record. PMcD confirmed that it will and that there will not be a separate system. The Finance Sub-Committee noted the ISP domiciliary care pilot (Digital), as the business case has already been approved by AK and CJ.
6.3	COPD redesign – exception report
	Louise Brent asked the Sub-Committee to note the increase in cost of the COPD redesign by £20k which has been signed off virtually by AK and CJ. The reason for the increase is because in the business case signed off in October 2021, it was noted that Barking and Dagenham already had 0.5 WTE consultants working in the community and requested funding for an additional 1 WTE consultant to work across Havering and Redbridge. However, the existing WTE was not shown in the financial section of the business case; and the NELFT SLA is for 0.3 WTEs consultant in Barking and Dagenham, although, operationally, BHRUT provide 0.5 WTEs consultants. Therefore, the paper clarifies 0.3 WTEs are within the current funding arrangements and an additional 1.2 WTEs are required in 2022/23. The Finance Sub-Committee noted the increase in cost of £20k for the COPD redesign.

6.4	Heart Failure Pathway Redesign extension
	Louise Brent presented the paper and stated that this paper will supersede the paper approved in October. LB outlined the differences from the previous business case: - Increases the service to out of hours service from 8am to 8pm during the week and 9am to 5pm on weekends. - This increases the cost of the service by £333k. - These changes will allow the service to increase its effect on admission avoidance from 3% to 7% which equates to a reduction of 483 spells in hospital. - The changes will also provide assisted discharges from 1% to 3%. This is a quality business case that will require a total of £803,896 which is a reduction of £41,910 of investment. LB added that NELFT will confirm within the next few weeks, when the service has gone live. AM commented that it makes sense to provide the service at the weekends. CB stated that the business case mentions there will need to be a training budget. CB felt that more focus should be put on this. LB stated that there is an item in Part 2 that will address this point. The Finance Sub-Committee endorsed the Heart Failure Pathway Redesign extension and recommend approval to the Area Committee.
6.5	Physician Response Unit
	Kirsty Boettcher presented the PRU business case. KB highlighted the key points about the business case and service: - The service will cost £410k per annum. - The car will be staffed by a registrar and a paramedic to cover BHR from 8am – 11pm and will aim to see 5 patients a day. - The PRU will see more complex patients and aim to keep at least 3 patients at home. This will save 910 ambulance conveyances a year and potentially 300 avoided admissions a year. - There are already 2 cars running in TNW and patient feedback has been positive. They are able to support complex frail patients and end of life patients at home. - The proposal is to fund the service for 2 years, as a pilot, to align with the work TNW is undertaking with their cars and then carry out a joint review with TNW, at the end of the 2 years. KB clarified that BHR already has a car for a paramedic and the community treatment team (CTT) nurse who respond to falls. The PRU will compliment the falls service. KP raised concerned that one car to cover BHR may not be enough. KB explained that one of the TNW cars already covers some of Redbridge and the CTT links in with them and asks them for support. KB added that 3 registrars will be recruited. The service will attract registrars, who will work half the time in the car and the other half in either Queens or King Georges. The service will start in July 2022. AM asked how GPs will contact the car and queried whether the emergency registrars will be happy to spend half their time in a car. KB confirmed that the registrars have reported that they enjoy spending time with patients and can carry out a full clinical review. The role

	is also linked to the helicopter emergency medical service (HEMS) and as part of their rotation, the registrars will go out in the air ambulance. KB also confirmed that GPs will be able to refer into the service, after the service has been commissioned and the pathway has been developed. MG queried whether this service will be filling a gap in the LAS service. KB stated that it is a joint venture between the London ambulance service (LAS) and Barts. LAS will drive the vehicle. KB noted that paramedics are not qualified to registrar level. RA confirmed this service will be funding by the ISP funding. The Finance Sub-Committee approved the Physician Response Unit business case.
6.6	Community Gastroenterology Service
	Tracy Rubery presented the item. The business case is for a 2 year extension of the community virtual gastroenterology service, from 1st June 2022, in line with the existing contract terms. There is overperformance in activity by 159%, which has led to a 70% increase in the cost of service, compared to the original cost of the contract. There will be an impact on the BHR system and the PTL, if the service is not renewed. The provider is still delivering against the onward pathway and meeting the percentages on patients referred back to GPs with a management plan and patients referred onto acute care. The funding required is £3.5m. There have been some changes to the contract, to include a holding bay for consultant overview of patients who needed to be referred on but could not, due to Covid and a single point of access for endoscopy. CB highlighted that the cost per activity is lower than in the acute setting. TR confirmed this is correct and that the service is value for money. AM added that it is an essential service that works well and supports the business case. The Finance Sub-Committee endorsed the Community Gastroenterology Service and recommend approval to the Area Committee.
7.0	**Key messages for the BHR ICPB and NEL Finance and Performance Committee**
	Key messages will be picked up outside of the meeting.
8.0	**Any other business**
	KP stated that the time of the June meeting will be amended.
9.0	**Items for information only**
9.1	Sub-committee forward plan
	The sub-committee noted the forward plan.
9.2	FSPPDM actions log
	The sub-committee noted the action log.
10.0	**Date of next meeting – Tuesday 24th May 2022, 13:00-14:30**