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

Barking and Dagenham, Havering and Redbridge Integrated Care Partnership Board

31 March 2022

1.00pm – 2.30pm

via Microsoft Teams

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

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	**1:00**	**Chair**	Verbal	Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meeting held on 27 January 2022			Attached	Approve
1.3.	Actions/matters arising			Attached	Note
2.0	**Managing Director's report**	**1:05**	**SR**	Attached	Note
3.0	**Risk Management Policy and Process**	**1:20**	**SR**	Attached	Note
4.0	**Transformation**	**1:40**			
4.1.	Primary care development update		**SS**	Attached	Note
5.0	**BHR ICP performance**	**1:55**			
5.1.	BHR priority actions update		**SR**	Attached	Note
5.2.	Finance report		**SC**	Attached	Note
6.0	**Any other business**	**2:10**	**All**	Verbal	Discuss
7.0	**Items for information**				
7.1.	Confirmation of virtual Area Committee approval: • Urgent Care Response, CTT expansion - business case • Diabetic foot protection - business case • Beam Park - strategic outline business case • Ilford Exchange - strategic outline business case	**2:15**	**Chair**	Verbal	Note

	Item	Time	Lead	Attached/ verbal	Action required
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	**2:20**	**Chair**	Attached	Note
7.3.	ICPB effectiveness survey results	**2:20**	**Chair**	Attached	Note
8.0	**Questions from the public**	**2:25**		Verbal	Discuss
9.0	**Date of next meeting – 26 May 2022**	**2:30**			

Glossary of terms and abbreviations

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

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

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

LTC	Long Term Conditions
MASH	Multiagency Safeguarding Assessment Hub
MD	Managing Director
MLU	Mid-wife Led Unit
MOU	Memorandum of Understanding
MPIG	Minimum Practice Income Guarantee
MSK	Musculoskeletal
MSRB	Maternity Systems Readiness Board
NEL	North East London
NELCA	North East London Commissioning Alliance
NELFT	North East London Foundation Trust
NELHCP	North East London Health and Care Partnership
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
OD	Organisation Development
ONEL	Outer North East London
OOH	Out of hours
OPD	Outpatient department
PALS	Patient Advice and Liaison Service
PCCC	Primary Care Commissioning Committee
PEF	Patient Engagement Forum
PELC	Partnership of East London Cooperatives
PHE	Public Health England
PBP	Place Based Partnership
PMCF	Prime Minister's Challenge Fund
PMO	Project Management Office
PMS	Personal Medical Services
POD	Point of Delivery
PPGs	Patient Participation Groups
PPI	Patient and Public Involvement
PSED	Public Sector Equality Duty

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

NHS
North East London
Clinical Commissioning Group

Name	Position/Relationship with CCG	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
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
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	Maylands Healthcare	GP Partner	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Maylands Healthcare Ltd	Director and shareholder in on-site pharmacy	2013-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Essex Medicare LLP	Part-owner (which owns Westland Clinic, Hornchurch. Space rented out to: · Inhealth (Diagnostics) · Nuffield Health (Brentwood) · Communitas Clinics (Dermatology and gynaecology)	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Havering Health Ltd	Shareholder. GP partner at Maylands Surgery (Dr joti) is a Director	2014-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Parkview Dental Practice	Sister is NHS Dentist within Havering she is an associate and does not own the business	1996-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Westlands Clinic (Langton Dental) who has an outsourced contract with BHRUT for oral surgery)	Spouse is dentist	2018-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking, Dagenham and Havering LMC	Co-opted member	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Havering and Wellbeing Board	Member	2013-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Anglia Ruskin University Medical School	Lecturer	2019-01-01		Declarations to be made at the beginning of meetings

			Non-Financial Personal Interest	NEL CCG	Registered as a patient at a GP practice in NEL.	1990-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica LTD	Prather at Surgery who is director or company - I am a shareholder	2021-10-31		Declarations to be made at the beginning of meetings
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		
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
Jayam Dalal	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		
			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		
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
			Financial Interest	Drs. Sanomi &Olajide Surgery - Rush Green Medical Centre. Romford.RM7 0XR	I am a GP Partner at the above surgery within BHR, part	2000-05-01		

					of NEL CCGs.			
			Financial Interest	Drs. Sanomi &Olajide Surgery - Rush Green Medical Centre. Romford.RM7 0XR	I am a GP Partner at the above surgery within BHR, which is part of NEL CCGs	2000-05-01		
			Non-Financial Professional Interest	BHR ICP	I am the GP Tutor and Education Lead for Havering area, part of BHR ICP /NEL CCGs	2000-05-01		
MAURICE SANOMI	CLINICAL LEAD	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	Practice Based Clinical Services Limited	Director and Shareholder Practice Based Clinical Services Limited – Providers of Community ENT Services. No longer providing services in NEL CCGs area since 2018.	2007-07-01	2018-08-01	
			Financial Interest	Havering Heath Limited GP Federation.	My practice is a Shareholder of Havering Health Limited GP Federation.	2014-08-05		
			Non-Financial Professional Interest	Local Medical Committee (LMC)	I am a member of the LMC	2003-07-01		
			Financial Interest	ROWSANO MEDICAL SERVICES LIMITED	Director and shareholder of the above company - HAS NOT STARTED TRADING Providers of health and care services	2019-10-09		
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
			Financial Interest	Barking, Havering & Redbridge University Hospitals Trust	Chair in common with Barts Health NHS Trust	2021-10-01		
			Financial Interest	Sandwell Children's Trust	Chair	2021-10-01		
			Financial Interest	Jacqui Smith Advisory Limited	Director	2021-10-01		

Rt Hon Jacqui Smith	Member of Integrated Care Partnership Board	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Financial Interest	Dalgety Limited	Non-Executive Director	2021-10-01		
			Financial Interest	Global Partners Governance	Associate	2021-10-01		
			Non-Financial Personal Interest	Jo Cox Foundation	Chair	2021-11-01		
			Non-Financial Professional Interest	Kings Fund	Trustee	2021-10-01		
			Non-Financial Personal Interest	The Precious Trust	Chair	2021-10-01		
			Non-Financial Professional Interest	UCL Partners	Director	2021-10-01		
			Non-Financial Professional Interest	Barts Charity	Trustee	2021-10-01		
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
Stephen Rubery	Director of Planning & Performance	BHR ICP Finance Sub-committee BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indirect Interest		My wife is Director of Transformation within the BHR ICP	2021-07-03		
			Non-Financial Personal Interest	Fullwell Cross Medical Centre	I am registered as a patient with Fullwell Cross Medical Centre	2018-04-01		
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	Non-Financial Professional Interest	Trisett Limited (business support service)	Director	2003-01-01		Declarations to be made at the beginning of meetings

		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	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
Tracy Rubery	Director of Transformation (BHR)	BHR ICP Finance Sub-committee BHR ICP Health and Care Cabinet BHR ICP Quality and Performance Oversight Group (QPOG) BHR Integrated Care Executive Group (ICEG) BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indirect Interest	NEL CCG	Husband is Director of Planning and Performance at the CCG (BHR area)	2021-07-03		No action required as no conflicts declared.
			Non-Financial Personal Interest	Fulwell Cross Medical Centre	Registered as a patient with Fulwell Cross Medical Centre	2018-04-01		

- Nil Interests Declared as of 24/03/2022

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)	Indicated No Conflicts To Declare.

		NEL CCG Quality Committee	
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.
Joe Fielder	BHR ICPB member	BHR Integrated Care Partnership Board (ICPB)/ Area Committee	Indicated No Conflicts To Declare.

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

Draft minutes – BHR Integrated Care Partnership Board

27 January 2022

1.00pm – 3.00pm
Via MS Teams

Members:

Cllr Maureen Worby (MW)	ICPB **Chair** (LB BD)
Kash Pandya (KP)	Lay Member, Governance & Area Committee Chair, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP, 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
Jacqui Van Rossum (JVR)	Acting CEO, NELFT
Andrew Blake-Herbert (ABH)	Chief Executive, LB Havering
Dr Jagan John (JJ)	NEL CCG Chair and B&D Clinical Chair
Dr Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Dr Anil Mehta (AMe)	Redbridge Clinical Chair, NEL CCG
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
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT

Attendees:

Caron Bluestone (CB)	Associate Lay Member, BHR ICP
Jayam Dalal (JD)	Associate Lay Member, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Keeley Chaplin (KC)	Governance Officer, NEL CCG
Emily Plane (EP)	Programme Lead, BHR ICP
Dr Caroline Allum (CA)	Executive Medical Director, NELFT
Kenye Karemo (KK)	For Kathryn Halford, Director of Education, BHRUT
Nassib Gungoo (NG)	Project Officer, NEL CCG

Apologies:

Magda Smith (MSm)	Chief Medical Officer, BHRUT
Adrian Loades (ALo)	Corporate Director of People, LB Redbridge
Claire Symmonds (CS)	Acting CEO, LB BD
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Cllr Mark Santos (MS)	LB Redbridge
Dr Rami Hara (RH)	Deputy B&D Clinical Chair, NEL CCG
Henry Black (HB)	Acting Accountable Officer, NEL CCG
Cllr Jason Frost (JFr)	LB Havering

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

		Action
1.1	**Declarations of conflicts of interest**	
	The chair reminded everyone of their obligation to declare any interest they may have on any issues arising at the meeting. No additional conflicts of interest were declared. The register of interests was noted.	
1.2	**Minutes of the last meeting**	
	The notes of the meeting held on 25 November 2021 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**	
	CJ presented the progress report which covered the following areas: • Implications of the latest Planning Guidance and revised target date of 1 July 2022 for the new arrangements to take effect and ICBs to be legally and operationally established. • BHR vision for collaboration at a multi place based level • Clinical and Care Leadership model development for NEL • Ongoing development of our BHR Place Based Partnerships In addition, CJ highlighted further changes to the NEL Commissioning Support Unit (NEL CSU) and that the consultation with remaining CSU staff will be initiated shortly and members will be kept updated on progress. Place based partnerships continue to progress, with supporting development sessions bringing all partners together to focus on shaping key areas of development such as the finance strategy, delegation and provider collaboratives. JF asked if workforce planning will factor in data from the Academy and if it will look at the high priority vacancies initially. CJ advised that item 4 will provide more information on the Academy work but confirmed there is a strong focus currently on addressing recruitment and retention issues around therapists, of which there is a shortage across the health and care system, and what can be offered to encourage uptake such as apprenticeships and rotation work. Members of the ICPB: • Noted progress to develop our BHR Place Based Partnership and ongoing multi borough collaboration.	
3.0	**BHR Integrated Care Partnership Risk Management**	
	SR presented the risk update and advised that the current key NEL CCG level risks relate to: • Underperformance against H2 metrics, specifically elective recovery • Continuing Healthcare • Use of resources and financial balance • Health inequalities • Vaccine delivery – workforce challenges	

		Action
	The current key risks within BHR ICP relate to: • Supporting children with learning difficulties and mental health needs, access to services and discharge from inpatient beds • Appropriate digital infrastructure • Financial balance across the BHR system, including the Local Authorities • Workforce, including adult social care provider workforce • Risk of future waves of COVID-19 • Backlog of elective activity • Health inequalities The NEL governing body has been presented with its assurance framework and detailed assurance work is to be undertaken on risks. CB asked how the mandatory vaccination of staff programme is progressing. In BHRUT there are approximately 750 unvaccinated staff with the principle area of concern being in maternity. In NELFT there are approximately 700 unvaccinated staff currently with IAPT being the main area of concern. There are also risks in primary care, in particular in under doctored areas as well as expectations on primary care to sign exemption forms. JF requested more time at the next meeting to look at the risks in more detail to take a collective view on the biggest risks and mitigations that can be put in place. SR will review this with colleagues in readiness for the next meeting. Members of the ICPB: • Noted the current risks to the BHR ICP and the key risks to the NEL CCG Governing Body.	SR
4.0	**Integrated Care System Development**	
4.1	**Final proposal - Developing our Barking and Dagenham, Havering and Redbridge Partnership within the North East London Integrated Care System context**	
	CJ presented the proposal for ongoing multi borough collaboration which has been developed in partnership across health and care. The proposal brings together all the discussions that have taken place including with Place Based Partnerships. Through the 'collaboration' interviews and discussion with Partners, it has been agreed that 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 This approach will be reviewed on a six monthly basis.	

		Action
	The BHR Health and Care Cabinet will continue until the NEL Senate has been re-established, and the System Operational Command Group will continue to manage system pressures collectively across health providers and local authorities. The ICPB will no longer be a delegated function from July 2022 and the proposed governance to support continued collaboration will see the Integrated Care Executive Group (ICEG) evolving into a committee in common meeting to ensure delivery and to unblock key areas for the Place Based Partnerships. BHR Health and Wellbeing chairs and health provider chairs to discuss further the ICPB role for outer NEL. CB asked if organisations in other parts of the country that are further ahead in the process than NEL have shared their learning? CJ confirmed that there is national sharing of learning, information and principles as organisations progress. MW added that there has been a lot of dialogue at a London level and acknowledged the different approaches being taken across the five structures and where they can align. JD asked where patient and public engagement will sit in the new world. CJ advised this is an opportunity at borough level to join up with practice patient engagement groups, local authority public engagement groups as well as with the voluntary sector and will sit at both borough level and NEL level but they can also work collectively with other boroughs where helpful. MW noted there is a gap in the system at present for public representation and there is also a need to review what the Non-Executive Director roles will look like. *JVR joined* JF noted the organisational structure is currently clinically led however the new structure may impact this initially and suggested that a shadow ICPB remains until there is more clarity and greater representation of clinical leaders in the new structure. CJ clarified that the ICPB cannot exist in these new governance arrangements but suggested a meeting with the local councillors and provider organisations is held to discuss this further. MW suggested that members of the ICPB continue to meet twice yearly on an informal basis which members agreed would be useful. JJ updated members on the work that is taking place on the clinical and care structure and how to support people into these roles and strengthening the development of the partnerships. JJ added that the best work has come from working together in partnership for the local population to make a positive difference. *CJ left the meeting* MW considered that there is still a long way to go in some areas such as contracts across three boroughs that will potentially need to be disaggregated before the borough partnerships can start to make their own decisions from July. MT advised disaggregating contracts into a borough by borough contract is not always optimal; the current approach ensures economies of scale across more than one borough, along with ensuring that local people, regardless of location, can access services. JJ agreed that these discussions need to be held but contracts will all be held by NEL as	CJ

		Action
	the statutory body. JJ noted that the foundation will need to be built first and priorities made clear, before contract conversations can commence. SC brought members attention to the report which identifies which transformation boards are likely to work at borough or NEL level and that a further discussion could be held to look at what the end of year 1 would look like as it is not likely that everything will be able to change immediately from July. Members agreed that there would be value in meeting as a group, six monthly, to form a transition oversight function. Members of the ICPB: • Noted the proposal for ongoing collaboration in BHR, including consideration of how partner organisations will seek to align resources to the BHR collaboration and BHR Place Based Partnership elements of the system • Noted the further work to be undertaken to define how the areas of multi-borough collaboration will be overseen by the BHR Integrated Care Executive Group and what the terms of reference for this group could look like post July 2022.	
5.0	**Transformation**	
5.1	**BHR Health & Care Academy 2022/23 and beyond**	
	KH presented the proposal for an enhanced delivery team for the Barking, Havering, and Redbridge (BHR) Health and Care Academy. The essence of the proposed delivery team is to optimise the continued delivery of BHR Academy's ambitions and address the new and emerging organisational obligations and expectations of local people and staff. An understanding on what should delivered in BHR has been developed and what the workforce looks like across health and social care and there has been increased engagement with local stakeholders. To date the Academy has been funded on a pump-prime basis but to maximise the benefits we need a more sustainable approach to funding. KH has been the SRO but to take on a broader vision it is proposed to have a group of leads representing health and social care to take this forward as detailed in the structure within the report. Members supported the proposal and agreed there is great value and opportunities in having the Academy in BHR which benefits staff and the local population and supports integrated care. Members of the ICPB: • Noted the content • **Endorsed** the recommended new team as proposed in the report	

		Action
6.0	**BHR ICP Performance**	
6.1	**BHR priority actions progress update**	
	SR presented the update on the agreed four key priorities for the BHR ICP; recovering well; addressing inequalities and prevention; Anchor Organisations; Leadership, Culture, and Leading Change. The report included a 'plan on a page' for each of these areas and the progress made was noted. It was also noted that a deep dive on anchor organisations was held at ICEG meeting. Members of the ICPB • Noted the progress update.	
6.2	**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. The CCG and ICP plans are part of the NEL system plan which has been set to break-even. At month 9 (period to end of December 2021), BHR ICP and each of the ICPs in NEL CCG have reported a break-even position across core budgets. To meet pressures the use of non-recurrent mitigation funding of £7.5m and accessing Covid contingency funds has been required. Managing pressures through core providers and there is an increase in CHC in the last month that is being monitored. MW noted concern for 2022-23 particularly addressing the impact of the pandemic on local people. SC advised that prioritisation into cost has yet to be undertaken but there may be a need to continue with schemes such as the discharge hub. There is more work on Advice and Guidance as well as continued work with the independent sector to share the elective load but this will remain a challenge. There is likely to be a 6% growth into primary care and a £58m fund for transformation. There is a need to focus on local areas that will make a big difference and to find the funding for these. AA added there are patients that are not yet diagnosed that will add to the cost and is working with public health to identify potential numbers which can then have potential costs attributed to it. MT added that BHRUT have undertaken some work to monitor any potential increase in patients attending ED that are on the long waiting list and cancer referrals. MW noted that the Joint Strategic Needs Assessments (JSNAs) in BHR are useful to feed data into system discussions which is a useful tool for Finance to identify where funding should be allocated. Members of the ICPB • Noted the content of the report.	
7.0	**Any other business**	
	No additional items were raised.	

		Action
8.0	**Items for information**	
8.1	**BHR Area Committee approvals**	
	ICPB members were advised that the following items received Area Committee approval during December 2021 and January 2022: • Ageing Well' overarching business case • Dementia pathway – Havering business case • Expansion of the BHR community falls service business case • Voids and Nominations agreement	
8.2	**Minutes of relevant fora:**	
	The minutes of the following meetings were noted: • Integrated Care Executive Group – November 2021 • Health & Care Cabinet – November 2021 • Quality & Performance Oversight Group – November 2021 • Integrated Safeguarding Assurance Board – November 2021	
9.0	**Questions from the public**	
	None raised	
	Date of next meeting – 31 March 2022	

Integrated Care Partnership Board – open actions

Action ref:	Meeting date	Action required	Lead	Required by	Status
2.0 Managing director's report	**29 Nov 2021**	Community Links - SR and TR to ensure 'Community Links' are provided with the most appropriate contacts across BHR to ensure they liaise with the sectors already in place in BHR.	SR/TR	Jan 2022	Catch 22 (previously Community links) have been asked for an update on their mobilisation and recruitment plan, including details around any particular organisations that they have been in touch with across BHR. **Update**: Catch 22 have recruited a project manager and they are going to utilise their current workforce to deliver the engagement events. We have agreed that they could use the CRUK leaflets and bespoke leaflets for some of the targeted communities. Catch 22 are also going to do a mapping exercise of the communities and organisations to engage. The minute taker can forward suggested organisations onto the relevant officer
3.0 BHR Integrated Care Partnership Risk Management	**29 Nov 2021**	Narrative relating to financial balance and resources/ workforce to be more explicit so that the risk register fully reflects the financial pressures and workforce pressures in Local Authorities as well as health.	SR/PD	March 2022 **Request to close**	Full review of risk register completed and will be presented to March ICPB meeting. **Completed**
6.1 BHR Transformation Boards 21/22 – key progress and achievements to date	**29 Nov 2021**	The report to be presented to the Overview & Scrutiny Committees.	TR	Dec 2021 **Request to close**	Presented to Redbridge OSC 11 Jan 2022. B&D OSC scheduled for February 2022. Presented to Havering OSC 16/03/22. **Completed**

Action ref:	Meeting date	Action required	Lead	Required by	Status
6.2 BHR community phlebotomy update	**29 Nov 2021**	JK to follow up on a request made by RH for the survey results to be broken down by age groups and provider groups.	JK	Dec 2021	Being actioned as part of 6 month review to determine what is possible in terms of breaking down the data.
3.0 BHR Integrated Care Partnership Risk Management	**27 Jan 2022**	More time allocated at March meeting to review risks in more detail to take a collective view on the biggest risks and mitigations that can be put in place. SR will review this with colleagues in readiness for the next meeting.	SR	Mar 2022 **Request to close**	Full review of risk register completed and will be presented to March ICPB meeting. **Completed**
4.0 ICS Development	**27 Jan 2022**	CJ clarified that the ICPB will not exist under new governance arrangement but suggested a meeting with the local councillors and provider organisations is held to discuss this further.	CJ	Mar 2022 **Request to close**	HWBB Chairs and the Trust Chairs have agreed they will continue to meet informally once or twice a year as needed. **Completed**

BHR Integrated Care Partnership Board

31 March 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	Steve Rubery Director of Planning and Performance
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: - Key points from the recent White Paper - Health and social care integration: joining up care for people, places and populations, published February 2022 - Our BHR vision for the arrangements to support collaboration at a Multi Place Based level (proposed continuation of the BHR ICEG meeting, with revised terms of reference) - Update on progress to progress the Transformation Cycle within NEL ICS work; 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 anticipated new Health and Social Care Bill, alongside the more recent (February 2022) White Paper on integration reinforce our approach to support the ongoing establishment and development of Borough Partnerships, alongside our multiborough partnership collaboration approach in Barking and Dagenham, Havering and Redbridge.

1.2 2021/22 is a key transition year and it is essential that as a Partnership we collectively consider the options for delegation and which option we believe would work best for us; support development of our Place Based Partnerships and thinking around what functions they would like to take on in the coming years; continue to take forward work on our key enabling programmes such as establishment of the BHR Health and Care Academy, ongoing development of the BHR Integrated Sustainability Plan and digital and estates programmes, and develop our proposed clinical and care leadership model (which will operate in partnership with the North East London Clinical and Care Leadership Model and emerging Provider Collaboratives and Clinical Networks).

Progress update – key areas

<table>
<tr><th colspan="2">Progress update since the last ICPB meeting on key partnership initiatives</th></tr>
<tr><td>White Paper; Health and social care integration, Feb 2022</td><td>
The integration white paper sets out the Government's ambitions and plans to ensure greater integration between NHS and social care services. Children's social care is not within scope of the white paper, although it does encourage place-level organisations to consider how these could be integrated (the Independent Review of Children's Social Care is reviewing this in more detail).

The white paper is divided into four key areas, with the key points set out below:
<table>
<tr><th>Area</th><th>Key points</th></tr>
<tr><td>Shared outcomes</td><td>
▪ There are a range of existing oversight frameworks across public health, NHS, adult social care and local authorities more broadly. There are also the NHS Long Term Plan and Mandate commitments.
▪ The Government will revisit how outcomes are articulated and priorities are set. There will be greater alignment. A new approach to shared outcomes will be published. This will set out national priorities and a broader framework for prioritisation locally that will be implemented from April 2023.
▪ The design principles for the Shared Outcomes Framework will focus on place-level outcomes. Local shared outcomes will be agreed by partners across a system and with citizens. An approach for agreeing these local shared outcomes will be part of the framework.
▪ The shared outcomes will sit alongside/complement existing statutory responsibilities and wider regulatory frameworks.
▪ Initially, the outcomes will focus on health services, public health and adult social care. The plans for how organisations will meet these outcomes will need to be in place for April 2023.
</td></tr>
</table>
</td></tr>
</table>

	Leadership, accountability and finance.	**Leadership** ▪ The Government will develop a national leadership programme focused on effective system transformation and local partnerships, subject to the recommendations from the Health and Social Care Leadership Review which is to be published in early 2022. A delivery plan will be developed following the completion of the review. **Accountability** ▪ By April 2023, place-level will have a model of accountability agreed and in operation. Alongside this a governance model will be adopted, which needs to have the following characteristics: o A clear, shared resource plan across partner organisations for delivery of services. o Develop a track record of delivery against agreed and shared outcomes. o Significant and growing proportion of health and care activity/spend will be overseen and funded through the place-based arrangement. ▪ The governance model will clarify decision-making, including: how contentious issues will be resolved; arrangements for managing risk and resolving disagreements; and agreeing local outcomes. ▪ A clearly identified person will be accountable for delivering the outcomes in the Shared Outcome Framework. They will be working to ensure agreement between partners and provide clarity over decision-making. ICBs and LA will need to agree or appoint this individual. ▪ It is expected that the place-level arrangements will develop ambitious plans for the services and spend to be overseen by the place-board. ▪ Making use of existing structures (HWBs and BCF) is advised as a starting point. Design of these arrangements should build on the joint LGA and NHS England guidance 'Thriving Places' (published September 2021). **Finance** ▪ The Government are planning to review section 75 of the NHS Act 2006 (NHS bodies and councils can use this to pool and align budgets) with a view to simplifying and updating the underlying regulations. ▪ Pooling requirements more formal arrangements whereas alignment is less formal. Pooling budgets will remain subject to NHS and LA leadership and agreement of what constitutes a fair and appropriate contribution to the services. ▪ These arrangements will be added to by the health and care bill, which includes options such as joint committees (which have the option of pooling funds). ▪ A policy framework for the Better Care Fund from April 2023 will be published which will include how the programme will support the new approach to integration at place-level.

		▪ The white paper reaffirms the commitment to personal health budgets, personal budgets and integrated personal budgets.
	Digital and data.	▪ By 2024, each ICS will have a single health and adult social care record for their population. There is a statutory duty in the health and care bill for organisations to share anonymous data. ▪ Individuals will have access to their own shared care record - it will cover their health and care records. Where appropriate, staff will have full access to the shared care record. ▪ ICSs will implement a population health platform that will have care coordination functionality. This will use joined-up data to support planning, population health management and plan public health interventions. Due by 2025. ▪ ICSs will be supported to develop digital maturity across health and social care (many providers are still reliant on paper records). This will include ensuring organisations have digital capabilities and access to the shared care record by 2024. ▪ A final version of the strategy 'Data Saves Lives' will be published in 2022. This will set out the vision for data transfers across health and social care, ensuring transparency and giving access to high quality, timely data. ▪ The NHS number will be used universally across health and social care. Social care providers will be supported to implement digital social care records and connect to the shared care record. ▪ Standards will be developed for adult social care to enable NHS and Social Care providers to share information. ▪ Mandatory reporting against the shared outcomes at place-level will be developed.
	▪ **Workforce**	There are a large number of commitments relating to workforce within the paper which include: ▪ The Government will review regulatory requirements that prevent flexible deployment of staff across health and social care. ▪ Adult social care professions will now be included in the work of HEE looking at longer-term workforce trends and strategies (15-year forward view on workforce). ▪ The health and care bill proposes a report that will set out the roles and responsibilities of bodies in relation to workforce planning. This will be called the workforce accountability report and will focus on primary, secondary, public health and community NHS services; but also, shared workforces between NHS and social care. ▪ The white paper sets out that the Government will develop opportunities for training and opportunities that span both health and social care sectors, and promote careers across the two. Further proposals include: o Testing joint roles in health and social care. o Considering the introduction of an Integrated Skills Passport to allow staff to transfer skills and knowledge between the NHS, public health and social

	care (a similar scheme is currently being developed by NHSE and DHSC for health staff). o More learning experiences in social care for health staff (for example, including social care placements in the undergraduate training for health staff). o Developing a national framework of appropriate clinical interventions that can be undertaken in care settings. ▪ Finally, the White Paper stresses the need for place-level arrangements to build a culture that supports integrated service delivery, sets a shared vision, develops a common language that covers the whole workforce and engenders a culture of partnership. As its heart, whilst the white paper recognises the importance of systems (ICS), it sets out that place-level integration and collaboration is the key to resolving many issues and facilitating the improvements sought.
Our BHR vision for the arrangements to support collaboration at a Multi Place Based level	Through the 'collaboration' interviews and discussion with Partners, it has been agreed that 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 ▪ This will be reviewed on a six monthly basis ▪ Work will continue on the Primary Care transformation agenda across each borough ▪ The BHR Mental Health Transformation Board will be led from a NEL level, and Providers across BHR and wider (including collaboration with Waltham Forest) will be taken forward by the Mental Health Provider Collaborative. ▪ The Planned Care Transformation Board will be folded into the NEL Planned Care Board with local transformation delivery led and coordinated by the BHR Delivery Group. ▪ For Cancer transformation the BHR group will remain, linking in the NEL Board ▪ BHR Health and Care Academy, noting that NEL colleagues are keen to learn from and roll out this integrated model more widely than BHR ▪ The Health and Care Cabinet will continue until the NEL Clinical Senate is fully re-established ▪ The System Operational Command Group will continue to manage system pressures collectively across health providers and the LAs for as long as partners find it helpful with frequency to be agreed by the members ▪ Redbridge PBP will continue to work with WF PBP on the Whipps Cross Development ▪ B&D PBP will continue to work with Newham PBP on planning for population growth ▪ 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. As the February ICEG meeting, proposed Terms of Reference were endorsed for the group post July, and are being shared with the Barking and Dagenham, Havering and Redbridge Place Based Partnerships over the next several weeks for final review and endorsement.

Update on progress to progress the Transformation Cycle 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 anticipated 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 are taking 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. Next steps include: ▪ Drafting a first iteration of the output paper based on workshop inputs and wider feedback ▪ This output paper will form the basis for workshop 3 (in April) where it will be sent to participants in good time to review ahead of the session ▪ Workshop 3 will also provide some examples of the how the output paper will feed into the text for documents such as terms of reference and Standard and Standing Financial Instructions.
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. Individual, more detailed letters will go out shortly which will include further information on the extension of current Clinical Lead roles, and will set out the end dates for roles. - There are some roles which will be standard across the seven Place Based Partnerships which include: o System Place Based Leads x 7 (one for each Place Based Partnership) o Primary Care Development Leads x 7 (one for each Place Based Partnership) - Draft job descriptions for the System Place Based Lead, and the Primary Care Development Lead, alongside a more generic job description for the other clinical and care roles are being developed and will be shared with partners shortly. - It is intended that the System Place Based Lead and Primary Care Development Lead roles will be recruited to in April, with the intention that these will be in post by March 2022. Place Based Partnership members will be key members of the interview panels for the roles relating to their respective boroughs.

	- Executive team appointments will take place in February 2022, including the ICB Chief Medical Officer and Chief Nurse posts. - The NEL finance team are working on outlining the budgets for clinical and care leadership for each PBP, and will share this shortly - Each Place Based Partnership is being asked to consider and set out a proposal for clinical and care leadership by the end of March 2022 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 is in the process of articulating their clinical and care leadership model
Ongoing development of our BHR Place Based Partnerships	- Our BHR Place Based Partnerships continue to develop and progress. - The Havering Place Based Partnership have recruited an interim Place Based Partnership Development Director, Luke Burton, who has now taken up post (from 1 March 2022) - BHR Place Based Partnership development sessions continue, with the next planned for Monday 21 March 2022. The agenda will include: o Provider Collaboratives and links to PBPs - Selina Douglas/Ceri Jacob/Ann Hepworth o Outputs from the Transformation Cycle work and the expected functions at a PbP level – Ceri Jacob/Chris Cotton o PbP updates – focus on approach and progress to develop clinical and care leadership model – each BHR PbP - 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. - Discussion is underway regarding the future of the BHR Joint Commissioning Board, and the potential benefits of continuing this post July 2022. A proposal is being developed for the future of this group with partners and will be shared with ICEG and ICPB members at their next meetings. - Chetan Vyas, Director of Quality and Safety is progressing discussion with Place Based Partnerships regarding the future model for Quality at both a PbP and NEL level post July 2022.

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 2021/22 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the 'integration and innovation' White Paper from 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
March 2022

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

BHR Integrated Care Partnership Board

31 March 2022

Title of report	Risk Management Policy and Process
Author	Anne-Marie Keliris, Head of Governance
Presented by	Steve Rubery Director of Planning and Performance
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	At its last meeting in March the NEL CCG governing body received an update on the Governing Body Assurance Framework (GBAF) which had been updated following discussion with the senior management team (SMT). The current key risks relate to: • Underperformance against H2 metrics, specifically elective recovery • Continuing healthcare • Use of resources and finance balance • Vaccine delivery (workforce) • Health inequalities A recent internal audit on governance and risk management recommended that the current risk management policy should be reviewed to strengthen the policy and process to ensure it is fit for transition to the Integrated Care Board in July 2022. The review recommended that the current ICP risk registers were reviewed as there was significant duplication across each of the ICPs. It also recommended that ICP risk registers be removed from the process to support the triangulation of all risks both at a local and NEL level.

	A review has been undertaken of all current risk registers at a NEL and ICP level to produce a new corporate risk register (CRR). Directors and SROs 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. The governance team are developing an operating procedure to support directorates managing risk.
Action required	The ICPB is asked to: • Note the revised risk management policy and process.
Where else has this paper been discussed?	Discussion with individual Directors and SROs.
Next steps/ onward reporting	Regular reports to NEL CCG governing body and ICP area committees/ICPBs.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Through effective management of risks to delivery of the CCG's objectives which focus on improving patient experience, quality of care, recovery post pandemic, preparations for potential further waves and our transition to an ICS.
Conflicts of interest	None identified.
Strategic fit	Implementing the risk strategy and policy for NEL CCG should support achievement of the CCG's corporate objectives through managing risks to delivery.
Impact on finance, performance and quality	Relates to achievement of our corporate objectives on these matters.
Risks	This report relates specifically to risk. The key risk in relation to this process is ensuring that we retain high levels of delegation but ensure a joined-up approach to ensure proper management and oversight of risk both locally and NEL wide
Equality impact	N/A
Attachment(s)	NEL CCG risk management policy

North East London
Clinical Commissioning Group

North East London Clinical Commissioning Group

Corporate Risk Management Policy

Policy title:	**Corporate Risk Management**
Description	This Policy sets out the CCG's detailed risk management arrangements and the process by which risks are managed.
Supersedes:	All previous policies of the same name or similar name held by: Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (NEL CCG), Newham CCG, Tower Hamlets CCG, Waltham Forest CCG (WEL CCGs) and City & Hackney CCG.
This policy will impact on:	All staff, governing body/committee members, sub-committee members, and anyone including GP members working closely with the CCG assisting it in carrying out its role.
Financial implications:	None identified
Policy area:	Governance
Version No:	V 2.0
Issued by:	Corporate Affairs
Author:	Corporate Affairs
Document reference:	
Effective date: (issued)	1 April 2022
Review date:	1 April 2024
Impact assessment date:	May 2021

APPROVAL RECORD	
Committees/Group/Individual	Date
North East London CCG Governing Body	May 2021
North East London CCG Audit and Risk Committee	March 2022

Contents

North East London Clinical Commissioning Group
Corporate Risk Management Policy

A. INTRODUCTION

A1. Introduction

This document sets out the Corporate Risk Management Policy of North East London Clinical Commissioning Group (CCG). It provides guidance on the policy, processes and procedures for risk management and supports the Risk Management Strategy.

A2. Equalities

This policy has been created and written in accordance with the provisions of the Equality Act 2010 (EA 2010). In addition, it supports the achievement of the aims of the EA 2010 and the Public Sector Equality Duty contained therein.

A3. Fraud and Bribery

This policy helps to reduce the risk of fraud and bribery by providing a robust system of internal control for risk management. This policy supports and compliments the CCG's Counter Fraud, Bribery and Corruption Policy and has been reviewed by the CCG's Local Counter Fraud Specialist.

A4. Help and Support

For any support with this policy please contact the Governance Team (see Schedule 1). Schedule 1 does not form part of this policy and may be amended or updated as necessary without the need to formally approve this policy.

B. AIMS AND PRINICPLES

B1. Policy Aims

The aims of this policy are to:

- Promote organisational success and help the CCG to achieve its objectives
- Have organisational grip of key risks
- Empower staff to manage risks effectively
- Promote and support proactive risk management
- Support a culture of openness, transparency in the reporting and management of risks Help create a culture that recognises uncertainty and supports considered, measured and appropriate risk taking and effective risk management
- Support new ways of working and innovation
- Provide clear guidance to staff
- Have a consistent, visible and repeatable approach to risk management
- Support good governance and provide internal controls
- Evidence the importance of risk management to the CCG.

B2. Aims of Risks Management

The CCG is committed to commissioning high quality, cost-efficient, sustainable and effective healthcare services for its population and meeting its organisational objectives.

To achieve this the CCG recognises and appreciates that it will need to take risks in a measured, considered and appropriate way. Good risk management is a tool that supports and empowers staff in this regard by enabling them to identify, assess and control risks in a way that is visible, consistent and makes best use of resources.

B3. Proactive Planning Tool

Effective risk management is a tool that is used proactively and forms a key part of planning. The work is front loaded with the time staff invest in properly identifying, considering, assessing, planning and managing risks paying dividends as work progresses, as problems are dealt with before they become issues and opportunities are maximised before they pass.

B4. Type of Risks

This policy applies to all corporate risks which include but are not limited to:

- Business risks
- Commissioning and Clinical Commissioning risks
- Clinical risks
- Communications risks
- Environmental risks
- Financial risks
- Fraud risks
- Governance risks
- Information risks
- IT risks
- Operational risks
- Quality and safety risks
- Regulatory and compliance risks
- Reputational risks
- Strategic risks.

B5. Definition of Risk

Risk is defined as an uncertain event or set of events which if they occur will threaten the achievement of one or more objectives, such as poor performance in one or more of our hospitals or trusts risking our ability to ensure we meet the financial duty to breakeven.

B6. Definition of Issue

An Issue is an event or set of events that have materialised or will definitely materialise. An issue is different to a risk as a risk is something that may happen where as an issue is something that will or has happened, such as not meeting our financial duty to breakeven. Issues fall outside the scope of this policy.

B7. Key Risks

The CCG wants to create a culture that supports effective risk management and using resources in the most appropriate way.

The management of risks need to be proportionate – with key risks needing to be managed formally. Key risks fall into one or two categories:

1. Risks identified as so serious or difficult to control that staff feel they need to take a formal approach to effectively manage them
2. Risks identified as being sufficiently serious and difficult to effectively control that they will stop the CCG from achieving one or more of its strategic corporate objectives.

What constitutes a key risk is a matter of judgment and involves a level of subjectivity. However, it excludes the vast majority of uncertainties or everyday risks which teams have tried and tested methods for dealing with. It also excludes those risks that can be resolved or mitigated in a relatively straightforward way.

B8. How is Risk Measured?

Risk is the combination of two factors:

- The consequence or impact on an objective if the risk occurs ('Consequence'); and
- The likelihood or probability of the risk occurring ('Likelihood').

Both Consequence and Likelihood are measured on scales of 1-5 in accordance with the charts below:

Consequence Scale:

Descriptor of Level of Impact on the Objective	Consequence for the Objective	Consequence Score
Very low impact	Very Low	1
Low impact	Low	2
Moderate impact	Medium	3
High impact	High	4
Very high impact	Very High	5

Likelihood Scale:

Descriptor of Level of Likelihood the Risk will Occur	Likelihood the Risk will Occur	Likelihood Score
Highly unlikely to occur	Very Low	1
Unlikely to occur	Low	2
Fairly likely to occur	Medium	3
More likely to occur than not	High	4
Almost certainly will occur	Very High	5

Schedule 3 outlines how the impact score should be calculated and provides examples of what constitutes a score of 1-5 in a number of different work themes.

B9. Calculating the Risk Score

Once a risk has been measured it needs to be scored as this indicates how serious the risk is, the level of importance and the priority that should be attached to controlling the risk. The risk score is calculated as follows:

Consequence Score x Likelihood Score = Risk Score

The Risk Score is then matched against the following chart to understand the level of seriousness, importance and the priority the risk should be given:

LIKELIHOOD	CONSEQUENCE				
	Very Low (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Very Low (1)	**1**	**2**	**3**	**4**	**5**
Low (2)	**2**	**4**	**6**	**8**	**10**
Medium (3)	**3**	**6**	**9**	**12**	**15**
High (4)	**4**	**8**	**12**	**16**	**20**

Very High (5)	5	10	15	20	25

1-3 Low Risk Low Priority	4-6 Medium Risk Moderate Priority	8-12 High Risk High Priority	15-25 Very High Risk Very High Priority

B10. Perspectives

Risks should be identified, assessed, understood and controlled at the appropriate organisational level based on the objectives to which they relate. This is because risks have different meanings and significance depending on what they are a risk to and should therefore be given the appropriate priority. A risk at one organisational level may or may not be a risk at another level. In addition, a risk at one level may pose or generate a totally different risk at another level.

B11. Risk Appetite

The Risk Appetite is the amount of risk that an organisation is willing to accept. All staff must work within the agreed Risk Appetite levels when managing risks. The Governing Body decides and sets the Risk Appetite levels.

It is important that the Risk Appetite does not exceed the CCG's capacity to effectively manage its risks and the CCG's ability to meet its financial control total.

The Risk Appetite is set out in Schedule 2. Schedule 2 does not form part of this policy and may be amended or updated as necessary without the need to formally approve this policy.

B12. Openness, Honesty, Transparency and Continued Learning

Risks at the CCG will be managed in an open, honest and transparent way within a culture that supports and encourages this approach.

B13. Proportionality

Risks should be managed in a way that is proportionate to the level of risk. This will vary on a case by case basis depending on the nature of the risk.

B14. Training

The CCG aims to manage risks effectively and create a culture that recognises uncertainty and supports considered, measured and appropriate risk taking. To achieve this all staff will be provided with appropriate training.

It is the responsibility of all staff and their line managers to ensure they are available for and receive risk management training.

All staff are able to request additional risk management training if they feel it will help support them in their role or are interested in developing their skills further. All requests should be made to the Governance Team.

C. RISK MANAGEMENT PROCESS AND RISK OWNERSHIP

C1. Risk Owners and Accountability

Each risk will have a designated owner that has accountability for that risk. Each risk will be owned by a Director and each Director owns all of the risks within their Directorate. The Risk Owner is responsible for ensuring risks are effectively managed and for ensuring all actions to manage the risk are completed.

C2. Operational Oversight and Handling of Risks

It is important for effective risk management that all risks are owned, overseen and managed by the right person, at the right time and at the right level. To help ensure this the Risk Owners may delegate the management of each risk to appropriate members of their team. The person who manages a risk on a day to day basis is known as the Risk Manager.

C3. Staff Management Structure and Good Risk Management

To ensure effective risk management, it is important each Directorate has a supportive risk management culture. Staff should regularly discuss their key risks and share knowledge, perspectives, skills and learning.

Risk discussions should be structured and be of sufficient frequency so that the Risk Owner is genuinely assured that all risks are being effectively overseen and managed at the right time, by the right people, in the right way and at the right level. As a result of these discussions risk registers should be updated in a timely manner.

C4. Directorate and Programme Risk Leads

Directorates will appoint a 'Risk Lead' to:

- Support directors in managing the risk management process within their Directorates and assist with risk reporting
- Support the Governance Team in delivering and embedding the CCG's approach to risk management
- Provide a source of expertise and advice embedded within each Directorate to help support and empower staff to manage risks
- Help drive effective risks management within the Directorate
- Help support staff to implement the CCG's risk management policies and procedures;
- Assist staff within their Directorates to co-ordinate risk reporting
- Maintain a central folder within each Directorate containing the meeting notes/minutes from risk management meetings within the Directorate.

D. KEY ROLES

D1. Role of the Governing Body and Committees

The NEL CCG Governing Body and its committees will provide oversight and scrutiny of the most serious organisational risks and hold people to account in this regard. In addition, the CCG's Lay Member for Audit and Governance and the Audit and Risk Committee will play a lead role in ensuring effective oversight and scrutiny of the CCG's risk management policies, procedures and systems.

The Governing Body will:

- Provide oversight, review and scrutiny of the organisation's highest level risks
- Receive regular risk reports
- Hold risk owners to account for their risks
- Review the Governing Body Assurance Framework
- Approve the CCG's Risk Appetite.

The Audit and Risk Committee will:

- Approve the Risk Management Strategy/Policy and subsequent revisions
- Provide independent assurance to the Governing Body on the effectiveness of risk management process in the CCG and compliance with risk management

policies
- Receive independent reports on the effectiveness of risks management in the CCG
- Challenge the way in which risk is managed where there is uncertainty or concerns over the effectiveness of risk management arrangements
- Formally assess on an annual basis the overall effectiveness of the risk management processes in the CCG and report to the Governing Body
- Review risk management arrangements for the purposes of the Annual Report and the Annual Governance Statement
- Horizon scan and communicate findings for action
- Hold risk owners to account for their risks.

Governing Body Committees will:
- Provide scrutiny, review and oversight of key risks (appropriate to the remit of each Committee)
- Receive risk reports
- Horizon scan and communicate findings for action
- Hold risk owners to account for their risks.

D2. Senior Management Team

The Senior Management Team will:
- Approve the risk management procedures
- Agree and approve resources for risk management across the CCG
- Provide operational oversight and scrutiny of high level risks across the CCG
- Ensure staff are effectively managing risks and that the CCG has an effective system of risk management in place
- Ensure staff are acting in accordance with risk management policies
- Have oversight and responsibility for operational risk management issues faced by the organisation
- Prepare a complete, accurate and reliable report on risk management for the purposes of the Annual Governance Statement to ensure it is fair and representative of the organisation's risk management arrangements
- Provide feedback on the risk management processes and policies supporting this strategy to the Governance and Risk Team
- Ensure directors provide risk reports to the Governing Body and its committees as appropriate
- Be held to account by the Accountable Officer and Chief Finance Officer for effective risk management.

D3. Managers and Staff

The CCG's managers and staff will:
- Manage risk within their area of responsibility as appropriate and report on these risks to the Risk Owner
- Support the Risk Owner in the management of their risks and writing risk reports
- Work within this policy
- Ensure the teams and staff under their control manage risk effectively and follow this policy
- Ensure they and their teams receive risk management training
- Work with the Governance Team and help ensure timely and smooth production of risk reports, the NEL Corporate Risk Register and the Governing Body Assurance Framework - and the smooth operation of the risk management system
- Highlight any problems or concerns with any risk with the Risk Owner.

D4. Governance Team

The Governance Team provides:

- Central oversight of the risk management process and system in the CCG and this policy
- Prepare risk reports for the Governing Body / Committees
- Training for staff and Governing Body members in relation to risk management.

The Governance Team is not accountable or responsible for the actual management of the risks and this sits with Risk Owners and Risk Managers.

E RISK REGISTERS AND RISK OVERSIGHT

E1. Directorate Risk Registers

Named Directorates/SRO shall have a Directorate Risk Register, which contain all of the key risks. Risks with a current risk score of 12 and above assessed at the corporate level will be included in the NEL Corporate Risk Register. The Directorate Risk Registers shall use the same template as the NEL Corporate Risk Register. The risks from the Directorate Risk Registers with a current risk score of 12 and above will be sent to the Governance Team for inclusion on the NEL Corporate Risk Register as per local agreement.

E2. NEL Corporate Risk Register

The CCG will have a Corporate Risk Register (CRR). The CRR will contain all of the CCG's key risks with a current risk score of 12 or higher assessed at the corporate level against the CCG's strategic objectives. There will be occasions where a risk is escalated for continued oversight on a case by case basis, particularly for risks that are subject to scrutiny from regulators and/ or are of public interest.

E3. Governing Body Assurance Framework

The CCG will have a Governing Body Assurance Framework (GBAF). The GBAF will be comprised of all of the CCG's key strategic risks, aligned with the corporate objectives, and include those risks with a current score of 15 and above from the CRR.

E4. Risk Oversight

The Directorate Risk Registers will be reviewed by the appropriate director, along with a member of the Governance Team, on a bi-monthly basis or as otherwise required. Risks with a current risk score of 12 and above assessed at the corporate level will be included in the CRR. Some risks will also be escalated if they are subject to scrutiny from regulators and/ or are of public interest.

The CRR will be included as a standing item for information at each Senior Management Team meeting and will be presented for operational scrutiny, review and oversight at least quarterly. The Senior Management Team may re-grade, add amend or remove risks at its absolute discretion.

The Senior Management Team will assess and decide if any CRR risks should be presented to the appropriate Governing Body Committee for scrutiny, review, oversight and be considered for escalation to the GBAF, at each committee meeting or as otherwise agreed by the committee.

Risks with a current risk score of 15 or higher from the CRR will be presented to the Governing Body for scrutiny, review and oversight at each Governing Body meeting or

as otherwise agreed by the Governing Body. This ensures that the Governing Body can concentrate its focus and attention on the most serious risks.

There will be a small number of risks on the CRR which are purely operational, or it is clear that mitigation can only happen at a local level, and may reach the threshold for escalation to committees but do not reach the threshold for the GBAF. These risks may on a case by case basis and at the discretion of the Risk Owner(s) be presented to the Senior Management Team for scrutiny, review and oversight only and will not be presented to a Governing Body committee. In most instances, it will be clear whether a risk is purely operational whereas at times it will be a matter of judgment.

E5. Inclusion and Removal of Risks from the CRR and GBAF

Risks may be added to or removed from the CRR or the GBAF by Directors, Governing Body members, the Governance Team, the Governing Body and/or any Governing Body committee.

Risks assessed at a corporate level with a current risk score of 12 or higher will be included on the CRR. Risks with a current risk score of 15 or higher from the CRR will be included on the GBAF.

Risks may be removed from the CRR and/or the GBAF under the following circumstances:

- The risk is no longer relevant
- The risk has been effectively mitigated
- The risk no longer reaches the relevant threshold
- The risk has materialised and is an issue.

Where a risk has dropped below the relevant thresholds the respective Governing Body or any of its committees may decide that the risk needs to stay on the CRR or the GBAF for continued oversight on a case by case basis and at its absolute discretion, particularly for risks that are subject to scrutiny from regulators and/ or are of public interest. Risks that have dropped below the threshold will be reported at the following Governing Body and/or committee meeting for information.

E6. Project and Programme Level

Risks at the project and programme level are overseen and managed within Directorates as per the management structure. It is at the discretion of each Director as to how this is done in their Directorate, but should be undertaken in a manner which provides assurance to the Director that the Directorate risks are being both appropriately managed and overseen at the right level. Programme Directors may seek input from the Senior Management Team if required.

Projects and programmes tend to have a high number of lower level risk that are being dealt with at any one time which results in lengthy risk registers.

All project and programme risks continue to be owned by the appropriate Executive Director. However, when any of these risks become a key Directorate risk they will be shown as full entries on the Directorate Risk Register.

Schedule 1 Key Contacts

This schedule sets out the names and contact details of key contacts.

Name	Role	E-mail
Marie Price	Director of Corporate Affairs	marie.price9@nhs.net
Anne-Marie Keliris	Head of Governance	annemarie.keliris@nhs.net
Katie McDonald	Governance Manager	katie.mcdonald3@nhs.net

Schedule 2 Risk Appetite

This schedule sets out the CCG's risk appetite. This has been included by way of example only and is illustrative of the content to be included based on good practice. The Governing Body sets the CCG's risk appetite.

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

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

This schedule sets out the CCG's service areas for which the Governing Body will agree a risk appetite.

No.	Service Area	Governing Body Statement	Appetite Level
1.	Quality	We will ensure good quality service for all the people of north east London and will only rarely accept risks that threaten that goal.	2
2.	Safety	We hold patient and staff safety as the highest priority and will not accept any risk that threatens either.	1
3.	Compliance with legislation and statutory guidance	We will comply with all legislation relevant to the CCG and will not accept any risk that, if realised, would result in non-compliance.	1
4.	Compliance with non-statutory NHS England/Improvement guidance	The CCG will comply with all non-statutory guidance issued by NHS England/Improvement and will not accept any risk that, if realised, would result in non-compliance except in very exceptional circumstances.	2
5.	Procurement	We will procure services in line with English law and national guidance but will accept some procurement risk in the achievement of the CCG's objectives.	3

6.	Conflicts of Interest	We will preserve the integrity of our decision-making processes and our decisions and will comply with statutory guidance. Given the nature of the CCG and the challenges of delivering national and local plans, we are willing to accept exceptional risk in certain circumstances but these will be managed robustly.	2
7.	Reputation	We intend to maintain high standards of conduct and will accept risks that may cause reputational damage only in certain circumstances, and only when the benefits for patients and residents merit the risk.	3
8.	Innovation & Productivity	We aim to foster, and will encourage, a culture of innovation and efficiency; in so doing we are prepared to accept moderate risk. However, when doing so we will work within the risk appetite levels for each Service Area set out in this document and will not exceed them.	4
9.	Finance	We will strive to work within set financial limits and mitigate any risks that, if realised, would cause a breach to the CCG's agreed budget. The	3
10.	Partnerships- Integrated Care System ('ICS')	We will accept a moderate level of risk in working with ICS partner organisations to achieve the aims and objectives of the NHS Long Term Plan and ensure the best outcomes for patients.	4
11.	Partnerships- Integrated Care Partnerships/Providers ('ICP')	We will accept some risk in working with ICP partner organisations to achieve the aims and objectives of the NHS Long Term Plan and ensure the best outcomes for patients.	3
12.	Partnerships- Other partnerships including non ICS, non ICP, other NHS providers, the third sector and the private sector.	We will accept some risk in working with non ICS/ICP partner organisations, other NHS providers, the third sector and/or the private sector to achieve the aims and objectives of the NHS Long Term Plan and ensure the best outcomes for patients.	3

Precedence of Risk Appetite Scores

For the avoidance of doubt where two risk appetite scores conflict with each other the lowest risk appetite score takes precedence. For example, the CCG may be working on a new and innovative service and so work within the risk appetite level of 4 for Innovation and Productivity. However, while doing so the CCG will work within the risk appetite levels of 1 for Safety and 2 for Quality.

Schedule 3 – Impact scoring

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

Appendix 1 – Equality Impact Assessment

Equality Impact Assessment

Title of the change proposal or policy:

Corporate Risk Management Policy

Brief description of the proposal:

This Policy sets out the CCG's detailed risk management arrangements and the process by which risks are managed.

Name and role of staff completing this assessment:
Date of Assessment:

Katie McDonald, Governance Manager

Please answer the following questions in relation to the proposed change:
Will it affect employees, customers, and/or the public? Please state which.

All staff, governing body/committee members, sub-committee members, and anyone including GP members working closely with the CCG assisting it in carrying out its role.

Is it a major change affecting how a service or policy is delivered or accessed?

No.

Will it have an effect on how other organisations operate in terms of equality?

No.

If you conclude that there will not be a detrimental impact on any equality group, caused by the proposed change, please state how you have reached that conclusion:

There is no anticipated detrimental impact on any equality group. There are no statements, conditions or requirements that disadvantage any particular group of people with a protected characteristic.

BHR Integrated Care Partnership Board

31 March 2022

Title of report	Primary care development update
Author	Julia Cory, Deputy Director of Primary Care
Presented by	Sarah See, Director, Primary Care Transformation
Contact for further information	julia.cory@nhs.net
Executive summary	This report provides an update on five programmes relating to primary care development. • **PCN CD development** – as part of ongoing development meetings with PCN clinical directors were held during Autumn 2021. The risks, issues and development needs were discussed focussing around the three 'asks' of the ICP. Themes from developments needs were project manager support, manager development, estates support, and managing workload both in and out of primary care, as well as workforce needs. • **LIS equalisation –** the programme has considered three LIS so far: safeguarding, phlebotomy and duty doctor scheme. Safeguarding has been launched and the other two are going for business case approval. The next LIS's to be considered are home visiting service, respiratory and anti-coagulation. • **Winter Access Fund** – gives an update on the development of both practice level and system wide schemes; including how the focus on managing the demand for face to face appointments is being met. There is also an update on how QI initiatives are being developed to support and embed the ongoing access work once the initial investment ends. • **Covid-19 vaccination spring booster campaign-** this section of the report focuses on the next stages of the vaccination campaign relating to booster doses for eligible cohorts starting during March 2022. The most recent uptake information from the programme so far is included for each borough.

	• **Influenza vaccination uptake** – uptake generally has not reached targets in all cohorts in any of the three boroughs. The reasons for this relate to the 'flu programme competing with the Covid-19 vaccination campaign, low incidence of circulating 'flu meaning vaccination not seen as priority, data issues and delay in supply at the start of the season. • **Population Health Management** – gives an overview of BHR ICPs involvement in the wave 3 pilot scheme, describing the focus of the programme and intended outputs; which link to borough and place-based partnership work as well as tackling inequalities for residents.
Action required	This report is for **noting**
Where else has this paper been discussed?	N/A; this paper is part of a regular update relating to primary care development
Next steps/ onward reporting	N/A
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The comments and feedback from the board will be used to further shape and define primary care development and collaboration during 2022/23.
Conflicts of interest	As this report is for noting only there are no conflicts of interest. It should be noted though that some of the issues discussed relates to payment made to GP practices; therefore any GP on the board may be conflicted.
Strategic fit	All areas discussed in this report relate to either local or national workstreams.
Impact on finance, performance and quality	There are no direct finance, performance or quality impacts relating from this report.
Risks	There are no immediate risks relating to this update.
Equality impact	There are no equality impact issues arising from this update.

NHS
North East London
Clinical Commissioning Group

Primary Care Development Update

Meeting name: BHR Integrated Care Partnership Board
Presenter: Sarah See, Director, Primary Care Transformation
Date: 31 March 2022

Background and Context

- General practice is the cornerstone of the NHS and a key element of the primary care transformation work in the BHR ICP is to commission high quality services with improved health outcome for our population.
- We also know our population is increasing and demand for services is rising. There are workforce challenges in primary care which have been exacerbated by the Covid-19 pandemic.
- In response to these challenges, the CCG has developed a wide portfolio of development projects, some of which are nationally driven, others which relate to local projects. The key aim of all of the projects or programmes of work is to improve access to high quality of service, with a key focus on reducing health inequalities for our diverse population.
- The ambition is to develop a sustainable model for Primary Care as a key element of the NEL Integrated Care System.
- This report provides an update on the following areas linking to the above ambitions: 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

PCN development in the context of the ICS

During October and November 2021, meetings took place with PCN CDs across the three boroughs with a view to understanding how PCNs were developing, any key risks or issues and areas where development or support is required.

The PCN CDs also discussed the three ‘asks’ of PCNs by BHR ICP which are:

1. **Reducing the variation in general practice,** starting with by refreshing the model of primary care to address health inequalities due to access and to take away unnecessary activity from general practice
2. **Having a functioning MDT working with other local health, care and voluntary providers, and where appropriate, nurseries, schools, emergency services, to support planned care** eg care homes, homeless and asylum seekers
3. **Identifying and working together with neighbourhood teams to develop a placed based public health programme to address health needs** e.g. health checks or for cancer and other long-term conditions there is a need to narrow covid exacerbated inequalities and poor outcomes through effective and targeted case finding

PCN development in the context of the ICS – key findings

Risks

The PCN CDs felt there were four key risks impacting on delivery of PCN ambition – these are:

- Workforce – particularly GP workforce, gaps left my retiring GPs, recruitment and retention of staff more generally. ARRS staff recruitment has helped to mitigate those risks in part
- Access targets – patient expectations and the ability to deliver to those expectations
- Management of Long Term Conditions – concern that management is target focussed
- Estates – difficulty accommodating new roles within the current primary care estate

Summary of needs

- Project management support
- Estates support
- Understanding systems and processes including data management
- Access support including QI expertise and software roll out - Edenbridge and Equip programme
- PCN manager development
- Understanding the flow of work from secondary care and how that can be managed
- Workforce support – including planning for the future and priority setting
- Understanding integrated working and what that means in relation to population health management and the ICB

LIS equalisation update

- First round of task and finish groups completed their reviews in December 2021 (Phlebotomy, Duty Doctor, Safeguarding)
- Whilst safeguarding has proceeded to implementation, there have been challenges moving other schemes through sign off processes
- These challenges relate to the financial case for change not being sufficiently described and the process had not taken account of local variations/challenges with regards to recommendation – including financial modelling

The overall approach is to level up in terms of both outcomes and funding into primary care over a three year period.

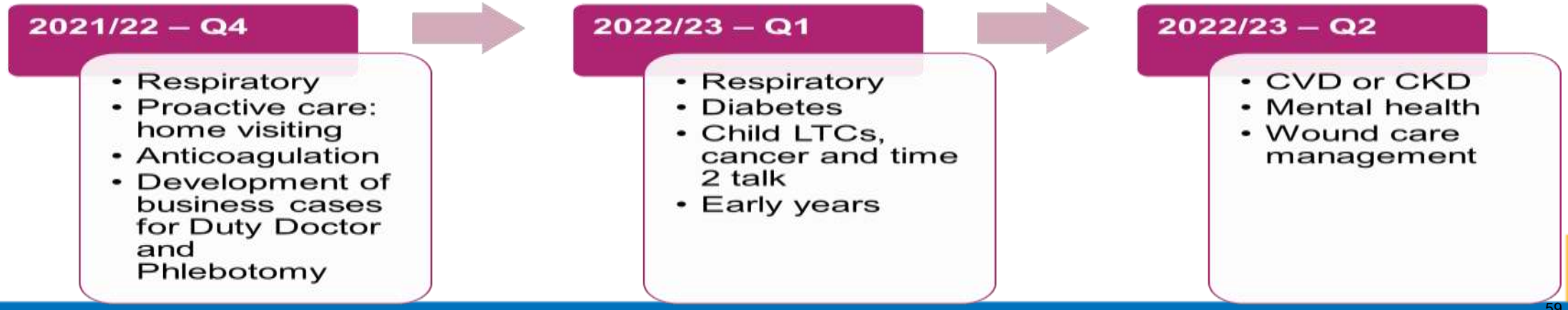
Principles of the equalisation process:

- No investment will be removed from borough-level investment in locally commissioned services. As schemes are reviewed there may be reduction in rate or decisions to decommission some schemes, but any locally released financial resource will continue to be available within that locality
- Services will be reviewed across NEL to develop a service specification, supported by business case, that supports delivery of fair price across the whole of NEL for an agreed service/s
- The business case process will be used for all services being reviewed to ensure the pricing and levelling up for prioritised services is agreed through NEL governance processes, ready for implementation within the seven boroughs.

LIS equalisation – business case approach

- To address the issues arising from first round of reviews it is proposed the end product of the task and finish groups should become a formal business case
- All stakeholders will be given opportunity to comment on schemes as taken through local and NEL governance routes
- This should ensure that outcome/quality and financial benefits can be clearly laid out alongside one another, and that local concerns are addressed fully
- Requested that business case be prepared for Duty Doctor and Phlebotomy as well as all new reviews going forward

Timeline for reviews:



Winter Access Fund context

- On the 15 October NHE&I London Region wrote to advise of the Winter Access Funding Programme. The purpose of the programme is to support access initiatives in general practice, with a view to moving practices to a model of equal face to face and virtual consultations. This was to be achieved by focussing on a system wide access offer, quality improvement programme support focussing on access and discussions with a group of practices
- The Regional Team shared data on a number of metrics including:
  - Practices reporting less appointments than the same period last year
  - Practices with a low percentage of face to face appointments recorded
  - Practices with a high rate of A&E attendances
  - Practices approached to take part in the Access Improvement Programme (AIP)
  - Complaints and concerns (routed through NHSE)
- Systems were asked to validate this data to identify the cohort most requiring enhanced support (not more than 20% of practices)

Winter Access Fund and GP access

There are **eleven system wide schemes** and **two practice based schemes**. The **system** wide schemes are:

- NEL wide flexible working pool/digital bank platform
- Embedding QI practice in primary care – particularly relating to access initiatives and to help with appointment system management
- Rapid response service – to provide additional GP availability during the day to speak to either patients or other health care professionals
- Review of best performing practices with a view to using the learning to produce resource packs for all practices
- Support and training for non-clinical workforce to support both recruitment and retention
- Personalised care – increase the personalised care workforce to support PCN to deliver this workstream
- Develop communications to support patient to understand changes in primary care access and how they can manage their own care
- Enhance digital functions especially the roll out of Edenbridge Apex to support appointment management in practices
- Increase primary care single point of access capacity
- Support development of a daytime hub for 111 referrals in hours, and upgrade IT system to support this work
- Community Pharmacy Consultation Service referral scheme roll out

Winter access fund practice initiatives

In the BHR ICP 29 practices have been identified as being eligible for accelerator support, meaning they will have access to quality improvement initiatives, support with local access issues and the ability to draw down further funding to support training within each practice.

The primary care transformation team within BHR ICP have been working with these practices in order to further understand resources are required, how diagnostics may be applied and any specific local issues practices may have that are affecting their access. Coaching conversations and QI initiatives are also available to allow practices to produce an action plan to drive and embed further improvement.

Themes highlighted by practices relate to coding of appointment data being inconsistent, lack of clarity about services available in primary care from a patient perspective, difficulty managing the different ways that patients can access appointments.

Themes discussed with practices are how NHS 111 slots are made available, use of software to monitor access demand and capacity, patient perception of services and how that can be changed if negative.

All practices across BHR (116) have been offered financial support (£1.16 per registered patient) to increase appointment availability particularly over the winter period, focussing on increased provision of face to face appointments

Covid-19 spring booster and 5-11 year old vaccination campaign

BHR ICP along with the other NEL systems are planning the roll out of the spring booster and 5-11 year olds vaccination campaign. The programme for these patients will commence from 21 March 2022 and run until May. Cohorts eligible for the spring booster are:

- Those over 75 years old
- Residents of nursing or residential homes
- Housebound patients
- Over 12 yrs old and immunosuppressed

In addition plans are also being developed to vaccinate children in the 5-11 year old age group during the school Easter holidays, with first vaccinations for this age group commencing on 4 April 2022. There will be a mixed model of delivery using local vaccination sites and community pharmacies.

The evergreen vaccination offer also continues for those who are yet to have first, second or booster doses. The focus continues on ensuring those patients in hard to reach communities are able to access a vaccination. Opportunities to make every contact with a patient count are being explored by offering health checks, health advice and signposting for all patients visiting vaccination sites.

Covid-19 vaccination uptake across BHR

Priority Groups	Patients	Eligible for booster dose	Booster doses given	Booster uptake	Booster doses left to do at 15 March
Age 80+	4,800	4,111	3,756	91.4%	418
Age 75-79	3,437	2,936	2,712	92.4%	275
Age 70-74	4,884	4,098	3,686	89.9%	474
Age 65-69	6,624	5,350	4,599	86.0%	857
Age 60-64	9,323	7,390	6,027	81.6%	1,517
Age 55-59	12,621	9,754	7,425	76.1%	2,564
Age 50-54	15,152	11,233	7,922	70.5%	3,580
Age 40-49	36,464	24,099	14,300	59.3%	10,673
Age 30-39	42,043	21,611	10,493	48.6%	12,778
Age 18-29	37,980	16,496	6,466	39.2%	12,278
Age 16-17	6,699	914	219	24.0%	1,620
Barking & Dagenham total	**180,027**	**107,992**	**67,605**	**62.6%**	**47,034**

Priority Groups	Patients	Eligible for booster dose	Booster doses given	Booster uptake	Booster doses left to do at 15 March
Age 80+	13,800	13,033	12,678	97.3%	436
Age 75-79	9,899	9,296	9,027	97.1%	311
Age 70-74	12,326	11,441	11,044	96.5%	461
Age 65-69	12,745	11,535	10,927	94.7%	711
Age 60-64	16,299	14,575	13,280	91.1%	1,430
Age 55-59	18,772	16,418	14,383	87.6%	2,181
Age 50-54	18,640	15,790	13,229	83.8%	2,737
Age 40-49	37,563	28,608	21,006	73.4%	8,253
Age 30-39	43,157	27,816	17,287	62.1%	11,943
Age 18-29	40,184	23,703	12,739	53.7%	12,811
Age 16-17	6,493	1,585	515	32.5%	2,248
Havering total	**229,878**	**173,800**	**136,115**	**78.3%**	**43,522**

Priority Groups	Patients	Eligible for booster dose	Booster doses given	Booster uptake	Booster doses left to do at 15 March
Age 80+	10,284	9,275	8,771	94.6%	635
Age 75-79	7,176	6,467	6,199	95.9%	354
Age 70-74	9,928	8,817	8,371	94.9%	588
Age 65-69	12,184	10,507	9,646	91.8%	1,080
Age 60-64	15,326	12,842	11,191	87.1%	1,900
Age 55-59	18,388	15,104	12,520	82.9%	2,891
Age 50-54	21,011	16,362	12,735	77.8%	4,070
Age 40-49	52,545	36,657	25,462	69.5%	12,449
Age 30-39	63,267	36,039	21,588	59.9%	16,657
Age 18-29	55,435	28,976	14,430	49.8%	17,757
Age 16-17	8,566	1,990	627	31.5%	2,789
Redbridge total	**274,110**	**183,036**	**131,540**	**71.9%**	**61,170**

Influenza Vaccine uptake performance for the 21/22 season

BHR ICP Influenza Vaccine Uptake as of 11/3/22										
Borough	65 and over (ex care home and housebound)		50-64 years old		18-49 at clinical risk		Pregnant Women - All		2-3 Year olds - All	
	National Target	Current Uptake	National Target	Current Uptake	National Target	Current Uptake	National Target	Current Uptake	National Target	Current Uptake
BARKING & DAGENHAM	85%	68%	75%	43%	75%	36%	75%	41%	75%	40%
HAVERING	85%	75%	75%	41%	75%	32%	75%	40%	75%	46%
REDBRIDGE	85%	73%	75%	44%	75%	35%	75%	41%	75%	46%

There have been a number of challenges with respect to delivery of the national flu programme this season, these include:-

- Competing with the COVID -19 vaccination programme.
- Vaccine mandates and ‘workforce vaccine fatigue’
- Delays in vaccine stock deliveries.
- Discrepancies in data sources (ImmForm Vs. Foundry)
- Low rates of influenza in the general population (less of perceived threat so why get a vaccine.)
- Missing uptake data from pharmacies (SONAR to EMIS).

Increased national targets: 85% 65 years and over, 75% Under 65s at risk including pregnant women and 50 – 64s, 85% in frontline health and social care workers

Population Health Management

Population Health Management is about:
Reducing health inequalities by taking action
Using data-driven insights and evidence of best practice to inform **targeted interventions to improve the health & wellbeing of specific populations & cohorts**
The wider determinants of health, not just health & care
Making informed judgements, not just relying on the analytics
Prioritising the use of collective resources to have the best impact
Acting together – the NHS, local authorities, public services, the VCS, communities, activists & local people. **Creating partnerships of equals**
Achieving practical tangible improvements for people & communities

The borough of Barking & Dagenham and Loxford PCN in Redbridge are involved in the wave 3 pilot of the population health management workstream.

The intention of the pilot is to bring together system partners and voluntary agencies to focus on how populations can best be supported using a range of tools, such as analytics, data.

In addition the programme also supports place and system integration, brings teams together across sectors with a view to collaborating on solutions for specific population needs driven by data analysis and local knowledge.

The 22 week programme will focus on what has worked well so far, and build on that knowledge, learning and experience. The first of the Action Learning Sets have taken place and focussed on learning from previous initiatives (an MMR uptake programme in Barking & Dagenham as an example), as well as lessons learnt from the Covid-19 vaccination programme, concentrating on how those ways of working could be built and developed.

BHR Integrated Care Partnership Board

31 March 2022

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

How does this drive change and reduce health inequalities?	resources and improving outcomes for local people. Reducing inequalities is a key priority for the BHR Partnership.
Conflicts of Interest	There are no conflicts of interest arising from this report
Strategic Fit	All areas of progress noted in this report align with national, North East London Integrated Care System, and BHR Integrated Care Partnership strategy
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage
Risks	Capacity, in the context of transitioning to an ICS from July 2022 and establishing our Borough Partnerships, alongside continuing to deliver transformation, is an ongoing risk, which is being mitigated by bringing in additional resource where required, e.g. funding to support Borough Partnership development
Equality Impact	Not applicable at this stage

Appendices:
Appendix 1 – BHR Priority Actions progress update

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

BHR Integrated Care Partnership

Better care, better lives, together for all

BHR Integrated Care Partnership

Key Priority Areas – PROGRESS UPDATE

Last updated: March 2022

Our BHR Partnership Development Programme – Plan on a Page

Overall Objective

Continue to establish and develop the key BHR elements of the NEL Integrated Care System in preparation for July 2022 and beyond

SRO / Sponsor

Sponsor: BHR ICPB
SROs: Chief Executives & MD on BHR ICEG, BHR Chairs

What we are collectively progressing to support BHR into the new ICS

Agree areas that we believe the Borough Partnership Boards should continue to collaborate on and contribute to NEL discussions on the overall shape of the ICS

A process to take this forward is underway, via discussion with partners.
December 2021

BHR Partnership (ICPB) key priority workstreams

Continue to progress the key workstreams with oversight from ICEG/ICPB/HCC:

- Recovering Well
- Addressing inequalities and Prevention
- Anchor Organisations
- Leadership, culture, and leading change

BHR Integrated Sustainability Plan

- BHR ISP agreed and socialised
- Refresh / agree requirements of Transformation Boards to deliver the ISP
- Process for one off investment fund across key areas of the BHR system / transformation

Continue to progress work of BHR Transformation Boards

- Business Case Approval process streamlined across Partnership (on hold pending NEL work)
- Work with ISP lead to map out investment and savings requirements
- Map requirements of enabling programmes e.g. workforce

Borough Partnership Boards Development

Ongoing development of BPBs in BHR:

- Operationalise Roadmaps
- Progress key priority areas
- Phase 2 funding (£100k per borough) released
- BHR Development Sessions - ongoing
- Local Authorities and health partners leading this process
- Explore delegation options and prepare for agreed NEL decision

Provider Collaborative Development

Support continued development of Provider Collaboratives through the CEOs and CCG Chair:

- Primary Care
- Acute
- Community / Mental Health
- Establish links from NEL collaboratives to BPBs in BHR

Progress enabling workstreams / programmes

- BHR Health and Care Academy establishment and development of BHR workforce Dashboard
- Digital Programme in BHR
- Business Intelligence
- Estates in BHR
- **NB** – enabling workstreams must relate to NEL wide workstreams

Primary Care Network Development

- Ongoing programme of support and development for PCNs – monthly sessions
- Progress programme of support for PCN CDs including mentoring
- Progress programme of support for PCN managers
- Progress QI programme approach
- Develop MDT approach with Borough Partnerships
- Strengthen role in Borough Partnerships
- Progress key role of PCNs to address variation and reduce inequalities

Organisational Development

- Progress BHR Clinical and professional Leadership development work (+secure commitment to develop leadership)
- Continue and expand OD programme started with ICEG / NHS Elect
- Initiate OD programme with wider staff so that they can shape the system and processes, ahead of formal steps to July 2022

New Models of Care – Key Developments

- St Georges Hospital
- Barking Riverside
- Ilford Exchange
- Beam Park
- Barking Community Hospital service planning

Engaging with local people to shape our work

- Establish People's Board – BHR
- Borough Partnerships to link in / engagement with local people in an ongoing way
- Non-Executive Director – Patient lead appointed

KEY
Complete
In Progress
Overdue

BHR ICP Priority – RECOVERING WELL

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

Overall Objective

To develop a **joined-up approach to recovery in BHR**. Building on borough based work on recovering communities, this element will focus on supporting better health and well-being providing a joined up, system approach to recovery.

SRO / Sponsor

Sponsor: Jacqui Van Rossum
SRO: Steve Rubery
with SOCG

2021/22 Aims

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

2021/22 Key Workstreams

Restoration and Recovery

BHR Recovery and Restoration plan first draft May 2021	Complete
Review and inclusion of Social Care Provider Recovery and Restoration into the master BHR Plan June 2021	Complete
BHR Recovery Summit – 6th July 2021	Complete
BHR Recovery Summit action plan developed	Complete
Ongoing review and update of the Recovery and Restoration plan via SOCG fortnightly	Complete – merging into winter plan
Leads progressing actions agreed at the BHR Recovery Summit	In progress
In Depth review of Recovery Summit actions at Oct Health and Care Cabinet meeting	Complete
Monthly meetings with Action Owners and HCC leaders to monitor progress	In progress

Surge planning, and meeting demand and unmet need

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

Staff Wellbeing

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

Service Changes

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

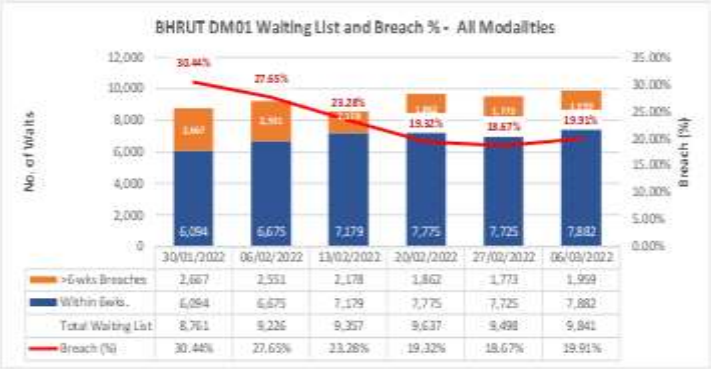
BHR ICP Priority – RECOVERING WELL

Elective Position

BHRUT overall Waiting List Times	Dec-21	Jan-21	Feb-21	Trend
Waiting list – Actual	53,956	55,796	57,744	↑
52 weeks + - Actual	997	1,060	1,137	↑
78 weeks + - Actual	-	67	42	↓
104 weeks + - Actual	-	9	11	↓

- Since January-22, across NEL, the monitoring and reporting of performance has been based on the requirements set out in the Operating Plan, with focus on reducing the number of 52 week waits, and eliminating 78 and 104 week waiters.
- The overall number of patients on the waiting list has continued to increase based on the latest provisional data to w/e 27th February.
- The number of 52+ week waiters are deteriorating compared to pre-December, coinciding with the Omicron wave and the Christmas period. However, the current position remains below the May-21 position of 1,638 52 weeks waiters.
- The level of 78 week waiters has slightly improved in February when compared to the previous month.
- The number of patients waiting 104 weeks + has slightly increased, however, the Trust has committed to clearing this by June, as submitted in the 22/23 Draft Operating Plan.

Diagnostics



- The provisional number of patients on the waiting has remained relatively stable over recent weeks, with the w/e 6th March reporting c9.8k currently on the list. The waiting list has been fluctuating between 8k-10k per month over the past few months.
- The proportion of patient with 6> week breaches have improved significantly with 19.9% of patients breached compared to 30.4% at the end of January.
- Performance has improved across nearly all nearly all Modalities.
- Challenges remain in Imaging Modalities which are reporting the following % breaches for the week ending 06/03/22 (unvalidated current data) :
  - MRI 35.9% (from 42.1% in Jan-22)
  - CT 32.4% (from 40.5% in Jan-22)
  - NOUS 9.5% (down from 27.6% in Jan-22)

Referrals

- GP Referrals into BHRUT, A&E referrals and 'other' referrals has remained relatively stable over recent weeks and months. However, the latest week has seen a small increase in GP referrals with c2.8k referrals compared to an average of c2.5k in previous weeks.
- 2ww referrals by BHR GPs have increased to c1,000 referrals in the w/e 13/03/22, compared to an average of c650 per week in previous weeks.
- The reported level of Outpatient 1st activity for January indicates that activity is at 77% of 19/20 levels. There is a risk that an increasing rate of referral (demand) will exceed capacity resulting in increased pressures on the growing waiting list

BHR ICP Priority – LEADERSHIP, CULTURE, AND LEADING CHANGE

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

Overall Objective

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

SRO / Sponsor

Sponsor: Ceri Jacob
SROs: As set out below

2021/22 Aims

- Development and delivery of the BHR ICP Integrated Sustainability Plan
- Supporting primary care networks, along with developing Borough Partnerships, and multidisciplinary leadership
- Continued development of the BHR partnership arrangements within the wider north east London Integrated Care System
- Develop a clear, streamlined and strong framework for decision making and mutual accountability

2021/22 Key Workstreams

BHR Integrated Sustainability Plan

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

Lead: Mark Eaton/Steve Rubery

Supporting PCN Development

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

Lead: Sarah See

Development of local arrangements within NEL ICS

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

Leads:
Ceri Jacob, Selina Douglas, Ann Hepworth, Barbara Nicholls

BHR ICP Priority – ANCHOR ORGANISATIONS

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

Overall Objective

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

SRO / Sponsor

Sponsor area 1: Jacqui Van Rossum/ Kathryn Halford
Sponsor/SRO area 2: Barbara Nicholls with BHR HCA Steering Group

2021/22 Aims

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

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

2021/22 Progress on Key Projects

BHR Health and Care Academy

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

Procurement

Pull together workshop with procurement leads, HR and contract leads to look at what we can collectively do around procurement. What areas can we collectively focus on as a first step, are there any key procurements coming up that we could do something collectively around	Complete
Workshop on 20th October - Directors of Strategy to brief their Procurement leads ahead of this	Complete
Second BHR Procurement workshop to be held in December 2021	Complete
Third BHR Procurement workshop to be held in Jan/Feb 2022	Complete
Fourth BHR procurement workshop to be held in March 2022	In progress
BHR 'Meet the Buyer' event at CEME to support local provider market	In progress

Long COVID

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

BHR ICP Priority – ADDRESSING INEQUALITIES AND PREVENTION

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

Overall Objective

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

SRO / Sponsor

Sponsor: Health and Care Cabinet
SRO: Dr Remi Odejinmi with HCC and BHR Prevention Group

2021/22 Aims

Developing an approach to Population Health Management in BHR; strong emphasis on the prevention, self-care, addressing inequalities and using all community assets – led via the BHR Transformation Boards and Place Based Partnerships

Supporting key priorities from each of our Borough Partnerships

2021/22 Key Workstreams

Progress BHR specific elements of prevention and addressing inequalities

Seek to learn from Care City's work on inequalities and to involve Care City in the work of the BHR Prevention Group	Complete
Borough Partnerships have submitted expressions of interest to take part in a Population Health management programme – process being led at a NEL level. Meeting towards the end of July to identify the successful areas.	Complete
Loxford (Redbridge) and B&D (Borough) progressing PHM Pilots	In progress
BHR Health and Care Cabinet Obesity workshop – September 2021	Complete
Progress BHR obesity action plan under oversight of the HCC; update at the next meeting in April	In progress

Supporting key priorities from each of our Borough Partnerships

Phase 1 £25,000 funding to BP's	Complete
19th May development workshop	Complete
Submission of Roadmaps 31st May	Complete
Feedback provided to BPs – 4 June	Complete
ICEG to review/endorse 2nd phase	Complete
£100,000 Phase 2 funding release	Complete
Borough Partnerships to use £100,000 to bring in resource to take forward their development	Complete
Recruit to Borough Director role for Havering	Complete
Borough Partnerships to take forward Operationalisation of their Roadmaps	In progress
NEL to draft a framework for Borough Partnership development within ICS, with BHR input	In progress
26th Jul – 2nd Borough Partnership development workshop	Complete
3rd Borough Partnership Workshop arranged 7th September	Complete
4th Borough Partnership Workshop arranged November	Complete
5th Borough Partnership Workshop – December 9th	Complete
6th Borough Partnership Workshop – February 2022	Complete
7th Borough Partnership Workshop – March 2022	In progress
£100,000 PbP development funding to be released for 2022-23	In progress

BHR Place Based Partnership Development Sessions - FORWARD PLAN

Wednesday 9th February 2021 12.00pm – 2.00pm

- Finance strategy and links to delegation
  Steve Beales
- Place Based Partnerships – articulating models for clinical and care leadership
  All

Monday 21 March 2022 1pm – 3pm

- Provider Collaboratives and links to PBPs
  Selina Douglas/Ceri Jacob/Ann Hepworth
- Update on transformation Cycle and implications for PbPs / Provider Collaboratives
  Ceri Jacob/Chris Cotton
- Each PbP to update on development of Clinical and Care Leadership models
  PBP Leads

Weds 13 April 2022 12pm – 2pm

- General ICS update and Q&A session
  Chris Cotton
- NEL Transformation / development of networks
  Simon Hall / Hilary Ross
- WRES Update
  Dr Jyoti Sood
- Progress update from each Place Based Partnership
  PBP Leads

Weds 4th May 2022 5pm – 7pm

- Progress update from each Place Based Partnership
  PBP Leads
- General ICS update and Q&A session
  Chris Cotton

Weds 15th June 2022 2pm – 4pm

- Progress update from each Place Based Partnership
  PBP Leads
- General ICS update and Q&A session
  Chris Cotton

BHR Integrated Care Partnership Board

31 March 2022

Title of report	Finance Overview Report, month 11 (February 2022) and 22/23 Draft Plan
Author	Julia Summers, Head of Finance, BHR ICP
Presented by	Steve Collins, Acting CFO, NEL CCG
Contact for further information	Steve Collins
Executive summary	**Key issues** 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. The CCG and ICP plans are part of the NEL system plan which has been set to break-even. At month 11 (period to end of February 2022), 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**.** A full review of information was undertaken in Month 11 and BHR ICP has worked through all known commitments in Month 11. The main items include transformation investments to support the Integrated Sustainability Plan (investments) and investment within the hospital discharge programme. As with previous reporting periods, a deficit has been reported against centrally held CCG budgets in relation to specific allocation arrangements in place. NHSE/I will make the hospital discharge pathway (HDP) / Covid and ERF allocation available post month end and until this is received, the position is reported as a deficit. The draft Operating Plan for 2022/23 was submitted on 17th March 2022. This showed a system deficit of £99.5m, with £36.7m being the CCG share. The main points are summarised in the attached presentation. An update on the final plan submission will be given at future finance committees.

	Recommendations BHR ICB is asked to note the contents of the attached presentation.
Action required	Note
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	Monthly updates to BHR ICP Finance Committee, NEL CCG Finance Committee and Governing Body.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Delivery of Financial plan Delivery of Financial plan
Conflicts of interest	N/A
Strategic fit	Finance – delivery of financial position
Impact on finance, performance and quality	Delivery of Financial Plan
Risks	Financial risks are outlined in the attached paper.
Equality impact	N/A

North East London
Clinical Commissioning Group

Month 11 Finance Overview Report 21/22 and 22/23 Draft Plan

Meeting name: BHR ICB
Presenter: Steve Collins
Date: 31 March 2022

Finance Report Month 11

CONTENTS	
Month 11 (February 2022) Executive Summary	Page 2 - 3
Month 11 position BHR ICP	Page 4
21/22 full year variances - BHR and NEL Breakdown	Page 5
BHR ICP key variances - Acute	Page 6
BHR ICP key variances - Continuing Healthcare	Page 7
BHR ICP key variances - Primary Care and Prescribing	Page 8
BHR ICP key variances - Other	Page 9
Hospital Discharge Pathway / Covid	Page 10
Elective Recovery Fund	Page 11
Financial Accounts Performance Metrics	Page 12
2022/23 Planning - NEL Overview - Revenue Funding	Page 13 - 14
2022/23 Planning - Applied Prices Increases	Page 15
2022/23 Planning - BHR Summary Financial Position	Page 16
2022/23 Planning - System Summary Financial Position	Page 17
2022/23 Planning - Risks	Page 18
Summary	Page 19
Appendix 1 - NEL Funds	Page 20
Appendix 2 - Investments (funded from non-recurrent reserves in 21/22	Page 21

Month 11 (February 2022) Executive Summary

- The CCG have submitted a H2 plan to NHSE and budgets have been set for the full financial year across the three integrated care partnership systems for NEL CCG. The CCG plan is a break-even position. **The total annual budget for BHR ICP is £1,274m, which is part of the total NEL CCG budget of £3,962m.**

- A full review of financial information has been undertaken for Month 11. For BHR ICP this shows a high level of consistency with the Month 10 reported position. With the exception of the Hospital Discharge Pathway (HDP), Winter Access Fund (WAF) and Additional Roles Reimbursement Scheme (ARRS), the year-to-date and forecast positions are consistent with H1 reporting and **BHR ICP has reported a break-even position against the full year plans.**

- A system wide exercise was undertaken at Month 10 to review all ICS partners forecast outturns. **This resulted in NELFT identifying £9.5m of funds that can be returned to the CCG.** This return of funds has been **used to cover the elective recovery shortfall at BHRUT.** Repurposing these funds has allowed the NEL system to remain within plan and forecast.

- As previously reported, budgetary pressures continue with Independent Sector (IS) contracts, prescribing and CHC budgets. A review of the trend and trajectory for each of these areas has taken place and forecast outturns have been adjusted accordingly.

- The CCG has worked through all known commitments at Month 11 to ensure that the year-end targets can be met. These have been factored into the Month 11 forecast position. The main items include transformation investments to support the integrated sustainability plan (appendix 2) and investments within hospital discharge programme.

- To meet the budgetary pressures, the use of **non-recurrent mitigations totalling £8.1m** has been required by BHR ICP. **Across NEL this rises to £57.6m, £38m of which was expected**. The BHR H2 plan assumes that spend will remain within plan.

- The independent sector (IS) planned budget was increased in H2 to reflect the expenditure profile. H2 IS spend is more or less in line with the budget set, meaning that the reported forecast overspend largely relates to H1.

Month 11 (February 2022) Executive Summary

- BHR ICP has received allocations for ageing well and funding to support PCN leadership and management in Month 11.
- The table below highlights the level of mitigation required for BHR ICP and the other NEL ICPs **to deliver the breakeven forecast position.**

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
In Year (Surplus) / Deficit Before NHSE top up, non recurrent funds, covid contingency	**8.1**	**2.8**	**53.2**	**16.3**	**74.8**
Retrospective Funding expected for HDP/Covid, WAF & ERF	0.0	0.0	-0.9	-16.3	-17.2
Adjusted (Surplus) / Deficit after NHSE expected top up	**8.1**	**2.8**	**52.4**	**0.0**	**57.6**
Covid Contingency	-0.1	-0.0	-4.8	0.0	-4.9
Non Recurrent Mitigation	-8.1	2.8	-47.6	0.0	-52.8
In Year (Surplus) / Deficit	**0**	**0**	**0**	**0**	**0.0**

- The Month 11 forecast **assumes that all system development funding (SDF), mental health investment standard (MHIS) and other specific transformation funds are fully spent**.
- The CCG submitted the first draft of the financial plan on 17 March 2022. **The draft plan showed a system deficit of £99.5m, with the CCG share of this being £36.7m.** Slides 13 to 18 provide a summary of the main headlines.

Month 11 Position – BHR ICP

- The position before CCG mitigations and after NHSE anticipated top-ups shows **a BHR ICP full year pressure of £8.1m, relating to the pressure seen in H1.**
- The use of contingency and non-recurrent mitigations has been necessary to **meet budgetary pressures with the acute independent sector, CHC and prescribing.** Additionally, **investments to support the ISP and local authority partners** has been factored into the forecast position.
- A return of funds from NELFT (£9.5m) has been used to cover the elective shortfall at BHRUT and allowed the system to remain within plan**.**
- The use of non-recurrent mitigations and the anticipated NHSE top-up means that the **CCG position for H2 is break- even.**
- Appendix 1 includes NEL CCG level information and central ICS funds. Appendix 2 details agreed investments funded through non recurrent mitigations.

BHR ICP Financial Summary H2 2021-22	Month 11				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	604.8	621.1	16.4		659.9	682.8	22.9	
Mental Health & LD	116.9	116.5	-0.4	3	127.6	127.4	-0.3	3
Community Health Services	97.0	94.4	-2.6	3	107.8	102.9	-4.9	3
Continuing Care	72.2	77.3	5.1	2	79.0	84.5	5.5	2
Other Programme	35.0	15.7	-19.3	3	38.4	19.8	-18.5	3
Prescribing	95.3	98.3	3.0		103.8	107.1	3.3	
Primary Care Services	18.2	18.3	0.1	3	19.9	20.0	0.1	3
Primary Care Co-Commissioning	112.3	112.3	0.0	3	122.5	122.5	0.0	3
Running Costs	13.7	13.7	0.0	3	15.0	15.0	0.0	3
Central Reserves & Efficiency Requirement	-0.0	0.0	0.0	3	0.0	0.0	0.0	3
TOTAL EXPENDITURE	**1,165.3**	**1,167.7**	**2.4**		**1,273.7**	**1,281.9**	**8.1**	
Revenue Resource Limit Total	**-1,165.3**	**-1,165.3**	0.0	3	**-1,273.7**	**-1,273.7**	0.0	3
In Year (Surplus) / Deficit Before NHSE top up, non recurrent funds, covid contingency	**0.0**	**2.4**	**2.4**		**0.0**	**8.1**	**8.1**	
Retrospective Funding expected for HDP/Covid, WAF & ERF		-0.0	-0.0	3		0.0	0.0	3
Adjusted (Surplus) / Deficit after NHSE expected top up		**2.4**	**2.4**			**8.1**	**8.1**	
Covid Contingency		-0.1	-0.1			-0.1	-0.1	
Non Recurrent Mitigation		-2.3	-2.3			-8.1	-8.1	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

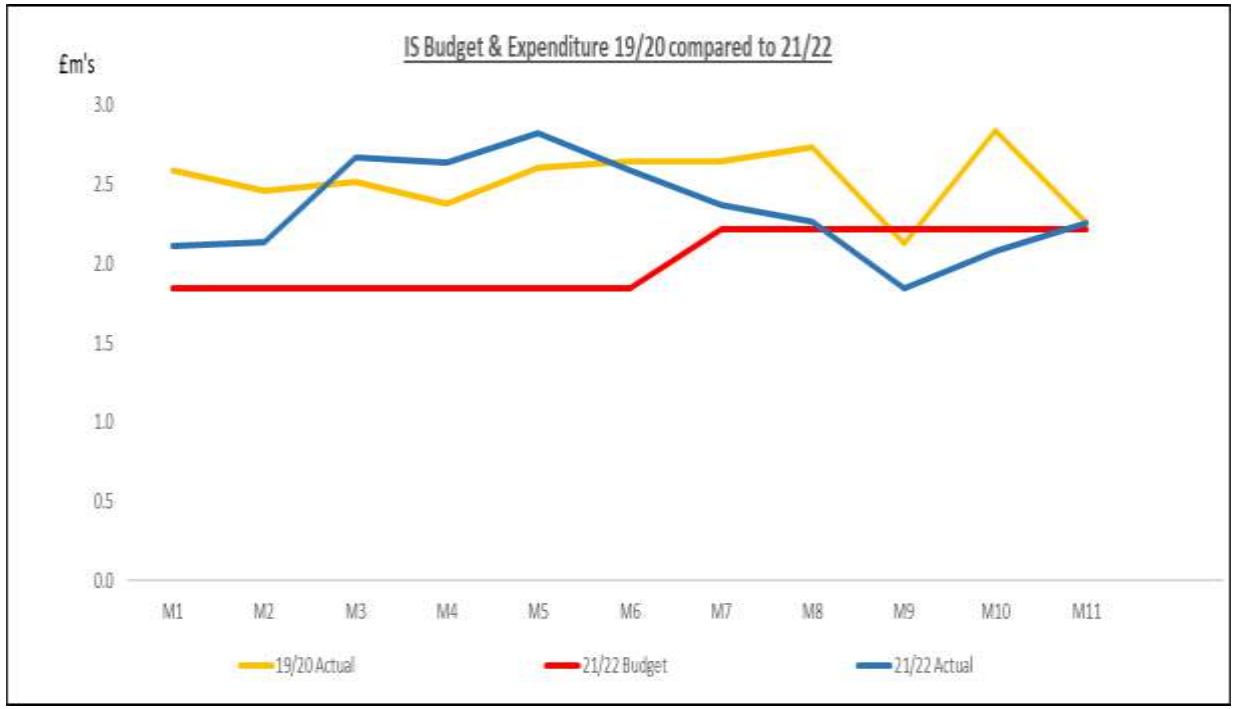
21/22 full year variances – BHR and NEL Breakdown

- This table shows the forecast BHR ICP and NEL CCG variances, including level of the deficit before non-recurrent mitigation.
- The table highlights some consistent trends **across NEL, particularly with regard to acute and prescribing.**
- NEL CCG is expecting an additional £17.2m of retrospective funding from NHSE / I (forecast position).
- Of this £17.2m, £9m relates to the Hospital discharge programme, **which is reported as a pressure in the Community Health Services line.** The balance relates to WAF (£6.8m), ARRS (£0.9m) and £0.5m for other Covid.
- Further detail on specific variances relating to acute, continuing care and prescribing can be found on the next few slides.

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown	
	BHR £m	NEL £m
Acute	22.9	28.9
Mental Health & LD	-0.3	0.0
Community Health Services	-4.9	5.8
Continuing Care	5.5	4.8
Other Programme	-18.5	-24.0
Prescribing	3.3	4.1
Primary Care Services	0.1	12.9
Primary Care Co-Commissioning	0.0	7.7
Running Costs	0.0	-0.0
Central Reserves	0.0	34.6
TOTAL EXPENDITURE	**8.1**	**74.8**
Revenue Resource Limit Total	**0.0**	**0.0**
In Year (Surplus) / Deficit Before NHSE top up, non recurrent funds, covid contingency	**8.1**	**74.8**
Retrospective Funding expected for HDP/Covid, WAF & ERF	0.0	-17.2
Adjusted (Surplus) / Deficit after NHSE expected top up	**8.1**	**57.6**
Covid Contingency	-0.1	-4.9
Non Recurrent Mitigation	-8.1	-52.8
In Year (Surplus) / Deficit	**0**	**0.0**

BHR ICP key variances - Acute

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown	
	BHR £m	NEL £m
Acute	22.9	28.9



- **BHR ICP have an acute forecast overspend of £22.9m compared to £25.1m at Month 10.** This increases to £28.9m at a NEL level.
- NHS block contracts are reported as breakeven.
- Forecast overspends are reported on BHR ICP **against urgent care (£0.9m), non contract activity (£2.2m) and independent sector (IS) providers (£4.6m).**
- Additionally, there is a **£15.1m reported overspend in acute relating to schemes and additional support that the ICP has agreed to fund outside of the BHRUT block contract.** These schemes are specifically around winter arrangements, the frailty unit and ERF, and have been funded from non-recurrent reserves and the £9.5m returned by NELFT.
- The forecast position on the independent sector assumes that the CCG will not receive any further ERF income.
- Overall H2 spend is more or less in line with H2 budget and is below the 19/20 run rate.

BHR ICP key variances – Continuing Healthcare

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown	
	BHR £m	NEL £m
Continuing Care	5.5	4.8

BOROUGH	ANNUAL BUDGET £m	FORECAST OUTTURN £m	FORECAST VARIANCE £m
BARKING AND DAGENHAM	18.6	19.5	0.9
HAVERING	27.9	30.9	3.0
REDBRIDGE	32.5	34.1	1.6
BHR ICP	**79.0**	**84.5**	**5.5**

	Package Numbers Per Month	Movement Month on Month
M2	1,581	
M3	1,613	32
M4	1,660	47
M5	1,651	-9
M6	1,687	36
M7	1,721	34
M8	1,753	32
M9	1,736	-17
M10	1,722	-14
M11	1,696	-26
Packages Mvmt M2 to M11 =		**115**

ICP → BHR - M11				
CHC Type	Start of Period Packages	New Packages	Removed Packages	End of Period Packages
Adults	701	184	199	686
Children	73	13	14	72
FNC	948	32	42	938
Total =	**1,722**	**229**	**255**	**1,696**

- **BHR are reporting a full year forecast overspend of £5.5m**. The NEL forecast overspend is £4.8m
- The BHR forecast position reflects a £0.3m increase from Month 10**.** The increased forecast in part reflects the additional costs of packages due to **service users requiring more 1:1 and 2:1 care and an assumed trajectory to the end of the financial year.**
- In previous financial years when all information from providers has been received, final outturn has exceeded forecast. Therefore, the trend assumes a similar position to previous years.
- The information on packages of care shows the split across adults, children and funded nursing care.

BHR ICP key variances – Primary Care and Prescribing

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown	
	BHR £m	NEL £m
Prescribing	3.3	4.1
Primary Care Services	0.1	12.9
TOTAL PRIMARY CARE	**3.4**	**17.0**

- **The BHR forecast variance on primary care and prescribing is £3.4m**. This increases to £17m across NEL.
- The prescribing forecast variance is based on the latest available data (month 9).
- The driver behind the overspend is the increased number and in some cases, cost of prescriptions.
- Primary Care Services show a forecast breakeven position for BHR, with a forecast overspend of £6.7m across NEL.
- The main drivers of the NEL overspend include; Covid service related costs including access (hubs), oxygen and additional costs to support 111 downstream pressures. This has been fully mitigated by the release of the CCG Covid contingency.

BHR ICP key variances - Other

1. **Mental Health** – at Month 11 there is a small reported variance against mental health, largely relating to the costs of activity driven packages of care. The MHIS plan has been set for the full financial year and the Month 11 return to NHSE shows a position that is compliant with the plan. The majority of SDF and spending review funds (SR) for mental health have transferred to NELFT and ELFT for them to deliver the services. At Month 11, it is assumed that NELFT and ELFT will utilise them in full.

2. A system wide exercise was undertaken at Month 10 to review all ICS partners forecast outturns. **This resulted in NELFT identifying £9.5m of funds to be returned to the CCG.** This return of funds has been used to cover the elective recovery shortfall at BHRUT.

3. **Investments** – as detailed in the ISP, non-recurrent funding sources have been agreed to fund transformation investments in 21/22, with the aim that savings will be delivered in the next financial year. These are detailed in Appendix 2. Total funding agreed is £9m, with £8.3m committed in the Month 11 forecast. The balance is expected to be utilised in Month 12 of this financial year. Spend is reported against service areas (largely acute and CHS), with non-recurrent mitigations offsetting the spend.

Hospital Discharge Pathway / Covid

Hospital Discharge Pathway

- HDP is reimbursed on actual spend against a notional budget capped at £20.4m for H1 and £17.9m for H2 (total £38.3m) for NEL CCG.
- **BHR ICP expenditure is £11.1m year-to-date and a forecast of £12.8m.**
- At month 11, NHSEI have reimbursed £23.6m across NEL. **Therefore, at month 11 there is an additional HDP year-to-date claim for both H1 and H2 of £5.3m**, with £9m expected for forecast costs.
- H2 forecast spend across NEL remains under the H2 cap. **There is a risk that any further increase in forecast costs will breach the H2 cap.**

	LA YTD M11 £m	CCG YTD M11 £m	Total YTD M10 £m	LA FOT £m	CCG FOT £m	Total YTD £000s
BHR ICP	8.1	3.0	11.1	9.4	3.4	12.8
CH ICP	1.2	0.3	1.5	1.3	0.3	1.7
TNW ICP	7.0	9.2	16.3	8.1	10.0	18.1
Total	**16.4**	**12.5**	**28.9**	**18.8**	**13.7**	**32.6**
HDP Funds received			-23.6			-23.6
Total Retrospective claim - M10			**5.3**			**9.0**

Other Covid

- Other than HDP, the majority of Covid costs are funded within the CCG baseline.
- **BHR ICP has a forecast claim of £0.9m in relation to vaccination costs**.

Elective Recovery Fund

	Total ERF
Elective Recovery Fund	**H1 & H2 £m**
BHRUT	8.0
Barts Health	12.1
Homerton	3.4
NEL CCG	3.5
Total ERF	**27.0**
Funding distributed - Trusts	-23.5
Funding distributed - NEL CCG	-3.5
Outstanding ERF claim	**0.0**

- ERF plans submitted to NHSE/I captures information from NHS and non-NHS providers. The H1 position resulted in a claim of £26.5m which has been fully reimbursed. In Month 10 NHSE/I transferred an additional £0.5m to the CCG, bringing the total ERF income received to £27m.
- £23.5m of the total £27m was payable to BHRUT, Barts and Homerton.
- The remaining £3.5m was allocated to the CCG to fund the non NHS costs elective recovery costs.
- **At month 11 the CCG is not expecting any further additional ERF income**.
- This expectation is based on the latest assumptions about IS activity data. Any changes to activity data will impact the expected ERF income.

Financial Accounts Performance Metrics

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

	2021/22 AP11 - FEB 22		2021/22 AP8 - JAN 22		2021/22 Year to date		2020/21 Outturn	
	Number	£000	Number	£000	Number	£000	Number	£000
Non-NHS Payables:								
Total Non-NHS trade invoices paid in the year	6,838	102,961	6,380	75,791	70,111	795,983	89,808	865,136
Total Non-NHS trade invoices paid within target	6,523	99,994	6,020	71,892	66,758	769,466	85,961	824,785
Percentage of non-NHS trade invoices paid within target	95%	97%	94%	95%	95%	97%	96%	95%
NHS Payables:								
Total NHS trade invoices paid in the year	466	224,527	350	226,337	3,701	2,558,696	12,449	2,407,453
Total NHS trade invoices paid within target	378	223,058	346	226,521	3,473	2,550,515	11,472	2,395,694
Percentage of NHS trade invoices paid within target	81%	99%	99%	100%	94%	100%	92%	100%
Combined non NHS and NHS:								
Total Non-NHS trade invoices paid in the year	7,304	327,488	6,730	302,128	73,812	3,354,678	102,257	3,272,589
Total Non-NHS trade invoices paid within target	6,901	323,052	6,366	298,412	70,231	3,319,981	97,433	3,220,479
Percentage of all trade invoices paid within target	94%	99%	95%	99%	95%	99%	95%	98%

- The number of NHS invoices paid within target reduced in February due to the clearance of invoices following the final agreement of performance. As a large number of invoices were involved this has also impacted on the cumulative position.

2022/23 Planning – NEL Overview - Revenue Funding

- A draft system and ICB (CCG) plan was submitted to NHSEI on 17 March 2022. The final plan is due on 28th April. The final plan will be returned to future finance committees for approval.
- Draft workforce and elective plans costed into provider plans, ERF distributed based on 104% activity achievement.
- ICS allocation totals £3.95bn. This includes a recurrent baseline of £3.74bn and a number of non-recurrent funding streams, a much reduced Covid fund (£105.1m lower than 21/22 at £79.4m and Elective Recovery Fund (£65.9m).
- **The draft submission shows a system deficit of £99.5m, of which £36.7m relates to the CCG.** The main system drivers of this are shown in the table below:

Above Inflation Provider Cost Pressures	**£'m**	**£'m**
CNST	6.4	
Utilities/Energy	22.8	
PFI Inflation	8.8	
Other Non-Pay Inflation	14.7	
Digital/Technology	3.9	
Depreciation	2.5	
High Cost Drugs	2.7	
Other	4.0	
		65.8
CCG - Excess price inflation e.g. AQP increases		**6.0**
Additional Retained funding of prior year commitments		**23.7**
Total		**95.5**

2022/23 Planning – NEL Overview - Revenue Funding (cont.)

- The financial gap in the plan requires further work and evaluation, especially for retained services as the system recovers from Covid. The CCG and providers will need to work together to close the planning gap before the final submission.
- Mitigations are yet to be fully identified for significant prices pressures in excess of inflation.
- Transformation SDF funding £63.9m – assumed this is fully utilised outside of current provider plans. The plan assumes that all SDF funding is fully utilised.
- The system plan includes Health Inequalities funding - £6.6m. This needs to be further reviewed before final submission.
- The plan assumes CCG efficiencies relating to prescribing, CHS and running costs. The system plan also includes Trust efficiencies – generally between 2.1% to 2.8%, BHRUT at 4.4%

		Annual Plan - Total Allocation £m	Agreed £m	Indicative £m
1	ICB Programme Allocation	3,336.3	3,336.3	0.0
2	Ockenden funding	4.6	4.6	0.0
3	Primary Medical Care Services	359.5	359.5	0.0
4	Running costs	38.7	38.7	0.0
5	**Total CCG recurrent Allocation (confirmed)**	**3,739.2**	**3,739.2**	**0.0**
6	Health Inequalities Funding	6.6	6.6	0.0
7	Elective Services Recovery Funding	65.9	0.0	65.9
8	COVID funding	79.4	79.4	0.0
9	Service Development Fund (SDF)	63.9	46.1	17.8
10	**Total CCG Non-Recurrent Allocation (confirmed)**	**215.8**	**132.1**	**83.7**
11	**Total CCG allocation (confirmed)**	**3,954.9**	**3,871.3**	**83.7**

2022/23 Planning – Applied Price Increases

- The CCG is facing a number of inflationary price pressures that have been built into the plan.
- The table sets out the core price inflation assumptions across the services.
- Notable inflation can be seen in services with historically lower paid workers, impacted by national insurance and wage increases.
- Additional significant risks continue to grow with RPI linked increases in areas such as utilities.

NEL CCG Planning assumptions 2022-23		
Directorate	**Price assumption**	**Total Growth Applied**
Growth on NHS provider block payments	1.70%	1.10%
Healthcare – Non NHS & IS	1.70%	1.70%
Prescribing	2.10%	2.10%
CHC	6.60%	6.60%
Domiciliary Care - AQP	9.20%	9.20%
Domiciliary Care - Non AQP	6.62%	6.62%
FNC	4.50%	4.50%
Nursing home AQP	4.40%	4.40%
Nursing home Non AQP	4.00%	4.00%
Hospice	2.02%	1.72%
Other programme	2.02%	0.92%
CCG community activity	2.02%	1.82%
Mental Health	4.88%	4.88%
Better Care Fund	5.30%	5.30%
Base Primary Care	4.80%	4.80%

2022/23 Planning – BHR Summary Financial Position

BHR Total	22-23 Net Opening Budgets (+)	Planning Assumptions	Investments	22-23 Do Nothing Plan (+)	QIPP - Recurrent and Non Recurrent	22-23 With QIPP Plan (+)
	£m	£m	£m	£m	£m	£m
BHRUT	381.2	4.2	16.7	**402.1**	0.0	**402.1**
Barts	117.2	1.3	0.0	**118.5**	0.0	**118.5**
Homerton	9.8	0.1	0.0	**10.0**	0.0	**10.0**
Associates	51.6	2.1	0.0	**53.7**	0.0	**53.7**
LAS	39.5	1.6	0.0	**41.1**	0.0	**41.1**
Other acute	62.6	1.1	6.9	**70.5**	0.0	**70.5**
Acute Reserve	0.0	0.0	0.0	**0.0**	0.0	**0.0**
Total Acute	**661.9**	**10.3**	**23.6**	**695.8**	**0.0**	**695.8**
Prescribing	103.1	5.3	0.0	**108.3**	(5.4)	**102.9**
Other Primary Care	16.4	0.6	3.1	**20.1**	0.0	**20.1**
Total Primary Care	**119.5**	**5.9**	**3.1**	**128.5**	**(5.4)**	**123.0**
NELFT MH Including IAPT	102.6	1.1	3.8	**107.5**	0.0	**107.5**
MH Reserves Investment	0.0	0.0	1.0	**1.0**	0.0	**1.0**
CAMHS	1.7	0.1	0.1	**1.8**	0.0	**1.8**
Other MH	12.5	0.6	0.2	**13.3**	0.0	**13.3**
Total Mental Health	**116.8**	**1.8**	**5.1**	**123.7**	**0.0**	**123.7**
NELFT CHS	84.5	1.0	5.3	**90.8**	0.0	**90.8**
Other Community	12.9	0.2	0.1	**13.2**	0.0	**13.2**
Community Reserves Investment	0.0	0.0	0.0	**0.0**	0.0	**0.0**
Total Community	**97.4**	**1.2**	**5.4**	**104.0**	**0.0**	**104.0**
CHC	**82.2**	**7.2**	**0.0**	**89.4**	**(2.2)**	**87.2**
Programme Projects	6.8	0.0	0.0	**6.8**	(0.6)	**6.2**
Non Recurrent Programmes	4.5	(0.0)	12.3	**16.8**	0.0	**16.8**
Other Programme Spend	27.5	1.1	0.0	**28.6**	0.0	**28.6**
Total Other	**38.9**	**1.1**	**12.3**	**52.3**	**(0.6)**	**51.6**
Delegated Primary Care	122.0	0.0	0.0	**122.0**	0.0	**122.0**
Total Delegated Primary Care	**122.0**	**0.0**	**0.0**	**122.0**	**0.0**	**122.0**
Running Costs	15.0	0.4	0.0	**15.4**	(0.4)	**15.0**
Total BHR Expenditure	**1,253.6**	**27.8**	**49.6**	**1,330.9**	**(8.7)**	**1,322.2**

- The final funding split across NEL is still to be finalised. However, once the full year impact of 21/22, non recurrent adjustments and planning guidance increases are applied to BHR level information this produces a draft ICP plan shown in the attached table.
- **The BHR ICP draft plan contributes to the CCG deficit position of £36.7m.**
- The BHR position includes pressures relating to the ISP funds, capacity pressures at BHRUT (including Sky A, critical care unit), MHIS investments and the full year impact of agreed business cases.
- **The draft plan includes a £8.7m QIPP target**, largely in relation to prescribing (£5.4m) and CHC (£2.2m).

2022/23 Planning – System Summary Financial Position

	BHRUT £m	Barts £m	ELFT £m	Homerton £m	NELFT £m	CCG £m	System Balance £m
Income	767.4	1,984.3	563.8	382.0	495.8	3,953.0	
Expenditure	(789.3)	(2,044.4)	(567.9)	(397.8)	(499.6)	(4,010.9)	
Surplus / (Deficit)	**(21.9)**	**(60.1)**	**(4.1)**	**(15.8)**	**(3.8)**	**(57.9)**	**(163.6)**
Plan Adjustments	10.3	27.9	0.0	4.7	0.0	21.2	64.1
Submission	**(11.6)**	**(32.2)**	**(4.1)**	**(11.1)**	**(3.8)**	**(36.7)**	**(99.5)**

- Before adjustments, the system plan deficit is £163.6m.
- The draft submission included £64.1m of adjustments including adjustments to ERF, and CCG and system stretch efficiency targets.
- **The submitted system deficit in the draft plan is £99.5m.**
- Specific cost pressures include utilities prices increases, estimated at £22.8m and general price inflation of £14.7m. The impact of RPI on PFI schemes is £8.8m and CNST pressures of £6.4m. Collectively these and small cost pressures contribute to £65.8m of the system gap.

2022 / 23 Planning – Risks

- **Elective Recovery**
  - System needs to deliver 104% of activity on a value basis. Current productivity in the 90%'s
  - Guidance indicates a reduction in follow up, not considered likely in the medium term despite greater investment in Advice & Referral
  - Marginal rates (for over and under-performance) at 75% of tariff
- **Inflationary Pressures**
  - Inflation is at the highest level for many years. the tariff uplift assumes 2.8%, whereas actual inflation is at 5.5% (January 2022).
  - CNST costs across NEL have increased by £7m, the national guidance suggested premiums had fallen.
- **Service Changes**
  - HDP has ceased and Covid funds have reduced, generating pressures within the system

Summary

- NEL CCG and the ICPs have submitted a break even plan for H2. It is expected that a break-even position will be achieved for the year. BHR ICP have set a H2 budget that does not rely on the use of non-recurrent mitigations.

- At Month 11, NEL CCG has reported a break-even position on the core budgets and a reported variance as a result of the outstanding NHSE/I retrospective top-up for HDP, claimable Covid, WAF and ARRS.

- The break-even position in BHR ICP has been achieved using non-recurrent mitigations (forecast £8.1m) relating to the overspend reported in H1.

- The CCG has worked through all known commitments at Month 11 to ensure that the year-end targets can be met. These have been factored into the Month 11 forecast position. The main items include transformation investments to support the integrated sustainability plan (appendix 2) and support to local authority partners in relation to increasing costs of the hospital discharge programme and associated packages. Additionally, NELFT have returned £9.5m of funds which has been used to cover the elective recovery shortfall at BHRUT.

- NHS contracts continue to be paid on a block basis. However, within the reported position there are risks on the independent sector, prescribing, NEL corporate costs and in-envelope Covid spend in primary care.

- The planning framework, business rules and allocation process have been worked through into a set of system and ICB plans. This shows a system deficit of £99,5m, with £36.7m being the CCG share. The final plan submission is due in April 2022.

Appendix 1 – NEL Funds

NEL CCG Financial Summary H2 2021-22	Month 11				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	1,998.9	2,020.2	21.3		2,178.9	2,207.8	28.9	
Mental Health & LD	361.9	361.9	-0.1	3	394.8	394.9	0.0	3
Community Health Services	335.2	344.3	9.0		365.7	371.4	5.8	
Continuing Care	150.7	155.1	4.4		164.5	169.3	4.8	
Other Programme	131.0	109.1	-21.9	3	146.3	122.3	-24.0	3
Prescribing	229.2	233.2	3.9		250.1	254.3	4.1	
Primary Care Services	75.5	88.3	12.8		83.7	96.7	12.9	
Primary Care Co-Commissioning	313.9	318.1	4.2		342.8	350.4	7.7	
Running Costs	37.0	37.0	-0.0	3	40.3	40.3	-0.0	3
Central Reserves	-1.0	28.5	29.4		-5.7	28.9	34.6	
TOTAL EXPENDITURE	**3,632.5**	**3,695.6**	**63.1**		**3,961.5**	**4,036.3**	**74.8**	
Revenue Resource Limit Total	**-3,632.5**	**-3,632.5**	0.0	3	**-3,961.5**	**-3,961.5**	0.0	3
In Year (Surplus) / Deficit Before NHSE top up, non recurrent funds, covid contingency	**0.0**	**63.1**	**63.1**		**0.0**	**74.8**	**74.8**	
Retrospective Funding expected for HDP/Covid, WAF & ERF		-10.2	-10.2	3		-17.2	-17.2	3
Adjusted (Surplus) / Deficit after NHSE expected top up	**0.0**	**52.9**	**52.9**		**0.0**	**57.6**	**57.6**	
Covid Contingency		-4.6	-4.6			-4.9	-4.9	
Non Recurrent Mitigation		-48.4	-48.4			-52.8	-52.8	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

Appendix 2 – Investments (funded from non-recurrent reserves in 21/22)

Scheme	Transformation Area	Non Recurrent Budget £000s	Commitments at Month 11 £000s	Further forecast - M12 £000s
ACR Hypertension	Long Term Conditions	10		10
LTC Diabetes – out of hospital management	Long Term Conditions	19		19
LTC Education	Long Term Conditions	10		10
Non Invasive Ventilation (NIV)	Long Term Conditions	55	55	
(ACP) Pharmacist in the Community Treatment Team (CTT)	Older People	34		34
Community Complex Dementia	Older People	182	182	
Expansion of the community falls service	Older People	217	217	
Home First Pilot	Older People	250	250	
Hospital Discharge Service	Older People	550	550	
Frailty Service	Other Non Recurrent Schemes	2,539	2,539	
Phlebotomy	Other Non Recurrent Schemes	1,214	1,214	
Redbridge Multiple Sclerosis Specialist Nurse	Other Non Recurrent Schemes	7	7	
Training Hub to provide LTC training for the ARRs roles	Other Non Recurrent Schemes	15		15
Reducing health inequalities through cardiovascular disease prevention	Other Non Recurrent Schemes	84		84
BHRUT AIRS	Planned Care	152	152	
BHRUT RAS	Planned Care	195	195	
Community Minor Surgery	Planned Care	80	80	
MSK e-referral Tool	Planned Care	256		256
MSK New Model Of Care-EOR	Planned Care	70		70
Ambulatory care	Urgent Care	56	56	
ED care Navigators	Urgent Care	88	88	
Pilot HALO (Hospital Ambulance Liaison Officer)	Urgent Care	105	105	
Virtual Ward	Urgent Care	34	34	
Winter scheme 1 - Community Beds	Urgent Care	160	160	
Winter scheme 1 - End of Life Care Home Pilot	Urgent Care	51	51	
Winter scheme 1 - Intensive Rehab Service	Urgent Care	655	655	
Winter scheme 1 - Queens beds - Skye A ward	Urgent Care	1,479	1,479	
Winter scheme 1 - Therapy assessment in ED	Urgent Care	189	189	
Winter scheme 1 - Weekend nursing home discharges	Urgent Care	8		8
		8,764	**8,258**	**506**

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

Minutes - Integrated Care Executive Group

20 January 2022 at 3.30pm – 5.00pm
Via MS Teams

Members:

Ceri Jacob (CJ)	Managing Director, BHR ICP – chair
Dr Caroline Allum (CA)	Medical Director, NELFT
Dr Magda Smith (MS)	Chief Medical Officer, BHRUT & Health & Care Cabinet Chair
Matthew Cole (MC)	Director of Public Health, LBBD
Craig Nikolic (CN)	Chief Operating Officer, B&D GP Federation
Ross Arnold (RA)	Chief Executive, Redbridge GP Federation
Matthew Trainer (MT)	Chief Executive, BHRUT
Barbara Nicholls (BN)	Director of Adult Services, LBH
Jacqui Van Rossum (JVR)	Executive Integrated Care Director, NELFT
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation

Attendees:

Lee Basso (LB)	Director, Strategy & Partnership, BHRUT
John Craig (JC)	Chief Executive, Care City
Ahmet Koray (AK)	Director of Finance, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Debbie Harris (DH)	Governance Officer, BHR ICP – note taker

In Attendance:

Kathryn Halford (KH)	Chief Nurse, BHRUT
Kenye Karemo (KK)	Director of Education, Workforce Development and Research / Programme Director – BHR Career Maps Programme
Hanh Xuan-Tang (HXT)	Deputy Director of Recovery Planning
Chris Cotton (CC)	Director of integrated care system transition
Rebecca Smith (RS)	Commissioning Programme Manager

Apologies/not present:

Henry Black (HB)	Acting Accountable Officer
Adrian Loades (AL)	Director of People, LBR
Claire Symonds (CS)	Interim Chief Executive, LBBD
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Emily Plane (EP)	Programme Lead, BHR ICP
Carrie-Anne Wade (CW)	Strategic Communications Leader, NELFT
Melissa Hoskins	Associate Director – Communications and Engagement (BHR and TNW), NEL CCG

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

1.1	**Declarations of conflicts of interest**	
	The register of interests was noted and the chair reminded everyone of their obligation to declare any interest they may have on any items discussed at the meeting. No additional conflicts of interest were declared.	
1.2	**Minutes of the last meeting**	
	The minutes of the meeting held on 18th November 2021 were agreed as an accurate record. The group noted that the Health and Care Cabinet is now Chaired by MS, and that this has been reflected in the Members of the Board section above.	
1.3	**Action log/matters arising**	
	The actions log was noted and updated accordingly. The group noted that there is agreement to keep this at Place level, working alongside a NEL Level Group.	
2.0	**Transformation**	
	2.1 BHR Transformation Boards 21/22 key milestones and Integrated Sustainability Plan (ISP) impact The following amendments made since the report at the November meeting; narrative has been added to the rag rating milestones to provide more context. A table on activity shifts has been added to highlight where the shifts are taking place, though at this stage, it is not showing the activity rating for prevention or anticipatory care. This will be provided in future reports. Members felt that an enhancement would be to see the investment that goes with the activity within the tables along with an explanation as to the performance in key areas. Reference was made to the Wound Care service. Primary Care was approached to consider options to develop this service; there are 2 phases of simple would care 1. Getting patients out of ED and UTCs which has gone live 2. Phase 2 is the element of Primary Care providing support Also discussed was the D2A with an ask that in the end to end pathway Primary Care GP practices be considered. BN advised she will pick this up with Sharon Morrow outside of the meeting. There was concern regarding the capacity of General Practice to support an additional 16,000 more patients; this needs to be considered and managed as a risk. The Chair asked members, outside of the meeting, to give some thought to the outcomes for patients. TR advised that work is taking place with each Transformation Board to get an outcome focus which can be shared with MS and CA once complete.	**Action**: BN to pick up D2A with SM outside of the meeting **Action**: TR to go through report in more detail with

	The Director of Transformation will meet with Local Authority colleagues to support an in depth understanding of the report. ICEG members: • Noted the current progress of the Transformation Boards in relation to the delivery of transformation schemes in 21/22 against the targets set out in the ISP, and the current performance against the key milestones for each Transformation Board	BN/AL outside of the meeting
3.0	**BHR Health and Care Academy 22/23 and beyond**	
	KH talked members through the attached paper. Members asked if the Academy could provide support in recruitment from abroad. BHRUT have the expertise and knowledge to recruit from abroad . Career maps have been developed and used across BHRUT where people are brought in as Health Care assistants and developed to become nurses; this approach can be replicated for social care careers. Local Authority colleagues to consider how this approach can be adapted further for the Social workforce. The BHR Academy has been approached to lead on work to recruit therapists across NEL, which currently has over 1000 vacancies. The approach will consider how we grow our own workforce, and bring local people via apprenticeships. This work is being scoped with a separate project team being set up to lead this work. The Academy was asked if they could also consider the PCN workforce having opportunities for trainee apprentices as their development framework is currently limited. It was agreed this is another great opportunity. Members agreed to invest to the Academy in the longer term. CJ/KH/AK to meet outside of the meeting to discuss the finances. ICEG members: • Noted the content of this paper • Endorsed the recommended new team as proposed	**Action**: BN to speak to her LA colleagues re linking in with KH on using the Academy to help with Social Care recruitment **Action:** CJ/KH/AK to meet outside of this meeting to look at the finances
4.0	**Local Area Co-ordinator evaluation**	
	RS talked members through the attached paper. Highlight findings include that Local Area Co-ordinators have been able to intervene at real crisis points in people's lives preventing further deterioration. A range of positive outcomes for residents, enabling them to have a positive outlook on life has been achieved. This is driving Havering's preventive agenda in delivering change. It was found that £150k had been saved across the system on 8 case studies, which have an investment of about £18k per person. More case studies are being evaluated to build a more robust cost avoidance model. To roll this service out across the whole Borough would require 22 co-ordinators and management structure would cost around 1.2m per year. Funding for this service is in place until the end of the next financial	

	year but partners are looking at how to sustain the service in the longer term, which will be picked up through Place Based Partnership meetings. Outputs will also be shared with LBBD and Redbridge once the Havering Partnership Board are sighted. Response to recruitment has been positive with a high number of applicants. The Chair agreed to receive bi-monthly updates to ICEG. DH to add to forward planner. ICEG members: • Noted the findings and recommendations of the evaluation • Discussed options for future funding for the service • Agreed to receive regular updates (every other month) on progress with the implementation of the Local Area Coordination Pilot	**Action**: DH to add bi-monthly updates to ICEG forward planner
5.0	**BHR ICS development**	
	5.1 BHR update The proposal for key areas of continued multi borough collaboration has been endorsed by the group, with a proposal around governance to support this in development. Work is also underway on the Clinical Leadership model, this will be the focus of the next BHR Place based development session along with a discussion on Place Based Partnership finance. A substantive item on the Transformation Cycle to come back to a future meeting. ICEG members: • Members of the BHR Integrated Care Executive Group noted the progress to develop the key elements of our BHR Integrated Care Partnership detailed within this report, and in particular to continue to support and engage with the process to develop our Place Based Partnerships within the wider ICS context. **5.2 Havering Place Based Partnership development update** Members received a progress report as set out on slide 4 along with an update on governance on slide 6. Membership of this group is quite wide which has been deliberate as they want it to be as inclusive as possible to include Health Care providers, Healthwatch, compact chair etc. This will need to be managed by an Executive. ICEG members: • Noted the content of this report • Agreed for future updates on HBP development to be presented in this forum	**Action:** Substantive item on Transformation Cycle to come to a future mtg. DH to add to forward planner **Action**: further updates on the Havering Placed Based Partnership to come back to this meeting. DH to add to forward planner

	5.3 NEL update: Latest ICS guidance/implications Members received an update as set out in the attached paper. Members agreed that it is sensible to keep the momentum of this work up over the next several months. Contracts were discussed with confirmation that ones continuing into next year will roll forward and novate. If the contract was coming to an end this year it would go through the normal evaluation process then either extend or novate 3 months later. Members discussed the roles for the ICB Executive. It was confirmed that these roles are part of the mandated National recruitment which will take place in Feb/Mar as planned. These roles will report into Zina Etheridge as the Exec lead for the ICB. For partnership roles on the ICP Board there is guidance due soon from NHSE on what the process may look like. For each Place Based Partnership, it is anticipated there will be a Borough Clinical and Care Professional Lead as well as a Primary Care development lead as standard across the seven NEL boroughs. This role does not displace any of the professional accountabilities that leads will have within their own organisations. The role is designed to be the clinical and/or care professional voice on this Placed Committee. A draft job description is being shared for review. Members were asked to note, that due to the extension to July of the ICP, we need to think about running in shadow form. it was agreed to discuss this further at the next Development session. ICEG members: • Noted the update	
6.0	**ICP performance**	
	4.1 BHR priority actions progress update SR advised that items in the performance report had already been covered in previous agenda items e.g. Deep Dive Anchor Organisations in the Academy report and the Local Area Co-ordination which fits into the second part of Anchor organisations. Members were updated on the collective work to embed social value in our procurement processes. Work is taking place on mapping relevant upcoming procurements linked to this to identify key opportunities. As part of this we will be looking at how we can collectively support market development and local businesses and Community and Voluntary Sector organisations to bid for procurements. ICEG members: • Members noted the progress to take forward the partnership priorities.	

7.0	**Any other business**	
	• Further meetings of the ICEG to be added to diaries through to June • Place Based Partnership Leads to contact CJ/EP should they wish to discuss parallel working in shadowing form • NC referred to this year's standard contract consultation asking that if anyone has sight of a copy of the sample specification would they kindly share it with him.	**Action:** DH to ensure 3 further meetings go into diaries.
8.0	**Items for information**	
	8.0 Virtual approval ICEG members noted the virtual approval of the below: • BHR Older People and Frailty Strategy • Proposal for ongoing multi- borough collaboration in BHR and beyond **8.1 ICPB – January agenda** ICEG members noted the agenda. **8.2 BHR Quality & Performance Oversight Group minutes** ICEG members noted the minutes of the meeting held in November and December 2021.	
	Date of next meeting – 17 February 2022	

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

Draft minutes - Integrated Care Executive Group

17 February 2022 at 3.30pm – 5.00pm
Via MS Teams

Members:

Ceri Jacob (CJ)	Managing Director, BHR ICP – chair
Dr Caroline Allum (CA)	Medical Director, NELFT
Dr Magda Smith (MS)	Chief Medical Officer, BHRUT & Health & Care Cabinet Chair
Matthew Cole (MC)	Director of Public Health, LBBD
Craig Nikolic (CN)	Chief Operating Officer, B&D GP Federation
Ross Arnold (RA)	Chief Executive, Redbridge GP Federation
Barbara Nicholls (BN)	Director of Adult Services, LBH
Jacqui Van Rossum (JVR)	Executive Integrated Care Director, NELFT
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG

Attendees:

Ann Hepworth (AH)	Director, Strategy & Partnership, BHRUT
Ahmet Koray (AK)	Director of Finance, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Debbie Harris (DH)	Governance Officer, BHR ICP – note taker
Emily Plane (EP)	Programme Lead, BHR ICP
Dr Ravi Goriparthi (RG)	B&D PCN Clinical Director
Umesh Gadhvi (UG)	Director of HealthCare Informatics, NELFT & BHRUT/item3
Steve Beales (SB)	Assistant Director, ICS Implementation

Apologies/not present:

Henry Black (HB)	Acting Accountable Officer
Adrian Loades (AL)	Director of People, LBR
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
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Matthew Trainer (MT)	Chief Executive, BHRUT
John Craig (JC)	Chief Executive, Care City

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

1.1	**Declarations of conflicts of interest**	
	The register of interests was noted and the chair reminded everyone of their obligation to declare any interest they may have on any items discussed at the meeting. No additional conflicts of interest were declared.	
1.2	**Minutes of the last meeting**	
	The minutes of the meeting held on 20th January 2022 were agreed as an accurate record.	
1.3	**Action log/matters arising**	
	The actions log was noted and updated accordingly.	
2.0	**ICS development**	
2.1	**Proposed governance to support ongoing multiborough collaboration**	
	CJ talked members through the attached paper. It was noted that the Terms of Reference have been presented to Local Place Based Partnership Boards but the ask wasn't for them to be signed off. Place Based representatives, on this call, where asked to formally take these Terms of Reference though their Partnerships for sign off. The topic of collaboration was raised and the need to work locally on some issues as there will always be the need to work differently in each Borough responding to population health need, alongside some common challenges across BHR. Reference was made to the recent publication of the Integration White Paper and the need for reconciliation of the approach set out, especially around the milestones, workforce, digital and shared outcomes. Concerns were raised on the equality and quality agenda linking in to social care along with where Mental Health is sitting. The Chair reflected that the concerns raised relate to NEL and not about BHR, and that these Terms of Reference are restricted to areas previously discussed, Local Transformation, ISP, BHR Academy and SOCG. The Chair offered to join local Place Based committees to advise on what is/isn't included in the Terms of Reference. ICEG members: • Noted and commented on the proposed governance to oversee ongoing collaboration in BHR • Endorsed the proposed governance approach for ongoing collaboration in BHR • Commented on and endorsed the proposed revised terms of reference for the BHR Integrated Care Executive Group on the understanding that they now go to Local Placed Based Partnerships then ICEG for formal sign off	**Action:** Chair to join local Place Based committees if asked to do so to advise on Governance Terms of Reference

2.2	**NEL update**	
2.3	**NEL update - NEL Financial Framework Development**	
	SB talked members through the attached paper. SB noted that NHSE will judge us as a system on our finances, looking at the Trusts balance sheet and the ICSs balance sheet considering these in totality. This is a shift from how it was done historically where they looked at individual organisations. It was noted that this was a similar presentation made in another forum where comments were made on the paper. It was felt it would have been useful to have added a slide on the feedback from this forum. Due to the timing of papers coming out for this meeting there wasn't time to include a summary sheet. Following the other meeting a summary sheet was produced and will be circulated to members later today. ICEG members noted that it would be helpful to explore the links between Provider Collaboratives and Place Based Partnerships in terms of flow, accountability and responsibility of finances work. The Chair advised that there is a significant piece of OD work taking place around how Provider Collaboratives and Place Based Partnerships will work together, and is asking JVR/AH to come and talk to the three Place Based Partnership at the next development session, to which they agreed. The question was asked if this is an opportunity to speed up the levelling up work across Primary Care. The Chair noted that the equalisation piece isn't just about funding, but achieving equity of outcomes for local people in relation to primary care as well, and will be across North East London. IGEG members: noted the update	**Action:** summary sheet of comments made on this financial framework presentation to be circulated following this meeting **Action:** JVR/AH to attend next BHR Development session to discuss how Provider Collaborations will work with Place Based Partnerships
3.0	**IT Digital bi-monthly update**	
	UG talked members through the attached paper. The question was asked on how flexible is this approach, does it cover social care and can it deliver the asks of the White paper? It was confirmed that it will include Social Care with invites to go out to Local Authority colleagues to join the BHR Digital Group. UG noted that there is an urgent need to identify a digital clinical lead for BHR – CJ to pick this up with Sarah See, Director of Primary Care Transformation for BHR, outside of the meeting. Reference was made to estates in Primary Care and a need to digitalise patient records to release space. The update on digitalisation will be shared to show where this sits on the roadmap. A request for additional laptops was also made in relation to primary care, which would allow more staff to be able to work from home. UG advised he would pick up the issue of laptops with Rob Meaker (RM). UB requested an offline conversation with UG to discuss PCN workforce, digital and technical issues. UG agreed to set this up.	**Action:** CJ to speak to SS re identifying a digital clinical lead **Action:** UG to speak to RM re additional laptops for practices. **Action:** UG to arrange call with UB

	The Chair referred to the previous conversation in item 2.1 on the agenda re ICS or Place Based Partnership stating that digital is not on the list asking members to discuss this when taking the proposal through to their Boards. It was suggested that a universal data sharing agreement is put in place for the Borough to allow information sharing. ICEG members: noted the update	outside of this meeting to discuss workforce, digital and technical issues.
4.0	**ICP planning and performance**	
	CJ talked members through the attached paper. Members were guided to slide 3 of the pack which highlights the work on Leadership, Culture and Leading Change with an overall aim to develop and embed a comprehensive approach to developing leadership, embedding a BHR culture, and leading change. Work on supporting PCN development is also taking place with Sarah See, Director of Primary Care Transformation for BHR, meeting with PCN CDs to determine their particular needs. ICEG members: noted the update	
7.0	**Any other business**	
	None noted	
	Date of next meeting – 17 March 2022	

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

Health and Care Cabinet

Thursday 9 December 2021
(via MS Teams)

Members:

Magda Smith (MS) – Chair	Medical Director, BHRUT
Debbie Smith (DS)	Director of Nursing, NELFT
Rahul Singal (RS)	Pharmacy Lead, NELFT
Gladys Xavier (GX)	Director of Public Health, LBR
Kate Dempsey (KD)	Social Care representative, LBH
Ramneek Hara (RH)	B&D Vice Chair / Clinical Lead, NEL CCG
David Derby (DD)	Havering GP Federation
Janaka Perera (JP)	Community pharmacy representative

Attendees:

Tha Han (TH)	Public Health Consultant, LBH
Uzma Haque (UH)	B&D Clinical Lead, NEL CCG
Ahmed Soliman (AS)	Deputy Medical Director (Quality Improvement and Clinical Outcomes) and Consultant Emergency Physician, BHRUT
Tim Buck (TB)	Chief Nurse Fellow, BHRUT
Keeley Chaplin (KC)	Minute taker, BHR ICP, NEL CCG
Hanh Xuan-Tang (HX)	Deputy Director of Recovery Planning, BHR ICP, NELCCG – item 4.1
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG – item 4.2

Apologies:

Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Kathryn Halford (KH)	Chief Nurse, BHRUT
Caroline Allum (CA)	Medical Director, NELFT
Chris Tuckett (CT)	Associate Director of AHPs, NELFT
Norah Rao (NR)	Practice Nurse representative
Jyoti Sood (JS)	HEE representative
Susanne Knoerr (SK)	Social Care representative, LBBD
John Peters (JP)	Acting Medical Director (Whipps Cross), Barts Health
Matthew Cole (MC)	Director of Public Health, LBBD
Mark Ansell (MA)	Director of Public Health, LBH
John Craig (JC)	CEO, CareCity
Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Remi Odejinmi (RO)	BHRUT inequalities lead
Leila Hussein (LH)	Social Care representative, LBR
Shanika Sharma (SS)	Clinical Director for B&D PCN
Hilary Ross (HR)	Director of Strategic Programmes, ELHCP - item 3
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT – item 5

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

		Action
1.2	Minutes of the meeting held on 11 November 2021	
	The minutes of the last meeting were **agreed**.	
1.3	Matters/actions arising	
	The updated action log was **noted** and it was agreed to close action 176, 180, 181, 183, 184.	
2.0	**Update on inequalities and prevention approach**	
	Following discussion at the last meeting relating to possible duplication of prevention work across BHR and NEL, the Directors of Public Health met with Dr Magda Smith to review this approach. It was noted that was there is an overarching strategic approach to prevention setting and tackling inequalities at a North East London (NEL) level through the NEL Prevention Board. Each of the BHR transformation boards seek to address inequalities and embed prevention through their work programmes of which members of public health are linked in. Place Based Partnerships will also have a key role in the delivery of prevention and addressing inequalities at a local level. The outcome of the discussion was that there is no need for an additional BHR group to focus specifically on prevention and inequalities but where necessary, the BHR Health and Care Cabinet will commission / oversee specific pieces of work at a BHR level around prevention where gaps are identified, such as discussed at the recent obesity session. Members agreed to receive a monthly briefing from the NEL prevention group for information. The Chair thanked all involved in moving the prevention agenda forward, in particular UH and TH. The cabinet noted and agreed the approach going forward.	
3.0	**ICS Place based clinical/professional model of leadership**	
	Unfortunately, HR was not available to present this item and MS agreed to discuss separately regarding the involvement of the health and care cabinet going forward as the model of leadership evolves.	MS/HR
4.0	**Transformation boards**	
4.1	Key progress and achievements to date	
	HX presented the paper which provides a progress update on the work of the Transformation Boards in 2021/22, and the impact of transformation schemes which were implemented previously. Each transformation board sets its priorities for the year in the form of a plan on a page, and an update on progress will be provided to the cabinet every six months. The report details the size of each programme and at what stage they are at eg at concept, in development or live. Members reviewed the achievements made in each transformation board. UH added that the Older People Transformation Board covers a wide remit which includes frailty, care homes and falls and feedback from patients and the CQC is that they are impressed with the frailty unit and there is excellent collaborative work.	

		Action
	MS noted the fantastic work around the high intensity user forum and that it would be useful to see if there has been a change in balancing metrics eg has there been a difference in attendance types as a result of this targeted intervention in a future update. MS asked if the LTC transformation board are considering potential discrepancies across the three boroughs regarding Children and Young People (CYP) asthma. RH advised that Richard Burack is leading on CYP and it would be good to check that the appropriate template is being used and to find out how many children receive a follow up from the paediatric respiratory consultant following a hospital attendance. AS noted that work should be done collaboratively with pharmacists who can also provide advice on medicines optimisation. HX informed members that an audit plan is built into the CYP asthma LIS business case and could provide results from these audits at a future meeting. The cabinet **noted** the current progress of the Transformation Boards in relation to the delivery of transformation schemes in 2021/22, and the achievements made to date in terms of reducing activity in Secondary Care through the provision of alternative services through transformation.	
4.2	Older People and Frailty Transformation Board strategy - refresh	
	SM briefed members on the approach that the Older People and Frailty Transformation Board is proposing to deliver its transformation plan over the next two years. The transformation plan focuses on a small number of high impact areas supported by an end to end delivery approach and it is recommended that a diagnostic is undertaken in the priority areas to build the evidence base and inform the next stage of transformation delivery. Much of the transformation work to date has focused on the acute end of the pathway and it is recognised that more needs to be done on population health management and anticipatory care. The scoping of the next stage of the programme is being supported by Newton Europe. The workstream would support admission avoidance and decision making across practitioners to ensure they have alternatives to hospital admission in the community. It would also build on system pathway work around discharge that is overseen by the discharge working group. Personalisation is the thread that will ensure focus is around the patient and not around services. In order to mobilise the programme, the system would need to identify the resources to fund the transformation programme. This would be structured to cover the diagnostic phase initially and through this process the resource requirement to implement transformational change would be identified. The gross system saving is £40m over 5 years. External resource will need to be brought in to build on capacity and capability and bring in additional skillsets. There are also patient safety and improvement benefits to be achieved. The proposal is being taken back to ICEG in December seeking its support. DS asked in terms of personalisation has there been any co-production work with service users and families. SM confirmed that there will be co-production. DS offered to link SM with NELFT involvement representatives if	

		Action
	required. DS also offered to link with SM regarding the proposal for a workforce rotation programme. SM clarified to members that local authority leads attend the task and finish group and are engaged with each local authority commissioning lead and will provide a briefing to the local directors of Social Services. UH added that the group will be looking at referrals in from GPs, acute, community and how patients can refer in too. The Health and Care Cabinet **endorsed** the proposal which will be presented to the December Integrated Care Executive Group.	
5.0	**Update on recovery summit action**	
5.1	Resource for clinician to clinician referrals and Discharge Hub RP was not available to join the meeting however MS briefed members. The aim to reduce clinician to clinician (C2C) referrals will require project management resourcing to manage behaviour change and referral access into community providers. Additional resource is also needed to increase the pace of work on the discharge hub. This will be brought back to the next meeting.	
6.0	**Any other business**	
6.1	Covid update	
	GX provided a verbal update on Covid-19: • There has been an increase in Omicron cases locally that have been community acquired. • SAGE have stated Omicron may become the dominant variant if measures are not put in place. These are being followed by national and local public health teams. • Current rate in BHR is 413/100,000. • Local plans have been reviewed and focus is on promoting the booster vaccine for all eligible people as well as promoting government messaging such as mandatory mask wearing in specific locations. • Increased access to vaccinations will be offered. Housebound patients are a priority. • Areas that have had less uptake of the vaccination will be targeted with government resources being offered to help with this. An evaluation will then be undertaken to see if this focus has made an impact. • There has been a large increase in cases in children aged 11-16 and public health are working with schools. • Communications are being sent out to residents. Members noted the verbal update.	
7.0	**Date of next meeting**	
	13 January 2022 at 1:30pm-3:00pm	

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

Health and Care Cabinet

Thursday 10 February 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
Rahul Singal (RS)	Pharmacy Lead, NELFT
Gladys Xavier (GX)	Director of Public Health, LBR
Janaka Perera (JP)	Community pharmacy representative
Chris Tuckett (CT)	Associate Director of AHPs, NELFT
Kathryn Halford (KH)	Chief Nurse BHRUT
Rahul Singal (RS)	Pharmacy Lead, NELFT
Susanne Knoerr (SK)	Social Care representative, LBBD
Hanorah Rao (HR)	Practice Nurse representative
Anil Menta (AM)	Redbridge Clinical Chair, NEL CCG
Leila Hussein (LH)	Social Care representative, LBR
David Derby (DD)	Havering GP Federation
Matthew Cole (MC)	Director of Public Health, LBBD

Attendees:

Tha Han (TH)	Public Health Consultant, LBH
Uzma Haque (UH)	B&D Clinical Lead, NEL CCG
Ahmed Soliman (AS)	Deputy Medical Director (Quality Improvement and Clinical Outcomes) and Consultant Emergency Physician, BHRUT
Debbie Harris (DH)	Minute taker, BHR ICP, NEL CCG
Ramneek Hara (RH)	B&D Vice Chair / Clinical Lead, NEL CCG
Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Dr Ben Molyneux (BM)	C&H Clinical Lead / NEL Personalised Care clinical lead - item 2
Paul Olaitan (PO)	BHR CEPN
Umesh Gadhvi (UG)	Director of HealthCare Informatics, NELFT & BHRUT – item 4
Dr Amit Sharma (AS)	B&D Clinical Lead / BHR Personalised Care clinical lead - item 2
Nassib Gungoo (NG)	Project Officer, Transformation
Tracy Rubery (TR)	Director of Transformation
Kirsty Boettcher (KB)	Deputy Director of Transformation, Urgent Care – item 6

Apologies:

Jyoti Sood (JS)	HEE representative
Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Shilpa Shah (SS)	CEO NELLPC
John Peters (JP)	Acting Medical Director (Whipps Cross), Barts Health
Mark Ansell (MA)	Director of Public Health, LBH
John Craig (JC)	CEO, CareCity
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
Shanika Sharma (SS)	Clinical Director for B&D PCN

1.0	**Welcome, introductions and apologies**	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 9 December 2021**	
	The minutes of the last meeting were **agreed**.	
1.3	**Matters/actions arising**	
	EP updated members on action 185, advising that Hilary Ross is leading development of proposals for the Clinical and Care Leadership model for the new ICS in partnership with Place Based Partnerships. EP noted that there will be some Transformation Boards that will take place at a NEL level, alongside the local clinical and care leadership within each place. Discussions are taking place to agree what the model will look like, taking into consideration how the Place Based Partnerships will interact with Provider Collaboratives, alongside NEL led Transformation and clinical networks. Placed Based Partnerships are thinking through how their model might look, with the ask that they articulate a high-level outline of this by the end of March 2022. The new models will be based on wider clinical and care leadership, and will be focused on addressing the key population health challenges within each Place Based Partnership. There will be a strong communications plan around this to ensure that Practitioners across the system are aware of the work taking place and the opportunities arising for them to be involved. There will be some consistent roles across each Place Based Partnership, including a Primary Care Transformation Lead and a Clinical and Care Leader. Job descriptions for these two roles are being developed and going to the NEL Senate for endorsement. MC noted that in B&D they have discussed in the first instance the formation of a group something akin to the old Professional Executive Committee of the PCT, having a similar set of responsibilities on quality and transformation. A large part of the monies can then be used to fund the Clinical Leadership as a pot, focusing this into specific priorities decided by the Place that need to be looked at by a Clinical and Professional perspective. This Group would then, in essence, act as the BHR PEC covering issues that cross rather than the Place. BM noted that each system does need to develop its own way forward in terms of Clinical Leadership but asked for consistency as a NEL collective. BM also advised that the current set up for Clinical Leadership creates barriers to delivering Equality and Diversity due to being 'office holder' roles rather than being employed, and advocated a change in the new model. EP to feed comments back to Hilary Ross.	**Action:** EP to feed comments back to HR on the Clinical and Care Leadership model
2.0	**Social Prescribing update**	
	BM presented a paper that provides a summary of the work taking place advising that North East London (NEL) has many health inequalities, exacerbated by the pandemic. NEL also has a long history of social prescribing and link worker expansion across primary care networks provided an opportunity to address inequalities and support communities through an Integrated Care System approach. AS then updated members on the work taking place within BHR. AS drew members attention to the four key elements of the programme as set out in slide 2 of the presentation pack. It is hoped that the Digital platform will be on EMIS for system one practices in BHR in the next few months.	

	Looking at the gaps is a key element of this programme e.g. CYP is a priority for the group as well as the programme with a buffer in each Borough by March 2023 and in each PCN by March 2024. JP asked that the model gives consideration for the workforce to encompass the Voluntary sector, with Social Prescribing being dependent upon the relationship between Social Prescribing and the Voluntary sector. There is a need for commitment to funding from each stakeholder to sustain ongoing work. Redbridge Borough have a funded social care programme in place with 20 social trained prescribers that are employed by the RCS with referrals coming through GPs to EMIS. UEL are going to do an evaluation and make some recommendations. The proposal will then go through the Redbridge Place Based Board for discussion. It was also felt that this will be a good opportunity to link this work with the BHR Academy. **Members of the HCC**: Noted the update	
3.0	**Workforce Race Equality Standard (WRES) Priorities**	
	PO presented a paper that gives an overview and update of the WRES agenda, how it relates to Primary Care and how it translates into the Training Hub delivery across NEL and in particular BHR. Reference was made to the London picture and how NEL relates compared to our other ICS partners with NEL fairing well, in comparison against a low base, so with still plenty of work to do across NEL. Across the London GP workforce the majority is from the white population with good representation from Asian communities but work needed on the other communities. Attention was drawn to bullet 9 on slide 5 of the presentation to develop a white allies programme where our workforce is looking out for each other. However, when we look at it from a NEL perspective we need to question whether we have the constituent population to enable us to do this in a meaningful way. A Pan-London Discrimination and Racism Survey in Primary Care took place with over 1000 Primary Care workers taking part. Proportionally for NEL we might have expected around 200 responses, however, the 177 responses received is an indication of the work needed across NEL to help this agenda resonate more meaningfully with the workforce. Next steps will be to understand the impact of the work, keen to maintain engagement seeing this survey as a baseline to measure progress and impact. An update of the work taking place in BHR is shown on slide 15 with the highlight being the recruitment of PCN-based Clinical Educational Leads to promote educational governance and equity across BHR. A discussion took place on the role of how, in PCNs, the ARRS staff need to have an educator role. More information was requested as some practices have GP trainers and some PCN CDs who can have a role in education. The feeling is that it is all blurred so can PCN's do what they feel is right? PO replied that he feels that PCN's should do what they feel is right. There is value for educators from other professions to deliver on the multi-disciplinary practitioner but also training faculty agenda.	

	MS suggested that a similar presentation around WRES could be made at the Acute Trust to take advantage of joining up resources, especially around the training and education awareness component. **Members of the HCC**: noted the update	**Action:** MS to share presentation with RO and ask her to contact PO
4.0	**Digital update**	
	UG presented the attached paper which provides an update around NEL Digital strategy and update on the development of BHR digital strategy to support the overarching NEL digital/data strategy. UG advised that there is a real need to appoint a BHR Digital Clinical lead to engage with clinical specialities across the BHR economies. The NEL digital strategy has identified across BHR a considerable amount of levelling up and investment into infrastructure. A new NEL data strategy is being created so members are welcome to participate in this group which will look at what data is flowing through NEL. It was noted that a number of Transformation Boards are working on digital issues so a need, as part of the BHR digital governance, for more discussions. So the digital agenda can be joined up across the system a BHR Digital and Data Steering Group is being set up. As a starting point a central project list will be created so all projects associated with digital comes to one single place. **Members of the HCC**: noted the update	
5.0	**Resource to embed behaviour change around the C2C policy**	
5.1	TR presented the attached paper which outlined the 6-month suspension of the C2C policy due to Covid. Over the last few weeks there has been an increasing number of referrals flowing back to Primary Care in particular. This has been identified as a lack of understanding/awareness in BHRUT. A request is being made to the HCC to put in place a Band 8a 6-month placement to work in BHRUT to raise awareness of changes to the C2C policy. The question was asked if this would link into NELFT with clarification from TR that this is BHRUT specific in terms of the C2C policy but if there are problems within NELFT these issues could be looked into. CA agreed to pick this issue up. **Members of the HCC:** endorsed this paper	**Action:** CA to pick up the issue of referrals into BHRUT from NELFT
6.0	**Transformation boards concept plans**	
6.1	**Physician Response Unit** KB presented the attached paper which outlined the Physician Response Unit. The proposal is to commission a third car that will focus on the BHR area but the three cars will work together to cover the BHR and TNW areas. The patient benefits are: reduced risk of infection; reduced risk of deconditioning (for older patients); maintaining independence. The system benefits are reduced ED demand and increased ED staffing. A senior medical Dr on the car provides a greater level of input and support in a patient's home. A benefit for BHRUT would be that the registrars would also work in Acute ED.	

	A member asked if the service covers children but unfortunately it doesn't at present. There was confirmation that links will be made between CTT/K466 and the PRU though this could be strengthened. If this service is to be commissioned there is a need to have appropriate links back into the community services. With endorsement in principle from HCC members the business case will go to for assurance at the FSPPDM in March, if approved then to the Finance Committee for sign off. **Members of the HCC:** Endorsed the Paper in principle	
7.0	**Update on Prevention Priorities standing item**	
7.1 7.2	**BHR Priorities Plan on a Page** Due to RO being unable to attend the meeting MS suggested that this item is taken as read and move onto item 7.2. MS to have a conversation outside of this meeting to discuss this workstream update. **NEL Prevention Group** GX updated members on the 4 key areas set out in the attached paper. A query was made around the tier system for the smoking cessation services as each borough have different levels available so its important to know what tier is being provided and for this to be standardised. A mapping exercise is taking place across NEL. **Members of the HCC:** noted the update	**Action:** MS to have a conversation, outside of this mtg re the BHR priorities Plan on a Page
8.0	**Any other business**	
8.1	• Janaka advised this will be his last meeting as he is leaving the LPC on 18 February but the new CEO Shilpa Shah will continue to support this group. He thanked members for their support. MS replied by thanking Janaka for his input into the HCC. • GX advised that some GP and Public Health registrars have requested to observe this committee. Members agreed to this. • TR thanked the HCC for allowing NG to observe this meeting • MS advised that DH will be circulating a link to members/regular attendees asking them to participate in an Effectiveness survey.	
9.0	**Date of next meeting – 10 March 2022**	
	10 March 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
2 December 2021 by MS Teams

Minutes

Members

Dr Sarah Heyes (SH) - CHAIR	Redbridge Clinical Lead, NEL CCG
Steve Rubery (SR)	Director of Planning and Performance, BHR ICP, NEL CCG
Mark Gilbey-Cross (MGC)	Deputy Nurse Director, BHR ICP, NEL CCG
Caron Bluestone (CB)	Associate Lay Member for Quality, Performance & Finance, BHR ICP, NEL CCG
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Jacqui van Rossum (JvR)	Executive Integrated Care Director (London), NELFT
Omar Hashmi (OH)	Joint Medical Director, PELC
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT
Dr Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG

Attendees

John Flood (JF)	NEL Provider Performance Director, NELCSU
Carol White (CW)	Integrated Care Director (Havering), NELFT
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Tracy Rubery (TR)	Director of Transformation, BHR ICP, NEL CCG
Michael Hepworth (MH)	Specialty Manager – Radiology, BHRUT – for item 2.0
Sheryl Saunders (ShS)	Head of Governance and Streaming, PELC
Sarfaraz Munshi (SM)	PELC
Russell Perera (RuP)	Clinical Director, PELC
Keeley Chaplin (KLC)	(Minute taker) Governance Team, BHR ICP, NEL CCG

Apologies

Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Debbie Smith (DS)	Director of Nursing / Patient Experience, NELFT
Hilary Shanahan (HS)	Interim Head of Quality & Clinical Governance, BHR ICP, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Dr Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Dr Ramneek Hara (RH)	Deputy Barking & Dagenham Chair, NEL CCG
Diane Jones (DJ)	Director of Nursing & Quality, NEL CCG
Dr Ahmed Soliman (AS)	Deputy Medical Director of Quality Improvement and Clinical Outcomes, BHRUT
Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG

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

No.	Agenda item and minute
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on issues arising at the meeting which might conflict. There were no conflicts of interest declared pursuant to the business of this oversight group.
1.2	Minutes of the meeting held on 4 November 2021
	The minutes of the BHR Health System Quality and Performance Oversight Group held on 4 November 2021 were duly **noted and approved**.
1.3	Matters/actions arising
	The actions log was **noted** and members agreed to close ACT017, ACT027, ACT028, ACT030 and ACT031.
2.0	**BHRUT Radiology Update**
	MGC introduced Michael Hepworth, Specialty Manager from BHRUT Radiology who was invited to present to members on concerns raised in relation to recent serious incident (SI) reports that relate to delays in radiology reporting and to outline these incidents and mitigations that have been put in place. MH advised that Barts Health have the larger backlog relating to scanning with three modalities most under pressure - Ultrasound, MRI and CT. In BHRUT, Ultrasound DM01 are compliant and they are offering mutual aid to Barts Health, there is good access for front door x-ray. The areas with scanning backlogs relate to MRI equipment issues, scanner replacement and CT acuity and the volume of requests being received. The elective restart has commenced with a rise in outpatient and GP referrals for CT scans. MRI scan recovery is improving but is not yet to the trajectory set and are looking for external support to speed this up. The radiology department received significant investment which has been used to update equipment with new and speedier scanners that are in place or on order. Work has commenced on improving the booking process with the aim to meet 7 days to scan for 2-week wait (ww) patients. The radiology information system (RIS) received an upgrade during October which encountered some teething problems but there has been a huge team effort to work through these. However, rebuild links to RIS and performance reports resulted in an information gap which resulted in a backlog of approximately 1000 x-rays. The link to the GP system has been repaired and results have now been sent to primary care. Routine reporting will be outsourced to improve the position and four new radiologists will be joining in January 2022. The new dashboard will provide a live view of the front door that will allow faster action. The incidental findings process has remained in place with the referrer being emailed and called when an incidental finding is identified. It was noted that the volume of incidental findings has increased due to the impact of Covid 19. SH acknowledged the huge amount of work that has been undertaken and that investment has been made however there are concerns there was a lack of communication regarding the issues and that a very high number of reports were received in primary care on Monday. MH confirmed that there had been communications circulated to practices but the decision was taken to deliver the reports in one batch and that the larger practices could have received up to 400. AA queried if only the reports requested by GPs had been sent or had all reports relating to their patients been sent, including those requested by consultants? MH

No.	Agenda item and minute
	advised it should only be reports that were requested by the GP but would confirm. **Action: MH** CB queried if a harm review has been undertaken on the patients that had their results delayed as a consequence. MH advised he was aware there was one patient at risk of harm who had been fast-tracked for a scan and which was taken within a day. The Group noted the update and agreed to receive an assurance update at the **next meeting.**
3.0	**BHRUT ED Sepsis Pathway**
	MGC notified the group that a GP colleague had raised a concern in relation to a severely frail older patient who sent them to the emergency department (ED) to identify the cause of tachycardia and low blood pressure. The ED gave the patient IV fluids, undertook blood tests and discharged the patient home, however the patient returned to the GP feeling unwell. The GP checked the blood tests and noted that the hospital had not reviewed the results. The GP sent the patient back to ED with suspected sepsis. The ED provided a diagnosis of post viral fatigue syndrome and infectious gastritis. MGC raised this incident with BHRUT and requested a review and report back to the QPOG. KH advised a response will be sent within the week. **Action KH** The Group **noted** the verbal report.
4.0	**Assurance**
4.1	L3 Investigation (CE) Stage 1 Report
	Following the presentation of the stage two report at the September meeting, MGC provided additional information relating to the review of the care and treatment provided to the patient prior to admission at BHRUT. The report is presented to members for oversight and assurance. Members noted that this was a very tragic case and agreed that commissioning the level 3 report had been appropriate. KH added that they have been supporting the family where they can. The group **noted** the recommendations made to mitigate the identified care and service delivery issues and agreed to receive an update on related recommendations and actions at a future meeting. The group thanked Christine Kane for preparing the report.
5.0	**Performance**
5.1	System performance report
	JF provided updates by exception on performance against constitutional standards highlighting the following: • BHRUT's patient treatment list (PTL) increased to 52k in September and continued to rise in November. • Their 52ww position has been better than the trajectory but has begun to slow. There was a total of seven 104+ week waiters spread across specialties. • BHRUT achieved the 2ww cancer standard in September. The 62-day urgent cancer standard is improving though it has not yet reached target. • Urgent care 4-hour performance has continued pressure and winter levels are higher than last year. • NELFT service users entering treatment for Improving Access to Psychological Therapies (IAPT) is below plan but recovery is on target. There are some issues on

No.	Agenda item and minute
	waits from first to second appointments with slight deterioration showing in Havering and B&D. Members asked if the 104+ ww figures can be cleared? RP noted that these patients tend to have complex conditions with multiple surgeons required. He added that the clearance of the 52ww list is ahead of trajectory. The specialities these mainly relate to are gynaecological surgery, general surgery and neurosurgery. Actions to help clear the backlog include increased theatre capacity with a focus on 78+ww. Members asked what assurance can be given against potential clinical harm to patients waiting a long-time for surgery. RP confirmed that harm reviews are undertaken on very long waiters and are prioritised under four categories. A report will be provided at the next meeting on how they manage potential harm. **Action: RP/KH** CB asked how the recovery rate for IAPT service users is measured and does it include online and self-help management? CW explained how the recovery rate is measured and that interventions could include online self-help. Discussion ensued on the number of patients attending ED noting that some patients reported that as they could not get a GP appointment they presented at hospital. A communications plan including using social media to direct patients on where to access health is being prepared. OH recognised the pressure the whole system is under and that collaborative work is key. The group **noted** the content of report and actions being taken to address risks.
5.2	BHRUT performance challenges and recovery
	Members **noted** the report of operational performance in BHRUT and actions being taken to reverse downward trends.
5.3	NELFT performance challenges and recovery
	There has been continued pressure at the front door relating to CAMHS and this is reflected in the 6-week referral target data. Urgent cases are triaged as a priority. Communications to practices with access to the form was requested on the single point of access for children services. CW will liaise with MGC to send out communications. **Action: CW/MGC** The NELFT performance report for which was duly **noted**.
5.4	PELC performance report
	ShS presented the PELC performance report which is part of the integrated quality report noting the following: • The four-hour performance dropped slightly in the month. There are a number of projects to tackle these and daily updates with senior managers are held. The utilisation target is up and above KPI. • A concierge pilot to pre-book patients at the front of the streaming queue has commenced and the data analysis will be shared with the group at a future meeting. The Group **noted** the contents of the report.

No.	Agenda item and minute
6.0	**Quality**
6.1	BHR System Quality and Safeguarding Report

	MGC provided an overview of quality and safeguarding issues and risks across the BHR system highlighting:
	
	• BHRUT
	  • Since the previous report, two Never Events have been declared and MGC provided information relating to each.
	  • The four-hour target compliance and patient safety/experience has seen a drop in performance. MGC had arranged to spend half day at BHRUT sites, supported by BHRUT, to provide a snapshot in time of the departments, and to include a review of elements such as staffing levels, waiting times, including the areas of potential and actual harm, however this visit has been superseded by a CQC visit.
	  • There have been no Regulation 28 Reports issued to the Trust.
	
	• NELFT
	  • Initial Health Assessments (IHA) and Review Health Assessments (RHA) for Looked After Children (LAC) continue and the CCG has allocated one of the designated nurses to have oversight on this work.
	  • Since the previous report, no Never Events have been declared.
	  • There has been no Regulation 28 Reports issued since the previous report.
	
	• Primary care
	  • A NEL primary care deep dive has been undertaken with an approach to primary care quality and highlights key activities happening at a NEL and ICP level.
	
	SH advised the primary care report would be useful to have data broken down to PCN level or individual practices to see which practices are sending most patients to A&E. It was confirmed that the primary care dashboard being developed will allow users to view practice specific data.
	
	It was suggested that when people attend PELC they could be signposted to nearby vaccination clinics to receive the Covid vaccine. MGC advised that this should be raised with Director of Primary Care to look at this.
	
	The Group **noted** the detail of the report and actions being taken to date to mitigate the identified risks.

6.2	BHRUT Quality Report
	KH presented the group with the 'flash' report to provide assurance on the Trust's most up to date Quality and Safety data for October 2021 and highlighted the following: • There has been an increase in inquests as a result of the pause in Covid and staff are being asked for a lot of information and statements. The legal service is outsourced and a solicitor has been brought in to work in-house to streamline the process. • There is continued work on investigations of SIs. • There has been an increase in C. Diff cases year possibly due to an increase in antibiotic prescribing. • The volunteer programme is expanding with a number of new volunteers joining the Trust. • An unannounced CQC visit has just taken place in Queens over two days. Initial feedback was complimentary regarding staff and resilience and staff at all levels were working together well. They were also impressed with frailty unit and were

No.	Agenda item and minute
	pleased to note the improvements made and actions implemented. They have requested further information in areas such as the IPC pathways and medicines management. SH asked if the patient access resolution system has been progressed. AA advised that funding has been made available and is progressing. RP added that adverts for these new roles has gone out and it is hoped will be in place early in the new year. The Group **noted** the report.
6.3	NELFT Quality Report
	The NELFT quality and safety summary report and risk exceptions was presented to members. CW advised they are also receiving late notification of inquests from the Coroner that need reviewing and that there are more than they would usually request however there are not seeing an increase in Regulation 28 reports as a result. The Group **noted** the content of the report.
6.4	PELC Quality Report
	ShS presented the PELC integrated quality report noting the following: • There is a backlog of complaints as a result of Covid 19 and reduced staffing however this is now back on track. • PELC had a CQC visit in November. Verbal feedback has been largely positive and are now waiting for the written report. The Group **noted** the content of the report.
7.0	**Any other business**
7.1	QPOG
	SH raised with members that the group should work as a system and away from the commissioner / provider split that will ensure transparency and collaborative working in a supportive way. If issues arise relating to quality of care they should be brought to the group to discuss and learn. This group can also share good news and learn from best practice.
7.2	NEL CCG Director of Nursing
	MGC informed the group that he has been appointed to the role of Director of Nursing for NEL CCG.
8.0	**Minutes for information**
8.1	Integrated Safeguarding Assurance Board The minutes of the BHR Integrated Safeguarding Assurance Board held on 27 October 2021 was duly noted.
8.2	BHR IPC Area Prescribing Committee The minutes of the BHR Area Prescribing sub-committee held on 28 September 2021 was duly noted.
9.0	**Date of next meeting**
	13 January 2022 *(subsequently cancelled due to Covid pressures)*

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

Minutes

Members

Dr Sarah Heyes (SH) - CHAIR	Redbridge Clinical Lead, NEL CCG
Steve Rubery (SR)	Director of Planning and Performance, BHR ICP, NEL CCG
Mark Gilbey-Cross (MGC)	Director of Nursing, NEL CCG
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Carol White (CW)	Director of Operations for London, NELFT
Omar Hashmi (OH)	Joint Medical Director, PELC
Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT

Attendees

Sheryl Saunders (ShS)	Head of Governance and Streaming, PELC
Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
John Flood (JF)	NEL Provider Performance Director, NELCSU
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Ben Conway (BC)	Acting Deputy COO & Director of Performance Analytics, BHRUT
Julia Corey (JC)	Deputy Director of Primary Care (BHR) NEL CCG – for item 2.1
Jeffrey Middleditch (JM)	Divisional Manager, BHRUT – for item 2.3
James Lovell (JL)	Operational Manager, Radiology, BHRUT – for item 2.3
Dr Ramneek Hara (RH)	Deputy Barking & Dagenham Chair, NEL CCG
Sangita Lall (SL)	Associate Director, Adults, NELFT
Keeley Chaplin (KLC)	(Minute taker) Governance Team, BHR ICP, NEL CCG

Apologies

Caron Bluestone (CB)	Associate Lay Member for Quality, Performance & Finance, BHR ICP, NEL CCG
Debbie Smith (DS)	Director of Nursing / Patient Experience, NELFT
Tracy Rubery (TR)	Director of Transformation, BHR ICP, NEL CCG
Hilary Shanahan (HS)	Interim Head of Quality & Clinical Governance, BHR ICP
Dr Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Dr Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Diane Jones (DJ)	Director of Nursing & Quality, NEL CCG
Dr Ahmed Soliman (AS)	Deputy Medical Director of Quality Improvement and Clinical Outcomes, BHRUT
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG

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

No.	Agenda item and minute
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on issues arising at the meeting which might conflict. RH declared an interest pursuant to the discussion in item 3.4, whose spouse is an employee of AstraZeneca. The chair agreed that there was no direct conflict in relation to the item discussed and the chair agreed for RH remain for the entirety of the meeting. There were no other conflicts of interest declared pursuant to the business of this oversight group.
1.2	Minutes of the last meeting
	The minutes of the BHR Health System Quality and Performance Oversight Group held on 2 December 2021 were duly **noted and approved**.
1.3	Matters/actions arising
	The actions log was reviewed and further discussed as follows: ACT023: Blitz clinics – RP confirmed that GPs are not responsible to request diagnostics for patients attending these clinics. ACT025: The letter to Barts Health will not be sent as members noted there has been increased engagement. ACT032: It was confirmed the RIS reports were the reports that GPs had requested. It was agreed that if a similar incident should happen again a plan would be agreed with primary care colleagues on the process to send out large numbers out in batches and to acknowledge clinical responsibility until they are sent. ACT035: Some GPs are not aware of the new SPA form for referrals into children services and older forms were still being used. CW will ensure forms are updated on the system and old forms are removed. CW added there will be a systematic review of primary care, community and acute SPAs which will ensure there will be an accompanying communications plan. Members **noted** the update and agreed to close ACT023, ACT024, ACT025, ACT029, ACT032, ACT035
2.0	**Assurance**
2.1	Primary Care workforce pressures due to Covid
	JC provided an update on the support provided to GP practices reporting workforce pressures due to Covid-19. Practice Managers were asked to contact their primary care team who offer advice and support. The majority of practices have managed to continue as usual with some advice, tools and techniques. Practices have also used a 'buddy' practice for support, such as sharing of nursing resource, and the Federations have also provided support. In some cases, laptops were provided to help staff work from home, where appropriate. JC will ascertain if a laptop is allocated to a practice can it be used by multiple staff or if it would have to be allocated to an individual. **Action JC** Members **noted** the verbal update.
2.2	Omnes Electrocardiograph (ECG) Provision – close down report
	As reported at previous Quality & Performance Oversight Group meetings, it was identified that there was an issue with reporting of 24-hour ECG recordings in North East London. This issue was subject to an audit which identified a potential clinical risk.

No.	Agenda item and minute
	As a result, a serious incident was declared, and a more extensive review took place in order to identify patients who may have been harmed. A total of 16 patients were identified as having received inappropriate treatment. None of those patients had experienced an adverse event as a consequence of that treatment. Omnes have agreed to send Duty of Candour letters to these patients. All other actions from the action plan have been completed and the RCA, which had been received from the provider, has undergone review for quality assurance by the NEL CCG Quality team. Members **noted** the report and that as a result of the quality review, the serious incident will now be closed.
2.3	Assurance report on radiology incident
	Following the presentation at the December meeting, JM and JL provided an update with an analysis of the backlog, outcome and process of harm reviews and the rationale for selection of the patient population and measures that have been put in place to improve performance. A recovery plan was put in place which included a repair to the link with the GP system and the x-ray backlog clearance included outsourcing of routine reporting. Four new radiologists have been employed with two already in post. The established incidental findings process has remained in place but it was noted that volume has increased due to the impact of Covid-19. The referrer is contacted when an incidental finding is identified and for 2 week waits (ww) the appropriate MDT is included for review as well as the relevant oncology / haematology department. A review group of approx. 1100 patients were identified for harm reviews. Of these, 33 were above the waiting threshold and clinically harm reviewed and it was found three of these had positive radiological findings. These patients are having currently receiving priority investigations. Members noted the robustness of the harm reviews and the systematic approach undertaken. Work on the booking system is being undertaken which will help to shorten the waiting times but are awaiting national standards on reporting time from GIRFT. The last batch of delayed reports will be sent out to primary care and they will work with the GP liaison office to ensure numbers are manageable. JM suggested that they will produce a standard operating procedure (SOP) on how to communicate with GPs if a similar issue arises. Members thanked JM and JL for the update report which was **noted**.
3.0	**Quality**
3.1	BHR System Quality and Safeguarding Report
	MGC provided an overview of quality and safeguarding issues and risks across the BHR system highlighting: • BHRUT • Since the previous report, one Never Event has been declared and MGC provided information relating to this.

No.	Agenda item and minute
	• The report on the Queens Hospital Emergency Department (ED) governance review has been delayed. Once it has considered by the Trust's Board it will then be presented to this group. • ED 4-hour target compliance – following concerns in ED performance raised by the CCG and following a CQC inspection, a number of multi-agency meetings has ensued with input from BHRUT, PELC, NELFT, LAS, NEL CCG Primary Care and Quality Directorate colleagues, during which collaborative conversations were held to address the whole urgent and emergency care (UEC) pathways. A system-wide 128-point action plan has been developed and is being monitored monthly to ensure actions are progressing and outstanding risks are cleared. Positive feedback has been received by the CQC on the way services are working together to improve patient pathways. • There have been no Regulation 28 Reports issued to the Trust since the last report. • NELFT • Since the previous report, no Never Events have been declared. • IHAs – development sessions have commenced and an update will be shared at the next meeting. • There has been one Regulation 28 issued which is detailed in the report. The Group **noted** the detail of the report and actions being taken to date to mitigate the identified risks.
3.2	BHRUT Quality Report
	KH presented the group with their Board report to provide assurance on their most up to date Quality and Safety data and highlighted the following: • Planning for a new Patient Safety Strategy has commenced. • There has been an increase in the number of C-Diff cases. The IPC team is continuing to work with relevant teams to address themes and arrange training in early management and identification of cases. • Radiology is seeing an unpredicted demand for their services across all modalities. A Radiology Consultancy organisation has been asked to work with the department to help design an improvement programme that will increase efficiency. • The Therapies workforce has seen an increase in demand and a workforce strategy to address this has been developed along with agency cover to meet demand in the short term. • The risk rating for maternity remains at 25 on the register. A number of mitigations have been put in place and this rating is due to be reviewed. It was noted that the rating is reviewed daily and can fluctuate from low to high. MGC congratulated BHRUT for their ward accreditation programme and suggested more detail is brought back to the April meeting. SH suggested communications on the increase in C-Dff cases be sent to GPs to make them aware. MGC advised that this is already being planned across NEL and MS added they could include this in their GP newsletter. The Group **noted** the report.
3.3	NELFT Quality Report
	The NELFT quality and safety summary report and risk exceptions was presented to members with key highlights as follows:

No.	Agenda item and minute
	• Risks continue in staffing, resources, and capacity. Many community services are in business continuity with restrictive services but work is ongoing to mitigate these risks. Improved communication with frontline staff to assure them that the organisation is acting on their feedback and risks. • There has been a large rise in referrals which affects the bed base at Sunflowers Court and work is ongoing with partners across the system to make improvements. • Equality, Diversity, and Inclusion team awards have been won. • The new governance framework is being implemented which will make oversight and monitoring more effective, efficient and responsive. An update on the revised nursing structure to be included at the next meeting. **Action KH/LB** The Group **noted** the content of the report.
3.4	PELC Quality Report
	OH presented the PELC integrated quality report noting the following: • The number of open complaints is reducing and will keep working to reduce further. • The number of open incidents is 72 with 42 closed over the last month. • There were no serious incidents (SIs) declared in December but 4 incidents remain open • There were 12 safeguarding referrals made in December and it was noted the quality of referrals has improved. • The risk register is currently being reviewed but currently there are no red rated risks. MGC asked for further clarity regarding the patient death following receipt of the AstraZeneca vaccination. OH advised that this was declared as a system SI and that a report has been submitted to the coroner. MGC will provide a briefing at the next meeting. **Action MGC** RH declared an interest as set out in 1.1. The Group **noted** the content of the report.
4.0	**Performance**
4.1	System performance report
	JF provided updates by exception on performance against constitutional standards highlighting the following: • In BHRUT there was a slight increase in the number of patients on the elective patient tracking list (PTL). • Unvalidated data flow shows the Trusts 52+ww PTL has increased to 1,063 over a range of specialisms and there were eleven waiting over 104 weeks. There remains a strong focus on backlog clearance of long waiters. • Diagnostics performance has deteriorated with MRI and CT areas most under pressure. • Cancer standards for 2ww and 62ww was not met and work is ongoing • There was some improvement in the 4-hour performance but there remains pressure in the system. The ambulance receiving centre (ARC) opened at Queens Hospital and this has helped with the turnaround of ambulances.

No.	Agenda item and minute
	• The number of patients into IAPT is increasing and the recovery rate is increasing. The gap between patients first and second appointments have increased and work to understand this is being undertaken to address these. • The number of CYP with eating disorders are small but the target was not met. SH suggested it would be useful for GPs if NELFT could provide training on eating disorders. **Action CW** The next meeting will include a deep dive in NELFT. SH reported an issue that patients have been given a deadline to call the IAPT team to confirm they still wish to remain in the service and if they do not they will be discharged. However, patients have reported difficulties in getting through on the phone. **Action CW will look into this**. The group **noted** the content of report and actions being taken to address risks.
4.2	BHRUT performance challenges and recovery
	RP presented the BHRUT integrated performance report which details performance for December 2021. • Activity had been slowed down in December and January to manage the forecast surge in Covid however this was less than expected and the Trust were able to deliver elective critical care as part of their surgery which is a credit to the nursing team. • ASI Triage and PIFU pathways are being rolled out to the key specialties. • Triage – in general surgery vascular gynae and urology we will use this exercise to have regular review sessions with primary care to ensure not moving work around the system. Patient view to look at pathway improvement. • Neurosurgery blitz triaged patients in December, seen in outpatients in January and to theatre in February. • There are 24 patients at risk of breaching +104 ww at the end of March and these are being tracked. • The cancer backlog has been mainly driven by staff sickness but there is a blitz to see patients waiting over 63 days. • Since the ARC opened in November, there have been 486 patients received which has saved over 2,800 hours of ambulance crew time • An additional 10 beds will be opened in KGH to support general and acute and building works have commenced at Queens to provide further beds by end February. SH raised the issue with the cancer 2ww figures deteriorating. RP advised that weekly meetings with the NEL Cancer Alliance have been established with Gynaecology and Breast to monitor 2ww capacity recovery and is expected to improve from February. Members **noted** the report of operational performance in BHRUT and actions being taken to reverse downward trends.
4.3	NELFT performance challenges and recovery
	JH presented the NELFT operational performance report and provided the following key points: • There were no breaches in CAMHS eating disorders seen within 4 weeks, though one breach in routine. The next report will include the size of the caseloads. • CAMHS emergency assessment seen by the end of the following working day has been improving though this dropped slightly in December.

No.	Agenda item and minute
	• Urgent referrals to start assessment in two days has continued to retain a 100% rate and are above target for A&E completing MH assessments within 4 hours. • Measures have been put in place across the RIO system to ensure an IHA completion date is entered which will improve data quality. • IAPT met the thresholds for completed pathways. However, there was a decline for IAPT accessing treatment. IAPT recovery has been above target. • The report also details covid data relating to patients, staffing and vaccinations. • Work is being undertaken to map reporting to provide a breakdown for PCNs. Quality KPIs reporting is also being reviewed. The NELFT performance report for which was duly **noted**.
4.4	PELC performance report
	OH presented the PELC performance report which forms part of the integrated quality report noting the following: • During December there was a 14% reduction in footfall. • 94% of patients have been seen within the 4-hour target. The Group **noted** the contents of the report.
5.0	**Any other business**
5.1	Vaccination as a condition of deployment for all healthcare workers - risks ahead of the 1 April deadline
	It was **noted** that the directive to serve notice to healthcare workers that are not fully vaccinated has been paused whilst awaiting the outcome of the Parliamentary process to revoke the amendments made to the regulations. SH added there had been a marked increase in staff requesting their GP provide them with an exemption form since the amendments were made and that this U-turn will help with pressure in primary care.
6.0	**Items for information**
6.1	InHealth Endoscopy SI Closedown Report
	Members **noted** the closedown report following completion of all required actions resulting from the investigation and discussion with the CCG.
6.2	Forward planner to end June 2022
	Noted
7.0	**Date of next meeting**
	3 March 2022

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

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 25th November 2021 – 11.00am – 12.15pm

Via Microsoft Teams

Minutes

Members:

Kash Pandya (KP)	Lay Member, Governance and Audit Chair, NEL CCG
Caron Bluestone (CB)	Lay Member, BHR ICP
Malcom Young (MY)	Executive Director of Finance, NELFT
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

Attendees:

Tracy Rubery (TR)	Director of Transformation, BHR ICP
James Chapman (JC)	Head of Individualised Care, BHR ICP
Dean Musk (DM)	Head of Estates and Capital Programmes, NEL CCG
Pete McDonnell (PMc)	Lead Commissioner for Older People and Frailty, BHR ICP
Hanh Xuan-Tang (HXT)	Deputy Director of Recovery Planning, BHR ICP
Kirsty Boettcher (KB)	Deputy Director of Transformation: Urgent Care, BHR ICP
Carla Morgan (CM)	Senior programme manager – urgent care and cancer, BHR ICP
Sylvie Nachilyango (SN)	BHR ICP
Muna Ahmed (MA)	Governance Manager, NEL CCG

Apologies:

Ceri Jacob (CJ)	Managing Director, BHR ICP
Ahmet Koray (AK)	Director of Finance, BHR ICP
Nick Swift (NS)	Chief Finance Officer, BHRUT
Stuart Greenacre (SG)	Associate Director of Finance, BHRUT

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting and apologies were noted. It was noted that as Ahmet Koray and Ceri Jacob were not in attendance, there was no financial authority for approval. Therefore, any business cases will be sent to Ahmet and Ceri for approval, after the meeting.
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 28 October 2021**
	The minutes of the meeting were agreed as an accurate record.
1.3	**Actions log/matters arising**
	Business case process – HXT stated that discussions are ongoing around the BHR process and the new NEL governance process. Working on making the process efficient.
2.0	**H2 Update and Month 7 Finance Overview Report 21/22**
	RA presented the item. <u>H2 planning</u> The health system which includes the 5 providers and NEL CCG, submitted the H2 plan last week. A system breakeven position was submitted. RA highlighted that a large financial gap has been mitigated through the plan at a system level. For BHR, the H1 expenditure was used and applied the H2 planning guidance to it. For BHR ICP, a breakeven budget was set for H2. RA noted that there will not be a reliance on non-recurrent funding for mitigations and that non-recurrent funding will be utilised in H2 to fund various investments. System wide risks in H2 are around the significant amount of investment and transformation spend e.g. mental health investment standard, discharge, winter and the integrated sustainability plan (ISP). The other risk is around the 2022/23 baseline, as there are likely to be significant pressures. Expecting planning guidance for 2022/23 in mid December. <u>Month 7 finance update</u> BHR reported a breakeven position, taking into account the top-up funding from NHS England. The H2 forecast outturn use of non-recurrent funding will continue to be approx. £8m. The risks are in the independent sector contracts, continuing healthcare (CHC) and prescribing. MG commented that BHRUT will focus on planning in H2 and there will be new ICP guidance due soon which could impact the set up in hospitals, and understanding the legacy costs of covid in hospitals. MY stated that NELFT has agreed to cover off a £4.9m gap, partly driven by the efficiency factor and a shortfall on the P ward. Aiming to achieve a breakeven position by the end of the year which will be made up of a number of non-recurrent initiatives. Concern is around non-recurrent funding which will go into 2022/23 and workforce. JW sought clarity on the hospital discharge pathway and Covid. RA to pick up with Jane outside of the meeting. KP added that additional funding has been secured. RA stated that NEL has secured £6.2m of discharge funding, of which BHR will receive £3.7m. JW noted that Havering council has an £8m overspend in adult social care and need to understand the real pressure from covid. KP requested a deep dive on hospital discharges. AA stated that cancer referrals are currently lower than previous years and queried what will happen to the finances, if there is a surge in referrals. MG noted that there is a significant uplift of work in elective care and they will look to build in capacity and utilise capital funds, as well as continue with elective care during winter.

	KP raised concerned that the run rate is exceeding the resources and utilising reserves. KP would like to see best and worst case scenario figures and useful to get an update on financial sustainability in January. KP noted that there are other pressures at place level. KP summarised that the Committee remains concerned about the financial position and 2022/23. CB added that it is important to look at efficiencies. **Action: MA to add a deep dive on Hospital Discharges to the forward plan.** The Finance Sub-Committee noted the H2 update and the month 7 finance report.
3.0	**Transformation**
3.1	BHR Transformation Board finance update
	HXT presented the report. HXT clarified that the forecast for further investment is £2m and not £2.9m, as stated in the paper. HXT highlighted from the report: - Progress has been made with business cases – 6 schemes are live, 4 new schemes and 11 schemes are going through the process. - HXT highlighted a slippage in the forecast, against the plan. - The 2 hour urgent care response costs £2m. Recruitment has been completed and staff are due to start in January/February. Agencies are in place. - There has been slippage in the plan with the Older people's acute frailty service due to the hospital flow between ED and the front door. A review is in place. - Planned care – revisions have been made following the operating plan submission, to advice and guidance and patient initiated follow-ups. - Same day emergency care was implemented earlier in the year and has resulted in a large reduction in admissions. - Overall, areas of concern are older peoples and planned care. - A deep dive on Advice and Guidance is scheduled and it is hoped that it will improve the uptake and delivery of the A&G local incentive scheme (LIS). MG stated that the ambition of the plan is important for everyone and queried how we are going to measure the impact of the metrics and pathways. TR commented that a report on the transformation ISP has gone to the ICEG for the first time. TR suggested that they incorporate the information in that report into this finance report which will highlight impact and whether work is being shifted to other areas. There was a discussion about the activity of PIFU for cancer patients. TR confirmed that stratified pathways do count under PIFU. The prostate cancer PIFU has gone live this month. There was a delay in the roll out and the intention is to roll it out for other specialties. KP stated that there has been a lot of pressure on the transformation team due to staff moving on. TR added that new staff have been recruited and will be joining soon. There will still be gaps and it will take the new staff some time to get up to speed. Therefore, TR will prioritise areas that will have the biggest impact. Due to the staffing issues, the Committee agreed that the transformation board finance report can come to the sub-committee every other month.

	SR added that we are heading towards one of the busiest winters and are already seeing high numbers in primary care, acute Trusts and in mental health. We also need to acknowledge that clinical staff who are delivering the schemes are also under pressure. TR assured the Committee that her team will continue to monitor the finance of the Transformation Board. The Finance Sub-Committee noted the Transformation Board finance update.
4.0	**Provider Update**
4.1	BHRUT – consolidated update of all capacity changes
	MG presented an update on the capacity changes in BHRUT. MG has been to the Board with a number of capacity expansions. A strategic outline paper identified that Queens is 100 beds short. The paper also provided 3 actions required to address the bed shortage: 1) Open 1 additional ward from winter 2021/22 (30 beds). 2) Implement a Frailty model reducing admission (avoiding 24 beds). 3) Repurpose space to be vacated by Barts Renal when the St. Georges project in Hornchurch completes. The Sky A ward proposal and the frailty proposal have been to the Board and have been approved. The Sky A ward is a short stay ward. The cost is £1.1m and will be funded through winter and a recurrent cost of £5.6m. The Frailty Unit has been running throughout the year and funded non-recurrently and will cost £6m per year. The third proposal is critical care expansion. There is a shortage on critical care beds and a need to increase by 20% which means expanding from 47 to 57 beds. Capital has been allocated, however the revenue to run the beds is £3.5m. The benefit is that it will enable the elective programme to continue. The other benefit is that the unit builds in capacity to run the unit at safe levels where there is usually high occupancy. SR supports the proposals and noted that the Frailty Unit is not delivering the numbers of patients to have an impact on avoiding the use of 24 beds. SR queried what BHRUT is doing to increase throughput in the Frailty Unit. MG stated that they are seeing half the number of patients in the unit. The unit was approved until the end of March 2022. The issue is around the blockages in flow within the hospital and that it is the focus for the next few months. RA commented that there will be a recurrent impact in the next financial year and will need to discuss at a NEL system level. The Finance Sub-Committee noted the BHRUT consolidated update of all capacity changes.

5.0	**Deep Dives**
5.1	Continuing healthcare (CHC)
	The report was taken as read. JC presented the item. The last CHC update was presented in 2019. JC highlighted: - During the first half of the pandemic, new assessments were paused due to nurses being re-deployed, although fast track cases out of hospital continued. - At the end of 2021, a team was set up to deal with the backlog. - Getting back to a stable position and business as usual. - There was significant growth last year. - The packages of care are more expensive now and there has been an increase in 1:1 care. A new process has been set up to monitor the 1:1 care and employing a specific 1:1 nurse in the hospital, who will also go to the homes to assess if 1:1 care is still required. - Nursing home capacity has started to increase. - Continuing to place on the AQP framework, although 2 providers have come off the AQP and we are continuing to use them for continuity of care, despite the increased cost. - High cost packages can reach £500k per year. - BHR has a higher eligibility rate of the population in NEL CCG with the exception of Waltham Forest. This is due to an older population and considerably more nursing homes. There is also a higher rate of movement between nursing home to CHC. - Discharge to assess has moved from a 6 to 4 week pathway. The NHSE recommendation is 6 weeks. There are ongoing discussions about who funds the 2 weeks and the process from April 2022. CB queried whether we can we put pressure on providers to go onto the AQP framework and sought clarification on what a specialist placement is. JC stated that before the pandemic, new providers would be invited to join the AQP framework. This did not happen during the pandemic. Therefore, there were less providers on the AQP. BHR is in a strong position, as there are a lot of nursing homes. Specialist placements for nursing homes are rehabilitation centres, Marillac for LD, autistic, and violent patients. There are less specialist placements for domiciliary care but these would be for people with high autistic and LD needs. JW suggested that LBH and JC work together to understand the need in BHR, the movements and the market and work together in a joined up way. JC stated that they are already working together. The discharge to assess management has gone to the local authorities to place people and the CCG gets involved if there are clinical requirements, such as 1:1 care. There is currently a review underway to look at all discharge to assess patients. The Finance Sub-Committee noted the deep dive on CHC.
5.2	Advice & Guidance (A&G)
	The report was taken as read. TR highlighted that the A&G incentive scheme is a NEL wide scheme. The NEL target is already being achieved by activity in Barts and Homerton. TR insisted that BHR should still aim to achieve the target number of 3400 referrals per month and encourage GPs to embed A&G and good practice.

	AA noted it is across NEL and until April 2022. AA supports the scheme. KP is impressed with the progress made on A&G. The Finance Sub-Committee noted the deep dive on Advice and Guidance.
6.0	**Business cases for investment**
6.1	Ageing Well overarching concept
	PMcD presented the overarching business case for ageing well. There will be £4.5m of additional money for this year, next year and until March 2024. It is a national agenda and there are 4 main schemes: 1) Urgent care response – respond to patients in crisis within 2 hours. 2) Enhanced care in nursing home – to support the care home and the aligned GPs with a range of services and includes end of life and falls. 3) Anticipatory care – place based care, working with patients at risk in the community. 4) Re-enablement – 6 weeks support after discharge. The spend for this year will be around £3.6m. Some money has already been spent on the urgent care response since August. RA confirmed the schemes are funded by a specific funding source which is in place. AA queried where the workforce will be coming from. PMcD confirmed staff have already been recruited for the urgent care response and the community treatment team. It was a mixture of developing staff within the organisation and external recruitment. Recruitment will also be linked to the academy. There was a discussion about the capacity of the community treatment team. PMcD assured the Committee that the additional staff will address capacity issues and that there will be an additional phone line and administrator to manage the referrals and meet the 2 hour response time. CB felt the schemes are needed to keep people out of hospital and reduce the pressure in the system by reducing non-elective admissions and meeting national targets. KP requested a feedback report at the end of the year on schemes. The Finance Sub-Committee approved the ageing well overarching business case. **Post meeting update: Ceri Jacob and Ahmet Koray approved the ageing well overarching business case, outside of the meeting, on 1st December 2021.**
6.2	Older People and Frailty project support
	PMcD presented the business case for 2 additional Band 8A project manager posts to support the older peoples and urgent care transformation agenda. These posts are required to manage the volume of work and implement and manage the projects around dementia, homelessness and ageing well projects. RA stated that the funding for these roles is slightly complicated. RA suggested looking at specific transformation funds and then non-recurrent funds. RA suggested reviewing the posts after 9 months.

	TR added that this business case has been through the star chamber process and it was agreed that if the posts cannot be funded, then they will be funded by non-recurrent funding. The Finance Sub-Committee approved the Older People and Frailty project support business case and RA to confirm funding source. **Post meeting update: Ceri Jacob and Ahmet Koray approved the Older People and Frailty project support posts, outside of the meeting, on 1st December 2021.**
6.3	Winter scheme 1 - PELC – Winter Surge Resilience Programme - increased capacity
	The report was taken as read. The Finance Sub-Committee noted the business case.
6.4	Winter scheme 1 - Weekend nursing home discharges
	The report was taken as read. The Finance Sub-Committee noted the business case.
7.0	Estates Update
	The report was taken as read. The Finance Sub-Committee noted the update on the BHR estates delivery programme.
8.0	**Key messages for the BHR ICPB and NEL Finance and Performance Committee**
	Key messages will be picked up outside of the meeting.
9.0	**Any other business**
	None raised.
10.0	**Items for information only**
10.1	Sub-committee forward plan
	The sub-committee noted the forward plan.
10.2	FSPPDM actions log
	The sub-committee noted the action log.
	Date of next meeting – Thursday 27th January 2022

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 27th January 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
Malcom Young (MY)	Executive Director of Finance, NELFT
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
Anil Mehta (AM)	GP
Jeremy Kidd (JK)	Deputy Director of Transformation - Planned Care
Jacqui Czarnocki (JC)	Improvement Lead – Elective Care, BHRUT
Pete McDonnell (PMc)	Lead Commissioner for Older People and Frailty, BHR ICP
Hanh Xuan-Tang (HXT)	Deputy Director of Recovery Planning, BHR ICP
Muna Ahmed (MA)	Governance Manager, NEL CCG

Apologies:

Ceri Jacob (CJ)	Managing Director, BHR ICP
Nick Swift (NS)	Chief Finance Officer, BHRUT
Pauline Goffin	Director of Mental Health, Learning Disabilities and Autism, 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 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 25th November 2021**
	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) - CB queried why the costs per procedure are higher for the independent sector. AK added that the tariff-based mechanisms are the same for all providers and requested that JK provides clarity on the discrepancies in the table. JK stated that the costs per procedure for the independent sector are higher because of the number of diagnostics undertaken and the ability for the independent sector to code better. CB queried whether there was capacity to negotiate the cost and whether we are doing everything we can to streamline the activity within the independent sector. JK - stated that we can stipulate a pathway which includes some diagnostics. We are limited in our ability to streamline, due to the requirements of patients and would require changes to current pathways. **Action: AK requested JK to provide further analysis on how the pathways compare between independent providers and the NHS and what the differences are.**
1.4	**Summary of decisions taken outside of the meeting in December 2021 and January 2022**
	The Sub-Committee was presented with the business cases that were approved outside of the meeting in December 2021 and January 2022, due to the cancellation of the December meeting, as a result of the pressure on staff by the pandemic.

Business Case
Non Invasive Ventilation (NIV)
Ageing Well - Community Falls Care Home Service
Expansion of the community falls service
Remote Urine ACR & hypertension
Duty Doctor
Community Complex Dementia
Diabetes Psychiatry Service
WS1 End of Life Care Home Pilot
Ageing Well OOH End of Life RRT
MS nurse update
Ambulatory Care (Star Chamber)
ED Care Navigator (Star Chamber)

The Sub-Committee noted and ratified the business cases approved by Ahmet Koray and Ceri Jacobs, outside of the meeting, in December 2021 and January 2022.

2.0	**H2 Update and Month 9 Finance Overview Report 21/22**
	Ahmet Koray reported that there has been no significant change to the financial position. The deficit generated in H1 of £8.6m is continuing to be offset by non-recurrent funding. The pressures are from the independent sector in H1, CHC and prescribing. AK is not expecting the position to change significantly from now until the end of the financial year. Investment in the Integrated Sustainability Plan is forecast around £9m for the year. Operating planning guidance has been received. AK has seen some indicative high level allocation numbers. The finance team is working through the numbers and will assess what the impact will be across the system in 2022/23. Some significant changes are that Hospital Discharge Programme (HDP) costs will no longer be funded and covid allocations have been reduced. KP remains concerned about using reserves to offset the deficit which is further compounded by the reduction in allocations for next year. AK informed the committee that when the independent sector contracts were brought in, there was an allocation adjustment which has now come back to us a covid funding which goes to Trusts. Therefore, as a commissioner, we have lost out on the allocation but are still incurring the independent sector costs. AK will pick up with NHS England. KP added that with the HDP funding ending, it will have an impact on local authority. JW stated that they do not know what is in the reserves and whether there will be any additional funding available. JW is concerned about the HDP funding coming to an end. AK noted the concerns around HDP funding and is looking at adding funding into the HDP to support the local authority and discharge patients quicker. AK stated that he needs review the situation for next year with the local authorities, in order to mitigate risks. AK confirmed that at the moment, it looks like there will not be any further funding available and additional investment. For BHRUT, MG stated that they developed a top-down plan, not knowing what the allocation will be. Targeting approx. £35m in cost reduction and looking to receive £20m of additional funding for Elective Recovery. As well as, support for a frailty model and increase critical care capacity. MG is also concerned about hospital discharges and noted that there are issues with flow within the hospital which is impacting the frailty unit. For NELFT, MY stated that a lot of non-recurrent investment will see them through the new financial year. There have been issues with recruiting permanent staff which has driven up the cost by the use of agency staff. Still working through internal cost pressures. Looking at approx. £15m-18m in efficiencies. CB commented that we have a deep dive on prescribing next month, which will hopefully address the cost pressures. The Finance Sub-Committee noted the month 9 finance report.
3.0	**Transformation**
3.1	BHR Transformation Board finance update
	HXT presented the report. HXT stated that due to the fourth wave of covid in December, resources and time was redeployed to support covid efforts. Therefore, there has been

	some slippage in the Community Minor Surgery scheme, as additional primary care services were stood down. The scheme will now go live in April 2022, instead of March 2022. AA stated that he is hoping the training will still be validated when the minor surgery scheme starts. HXT added that due to the covid response and increased activity, we have not been able to achieve any reductions. The reduction would have been around £300k. In addition, the schemes that required clinical input have also been delayed, such as Hospital at Home and Children's services. AA commented that we need look at how we get PCNs and local partnerships involved in taking over the transformation work streams to reflect the development of the ICS and change in clinical leadership. KP suggested a deep dive on a specific transformation area, at each meeting. HXT stated that they can provide an overview and a focus on one scheme. MG would like to see a link to the impact on A&E and activity flows. AA added that it is difficult because lots of schemes will have an impact on lots of different areas and we may not see the benefits for several years. SR stated that although we are seeing similar numbers in ED to 2019/20 numbers, the case mix and patient cohorts are different and requires more work on it, as it is not just about the numbers. CB queried whether we could utilise the independent sector to clear backlogs and get back to business as usual. SR confirmed that we are exploring the independent sector and contracts are being negotiated centrally by NHSE. We also need to identify the right patient cohort and prioritise by risk. The Finance Sub-Committee noted the Transformation Board finance update.
4.0	**Provider Update**
4.1	Mental Health Investment Standard
	Ahmet Koray and Malcolm Young presented the paper in Pauline Goffin's absence. The paper sets out investments across mental health services in BHR and NELFT. The year to date actual spend against MHIS, Service Development Funding (SDF) & Spending Review (SR) 21/22 funding is £12.4m against the planned budget of £16.6m. Forecast annual spend is £21.6m against annual funding of £22.7m, giving forecast slippage against investment of £1.1m. The underspend will be used to offset pressures. It was noted that NELFT is facing significant financial pressures. The biggest challenge is workforce. It was clarified that there is no spend accounted for suicide prevention and LD/autism, in the report and this is because they are possibly SDF schemes. AK will confirm. RA added that they are not part of MHIS.

	Action: AK to confirm funding source for LD/Autism. The Finance Sub-Committee noted the update on the Mental Health Investment Standard.
5.0	**Deep Dives -**
5.1	Better Care Fund – Deferred to next month
6.0	**Business cases for investment**
6.1	Advanced Clinical Practice (ACP) Pharmacist and Nurse in the Community Treatment Team (CTT)
	Pete McDonnell presented the item. This work has come out of a pilot which NELFT ran for several months, working with the Community Treatment Team (CTT). The ACP and Nurse will support the prevention of acute conveyances, attendances and admissions. In 2019/20, in BHR, there were approx. 2k admissions related to medication, at a cost of £3m. The pilot worked with 46 patients and prevented 4 non-elective admissions and diverted 28 attendances from ED. The proposal is to extend the pilot for 2 years with an Advanced Clinical Practice (ACP) Pharmacist and Nurse, based in CTT, working longer hours. They will provide clinics and home visits. The referrals will be from ED, GPs, self referrals and post discharge. It is forecast that over the 2 year period, the impact will be a reduction of 96 non-elective admissions and 600 ED attendances. The cost of the service for 2.5 posts for 2 years is £392k, with a saving of £360k. Although no saving against the investment, it will improve patient experience and support the system. AA queried whether the posts will be fulfilled by new staff or extended existing staff. AA also had concerns about how these posts will link in with medication assessments carried out by pharmacists which is in their contracts, nursing home assessment of all medication, all patients discharged to assess by the community pharmacist and PCN community pharmacists. AA felt there is duplication in the service and no financial saving to be gained. PMcD stated that the roles will link in with pharmacists and PCN. The ACP and Nurse will refer to PCNs and link in to structured medication reviews. AA added that the cost savings can only be counted once and many organisations have this in their contracts already. PMcD confirmed this service would be across BHR. PMcD was unsure whether other areas of NEL have a similar service. CB commented that there are a lot of prescriptions being wasted, as people are not taking the medication and medicines reviews are not being undertaken. AM stated that a lot of practices have their own pharmacists and the ARRS role. The risk is that if too many people are doing the job, the job may not get done. AA felt there are better ways of doing medicines management. AA provided the example of dosette boxes not being checked, as an area that can be improved.

	CB suggested linking this business case with the deep dive on prescribing deep dive, next month. KP summarised that the committee is not convinced by the business case and the overlap with other pharmacist roles in the system is a concern. KP requested that the business case is reviewed and link in with the prescribing deep dive. The Finance Sub-Committee was unable to approve the ACP and Nurse business case as the committee requires more information on the potential overlap with other pharmacist roles.
6.2	Urgent Care Response (UCR) 2 Hour Response expansion
	Carla Morgan presented the business case. The service is in response to national guidance to UCR. The proposal is to invest in additional staff within CTT to enable us to respond to appropriate patients within 2 hours and increase our referrals from 999 and 111, into this service. The investment is for £1.3m, for additional staff and will be funded from ageing well. There will be an additional 12.5 posts a year and will manage an extra 13,450 patients a year. The CTT receives good patient feedback and 70% of their patients are managed, to avoid admissions. The additional funding will result in approx. 19 beds saved from admissions and a reduction of 1900 ED attendances a year. AK confirmed Ageing Well is a specific funding source. AA reported his own experience of difficulties in getting CTT to go out to patients. CM explained that there are now London standards in place and the service is supplemented by some pilots with close working with LAS, 111 and 999. CTT will manage Category 2 and 3 cases. AA raised concern about CTT's capability and queried what the total investment is in CTT. CM confirmed that staff have already been recruited. CB felt it will meet a national requirement and funding is from a specific source. It will also support the system and ambulance service. AM commented that CTT is currently not working and queried what the clinical value is. AM felt the scope of the CTT is too narrow, and they are difficult to contact. KP advised that the business case should be approved, as it is a national requirement and will be funded from the Ageing Well funding source. The issues with the CTT need to be picked up outside of the meeting. CM added that they have carried out several reviews on CTT. The Finance Sub-Committee approved the Urgent Care Response (UCR) 2 Hour Response expansion and recommended that it goes to the Area Committee for sign off, as it exceeds the financial limit of the BHR FSC. **Post meeting update: Ceri Jacob approved the business case. The business case was sent to the Area Committee to be approved virtually.**

6.3	Diabetic foot protection
	Jeremy Kidd presented the item. JK provided some background and informed the committee that the business case was developed in partnership with BHRUT and NELFT and is system wide. It was identified that there is a gap in the diabetic foot pathway. BHR has some of the worst outcomes for foot amputations. The proposal is to commission NEFLT to deliver a community foot protection service. The service is looking to have 75k contacts in a year and would be in the medium or high diabetic foot risk category. The service is aiming to prevent amputations. It was acknowledged that there will still be amputations. It was noted that the savings are related to a reduction in amputations. It was also highlighted that after amputations, other services are required, such as physio and wheelchair. It was highlighted that the service is in place in other areas. Redbridge is the 9th diabetic place in the country. This service is part of a package of measures to address the growth in diabetes. AA added that this service is about providing good care. AA queried accessibility and timeliness of the service. JK confirmed it will be timely and mobilisation will start once the committee has approved the business case. The service will proactively 'on board' patients and there will be various referral routes i.e. community podiatry and primary care. SR stated that this is about meeting a commissioning gap and quality of service. The cost of the service is in line with the cost in other areas. CB highlighted issues with recruiting Allied Health Professionals (AHPs). JK assured the committee that the risk is noted and they are exploring options. The service will be across BHR. The Finance Sub-Committee approved the Diabetic Foot Service and recommended the business case goes to the Area Committee for sign off, as it exceeds the financial limit of the BHR FSC. **Post meeting update: Ceri Jacob approved the business case. The business case was sent to the Area Committee to be approved virtually.**
6.4	BHRUT Referral Assessment Service (RAS) in General/Vascular surgery, Urology and Gynaecology
	Jacqui Czarnocki presented the item. Activity grew during the pandemic for general/vascular surgery, urology and gynaecology. There are currently over 5k people on the waiting list. The proposal is to set up a referral assessment service to enable clinicians to review the patients on the waiting list and see if they can be managed in a different setting, adjust their priority on the waiting list, transfer them to a 2 week wait pathway or bring them forward if high priority. BHRUT will work with CCG colleagues. The aim is to ensure patients are seen by the right clinician, at the right time and reduce consultant to consultant referrals.

	The service would be setup quickly, include administrative time to collate the information and primary care time to work with GPs, to align some of the pathways. AK confirmed there are no funding issues. AA sought clarification on whether the service will be looking at patients on the existing waiting list and if so, how far back will it go. Also, who will book any further appointments, e.g. scans, the consultant or the GP? JC confirmed it will depend upon the pathway agreed with GPs. The longest waiters will not be re-referred to GPs. Also, if the patient needs to be referred to another specialty, it will be done internally. KP requested a review of the service in a year's time. JC stated that they will audit the service, as they go along and will monitor the number of referrals going back to GPs. JC clarified that there will be a reduction in waste within the system and no financial savings will be achieved until the backlog is cleared. The Finance Sub-Committee approved BHRUT Referral Assessment Service (RAS) in General/Vascular surgery, Urology and Gynaecology business case. **Post meeting update: Ceri Jacob approved the business case.**
6.5	Lipid pathway pilot
	Louise Brent presented the item and informed the committee that the business case has been assured by the FSPPDM and approved by the Finance Sub-Committee. LB highlighted the issues that arose during the process: - Ensure GP privacy notices across BHR and NEL are clear to patients, on how their data can be used. - Ensure this work is added to the Barts contract (in progress). The pilot is live. LB added that the project team will be requesting an extension to the pilot, due to the delay from covid. The Finance Sub-Committee noted the Lipid pathway pilot.
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**
	None raised.
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.
	Date of next meeting – Thursday 24th February 2022

BHR Integrated Care Partnership Board

31 March 2022

Title of report	BHR Integrated Care Partnership Board effectiveness survey report
Author	Keeley Chaplin
Presented by	Cllr Maureen Worby
Contact for further information	Keeley.chaplin@nhs.net
Executive summary	It is good practice that an annual review of the effectiveness of the CCGs sub-committees is undertaken. This enables the CCG to ensure that its governance arrangements remain fit for purpose and respond appropriately to change internal and external environmental factors. There were six respondents.
Action required	For members to note the results of the recent effectiveness survey
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	Following review of this report comments will be considered in future planning and key themes will be included in the NEL CCG annual report.
How does this drive change and reduce health inequalities?	N/A
Conflicts of interest	There are no conflicts of interests pertaining to this report
Strategic fit	N/A
Impact on finance, performance and quality	N/A
Risks	N/A
Equality impact	There are no direct equalities implications arising from this report

BHR ICPB/Area Committee Effectiveness Survey
2021/22

Things that went well:

- Brings all agencies together into one conversation
- Good attendance
- Good chairing
- Meeting runs to schedule despite size of agenda
- Good contributions by all stakeholders
- Good quality of papers
- Sets direction for transforming care
- Allows a voice for all parties
- Provides a forum for system changes to be discussed
- Provides advice to the ICPB
- Understanding of current landscape information
- Joint membership of borough, CCG and providers
- Open communication
- Transparency
- Relationships
- Good cohesion from membership

What hasn't worked so well:

- Meeting agendas full which doesn't always allow time for discussion
- Going over the same areas over and over again
- Some parochialism
- Clear connection between H&CC and ICPB not fully established
- PCN voice not loud in this forum
- Papers should be sent at least 2 weeks in advance
- It has lacked sense of direction
- Often a lack of focus
- Would have been helpful if it was able to give recommendations to the transformation process and to the Borough partnership Boards
- Confusion about purpose
- Review and consideration of progress against the ISP not particularly evidence led

Any other comments:

- Good chairing
- Recommend it continues during ICS changes then review
- Ensure PCN leaders have a voice