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

Barking and Dagenham, Havering and Redbridge Integrated Care Partnership Board

25 November 2021

1.00pm – 3.00pm

via Microsoft Teams

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

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	**1.00**	**Chair**	**Verbal**	**Note**
1.1	Declaration of conflicts of interest			**Attached**	**Note**
1.2	Minutes of the meeting held on 30 September 2021			**Attached**	**Approve**
1.3	Actions/matters arising			**Attached**	**Note**
2.0	**Managing Director's report**	**1.05**	**CJ**	**Attached**	**Note**
3.0	**BHR ICP risk management**	**1.10**	**SR**	**Attached**	**Note**
4.0	**Patient and public engagement update**	**1.20**	**JD**	**Attached**	**Approve**
5.0	**Integrated Care System development**	**1.30**	**CJ**	**Attached**	**Approve**
5.1	Developing our Barking and Dagenham, Havering and Redbridge Partnership within the North East London Integrated Care System context				
6.0	**Transformation**				
6.1	BHR Transformation Boards 21/22 - key progress and achievements to date	**1.45**	**HX**	**Attached**	**Note**
6.2	BHR community phlebotomy pilot update	**2.00**	**JK**	**Attached**	**Note**
7.0	**BHR ICP performance**				
7.1	BHR priority actions progress update	**2.10**	**SR**	**Attached**	**Note**
7.2	Winter plan	**2.20**	**SR**	**Attached**	**Approve**
7.3	Finance report	**2.30**	**SC**	**Attached**	**Note**

	Item	Time	Lead	Attached/ verbal	Action required
8.0	**Any other business**	**2.40**	**Chair**	**Verbal**	**Discuss**
9.0 9.1 9.2	**Items for information** BHR Area Committee approvals:- • Individual Placement Support business case • COPD Community Redesign Project • Heart Failure with reduced Ejection Fraction • Proposal to extend BHR's community ophthalmology service (Evolutio) • Single Tender Waiver request to extend existing provision by North West Ostomy Services (NWOS) dressings provision services to BHR patients. Minutes of relevant fora: • Integrated Care Executive Group • Health & Care Cabinet • Finance Sub-committee • Quality & Performance Oversight Group • Integrated Safeguarding assurance Board	**2.45**			
10.0	**Questions from the public**	**2.50**		**Verbal**	**Discuss**
	Date of next meeting – 27 January 2022	**3.00**			

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

Barking & Dagenham, Havering and Redbridge Integrated Care Partnership's Conflicts of Interest Register
Date - 17 November 2021

Conflicts of interest will remain on the register for a minimum of 6 months following expiry

First Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk	Member of
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To		
Atul	Aggarwal	Havering Clinical Chair; NEL CCG	Maylands Healthcare	X			Direct	GP Partner	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Maylands Healthcare Ltd	X			Direct	Director and shareholder in on-site pharmacy	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Parkview Dental Practice			X	Indirect	Sister is an NHS dentist within Havering	1996	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Essex Medicare LLP	X			Direct	Part-owner (which owns Westland Clinic, Hornchurch. Space leased to: •Inhealth (Diagnostics) •Nuffield Health (Brentwood)	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Havering Health Ltd	X			Direct	Shareholder. GP partner at Maylands Surgery (Dr Kendall) is a Director	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Barking, Dagenham and Havering LMC		X		Direct	Co-opted Member	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Westlands Clinic (Langton Dental) who has an outsourced contract with BHRUT for oral surgery)			X	Indirect	Spouse is a dentist	2018	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			New Medical Centre (Havering Practice)			X	Direct	Family GP practice	1990	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Havering and Wellbeing Board		X		Direct	Member	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Anglia Ruskin University Medical School		X		Direct	Lecturer	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Caroline	Allum	Executive Medical Director; NELFT	Care City		X		Direct	Board member	TBC	TBC	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB

Henry	Black	Acting Accountable Officer; NEL CCG	BHRUT			X	Indirect	Wife is employed as Assistant Director of Finance	Jul-05	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Tower Hamlets GP Care Group			X	Indirect	Daughter is a Social Prescriber	Jul-05	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NHS Clinical Commissioners		X		Direct	Board Member	Jul-05	Jul-21	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Andrew	Blake-Herbert	Chief Executive; London Borough of Havering	London Borough of Havering	X			Direct	Employed as Chief Executive	May-16	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Steve	Collins	Acting Chief Finance Officer; NEL CCG	Trisett Limited (business support service)		X		Direct	Director	2003	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Sevenoaks Primary School		X		Direct	Chair of Governors	2002	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Hope Church Sevenoaks		X		Direct	Chair of Trustees	2020	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Fegans (charity)			X	Indirect	Wife is Chair of Trustees	2017	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			PwC			X	Indirect	Daughter is employed as a Senior Associate	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Joe	Fielder	Chair - NELFT	None									BHR ICPB
Jason	Frost	Councillor; London Borough of Havering; Cabinet Member for Health & Adult Care Services; Chair of Havering Health & Wellbeing Board	Local care provider which receives CHC patients			X	Indirect	Mother is employed as a registered nurse	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Ceri	Jacob	Managing Director; BHR ICP; NEL CCG	None									BHR ICPB
Jagan	John	Chair; NEL CCG	Parkstone Holdings Ltd	X			Direct	Director	Feb-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Aurora Medcare	X			Direct	GP Partner	Jan-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB

			Parkview Medical Centre	X			Direct	GP Partner	Mar-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Together First Limited (GP Federation)	X			Direct	Practice is a shareholder	May-14	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Harley Fitzrovia Health Limited	X			Direct	Director and shareholder	Jan-18	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Aurora Medcare			X	Indirect	Other employed GPs are family members	Jan-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			New West Primary Care Network			X	Indirect	Brother/ GP Partner is the Clinical Director	Nov-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Personalised Care - Healthy London Partnerships and NHS England Region		X		Direct	Clinical Lead	Mar-17	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NELFT - Barking & Dagenham Community Cardiology Service		X		Direct	GP with Special Interest (GPwSI) in Cardiology	Aug-11	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Barking & Dagenham Health and Wellbeing Board		X		Direct	Deputy Chair	2018	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Monifieth Limited **Historic**	X			Direct	Director and shareholder	Mar-18	Oct-20	Historic	BHR ICPB
			Diagnostics 4u (previously Monifieth Ltd)	X			Direct	Director and shareholder	Oct-20	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Adrian	Loades	Corporate Director of People; London Borough of Redbridge	None									BHR ICPB
Anil	Mehta	Redbridge Clinical Chair; NEL CCG	Fullwell Cross Medical Centre	X			Direct	GP Partner	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Metropolitan Police	X			Direct	Forensic Medical Examiner	2015	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			The Cleaning Company			X	Indirect	Sister-in-law is the owner	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NHSE	X			Direct	GP Appraiser	2015	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Healthbridge Direct (GP Federation)	X			Direct	Shareholder	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB

			Fouress Enterprise Ltd	X			Direct	Director	2015	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Prescon	X			Direct	Ad-hoc screening work	2018	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			London Healthwise Ltd (non-trading)		X		Direct	Director	2009	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			GMC		X		Direct	Associate	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Ilford Lane Surgery (Redbridge practice)			X	Direct	Registered patient (family)	2000	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Redbridge Health and Wellbeing Board		X		Direct	Vice Chair	2013	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Anglia Ruskin University Medical School		X		Direct	Lecturer	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Queen Mary University of London		X		Direct	GP Tutor	2021	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Chris	Naylor	Chief Execuive; London Borough of Barking & Dagenham	None									BHR ICPB
Kash	Pandya	Lay Member; NEL CCG	Southend-on-Sea Borough Council	X			Direct	Independent Audit Committee Member	2016	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Essex Police, Fire and Crime Commissioner's Audit Committee	X			Direct	Independent Audit Committee Member	2021	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			University of Essex		X		Direct	Independent Audit Committee Member	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Brentwood Citizen's Advice Bureau			X	Direct	General Advisor	2009	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Metro Bank			X	Indirect	Son is employed as Procurement Manager	2019	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			Accenture			X	Indirect	Son is employed as Senior Legal Counsel	2017	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Sangeetha	Pazhanisami	PCN Clinical Director; Redbridge	Clayhall Group Practice	X				GP partner	2014	Current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB

			Healthbridge Direct (GP Federation)	x				Shareholder			No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
			NHSE	x				Appraiser			No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Mark	Santos	Councillor; London Borough of Redbridge	Awaiting form									BHR ICPB
Oliver	Shanley	Chief Executive; NELFT	None									BHR ICPB
Gurmeet	Singh	PCN Clinical Director; Havering	Awaiting form									BHR ICPB
Jacqui	Smith	BHRUT & Barts Health Chair in common	Awaiting form									
Matthew	Trainer	Chief Executive BHRUT	None									BHR ICPB
Narendra	Teotia	Clinical Director; Barking & Dagenham North Primary Care Network	Together First CIC (B&D GP Federation)	X			Direct	Shareholder	2014	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	BHR ICPB
Maureen	Worby	Councillor & Cabinet member for Social Care & Health Integration - LBBD	None									BHR ICPB
Tony	Chambers- **historic** (*entry to remain on the register for minimum of 6 months)*	CEO, BHRUT- **historic**	None									**Historic** (*entry to remain on the register for minimum of 6 months)*
Michael	Bell **historic** (entry to remain on the register for minimum of 6 months)	Chair; BHRUT historic	BHRUT	X			Direct	Chairman	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	**Historic** (*entry to remain on the register for minimum of 6 months)*
			Croydon Health Services NHS Trust	X			Direct	Chairman	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	
			MBARC Ltd (service commissioning)	X			Direct	Director	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	
			Strasys Management Consulting	X			Direct	Senior Associate Consultant	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	
			ZPB Consulting Ltd	X			Direct	Senior Advisor	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	
			DAC Beachcroft LLP	X			Direct	Senior Leadership and Governance Advisor	Apr-21	current	No immediate action required. Declarations made at the beginning of meetings. Will not be involved in any decision making regarding the conflict.	

BHR Integrated Care Partnership
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Draft minutes – BHR Integrated Care Partnership Board

30 September 2021

1.00pm – 3.00pm

Via MS Teams

Members:

Cllr Maureen Worby (MW)	ICPB Chair (LBBD)
Kash Pandya (KP)	Lay Member, Governance & Area Committee Chair, NEL CCG
Ahmet Koray (AK)	Director of Finance, BHR ICP (rep SC)
Ceri Jacob (CJ)	Managing Director, BHR ICP
Dr Rami Hara (RH)	Deputy B&D Clinical Chair
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Dr Anil Mehta (AMe)	Redbridge Clinical Chair
Matthew Trainer (MT)	Chief Executive, BHRUT
Sultan Taylor (ST)	NELFT Chair representative
Dr Caroline Allum (CA)	Chair – Health & Care Cabinet
Andrew Blake-Herbert (ABH)	Chief Executive, LBH
Cllr Jason Frost (JFr)	LB, Havering
Adrian Loades (ALo)	Corporate Director of People, LB Redbridge
Cllr Mark Santos (MS)	LB Redbridge
Dr Gurmeet Singh (GS)	PCN Clinical Director, Havering
Dr Sangeetha Pazhanisami (SP)	PCN Clinical Director, Redbridge

Attendees:

Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Diane Jones (DJ)	Chief Nurse, NEL CCG
Mark Eaton (ME)	BHR System Recovery Adviser
Kirsty Boettcher (KB)	Deputy Director, Transformation, BHR ICP
Anna McDonald (AMcD)	Business Manager, BHR ICP
Caron Bluestone (CB)	Associate Lay Member, BHR ICP
Jayam Dalal (JD)	Associate Lay Member, BHR ICP
Sarah See (SS)	Director of Primary care, BHR ICP
Sophia Jaques (SJ)	Member of the public

Apologies:

Oliver Shanley (OS)	Chief Executive, NELFT
Mike Bell (MB)	Chair, BHRUT
Mehboob Khan (MB)	Non-Executive Director, BHRUT
Joe Fielder (JFi)	Chair, NELFT
Dr Jagan John (JJ)	NEL CCG Chair and B&D Clinical Chair
Henry Black (HB)	Acting Accountable Officer, NEL CCG
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Emily Plane (EP)	Programme Lead, BHR ICP

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies received were noted.	
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 29 July 2021 were agreed as an accurate record.	
1.3	**Actions/matters arising**	
	ICPB members noted the action taken since the last meeting.	
2.0	**Managing director's report**	
	CJ presented the update report which covered the following areas: • Latest ICS development guidance • BHR process to articulate our local vision for collaboration at a multi-borough level • BHR Borough Partnership development • Anchor Organisations – procurement workshop • Contracting discussion • Identification of our key priorities • Development of a BHR System Integrated Sustainability Plan • Development of an engagement structure and approach to support the local partnership The chair drew particular attention to appendix 1 – BHR partnership development programme and commented that the 'plan on a page' provides an overview of all the different elements of work. ST said he found the information very helpful and asked whether a summary could be sent to him for onward sharing with his non-executive colleagues at NELFT. The Chair advised that in advance of each ICPB meeting a summary of the agenda items is shared with the three PCN ICPB members and suggested that ST could be included going forward. Members of the ICPB: • Noted the update.	EP
3.0	**BHR Integrated Care Partnership Risk Management**	
	SR presented the update and advised that the current NEL level risks relate to four areas:- • underperformance against H1 metrics, specifically elective recovery	

	• continuing healthcare • use of resources and finance balance • vaccine delivery Members were advised that work to refine the BHR ICP risk register is continuing and a review of the risks is being undertaken. The current key risks within BHR ICP relate to: • Children with learning difficulties and mental health needs and access to services and discharge from inpatient beds • Appropriate digital infrastructure • Financial balance across the BHR system • Adult social care provider workforce • Risk of future waves of COVID 19 • Backlog of elective activity KP welcomed the progress made and referred to the funding issues within social care and suggested this needs to be considered as an additional risk for the system. SR confirmed that it is included as a high scoring on the System Operational Command Group (SOCG) risk register and agreed that it also needs to be added to the BHR ICP risk register. The chair suggested the increasing gap in health inequalities within the NEL system also needs to be added. RH referred to the risk relating to Covid-19 and advised members that work is being undertaken in regard to children with learning disabilities together with an additional piece of work on long-covid in children. KP confirmed that long-covid is being added to the NEL risk register as part of the recovery plans. JFr flagged that the increasing population across BHR is a risk and suggested the need to ensure population projections are built into the re-designing of pathways and any decisions around infrastructure. CJ assured the ICPB that population growth is woven into the clinical strategy, the Integrated Sustainability Plan (ISP) and estates planning. A discussion took place about funding flows and how there needs to be level of flex across the whole of the health & wellbeing system and CJ confirmed that will be taken forward as part of the ICS discussions. AK explained that as an ICS, there will be opportunities to look at how allocations are split across the boroughs going forward and as the ICS matures, there will be opportunities to do things differently. AMe expressed his view that the inequalities across NEL cannot be addressed until the low number of GPs and practice nurses in BHR is addressed. ICPB members agreed that consistency of practice across NEL is needed. SR to update the risk register with a narrative that reflects the discussion. Members of the ICPB: • Noted the current risks to the BHR ICP, the risk management cycle and the key risks to the NEL CCG Governing Body.	SR SR
4.0	**Integrated Care System Development**	

	4.1 Developing our BHR partnership within the North East London integrated care system context CJ gave an overview of the key points and confirmed that the process for agreeing what Borough Partnerships will continue to collaborate on post 1 April 2022 is underway. Once all the information has been collated, a proposal will come back to the ICBP. Good progress is being made in regard to the development of the Borough Partnership Boards. Further work is needed in regard to PCN development as a lot of the work was halted due to the pandemic and clinical leads are under continued pressure. CJ suggested that going forward a more detailed update on one or two areas of the Borough Partnership areas of development could be presented rather than an overall update on all of them. CA referred to Anchor Organisations and stressed the need to use the data resulting from the Nightingale census to ensure we get people into employment within health and social care. The Chair added that the BHR Academy is the key vehicle to help address the workforce issues. The Chair referred back to the point made earlier in the meeting about the shortage of GPs and practice nurses within BHR and asked how that is affecting PCN development. AMe responded that PCN development is key as they are the foundation for addressing population health but their development is a risk due to workload, workforce and resource. SP stressed the need to not overwhelm PCNs and for the system to clearly articulate what the expectations are and prioritise the work. The Chair suggested that each Borough Partnership needs to consider what the top three 'asks' for their PCNs are in terms of development. KP added that each Borough Partnership could also be asked to undertake their own self-assessment to see where they need more support in order to direct the support where it is needed most. CJ agreed to take both points forward. RH endorsed everything that was said and stressed that patient education is an important element in regard to PCN development and delivery as they need to understand the new GP model. The Chair recapped on a recent discussion she had in regard to the strong impact social media messaging can have particularly if the messages are coming from GPs. JD advised she will discuss how patient education can be strengthened as part of patient and public engagement with the CCG's Communications Team. Members of the ICPB: • Noted the report and the next steps to further develop our local partnership within the wider context of the developing North East London Integrated Care System. **4.2 Developing our proposal for ongoing collaboration in BHR** CJ recapped that members of the BHR Integrated Care Executive Group (ICEG) reviewed and endorsed the proposal in August 2021 and key meetings are being scheduled. Outputs from the discussions will be developed into a proposal which will be reviewed by ICEG in October 2021 and presented to ICPB members in November 2021. Once endorsed, the proposal will be shared with NEL colleagues in order to feed into and shape the framework that is being developed for the NEL ICS.	CJ/EP CJ/EP CJ/EP JD

	Members of the ICPB: • Noted the proposed process to design and articulate our proposal for ongoing collaboration in BHR. • Endorsed the proposed process to design and articulate our proposal for ongoing collaboration in BHR.	
5.0	**North East London Primary Care Development**	
	5.1 NEL integrated care system primary care collaborative CJ explained that the recent national ICS guidance requires a mental health collaborative and an acute collaborative. In addition, work is underway in NEL looking at a community collaborative and a primary care collaborative and CJ outlined their key areas of focus. The collaborations provide an opportunity to strengthen working across different areas of health. PCNs have a key role in forming the primary care collaborative in NEL so there is a need to agree how they can work together at a NEL level when necessary to drive consistency and to work together with the mental health and community collaboratives to be a strong community care voice. Views are being sought from PCNs, GP Federations, local primary care groups. Members of the ICPB: • Noted the report. **5.1.1 BHR primary care development** NEL CCG has developed a wide portfolio of development projects under the Transformation Programme with the key aim of improving both access to and the quality of services available to patients across the whole of NEL, with a key focus on reducing health inequalities for our diverse population. The aim is to develop a sustainable model for primary care as a key element of the NEL ICS. The presentation provided an update on; access and patient survey results; CQC ratings; local incentive scheme equalisation programme; workforce in regard to general practice nursing; Covid-19 and flu vaccination programme 2021/22. AMe welcomed the helpful summary and flagged that BHR has performed very well in regard to the Covid-19 and flu vaccination programmes despite having the least number of GPs and practice nurses which in turn has added to the pressures on an already exhausted workforce. A discussion took place about the increased demand for face to face appointments and the need to address the expectation of patients and recruitment issues. JFr suggested the need for GP practices to review the narrative used in recorded telephone messages that patients hear when phoning the surgery and gave his personal experience as an example adding that a much smarter approach to communicating messages to the public is needed. SP commented that a lot of remote monitoring of conditions is taking place successfully which is empowering patients and the data needs to be looked at differently. JD to discuss ways in which the advantages of having some appointments remotely can be best communicated to the public with the CCG's Communications Team. The Chair raised concern about the uptake of the Covid-19 vaccination in the 12-15year age group in B&D. SS clarified that the issue appears to be how consent is being sought and advised it is being addressed.	JD

	The Chair requested an update on primary care development in six months. Members of the ICPB: • Noted the report	SS
6.0	**Transformation**	
	6.1 Integrated Sustainability Plan (ISP) ME advised that the ISP was being presented for ratification prior to it being presented for final approval at the NEL CCG Governing Body meeting in October 2021. ME reiterated that the ISP is a five-year plan designed to bring significant change to the outcomes for patients within the system. The plan redresses the historic under-investment in primary care across BHR and will bring BHR primary care investment up to the level of Tower Hamlets. Historic underfunding in mental health is also being redressed. There is significant focus on prevention and early intervention to reduce the number of non-elective presentations and also to improve longer term outcomes. ME flagged that the national guidance for 2022/23 onwards is not likely to be received until early 2022 which will mean that some of the assumptions made will need to be reviewed. KP fed back that members of the BHR Finance sub-committee were very supportive of the ISP. JFr reported that the plan received very positive comments at the Havering Health and Wellbeing Board and MT fed back that the ISP had been approved by the BHRUT Board. Members of the ICPB: • Approved the Integrated Sustainability Plan.	
7.0	**Safeguarding update**	
	DJ presented the report and recapped that the CCG's Quality & Safeguarding Team members were asked to consider how safeguarding in BHR could be fed into the ICPB going forward to ensure members have oversight of the key issues around safeguarding. DJ outlined a proposal to submit minutes of the Integrated Safeguarding Assurance Board (ISAB) meetings to the ICPB for information and advised that the ISAB is a well-established and effective forum where detailed discussions of all safeguarding related issues, risks and mitigations are presented and discussed. The Chair gave her view that having sight of the minutes would ensure that ICPB members have oversight of safeguarding issues and the opportunity to flag any areas of concern. Members of the ICPB: • Noted the report. • Agreed to receive the minutes from the Integrated Safeguarding Assurance Board.	
8.0	**Winter plan assurance**	
	KB presented the winter plan which highlighted the risks and action being taken to try and reduce the risks. The plan has been developed across the BHR system with involvement from all system partners.	

	ABH referred to the additional services and asked whether the £2.9m includes cover across social care. KB clarified that the £2.9m is very specific to schemes being developed in regard to admission avoidance and supporting discharge, however, other discussions are taking place in regard to financial support for other packages to support social care through the winter and discussions will be held at the Discharge Working Improvement Group (DWIG). ABH asked for children to be included as there will be pressures relating to children as well as adults that need to be addressed. The Chair flagged that flu is likely to be a huge pressure this winter. Members of the ICPB: • Approved the winter plan.	KB
9.0	**BHR Integrated Care Partnership Performance**	
	9.1 BHR priority actions progress update SR reported that progress is being made against all four priorities. In regard to 'recovering well' SR asked members to note the impact of the flow of activity going into the BHR system. In regard to waiting lists, SR reported that 52 week waits are decreasing slowly but overall, the waiting list continues to increase which highlights the challenges faced by the system in addition to trying to address the backlog resulting from the pandemic. The Chair referred to the possible deterioration of health that may have occurred to patients on the waiting lists and SR clarified how the waiting lists at BHRUT operate, whereby the condition of patients on the list is regularly reviewed and prioritised accordingly. SR added that people who did not present for healthcare during the pandemic are coming forward now, with many having more complex needs. MT explained that the Trust tries to prioritise lists based on urgency and identifies the highest priority patients. It is going to take a sustained effort by the system as a whole and MT added that he will be looking to discuss with primary care colleagues, what can be done to reassure patients who are on a waiting list. AA commented that BHRUT is doing well compared to other Trusts and added that the Trust has a mechanism in place for clinical risk management. A lot of health promotion is being done in primary care and AA suggested a review of the screening programme might help. DJ referred to the clinical risk undertaken at BHRUT and questioned whether any clinical harm has been found whist undertaking the reviews. SR confirmed clinical harm reviews are carried out on an on-going basis by BHRUT and there are well-established processes in place. The BHR Quality & Performance Oversight Group (QPOG) monitor clinical harm at BHRUT and SR confirmed that no cases of significant harm have been reported. MT suggested the Chief Medical Officer at BHRUT could speak more about the clinical harm process if required and SR suggested a more detailed discussion could be held but it would be more appropriate for it to be undertaken at the QPOG meeting. DJ suggested it would be helpful to look at the demographics of the people who are on the waiting list in terms of addressing inequalities and MT responded that it would be hard to quantify the unfairness but added more people than ever are accessing private healthcare and there will be	SR

	residents in the borough who do not feel confident to get themselves heard in the same way others might. MT also pointed out that the anxiety that comes from being on a waiting list is not captured in the harm reviews. DJ fed back that data is showing that NEL as a whole does not access the independent sector for patients as much as other areas do. CJ fed back that the BHR Public Health Directors have been working with BHRUT looking at inequalities and the Chair requested a report on the demographics of the people on the waiting lists and data on the number of BHR residents being referred to the independent sector for treatment. ICPB members: • Noted the progress made. **9.2 BHR finance report** AK presented the update and reported that pressures are developing in some areas including the independent sector, prescribing and Continuing Health care (CHC). AK advised that the report was discussed in detail at the BHR Finance sub-committee held earlier in the day. Each of the NEL ICPs have reported a break-even position across core budgets. However, delivery of the break-even position is reliant on the use of non-recurrent balance sheet accruals. This has been necessary to offset budgetary pressures in the areas mentioned. KP reported that Finance sub-committee members have raised their concern about the budget gap being bridged through reserves as that means there is an underlying deficit which could get worse in the second half of the year. The sub-committee will be looking into the independent sector increase and also will be undertaking a deep dive in regard to prescription costs. ICPB members: • Noted the report.	SR
10.0	**Items for information**	
	10.1 Minutes of relevant fora: The minutes of the following meetings were noted: • Integrated Care Executive Group – July and August 2021 • Health & Care Cabinet – July and August 2021 • Finance sub-committee – July and August 2021 • Quality & Performance Oversight Group – July and August 2021	
11.0	**Any other business**	
	There was no other business.	
12.0	**Questions from the public**	
	No questions from the public were received.	
	Date of next meeting – 25 November 2021	

Integrated Care Partnership Board

Action ref:	Meeting date	Action required	Lead	Required by	Status
1.1 Declarations of Interest	**May 2021**	Outstanding declaration of interests forms to be submitted.	All	Nov	In progress – electronic system now operational.
5.1 BHR ICP risk management approach	**May 2021**	All current completion dates to be reviewed. Risk register to be aligned with each of the BHR Local Authorities risks.	PD/AMK	Nov	**Complete** - review undertaken. With the move to a NEL ICS and place based partnerships, work to develop a risk management strategy and policy of the ICS is underway and will form part of the place based partnership delegation arrangements.
2.0 Managing Director's report	**30 Sept 2021**	Sultan Taylor to be included when the summary of ICPB agenda items is shared with the three PCN ICPB members for on-ward sharing with his non-exec directors colleagues.	EP	Nov	**Complete** – MD's report will be shared in advance of each ICPB meeting.
3.0 BHR ICP Risk Management	**30 Sept 2021**	SR to update the risk register with a narrative that reflects the discussion held.	SR	Nov	**Complete** - risk register updated.
4.1 Developing our BHR partnership within the North East London integrated care system context	30 Sept 2021	A proposal on what the BHR Borough Partnerships will collaborate on post April 2021 to be brought to a future ICPB meeting.	CJ/EP	Nov	Agenda item – 5.1

		Going forward a more detailed update on one or two areas of the Borough Partnership areas of development to be presented rather than an overall update on all of them.	CJ/EP	Nov	Agenda item 7.1
		Each of the BHR Borough Partnerships to be asked to consider what the top three 'asks' for their PCNs are in terms of development and to undertake their own self-assessment to see where they need more support in order to direct the support where it is needed most.	CJ/EP	Nov	Being progressed with PCN leads and outcome will be shared. Place Based Partnership development is being progressed through the development session workshops and the BHR Place Based Partnerships are now directly involved in the NEL level piece of work around ICS development. This is starting with sessions with each BHR Place Based Partnership to work through current governance implications.
		Strong impact of social media messaging – patient Engagement lead to with Communications Team as to how this can be strengthened as part of patient and public engagement.	JD	Nov	Considered with partner communication and engagement leads to develop a shared and effective approach. It will form part of a NEL-wide approach to public engagement.
5.1.1 BHR primary care development	**30 Sept 2021**	JD to discuss with the Communications Team ways in which the advantages of having some appointments remotely can be best communicated to the public.	JD	Nov	Communications and engagement plan for primary care agreed for NEL with specific actions for BHR. Explaining the new model of primary care in an accessible way (including the benefits of virtual triage and appointments) is a key theme. Materials and messages are being tested with local community groups and patient representatives to ensure

					clarity of message.
		An update on primary care development to be presented in six months.	SS	Mar	**Complete** - added to f/wrd plan for March 2022.
8.0 Winter plan assurance	**30 Sept 2021**	Children's services to be included as part of the support package discussions as well as adult services.	KB	Oct	There are separate developments in relation to children that are being taken through the C&YP Transformation Board. Comms messages on management of childhood illness on-going and additional hub appointments for children being considered.
9.1 BHR priority actions progress update	**30 Sept 20221**	**Clinical Harm process** - a more detailed discussion to be held at the BHR Quality & Performance oversight Group.	SR	Nov	**Complete.**
		Waiting list at BHRUT - a report on the demographics of people on the waiting lists was requested together with data on the number of BHR residents being referred to the independent sector for treatment.	SR	Nov	**Complete** – information shared with members.

CLOSED ACTIONS

Action ref:	Meeting date	Action required	Lead	Required by	Status
5.1 BHR ICP risk management approach	**May 2021**	A performance dashboard that clearly demonstrates what the ICP is aiming to achieve and the progress being made to be presented at each ICPB meeting going forward. Changes in governance arrangements between BHRUT and Barts Health to be added to the BHR ICP	SR	Sept	**Complete** - a report against the 4 ICP priority areas will be presented at each ICPB meeting going forward (agenda item 9.1). **Complete.**

Action ref:	Meeting date	Action required	Lead	Required by	Status
		risk register. SR to work with BHRUT collegaues to agree the narrative.			
4.0 BHR ICP risk management	**July 2021**	The interface between BHR level risks and NEL level risks to be reviewed as it is not clear. OS gave C&YP as an example.	PD/AMK	Sept	**Complete.** ICPB members are able to escalate high level risks via the relevant NEL CCG director/lead for escalation to the NEL Governing Body Assurance Framework (GBAF). Further detail on the risk management cycle detailed within the risk report on the agenda.

BHR Integrated Care Partnership Board

25 November 2021

Title of report	Managing Director's Report – BHR Integrated Care Partnership Update
Author	Emily Plane, Programme Lead, BHR System Development
Presented by	Ceri Jacob, Managing Director, Barking and Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP)
Contact for further information	e.plane@nhs.net
Executive Summary	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: - Ongoing development of our Place Based Partnerships and local partnership priorities - Progress to map our proposed BHR vision for collaboration at a Multi Place Based level - BHR key milestones timeline - BHR Anchor Organisations workshop - Contracting discussion - Organisational development - St Georges Outline Business Case - Enhancing population Awareness project for cancer - New Conflict of Interest recording system
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, and our key milestones from a BHR perspective
Where else has this paper been discussed?	This is a recurring report from the BHR ICP Managing Director to members of the BHR Integrated Care Partnership Board
Next steps/ onward reporting	N/A; this report is intended to update members of the BHR Integrated Care Partnership Board on progress of our partnership work
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Every element of work referenced in this report has the aim of embedding more integrated working with a view to making best use of resources and improving outcomes for local people. Reducing inequalities is a key priority for the BHR Partnership as described within the body of this report
Conflicts of Interest	There are no conflicts of interest arising from this report
Strategic Fit	All areas of progress noted in this report align with national, North East London Integrated Care System, and BHR Integrated Care Partnership strategy
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage
Risks	One of the key overall risks for 2021/22 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the planned Health and Social Care Bill, from April 2022.
Equality Impact	Not applicable at this stage

1. Introduction

1.1 The latest Integrated Care System guidance and recent publication and reading of the new Health and Social Care Bill in Parliament both reinforce our approach to support the ongoing establishment and development of Borough Partnerships, 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. **A more detailed progress update on the BHR partnership key areas of work and the outputs from the process to articulate a BHR vision for multi Place Based Collaboration will be discussed under agenda item 5.**

Progress update – key areas

Progress update since the last ICPB meeting on key partnership initiatives	
BHR Process to articulate our local vision for collaboration at a multiborough level	A detailed update on the outputs of the BHR Process to articulate our local vision for collaboration at a multiborough level, alongside development of our place Based Partnerships will be discussed under agenda item 5. **Appendix 1** illustrates the key milestones for ICS Timeline Development from a BHR perspective.
Anchor Organisations – procurement workshop	At a NEL level, partner organisations have signed up to an Anchor Organisation Charter, committing to capitalise on the opportunity that Anchor Organisations present within local populations to have a positive impact, on the local population, local business, and local workforce. This will be achieved through a number of initiatives such as committing to decrease carbon footprint, and seeking to embed social value in our procurement processes etc. BHR Partners held a workshop with procurement leads from across partner organisations on 20th October 2021, to identify the opportunity for BHR Anchor Organisations to seek to embed social value in our local procurement processes. There was excellent attendance from across all partner organisations, and a comprehensive action plan has been drawn up which will seek to identify a number of ways in which partners can embed social value in procurement processes going forward. There was enthusiasm for a collective approach where possible across BHR, and partners intend to hold a follow up workshop in December 2021.
Contracting discussion	Given the key importance of new models of care and their associated developments across our system to deliver transformative care and continue to meet the needs of our growing population, BHR partners intend to discuss and articulate the way in which we believe we will contract post April 2022. A proposal to start this process is being drawn up which will be shared with partners shortly.
Organisational Development	There are a number of OD streams of work being progressed across BHR including: - **Primary Care Network development**; in progress - **Borough partnership development**; in progress - funding provided and working on key areas to progress development, alongside a series of workshops every two months run by the CCG

	- **Transformation Boards**; in progress, OD being scoped around a single Transformation Board (TBC), with the programme then planned to be rolled out to other TB's - **ICEG/ICPB;** Previously facilitated by NHS Elect, there is a need to review and consider next steps for this, including proposal to expand to next layer of leadership within each organisation - **Enablers programme**; to be scoped - ICEG Suggested in particular a session focussed around 'performance' with leads from across the system. OD sessions could be also held for other key enabling programmes such as Digital etc. - **Wider system staff to support new ways of integrated working**; To be scoped – potentially roll this out following the Transformation Board OD approach It is essential that BHR partners maintain synergy between these to ensure that they are aligned, complement each other, and support the direction of travel / bring all partners along on the journey needed to April 2022 and beyond. There is also a need to focus on taking forward OD based on practical projects / work, to anchor it in reality and test and embed new ways of working.
St George's health and well-being hub outline business case	An update on the progress of the outline business case (OBC) for the St George's development was presented to the NEL CCG Governing Body meeting on 28 October 2021. The hub is now fully designed and the plans have been agreed to a 1:50 level by all participants. A fully detailed panning application was submitted to the London Borough of Havering (LBH) in May 2021 and the planning application was heard at the LBH Strategic Planning Committee on the 4 November 2021. As the development is within the Metropolitan Green Belt, the application may be 'called in' by the GLA for further examination. On the assumption that the OBC is approved by the Joint Investment Committee and then receives Ministerial approval early in January 2022, the full business case should be submitted in March 2022, with an expected approval in May or June. Modern methods of construction will be employed, which greatly reduces construction time and it is planned to have the construction complete in late August/early September 2023. The building will then be commissioned and occupied, with an expected formal opening to take place in November 2023.
Enhancing population awareness project for cancer	BHR and TNW commissioning areas have come together to award a contract designed to enhance population awareness in regards to cancer and improve early diagnoses. The successful provider is Community Links, a social action group based in East London who are part of a wider not-for-profit organisation They deliver projects promoting early diagnoses of cancer by increasing the uptake of the NHS Cancer screening programmes and raising awareness in local communities. A number of colleagues and fora have been engaged with this contract award, including the Cancer Alliance Board, Cancer and Planned Care Transformation Boards and local governance fora before final approval at the September NEL CCG Finance and Performance Committee. The

	contracts were signed in October 2021 with services due to commence imminently.
New conflicts of interest management system	On 11 October 2021 NEL CCG launched the new conflicts of management system 'Disclose' which is provided by NEL CSU. The system allows for all employees, GP members and external partners to submit their declarations in an electronic format which can automatically generate registers of interest, following approval and oversight from the governance team. The system has been presented to the NEL CCG Audit & Risk Committee Working Group and was well received and welcomed by the Audit Chair and COI Guardian, Kash Pandya. As well as being presented to the Working Group, Disclose will be presented to the ICPs' Staff Engagement Groups to promote completion and to obtain feedback on staff experiences. The new system allows the CCG to effectively manage a significantly higher number of declarations across the three ICP areas and reduces the demand on administrative staff.

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.

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 April 2022.

3. Recommendations

3.1 Members of the BHR Integrated Care Partnership Board are asked to note and comment on the progress to develop the key elements of our BHR Integrated Care Partnership detailed within this report.

Emily Plane, Programme Lead, BHR System Development
November 2021

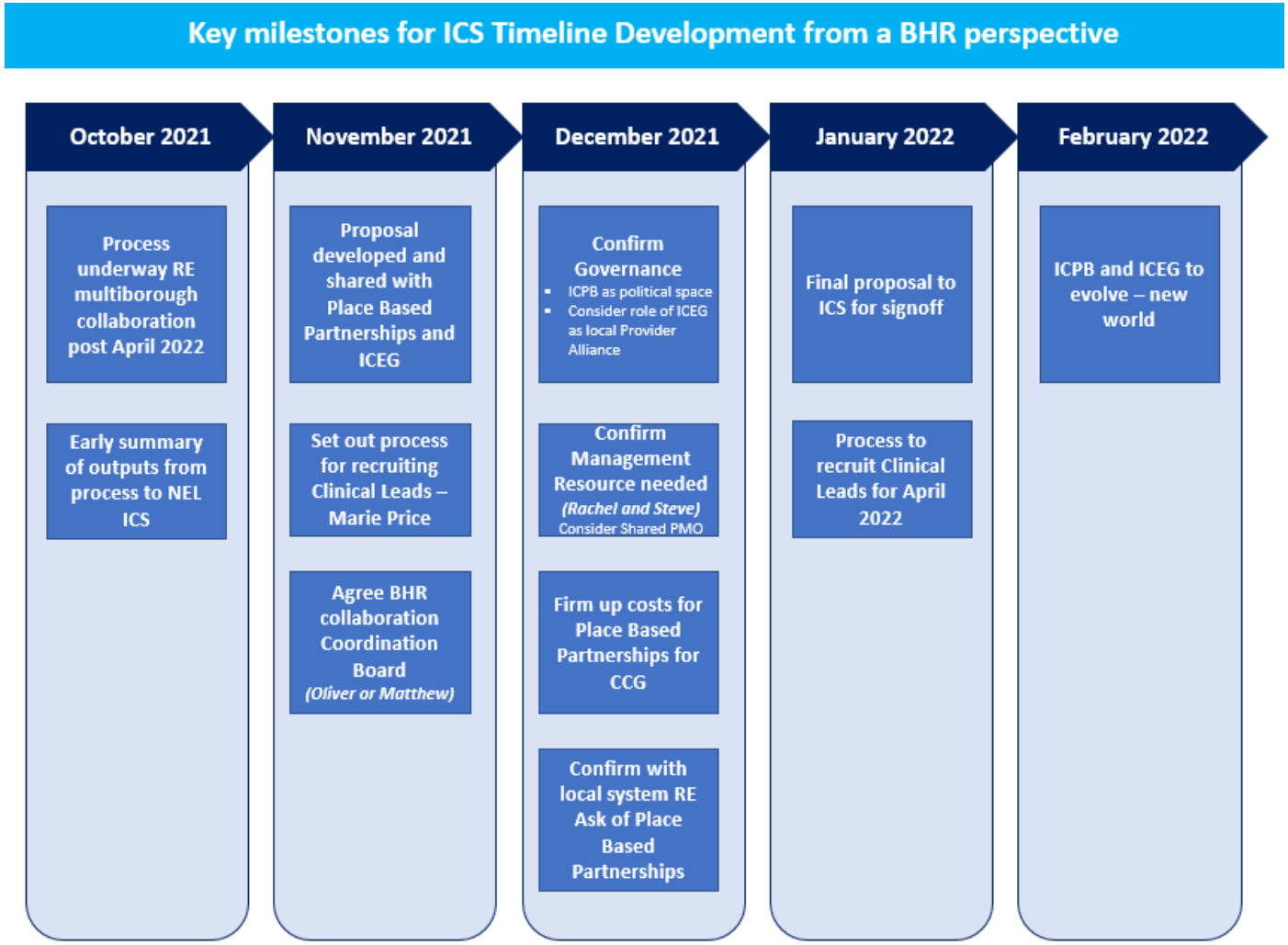
Attachments:

- **Appendix 1** – Key milestones for ICS Timeline Development from a BHR perspective

BHR Integrated Care Partnership

Better care, better lives, together for all

Appendix 1 – Key milestones for ICS Timeline Development from a BHR perspective



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

BHR Integrated Care Partnership Board

25 November 2021

Title of report	BHR ICP Risk Management
Author	Anna McDonald – Senior Governance Manger, BHR ICP
Presented by	Steve Rubery, Director of Planning & Performance, BHR ICP
Contact for further information	anna.mcdonald@nhs.net
Executive summary	Since the last meeting a Governing Body Assurance Framework (GBAF) was presented to the NEL CCG Governing Body in October 2021. Further work continues to refine the overall register and GBAF to ensure that ICP/Borough risks are managed appropriately locally, but that key risks of significant score or those that are applicable across NEL are escalated to the Governing Body. The current key **NEL CCG** risks relate to: • Underperformance against H1 metrics, specifically elective recovery • Continuing Healthcare • Use of resources and financial balance. A further risk is being developed in relation to **health inequalities.** The risk relating to **vaccine delivery** is a new one which specifically relates to **workforce challenges.** This degree of change regarding the nature of the risk will continue to be a feature given the fast-changing pace of the programme and guidance. Further work to refine the **BHR ICP** risk register has been undertaken and is attached.

	The current key risks relate to: • Children with learning difficulties and mental health needs and 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 Since the last ICPB meeting two new risks have been added to the risk register and further detail is attached on the risk register.
Action required	Discuss and note.
Where else has this paper been discussed?	Risks will be reviewed and managed at all levels and flow as follows: Group/Committee – Quality & Performance, Finance Clinical oversight – Health and Care Cabinet Executive oversight – Integrated Care Executive Group Assurance – Integrated Care Partnership Board/Area Committee and NEL CCG Governing Body.
Next steps/ onward reporting	Regular updates will be presented to the ICPB.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	That the CCG and local integrated care partnerships are actively managing and mitigating the key risks to our system and in meeting our corporate objectives which include a focus on high quality and safe services and tacking inequalities.
Conflicts of interest	There are no conflicts of interest associated with this report.
Strategic fit	Corporate objectives: 1. High quality services for patients 2. Put patient experience at the centre of our delivery 3. Ensure the best use of resources 4. Support our people to thrive 5. Develop our NEL integrated care system 6. Recover from the pandemic and be prepared for future waves
Impact on finance, performance and quality	Risks to delivery of financial balance, performance standards and high-quality care are addressed.

Risks	This report is about how we manage risks.
Equality impact	N/A

BHR Integrated Care Partnership Risk Register

ID no.	Date raised	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Mitigating actions		Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details (risk criteria for escalation being reviewed)	Close Down Status
						Likelihood	Impact	Risk Score (1-25)			Completed	Uncompleted						
BHR ICP 001_21	04/05/2021	8	Develop our NEL integrated care system	If the different accountability structures across health and social care (planning regimes and funding frameworks) are not reconciled with the new governance structures, system working may be compromised which could impact the effectiveness of the Integrated Care System (ICS) and ICP from April 2022.	8	2	4	8	6	Mar-22	• Creation of a strong BHR ICP governance structure, with the ICP Board as a sub committee of North East London (NEL) CCG. • BHR Joint Commissioning Board established.	Development of a BHR Integrated Sustainability Plan which will bring together a whole system view of the scale of the financial and activity challenge, including social care - in development	Ceri Jacob	Anne-Marie Keliris	ICPB	N		Open
BHR ICP 003_21	04/05/2021	8	Support our people to thrive/ Develop our NEL integrated care system	If Primary Care Networks and GP Federations do not reach sufficient stages of maturity, it will impact on the system's ability to improve quality and implement new models which could affect service delivery and patient experience/ outcomes. There will be further linked risk of the ability of Primary Care Networks to lead and influence at borough level. This will be especially important due the national spotlight on primary care services to deliver locally.	8	3	3	9	6	Mar-22	• Ongoing evening PCN / Federation Development Sessions • Agreement that Federations will work to support PCNs to deliver their key priorities, piece of mapping work underway to set out the key 2021/22 priorities for PCNs to support this	• Strong focus on supporting the establishment of Borough Partnerships	Anil Mehta	Sarah See	ICEG	N		Open
BHR ICP 004_21	04/05/2021	16	Develop our NEL integrated care system	There is a risk that culture change will not embed quickly enough at each level of the system to support the Integrated Care System development at the pace required."	16	3	4	12	6	Jun-22		• Organisational Development programme underway for the BHR ICP Governance structure and members. • Partners co-developing and signing up to the BHR System Sustainability Plan • Partner ownership of the BHR Transformation Boards are being progressed, linking them to the ISP • Development of Borough Partnerships and Provider Collaboratives is underway to further embed partnership work / take forward ICS development.	Ceri Jacob / CEOs	Emily Plane	ICPB	N	Score of 12 or above - escalate to NEL CCG corporate risk register.	Open
BHR ICP 005_21	04/05/2021	20	Support our people to thrive/ Develop our NEL integrated care system	If the current workforce is unavailable to deliver the new system models of care whilst maintaining current services, then delivery will be severely compromised now and in the long-term future which could impact on patient outcomes and staff wellbeing.	20	3	4	12	6	Mar-22	• BHR Health and Social Care Academy established to support BHR workforce to adapt to new ways of working and deliver more integrated Care - first ICS in the country to have achieved this level of strategic development.	• BHR Health and Social Care Academy planned to formally launch on 23rd Sept. This event will identify the approach and plans to 'grow our own' workforce. • A Data Management Dashboard (benefits for workforce planning. A single digital platform with total baseline workforce, i.e., total health and care workforce) has been developed to strengthen workforce planning capabilities and will underpin ICS development. To be showcased on the 23rd Sept. • Pitching to NEL People Board on 16th Sept in order to potentially roll out to NEL Region.	Kathryn Halford	Alison Crewe Dr Jyoti Sood	ICEG	N	Score of 12 or above - escalate to NEL CCG corporate risk register.	Open
BHR ICP 007_21	04/05/2021	20	Ensure the best use of resources	If the BHR system cannot sustainably reach financial balance, this could create a gap across partners which may require cost savings to be made that could impact on services and outcomes for local people; potentially increasing inequalities. This may also have implications for the investment of transformation schemes.	20	4	4	16	12	Mar-22	• A sub-group of the BHR ICP finance committee has been established to develop an integrated sustainability plan using the outputs of the Transformation Boards to inform the position across the system.	• Allocations received for H1 (first six months of 2021/22) with plans developed that manage the resource and financial risk. Allocations for H2 remain outstanding and plans will need to reviewed once resources confirmed. • Beyond H1, development of a BHR Integrated Sustainability Plan to bring together a whole system view of the scale of the financial and activity challenge, including social care.	Ahmet Koray	System DoFs	ICEG / ICPB	N	Score of 12 or above - escalate to NEL CCG corporate risk register and 15 or above escalate to GBAF	Open
BHR ICP 008_21	04/05/2021	20	Recover from the pandemic and be prepared for future waves	Do we have the estate capacity required to deliver activity required for the future / new models of care	20	3	4	12	12	Dec-21	Provider estate has been segregated to support cohorting of COVID, and non-COVID pathways		Carolyn Botfield	**Leads from estates for BHR including provider estates leads**	SOCG	Y	Score of 12 or above - escalate to NEL CCG corporate risk register.	Open
BHR ICP 009_21	04/05/2021	20	High quality services for patients	If the number of children with LD and Mental Health needs cannot access or move on from inpatient beds, this could result in poor patient outcomes which would further impact the health and care system as the patients transition into adult services. (Children are presenting from around 14 and often with complex histories including being in care of Child Protection services. This has been exacerbated by Covid and appears that this trend is set to increase).	20	4	5	20	12	Dec-21		• Meeting to be convened as soon as possible linking in with the CAMHS Task and Finish group to ascertain what plans have been developed to meet future potential surges - to include representatives from the 3 LA to address issues relating to social care, delayed discharge, safeguarding and provider collaborative reps. NELFT are confirming attendees from both community and Interact/CYPHTT provision. Whipps Cross is being requested to attend to agree common approaches. TOR, actions and required outcomes for subsequent distribution and assurance. • Urgently review the services that are in place for this cohort, and what this means for developments of community services - including system reconfigurations to enable a holistic 18-25 pathway, especially with many more young people transferring to adults.	Oliver Shanley	Elaine Allegretti	SOCG / CYP Transformation Board	N	Score of 12 or above - escalate to NEL CCG corporate risk register and 15 or above escalate to GBAF	Open
BHR ICP 010_21	04/05/2021	16	Support our people to thrive/ Recover from the pandemic and be prepared for future waves	If the adult social care provider workforce continues to face significant pressures relating to the pandemic response this could result in an increase in staff absences and affect staff members' wellbeing. This could then impact on the delivery of services and quality of care.	16	4	4	16	10	Dec-21	• Business continuity plans reviewed. • Asymptomatic NHS staff testing is being rolled out across the sector	• Mutual aid across providers being negotiated, including e.g. extra care, home care staff supporting in extremis • Mental health & wellbeing package for frontline provider staff, and currently reviewing a package that can be introduced to managers. • Ongoing recruitment campaign (London's Proud to Care) to bring people back into or into for the first time the social care workforce, including apprenticeships and career pathways. working. • Care home staff currently being vaccinated. Will extend to other care staff in next few weeks	Oliver Shanley	DASSs	SOCG	N	Score of 12 or above - escalate to NEL CCG corporate risk register and 15 or above escalate to GBAF	Open

BHR Integrated Care Partnership Risk Register

BHR ICP 011_21	04/05/2021	16	Develop our NEL integrated care system	If the Borough Partnerships are not sufficiently developed by April 2022 in line with the legislative changes regarding the statutory ICS, the Partnerships will not be prepared to effectively manage the additional funding and responsibilities associated with them. This could then impact on the delivery of services to patients and residents.	16	3	4	12	6	Jan-22	• Roadmaps now in place and signed off via ICPB for all 3 Borough Partnerships. • Second tranche of funding support (£100k per BP) also released to Borough Partnerships. • Ongoing series of workshops across BHR to support Borough Partnership development	• BHR ICP focus on ensuring that Borough Partnerships are established • Recruitment process underway for Band 9 support to Havering Borough Partnership. • Process to determine areas to continue to collaborate on post April 2022 set up and due to commence in October.	Ceri Jacob	BHR Borough directors / DASSs	ICPB	N	Score of 12 or above - escalate to NEL CCG corporate risk register	Open
BHR ICP 012_21	01/06/2021	16	Support our people to thrive/ recover from the pandemic and be prepared for future waves	Risk of future waves of COVID 19 and uncertainty of how these will play out	16	4	4	16	8	Feb-22		Surge planning workshop to be held by partners on 10th June 2021 to prepare for this surge alongside the ongoing capacity pressure of delivering the vaccination programme .	Oliver Shanley	Steve Rubery	SOCG	N	Score of 12 or above - escalate to NEL CCG corporate risk register and 15 or above escalate to GBAF	Open
BHR ICP 013_21	01/06/2021	16	High quality services for patients	The Coronavirus (CV19) Pandemic and subsequent lockdowns / reduction in face to face appointments has resulted in a backlog of elective activity which needs to urgently be addressed. On top of a backlog in many areas of elective activity that BHR was trying to address pre-pandemic. There is a risk going forward that additional peaks in covid activity alongside staff having to isolate/being unwell due to the virus, could impact on our ability to address this backlog of activity across each element of the system.	16	4	4	16	9	Mar-22		• BHRUT clinicians carry to out a clinical review of the backlog lists to prioritise the most urgent, to reduce the risk of clinical harm resulting from longer waiting times • Increase capacity to clear the backlog	Oliver Shanley	Steve Rubery	SCOG	N	Score of 12 or above - escalate to NEL CCG corporate risk register and 15 or above escalate to GBAF	Open
BHR ICP 014_21	01/06/2021	12	High quality services for patients	If the system is not able to create the capacity to meet the sustained and significant increase in demand for MH services, there is a risk that waiting lists will grow / an increasing number of people suffering with mental health issues will present at ED. As a result of CV19 pandemic and subsequent national lockdowns, there are a number of people of all age groups presenting with mental health needs, from low level to serious mental illness (SMI). These are across all ages (with particular increases in the younger cohort) and relate to a number of different factors including joblessness, home situation, homelessness, anxiety etc	12	3	4	12	8	Mar-22		• Transformation programme jointly with partners particularly for the SMI cohort - looking at the entire pathway for this group of people and how they can be better managed through an integrated system • Utilise national transformation funding for the community SMI programme • Crisis business case being developed with CCG and NELFT looking at specific provisions designed to meet crisis demand - for sign off by the MH Transformation Board by end August	Oliver Shanley	Jacqui Van Rossum	SCOG / MH Transformation Board	N	Score of 12 or above - escalate to NEL CCG corporate risk register	Open
BHR ICP 016_21	02/08/2021	20	Ensure the best use of resources	If the appropriate digital infrastructure is not implemented to support interoperability between IT systems, this will remain a barrier to information sharing to support the delivery of integrated care.	20	4	5	20	6	Mar-22		• BHR IT system lead and role to be identified / agreed, alongside key priorities • NEL CCG wide strategy to be developed • Scope what is currently in place • Look at how other ICS/ICPs have developed their digital infrastructure • Identify system budget • Sharing data/ organisations to update software / systems to facilitate interoperability)		Rob Meaker / Umesh Gadhvi	ICEG		Score of 12 or above - escalate to NEL CCG corporate risk register and 15 or above escalate to GBAF	Open
BHR ICP 017_21	02/08/2021	9	High quality services for patients	If the appropriate business intelligence infrastructure is not implemented, the BHR system will be unable to create accurate population health models or be able to share information at resident and population levels. This could result in duplication of work and inaccuracies.	9	3	3	9	6	Jan-22		Design work on fit for purpose business intelligence infrastructure has commenced, and wave 3 Population Health Management programme is underway.	Steve Collins / Bryan Matthews	Steve Rubery Umesh Gadhvi	Finance Committee	N		Open

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

BHR Integrated Care Partnership Board

25 November 2021

Title of report	Patient and public engagement update
Author	Melissa Hoskins, Head of Communications and Engagement
Presented by	Jayam Dalal, Associate Lay Member
Contact for further information	melissa.hoskins@nhs.net
Executive Summary	This paper provides an update on work to develop a system-wide approach to engaging and involving local people and their representatives in health and social care services.
Action Required	ICPB are asked to: • Note the update. • Approve the proposals for next steps
Where else has this paper been discussed?	Proposals in this paper have been discussed informally with a range of individual stakeholders including Healthwatch and the Chairs of the CCG's Patient Engagement Forums.
Next steps/ onward reporting	Outlined in the body of the paper.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	Reducing inequalities is a key priority for the BHR Partnership. Engaging and involving local people in planning and decision-making is crucial to driving change and reducing health inequalities.
Conflicts of Interest	There are no conflicts of interest associated with their update
Strategic Fit	All areas of progress noted in this report align with national, North East London Integrated Care System, and BHR Integrated Care Partnership strategy
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage

Risks	One of the key overall risks for 2021/22 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the planned Health and Social Care Bill, from April 2022.
Equality Impact	Not applicable at this stage.

1.0 Purpose of the report

This paper provides an update on work to develop a system-wide approach to engaging and involving local people and their representatives in the emerging governance structures across BHR and North East London.

The latest ICS guidance issued by NHSE/I sets out an expectation that partners in an integrated care system should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities.

This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Using this guidance, work has continued to develop proposals for how public participation and involvement (PPI) can be built into emerging structures within BHR as part of a NEL wide approach while ensuring the needs of local communities can be understood and met at every level of planning and decision-making.

The Committee is asked to note the report and support the proposals for the next stes.

2.0 Key messages

Work to develop a BHR system wide approach to patient and public engagement has continued. New guidance from NHSE/I on the expectations on how integrated care partners should work with people and communities has led to a refocus on the original proposals discussed earlier this year.

3.0 Body of report

Following discussions with a number of local stakeholders, and in light of the most recent ICS guidance and development [see Appendix A: Guidance on working with people and communities – September 2021 - [NHS England & NHS Improvement], the work on an engagement structure for BHR has refocused on three key areas:

- Supporting practices and Primary Care Networks
- Embedding patient and public involvement in Borough Partnerships
- Working across North East London to embed PPI into the NEL ICS

Partners have committed to co-designing the structure with local patient representatives and the voluntary and community sector, and this work continues through discussions at borough, BHR and NEL level.

4.0 Supporting Practices, PPGs and Primary Care Networks
Effective two-way patient engagement is at the heart of practice Patient Participation Groups (PPGs), but it is recognised that practices' capacity to fully support their PPGs has been impacted by the pandemic.

The CCG has considered what support it can provide practices and PCNs to revitalise the work of local PPGs and support them to become integrated into the patient engagement work that will be needed at a PCN level.

Proposals include:

- Working with PCN leads to develop a framework for engagement to support practices and PCNs in engaging local people and patients in their work. Potential to commission independent expertise to support this
- Explore potential to create paid roles for local people to specifically support PPGs. Work plan could include planning and delivering events for PPG members, training to support PPG members' skills, and working with local partners. Payment would be in lines with a NEL Reward and Recognition policy

5.0 Working at Borough Partnership level
The CCG continues to support its three borough-based Patient Engagement Forums, but is working with current members to explore the role of this forum in the future borough structures. The forums currently meet jointly in a virtual meeting, with additional engagement through a weekly e-bulletin. We continue to review future potential for restarting face-to-face meetings, but this is now not likely to commence until 2022.

Our three borough partnerships continue to develop their thinking on their approach for communications and public engagement at a borough level. Barking and Dagenham plans a dedicated session in December, with similar consideration in the two other boroughs. Good practice would see local patient representatives, voluntary and community sector organisations and individual residents involved in the shaping of the engagement structure and approach.

To help involve local patient representatives, voluntary and community sector organisation and individual residents in the shaping of the engagement structure, it is proposed that the CCG host a workshop that enables each borough to share its plans and invites discussion from attendees to help co-design the approaches.

Subject to discussions with Borough Partnership leads, this online workshop could take place in December. It will also be essential to consider how to involve or seek the views of those less digitally-able to ensure the future approaches support equitable inclusion of feedback and views from across our diverse communities.

The CCG is committed in strengthening and ensuring that engagement at the Borough level is reflective of the population, meets the needs of that particular Borough, and that it is able to make a meaningful contribution within the future ICS structure. The workshop will assist in formulating the new structures at the Borough level.

6.0 Working across North East London
A working group that includes representatives of BHR partner organisations is meeting monthly as part of work across the NEL Integrated Care System (ICS) to look at how best to embed people engagement into the work of the ICS.

Work being taken forward by the groups (and three sub groups) development of a shared NEL commitment to patient and public involvement (PPI) through co-designed shared principles.

There is also work underway to explore the development of an interactive online training course on people engagement aimed at both ICS staff and volunteers. The aim is to create a shared understanding of the importance of involving local people in the work of the ICS, as well as providing skills training.

7.0 Conclusion / Recommendations
The ICPB is asked to approve the content of the paper.

Attachments:

- Appendix A

Melissa Hoskins, Head of Communications and Engagement
November 2021

Appendix A

ICS implementation guidance on working with people and communities – September 2021 - [NHS England & NHS Improvement]

Ten principles for how ICSs work with people and communities

1. **Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.**

2. **Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.**

3. **Understand your community's needs, experience and aspirations for health**

4. **and care, using engagement to find out if change is having the desired effect.**

5. **Build relationships with excluded groups, especially those affected by inequalities.**

6. **Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.**
7. **Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.**

8. **Use community development approaches that empower people and communities, making connections to social action.**

9. **Use co-production, insight and engagement to achieve accountable health and care services.**

10. **Co-produce and redesign services and tackle system priorities in partnership with people and communities. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.**

BHR Integrated Care partnership Board

25 November 2021

Title of report	Our proposal for ongoing multi borough collaboration in Barking and Dagenham, Havering and Redbridge and beyond
Author	Emily Plane, Programme Lead, BHR System Development
Presented by	Ceri Jacob, Managing Director BHR Integrated Care Partnership
Contact for further information	e.plane@nhs.net
Executive Summary	The ICS Design Framework Guidance (June 2021), and draft Health and Social Care Bill (first published July 2021) set out in more detail how NHSE/I expect NHS organisations to respond in the next phase of this system development. Whilst this element of Integrated Care Systems is clear, what the internal governance will look like, what functions will sit at each level of the system, and the form that delegation will take is currently open for Integrated Care Systems to design, creating a system that works best for their local populations. The key principle that will shape how this is designed is that of **subsidiarity**, with key decisions being taken as close as possible to the communities that they will impact. This places a very strong emphasis on the Place Based Partnerships. The BHR system has worked very collaboratively over the last few years for the benefit of the local population and there has been a desire to retain the benefits of that collaboration whilst recognising the importance of Place Based Partnerships. In BHR our Place Based Partnerships have been established, and there is recognition that the form and functions that they take on from April 2022, will evolve over time as they become more mature.

	There is an ask from Place Based Partnerships to the NEL ICS that a framework is developed, making clear what elements and functions will need to be uniform across the seven NEL Borough Partnerships, and what will be open to local determination. BHR Partners intend to feed in to and shape the NEL framework described above; to do this a process has been undertaken with partners across the health and care system, to articulate a proposal for ongoing collaboration across the BHR footprint. The process to take this forward is set out in this paper. Members of the BHR Integrated Care Executive Group reviewed and endorsed this proposal at their meeting on 19 August 2021, with a further update in September 2021. The outputs from the discussions that have taken place have been shared with partners and Place Based Partnerships, and are brought together into a formal proposal within this paper. Post April 2022 it is proposed that the BHR Integrated Care Executive Group 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 programmes of work.
Action Required	ICPB members are asked to: ▪ **NOTE AND COMMENT** on the proposal for ongoing collaboration in BHR, including consideration of whether it would be of value if the BHR Health and Care Cabinet continues post April 2022. ▪ **ENDORSE** the proposal for ongoing collaboration in BHR ▪ **NOTE** the further work to be undertaken to define how the areas of multi-borough collaboration will be overseen
Where else has this paper been discussed?	This proposal has been developed in partnership with partners from across health and care, including discussion at the BHR Joint Commissioning Board meeting on Monday 9th August 2021, individual organisation discussions, and discussion with Place Based Partnership Boards. Initial outputs from the process have also been shared with North East London colleagues.

	Members of the BHR Integrated Care Executive Group reviewed and **endorsed** the process to develop this proposal at their meeting on 19 August 2021 and received an update on progress at their September 2021 meeting.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	As set out in the recent White Paper and reiterated in recent guidance, Place Based Partnerships, alongside Primary Care Networks and Provider Collaboratives, are the foundation blocks of Integrated Care Systems. Ahead of planned legislative changes in April 2022, it is imperative that we ensure that our BHR approach to Integrated Care System development is clear, and that we continue to strengthen our local arrangements ahead of this date.
Conflicts of Interest	None identified.
Strategic Fit	This paper relates directly to all emerging BHR System priorities alongside the emerging priorities of the North East London Integrated Care System.
Impact on finance, performance and quality	None identified at this stage.
Risks	With legislative changes planned nationally to place Integrated Care Systems on a statutory footing from April 2022, it is imperative that as a BHR system we continue to build on the momentum and progress that we have built, and that key foundation blocks which will be essential to providers post April 2022, such as the BHR Integrated Sustainability Plan and Transformation Boards, continue to be taken forward.
Equality Impact	Not applicable at this stage.

1. Introduction

1.1 The ICS Design Framework Guidance (June 2021), and draft Health and Social Care Bill (first published July 2021) set out in more detail how NHSE/I expect NHS and Care organisations to respond in the next phase of system development.

1.2 Subject to the passage of legislation, the statutory ICS arrangements will comprise:

- an **ICS Partnership**; a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an **ICS NHS body**; bringing the NHS and partners together locally to improve population health and care

1.3 Whilst this element of Integrated Care Systems is clear, what the internal governance will look like, what functions will sit at each level of the Integrated Care System, and the form that delegation will take is currently open for Integrated Care Systems to design, creating a system that works best for their local populations. The key principle that will shape how this is designed is that of subsidiarity, with key decisions being taken as close as possible to the communities that they will impact. This places a very strong emphasis on Place Based Partnerships.

1.4 In Barking and Dagenham, Havering and Redbridge (BHR) our Place Based Partnerships have been recently established and are progressing their development; there is recognition that the form and functions that they take on from April 2022, will evolve over time as they become more mature.

1.5 There is an ask from Place Based Partnerships to the NEL ICS that a framework is developed, making clear what elements and functions will need to be uniform across the seven North East London (NEL) Place Based Partnerships, and what will be open to local decision. This will also help to inform how resource should be distributed at each level of the system.

1.6 There is a recognition that the BHR system has been able to drive beneficial changes by working collaboratively on key areas and a desire to retain those benefits in a manner that does not undermine the Place Based Partnerships and the principle of subsidiarity.

1.7 BHR Partners have undertaken a process to consider and articulate the key areas that we believe we should continue to collaborate on at a BHR and multi-borough level. It is intended that this will feed into and shape the NEL framework described above.

2. The BHR Process to articulate our proposal for multi borough collaboration

2.1 The BHR process has involved a series of interviews with partner organisations across health, care and wider organisations alongside discussion with Place Based Partnerships, seeking views on key areas of ongoing collaboration for BHR partners and multi-borough working.

2.2 This series of interviews and meetings were conducted by Ceri Jacob, Managing Director of the BHR Integrated Care Partnership, alongside the BHR Borough Directors, Sharon Morrow, Tracy Rubery and Sarah See, supported by Emily Plane, Programme Lead for BHR System Development, and Debbie Harris, Business Manager.

2.3 The interviews and meetings took place between September and November 2021. A full list of all conversations can be found at **appendix 2** within this paper.

2.4 This paper brings together the outputs from these discussions into a proposal for ongoing multi borough collaboration, and suggests the key elements that should sit at each level of the Integrated Care System going forward, and is being presented to BHR Integrated Care Partnership Board members for endorsement.

2.5 Once endorsed, this proposal will be shared with NEL colleagues to feed into and shape the framework that is being developed for the NEL Integrated Care System.

3. BHR proposal for ongoing multi-borough collaboration

3.1 A full record of the discussions with each partner has been recorded separately and can be shared with partners. There were some strong themes from the discussion with partners including:

- One of the strongest themes to emerge from all of the partnership discussion to date is that BHR in particular has a strong and successful history of partnership working, with innovative and important partnership programmes that partners are keen to continue to collaborate on, such as the BHR Transformation Boards, the associated Integrated Sustainability Plan (ISP) and the BHR Health and Care Academy. There is a strong belief that there is real value in continuing to collaborate at a BHR and wider multi place based level.
- Recognition that BHR level collaboration seems to lend itself well to delivering innovation and transformation in a timely manner. Discussion noted that there will be benefit and economies of scale for working on a wider (e.g. NEL) footprint around some areas, however, need to ensure that this does not mean that innovation is delayed by working at this level / being across too large a footprint.
- The emerging preferred form of delegation from the NHS Board to Place Based Partnerships is a “committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources”, although this may evolve and change over time as the place Based Partnerships and local arrangements become more mature.
- Keen to allow Place Based Partnerships to develop over time and organically, with recognition that we may initially undertake more at a multi borough level from April 2022, with more then moving to the Place Based Partnerships over time as they become more established. Multi-borough working must not undermine development of the Place Based Partnership Boards (PBPBs) as place is still the main focus.
- Mental Health will sit at a NEL level from April 2022 in terms of the Transformation Board, linking with the Provider Collaborative approach. BHR

plans relating to local service changes and the BHR Integrated Sustainability Plan will need to be taken into account.

- Recognition that unpicking some budgets and services to be delivered at a place based level may be tricky initially due to historical commissioning of services on a wider footprint within block contracts, however, there is ambition to deliver more at a place based level over time, and agreement that just because it may be difficult to unpick some services to be delivered more locally/innovatively, this shouldn't be a blocker to attempting to do this.
- Resource will be absolutely key to delivering at each level of the system, and it is imperative that resource is distributed equitably based on the work that will sit at each level of the system, for example, partners need to consider and put into place the resource that is required at a Place Based Partnership level to ensure that these can progress.
- Whatever governance is established to frame each level of the system needs to be agile and flexible to ensure that we don't get bogged down in bureaucracy.

3.2 In summary, the BHR proposal for ongoing multi collaboration suggests that the following key functions should sit at each level of the system:

- **North East London ICS**: Strategy setting and translation of national policy and targets to a Place Based Level should take place at this level as well as oversight and assurance of the Place Based Partnerships.

  There is significant opportunity for achievement of economies of scale at this level, including building on successes of partnerships such as BHR around joint commissioning of services such as sexual health services across a three-borough footprint, which could be expanded across NEL.

  Enabler programmes that will benefit all Place Based Partnerships should be progressed at this level, including estates, digital, Business Intelligence and contract management, with strong links into the Place Based Partnerships.

  There was recognition that although the Place Based Partnerships need to be allowed to develop at an organic pace and be able to tailor services to the needs of their local populations, it is imperative that this does not lead to unwarranted variation across services – NEL ICS will be responsible for oversight of this to ensure that this is managed.

- **Multi borough collaboration – BHR**: Continued collaboration at a BHR multi borough level is essential, particularly in the first 18 months to 2 years post April 2022, to ensure that we don't lose the positive benefits to our population that have resulted from our partnership work on transformation and joint management of pressures such as during the pandemic, and to allow our Place Based Partnerships (as well as the NEL Integrated Care System itself) more time to embed and mature.

  There was strong agreement through the discussions that we should continue to collaborate along our natural footprint of the BHRUT Acute trust, spanning BHR, to improve pathways for local people. We note that whilst there is also a single provider of mental health and community services in the BHR system, NELFT also cover other boroughs and regions.

  At this BHR level, most of our Transformation Boards will continue, delivering on the key targets set out within the BHR Integrated Sustainability plan. However, there is a process underway to assess if elements of their work should now move to the Place Based Partnerships or if any transformation boards would be

more effective at a NEL ICS level with implementation driven through the provider collaboratives and Place Based Partnerships.

The BHR Health and Care Academy will continue to develop, helping us to address the unique workforce recruitment and retention challenges that we experience in BHR, with learning shared across the wider NEL ICS system.

Local Anchor Organisation work will be progressed at this level, achieving economies of scale by working together.

Continue to build on the power of coming together at this local level to lobby for equity of investment for BHR.

- **Wider multi borough collaboration**: Strong recognition of the overlaps between the Redbridge and B&D populations in particular in terms of use of the Whipps Cross and Newham sites, and that we should continue to collaborate to improve the delivery of health and care around these areas.

  Recognition that particularly for mental health, there is a need to collaborate at a wider multi borough level, linked to the aspirations of the Mental Health Provider Collaborative.

  Collaboration around commissioning and transformation of community services at a wider multiborough level, particularly where there is a shared provider / providers working collaboratively across a wider footprint.

- **Place Based Partnerships**: Service delivery and transformation will sit at this level. Place Based Partnerships will be key vehicles, at the right level to build and maintain strong and lasting relationships with their local communities and local community and voluntary sector services. They will be responsible for integrating care at a local level, and ensuring that services are tailored to meet the specific needs of their local populations.

  This is the place where addressing the wider determinants of health should be embedded in service delivery, having a true impact on the quality of experience, and in outcomes that local people experience.

  This will also be where local primary care transformation is delivered.

3.3 Post April 2022 it is proposed that the BHR Integrated Care Executive Group 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.

3.4 The full details for the BHR proposal for multi borough collaboration and what should sit at each level of the system can be found in **Appendix 1**.

4. Next steps

4.1 Present proposed framework to NEL CCG and NEL ICS for consideration as part of the wider work on establishment of the NEL ICS

4.2 Develop proposal for governance and oversight of areas of ongoing collaboration by the three BHR Place Based Partnerships and their constituent NHS providers and Local Authorities for agreement by Place Based Partnerships and the BHR ICPB.

4.3 **NOTE** the further work to be undertaken to define how the areas of multi-borough collaboration will be overseen

5. Risks and mitigations

5.1 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.

5.2 One of the key overall risks for 2021/22 is associated with ensuring that our BHR Partnership is prepared for the legislative changes described in the 'integration and innovation' White Paper from April 2022, which the BHR process for multi-borough collaboration is intended to positively impact.

6. Recommendations

6.1 Members of the BHR Integrated Care Partnership Board are asked to;

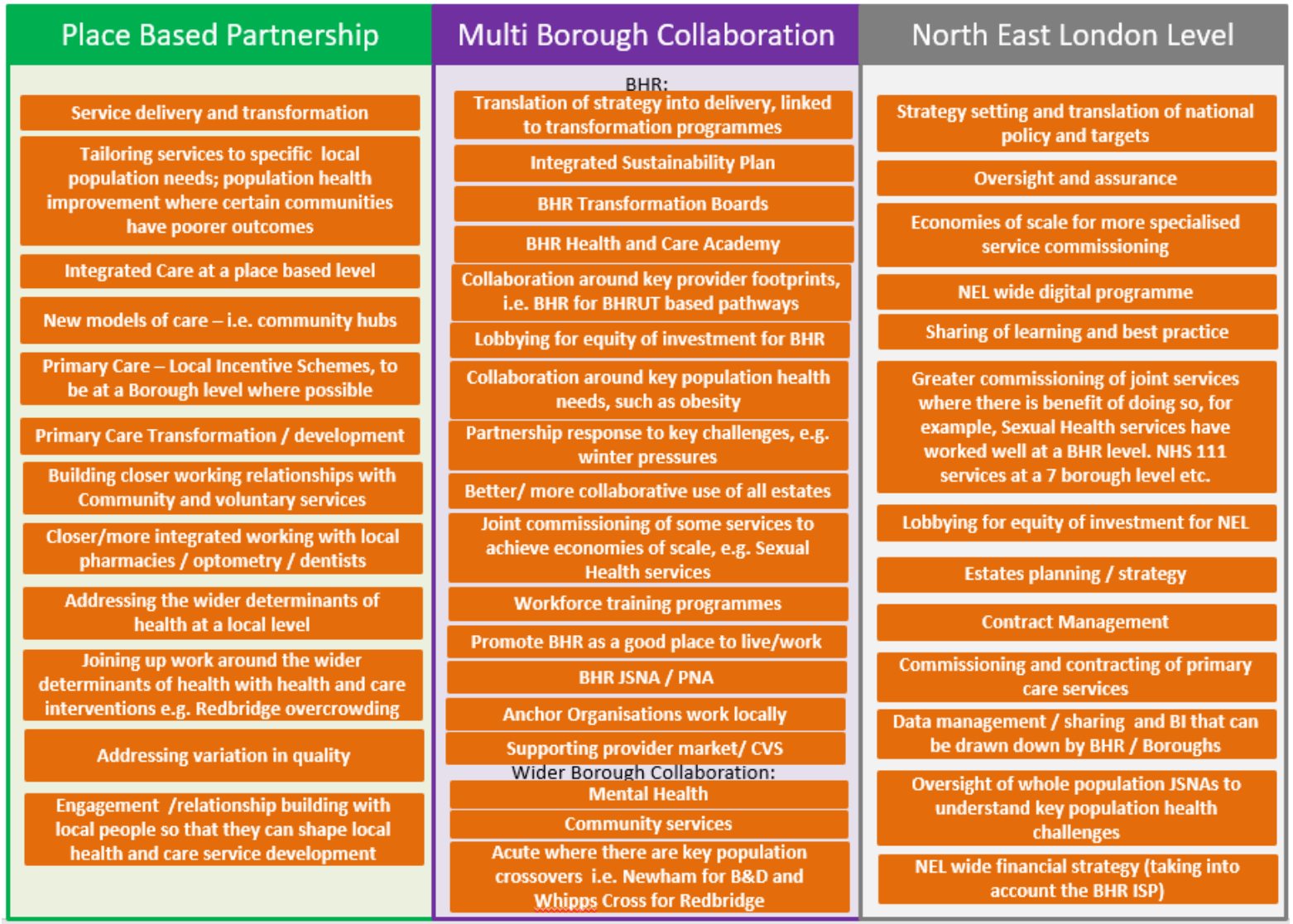
- **NOTE AND COMMENT** on the proposal for ongoing collaboration in BHR, including consideration of whether it would be of value if the BHR Health and Care Cabinet continues post April 2022.
- **ENDORSE** the proposal for ongoing collaboration in BHR
- **NOTE** the further work to be undertaken to define how the areas of multi-borough collaboration will be overseen

Emily Plane, Programme Lead, BHR System Development
November 2021

Attachments:

- **Appendix 1** – BHR Proposal for ongoing multiborough collaboration
- **Appendix 2** – Summary of key meetings and interviews conducted as part of this process

Appendix 1 – BHR proposal for ongoing multi borough collaboration



Appendix 2 – Summary of key meetings and interviews conducted as part of this process

Partners interviewed	Lead Interviewer	Support	Meeting date
Redbridge PCNs ▪Dr Shujah Hameed – Red + LMC Lead Greg Cairnes	Tracy Welsh	Debbie Harris	21.09.21 9.30 – 10.30
Primary Care – CCG ▪Dr Jagan John ▪Dr Anil Mehta ▪Dr Atul Aggarwal ▪Jane Lindo ▪Sarah See	Ceri Jacob	Debbie Harris	30.09.21 9.00 – 10.00
B&**D Primary Care meeting** ▪Dr Arun Sharma ▪Dr Shanika Sharma ▪Sandeep Sharma ▪Craig Nikolic	Sharon Morrow	Debbie Harris	30.09.21
London Borough of Havering ▪Andrew Blake Herbert ▪Cllr Jason Frost ▪Barbara Nicholls ▪Mark Ansell ▪Sarah See	Ceri Jacob	Emily Plane	07.10.21 3.00 – 4.00
BHR Clinical Leaders meeting ▪PCN CD and CCG Clinical Leaders from across BHR	Ceri Jacob	N/A	07.10.21
BHRUT ▪Matthew Trainer ▪Jacqui Smith ▪Magda Smith ▪Hannah Coffey	Ceri Jacob	Emily Plane	15.10.21 11.30 – 12.30
London Borough of Redbridge ▪Lesley Seary ▪Cllr Mark Santos ▪Adrian Loades ▪Gladys Xavier ▪Tracy Rubery	Ceri Jacob	Emily Plane	20.10.21 1.00 – 2.00
London Borough of B&D ▪Chris Naylor ▪Cllr Maureen Worby ▪Elaine Allegretti ▪Matthew Cole ▪Sharon Morrow	Ceri Jacob Dr Jagan John	Emily Plane	21.10.21 11.00 – 12.00
NELFT ▪Oliver Shanley ▪Joe Fielder ▪Jacqui Van Rossum ▪Dr Caroline Allum	Ceri Jacob	Emily Plane	21.10.21 1.00 – 2.00
B&D PCNs: ▪Dr Shanika Sharma, B&D	Sharon Morrow	Emily Plane	
Havering PCNs and Federation: ▪Dr Jwala Gupta / Dr Kullar, Hav + Dr Madhu Patak ▪Dr Dan Weaver / Urvashi Bhagat	Sarah See	Emily Plane	12.10.21 4.00 – 5.00
Waltham Forest: ▪Dr Ken Aswani ▪Sue Boon ▪Mark Lobban	Ceri Jacob	N/A	27.10.21 11am
CCG Ley Members ▪Jayam Dalal ▪Kash Pandya ▪Khalil Ali	Ceri Jacob	Debbie Harris	29.10.21
Healthwatch ▪B&D – Richard Vann + Manisha Modhvadia ▪Redbridge – Cathy Turland ▪Havering – Anne-Marie Dean	Hav – Sarah See B&D – Sharon Morrow Redbridge – Tracy Welsh	Emily Plane	**BD** 20.10.21 10am **H** 18.10.21 1.30pm **R** 11.11.21 10-11
PELC ▪Chad Whittington – Chief Executive, PELC	Emily Plane	N/A	01.11.21 1.00pm – 1.30pm

In addition to individual discussion with organisations as set out in the above table, discussion also took place with individual BHR Place Based Partnerships on the following dates:

Place Based Partnership	Lead Interviewer	Support	Meeting date
Havering Place Based Partnership meeting	Ceri Jacob	Debbie Harris	15.11.21 1.30pm – 3.00pm
Redbridge Place Based Partnership meeting	Ceri Jacob	Emily Plane	25.10.21
B&D Place Based Partnership meeting	Ceri Jacob	Debbie Harris	29.10.21 1.00pm – 2.30pm

BHR Integrated Care Partnership Board

25 November 2021

Title of report	BHR Transformation Board 21/22 - key progress and achievements to date
Author	Hanh Xuan-Tang, Deputy Director of Recovery Planning
Presented by	Hanh Xuan-Tang, Deputy Director of Recovery Planning
Contact for further information	Hanh.Xuan-Tang1@nhs.net 07736 117771
Executive summary	In May-21, a paper was provided to ICPB detailing the 21/22 priorities for each of the BHR Transformation Boards. Significant progress has been made to date with many of priorities now implemented or in a good stage of development. Additionally, transformational schemes which were implemented before, and during, the Covid pandemic has continued to make an impact on Secondary care through the provision of alternative Out-of-Hospital services and pathways. This paper provides a progress update on the work of the Transformation Boards in 21/22, and the impact of transformation schemes which were implemented previously.
Action required	The BHR ICPB is asked to: **NOTE** the current progress of the Transformation Boards in relation to the delivery of transformation schemes in 21/22, and the achievements made to

	date in terms of reducing activity in Secondary Care through the provision of alternative services through transformation.
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	An update report will be provided in 6 months reflecting on the delivery and impact of the Transformation Boards throughout 21/22.
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The role of the Transformation Boards is to develop and deliver service transformation to improve the outcomes of our population, tackling inequalities and inequities and in turn, deliver efficiencies and savings by reducing the burden on the Acute Hospitals. This will ensure that we can sustainably deliver our commitments into the future. Through Transformation, we will: • Bring Care Closer to Home • Support our population to start well, live well and age well • Tackle inequalities
Conflicts of interest	Please state if there are any conflicts of interest to manage in relation to the decision requested/issues raised? **This needs to include full details of who is conflicted, what the conflict is and how it will be managed in the meeting.**
Strategic fit	ICP Priority 4 – ICP Development & Sustainability
Impact on finance, performance and quality	Not applicable – will be part of individual schemes delivered under each Transformation Board
Risks	There is a risk that if schemes do not deliver as planned, the financial sustainability may exceed the time frames set out in the Integrated Sustainability Plan
Equality impact	Not applicable – will be part of individual schemes Business Cases

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

NHS
North East London
Clinical Commissioning Group

BHR Transformation Board 21/22 Key Progress and Achievements to Date – October 2021

Meeting name: Integrated Care Partnership Board (ICPB)
Presenter: Hanh Xuan-Tang, Deputy Director
Date: 25 November 2021

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

OLDER PEOPLE

- The expansion of the **NELFT Community Treatment Team (CTT)** went live in August-21 with 10 of the 11 additional posts recruited. The CTT supports the delivery of the National 2 Hour Community Crisis Response Standard. Based on August 2021 data, the service is forecast to provide a reduction in emergency admissions of 2,112, providing the BHR System with savings of £4m.
- The new **Single Point of Access Discharge** team, hosted by NELFT launched in October 21, , building on the enhanced Hospital Discharge Service (HDS) that was developed during 2020 in response to the covid pandemic. The service supports patients who require health and/or social care support to be discharged into their own home, or an appropriate community setting, as soon as they are medically fit. The service is expected to support c9 patients to be discharged each day, with at least 3,442 reductions in acute bed days per year.
- The **Acute Frailty Service** continues to support c250 patients a month with at least c80% avoiding an admission. Based on April to August data, the services are forecast to deliver 382 less emergency admissions, saving the BHR system £1.8m. The Queens Frailty Unit which was launched in May 2021 and alongside the King Georges Frailty Unit will continue to focus on seeing more elderly frail patients to help increase the speed at which they are discharged from ED and being managed in the community or their own homes and therefore avoiding an admission.

PLANNED CARE

- The **MSK Single Point of Access (SPA)** went fully operational in April-21, following a delay due Covid, with the **MSK Exercise on Referral (EoR)** due to go live in late November-21. Since April, the SPA has reduced 1,106 unnecessary Outpatient appointments and is expected to deliver a reduction of 2,444 unnecessary outpatient attendances in 21/22. With the procurement of the new e-referral system, the reductions are expected increase next year. The EoR will start to receive referrals from the end of November to provide patients with chronic pain an alternative treatment to clinical intervention.
- A **uro-gynae pathway,** to help reduce inappropriate referrals to the Gynaecology department and aid the long term aim of reducing GP referral volumes through targeted education, has been developed and launched in September 2021. The pathway is expected to reduce the number of referrals to BHRUT gynaecology department of 20% by 6 months post-launch.
- The **Community Minor Surgery** service is at the final stages of the approval process with an expected go live date of December-21. The service aims to undertake an over 2,000 additional minor surgery procedures each year in a Primary Care setting, and therefore reducing the burden on the Acute services and support the clearance of the current Elective backlog post covid. The service will also reduce waiting time for patients.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

URGENT AND EMERGENCY CARE

- A **Same Day Emergency Care (SDEC)** unit was successfully launched on Wednesday 28th July 2021. The service has 10 patient spaces and is located in the Majors facility within Queens Hospital. The service is currently seeing 6,720 patients a month, of which, the unit estimates 510 p/m (7.5%) are an avoided admission.
- The **Hospital Ambulance Liaison Officer (HALO)** service, at both the KGH & Queens sites, are in the process of mobilisation and is on track to go-live in November. The service will operate from 10am to 10pm, to help redirect crews to utilise alternative care pathways instead of the acute based services. This will aid with ambulance crews awareness and utilisation of alternatives services, and therefore, contribute to improved patient care by transferring patients to the most appropriate setting and ensuring that more patients are treated at the right place, at the right time, first time.
- A business case for a **Duty Doctor** Pilot is currently being taken through the CCG governance process for approval. The pilot which will run in Havering aims to have a dedicated doctor who will provide a dedicated call-in service which can be accessed by ambulance crews and community health care professionals when they need to seek advice from a GP about a patient's condition. The expectation is that the advice and guidance provided by the service will help prevent the patients from being automatically conveyed or sent to A&E when this could have been avoided. The service is on track to go live in November to support with winter pressures.
- A winter business case covering the following schemes: additional community rehab beds, additional intensive rehab service staff, additional care home rehab beds, increased PELC capacity, a Therapy Assessment at RAFTing pilot, additional 30 bed unit at Queens and a weekend discharge nursing home pilot has been taken through the Urgent & Emergency Care Transformation Board and governance processes. It is expected that all schemes will go live during November and December 2021 to support with winter pressures. All elements support the hospital with discharging patients so that bed capacity is freed up during the winter months, or provide additional capacity at the front door or within the hospital.

CHILDREN AND YOUNG PEOPLE (CYP)

- The **Paediatric Assessment Unit (PAU)** has been successfully implemented at the KGH site following the implementation at the Queens site last year. The service supports children attending ED to be appropriately assessed and monitored with the aim of reducing unnecessary emergency admissions.
- The integrated **Paediatric Hospital at Home** pathway is currently at the final stages of approval, and the expectation is that this will go-live in January-22. The service will support the PAU service through integrating the pathways between secondary care (from PAU), to care in community and home settings. The expectation is that 1,396 admissions will be avoided each year.
- A collaboration between the CYP Transformation Board and BHR Workforce academy has resulted in the successful delivery of a workforce workshop in September-21. The workshop identified short and long term solutions to address the shortage in the workforce affecting children across BHR, enabling further development of initiative's which was previously constrained by workforce capacity.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

LONG TERM CONDITIONS

- An **Atrial Fibrillation (AF) Case Finding** pilot in Havering has been approved and is in the final stages of mobilisation. The pilot will go-live by the end of November-21. The pilot utilises a specialised algorithm developed by Pfizer, and approved by the MHRA, to detect patients with high risk of AF related stroke. Patients are then admitted to a Rapid Access pathway for diagnosis and treatment, resulting in a reduced risk of imminent strokes. The pilot is expected to prevent 18 strokes between December-21 and March-22.

- The **Urine Albumin to Creatinine Ratio (ACR) Testing from Home/ACR Diabetes** initiative is a 'post covid catch-up plan' which is expected to be implemented in late November-21. Due to the Covid pandemic, and the reduction in face to face contacts with GPs/Nurses, Diabetic patients were not receiving the full 8 care processes required to detect any risks or issues with their condition that could result in complications associated with Diabetes. This initiative provides the ability to deliver a 'catch-up' plan at scale prior to returning to BAU levels and annual check-ups going forward.

CANCER

- A '**C the Signs'** digital tool was rolled out across BHR in Quarter 1. The tool helps to identify patients at risk of Cancer; which cancer or cancers a patient is at risk of and identifies the most appropriate next steps. There are currently 358 users, helping to improve early detection, referral and diagnosis rates and therefore improving the outcomes for the residents of BHR.

- The **Rapid Diagnostic Centre (RDC)** is now fully live and receiving referrals from B&D. Work is ongoing to roll out the RDC across Havering and Redbridge. The RDC is a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer, but do not "fit" into the Pan-London 2ww tumour specific pathways. The service provides personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally. This supports improvements in the Faster Diagnosis Standards (FDS) which is currently at pre-covid levels.

- The **Lung screening project (The SUMMIT study)** delivered by UCLH and GRAIL has to date delivered a service to over 13,000 participants. The aim of the project is to develop & evaluate a new blood test for detecting multiple types of cancer early including lung cancer amongst at-risk residents & contribute to the examination of the feasibility of a large-scale lung screening programme in England. Participants were invited via their GP practice to attend a lung health check, offered a blood test & a low-dose CT scan of lungs. If signs for concern were seen in first scan, these were followed up, either immediately or twice annually depending on severity. The screening project will run until July 2022 but has already impacted patients through early lung cancer detection & patients successfully treated.

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

Red schemes – denotes progress to next stage of process from previous month

Blue Schemes – New schemes added in current month

Concept Schemes

Ageing Well - OOH - End of life rapid response team
Ageing Well - Hospice End of Life Service (RRT 24hr helpline and Nurse)
Ageing Well - Hospice End of Life Service (Care Home EOL Nurse Specialist)
Ageing Well - Community Falls Care Home Service
Ageing Well - Discharge to assess pilot
EBI Wave 2
ECG LIS
ASD/ADHD
Weekend Nursing Home Discharges
Expansion of Community Falls Service
(ACP) Pharmacist in the Community Treatment Team (CTT)
Community Complex Dementia
LTC Diabetes – out of hospital management
Point of Care Testing (POCT)

Business Case

Hospital Discharge Service
Duty doctor
Winter schemes x8
Community Minor Surgery
Simple Wound Care
Diabetes Assisted Discharge
Tier 3 Weight Mgt
Local NIV Service
Long Covid Extension
Home First Pilot
PINS-Hospital at Home Pathway
ACR Hypertension

Mobilisation

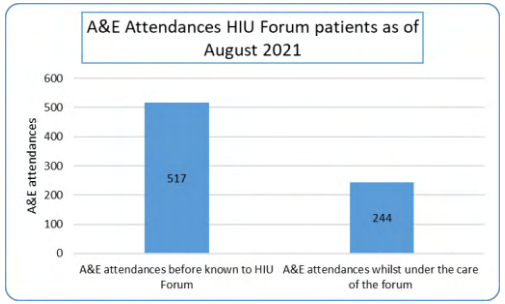
Ageing Well - UCR 2-hour response (CTT Expansion)
AF Case Finding-Havering
Complex Wound care Programme/Dressings and Lymphedema
v Chronic Kidney Disease (CKD) Pilot
Pilot HALO (Hospital Ambulance Liaison Officer)
MSK e-Referral Tool
ACR Testing from Home/ACR Diabetes

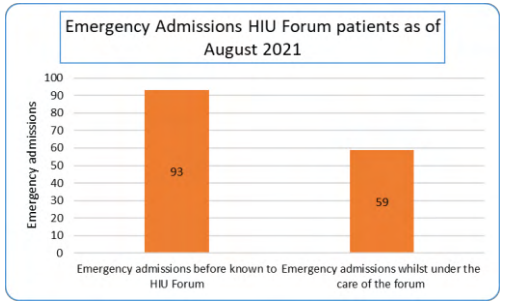
Live Schemes

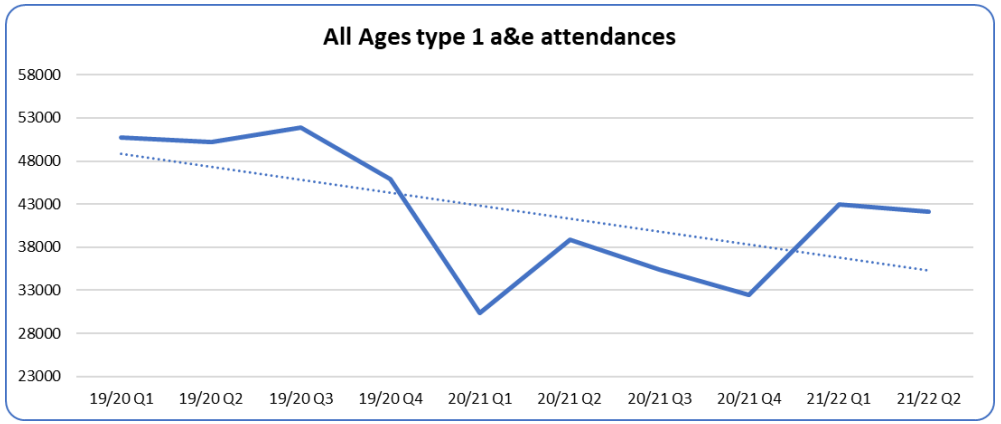
Queens Frailty Hub Service (AFS)
Falls Programme Line - Strength & Balance Service
Local Area Coordination - Havering
Local Area Coordination - Redbridge
Reduce attendances for HIU (ODISH)
Develop SDEC pathways
Advice & Guidance
C2C reduction - Triage/RAS
MSK New Model of Care:
MSK New Model Of Care-EOR
MSK New Model Of Care-Primary Care MSK Team
MSK New Model Of Care-Rheumatology Hub
PIFU (Patient Initiated FU)
Uro-gynae pathway
Children Asthma LISs
LTC LIS - Atrial Fibrillation
LTC LIS - Diabetes Injectables
Respiratory Care - LTC LIS Group 2 (COPD/Asthma)
Diabetes 8CP/3TT

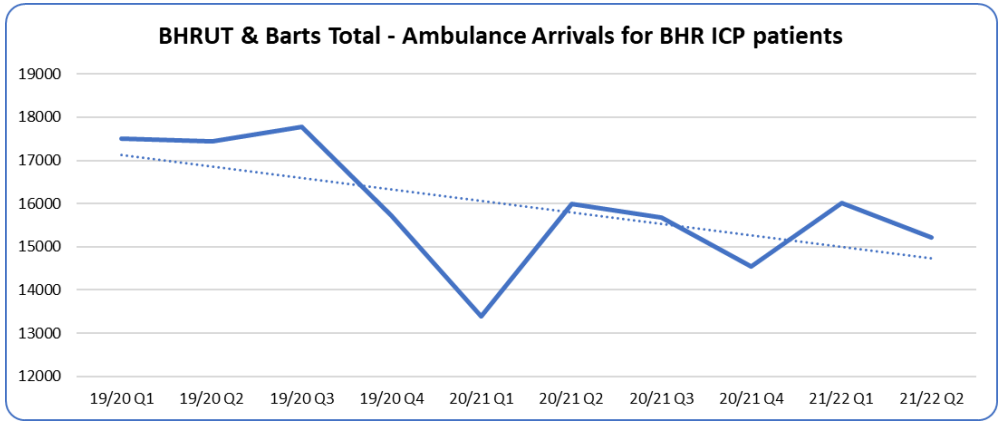
Impact of Transformation

Urgent & Emergency Care Transformation Board Impact Achievements









High Intensity User Forum & Open Dialogue service

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

In 21/22 (as of August 2021), the service has delivered a reduction in emergency admissions of 37% (34 less admissions) and a reduction in A&E attendances by 53% (273 less attendances).

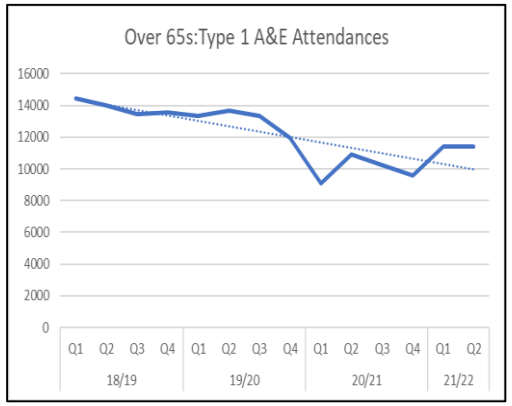
Alternative Care Pathways (ACPs)/Hospital Ambulance Liaison Officer Pilot (HALO)

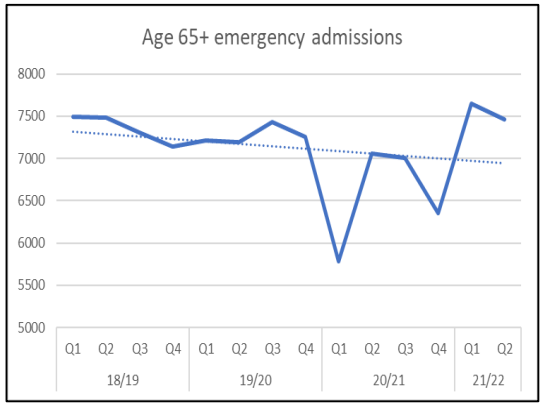
Type 1 A&E Attendances, relating to BHR patients of all ages at BHRUT, continue to show an overall downward trend with a 16% reduction (15,895 less) in A&E attendances in Q1 & Q2 FOT 21/22 when compared to Q1 & Q2 2019/20. Whilst some of the reduction is due to the Covid pandemic, especially in April and May, a significant contributor to this shift has been the successful implementation of 4 UTCs across BHR and the ongoing work to increase utilisation of alternative care pathways so that the emergency department is not the first port of call for patients when clinically safe to utilise alternative services..

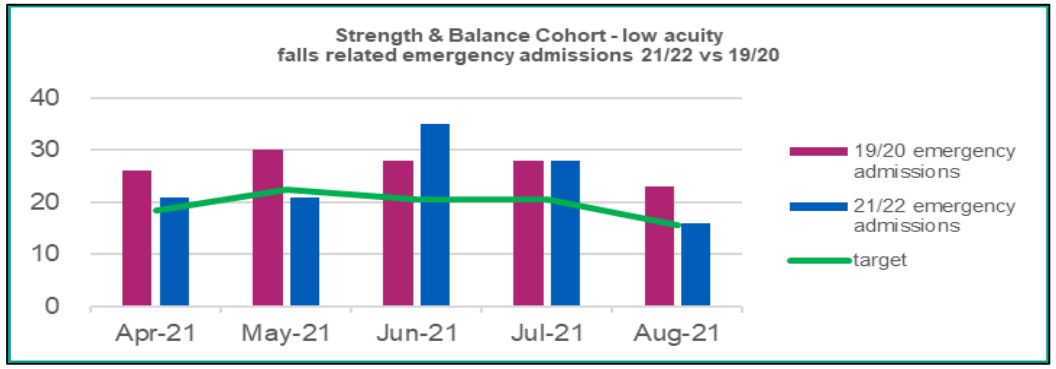
A significant amount of work has been undertaken to ensure alternative care pathways are increasingly available, such as CTT, UTCs, Crisis Centres and Frailty Units. As a result, ambulance crews are now able to take an increasing number of patients to these alternative services. The impact of this can be seen in the reduction of ambulance arrivals, when comparing Q1 & Q2 FOT 2021/22 with Q1 & Q2 2019/20, which shows a 11% reduction (3,699 less conveyances.).

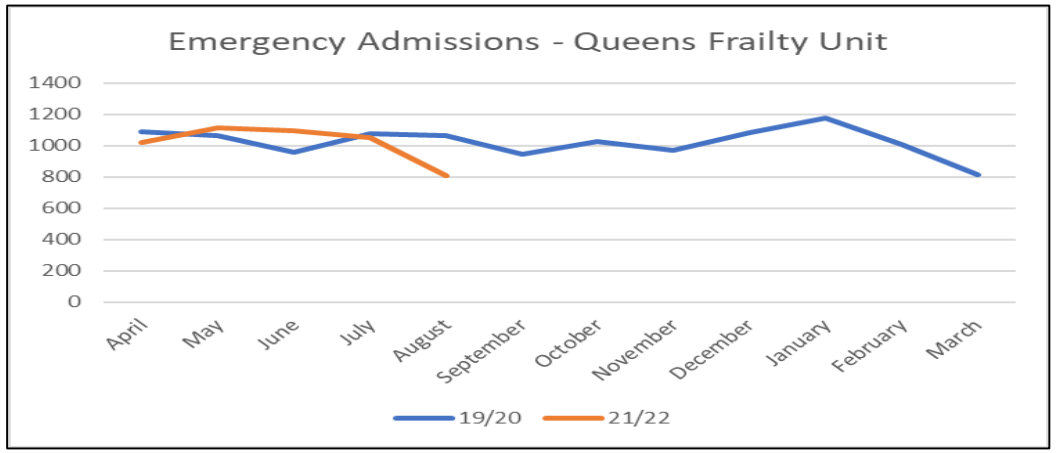
To enhance the usage of ACPs further and to support with winter, LAS has recruited paramedics (HALO) who will review ambulance arrivals, 7 days a week throughout winter and guide/educate their colleagues around the alternatives available. Through doing this, it is forecast to prevent 1,820 A&E attendances throughout winter.

Older People Transformation Board Impact Achievements





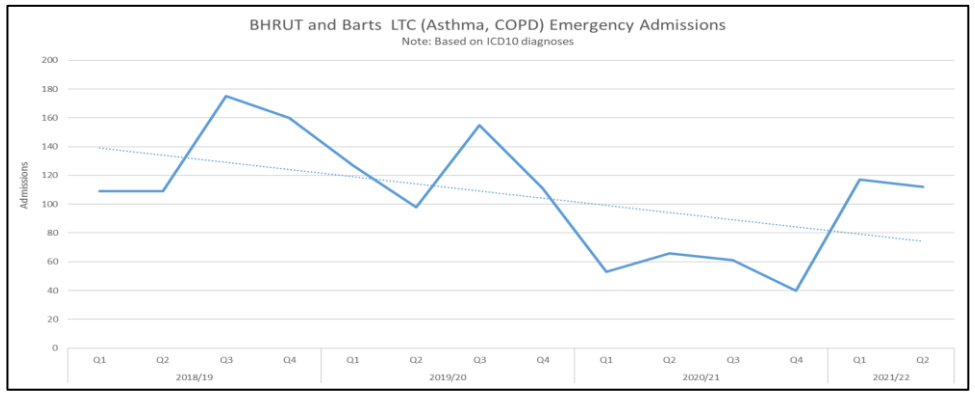


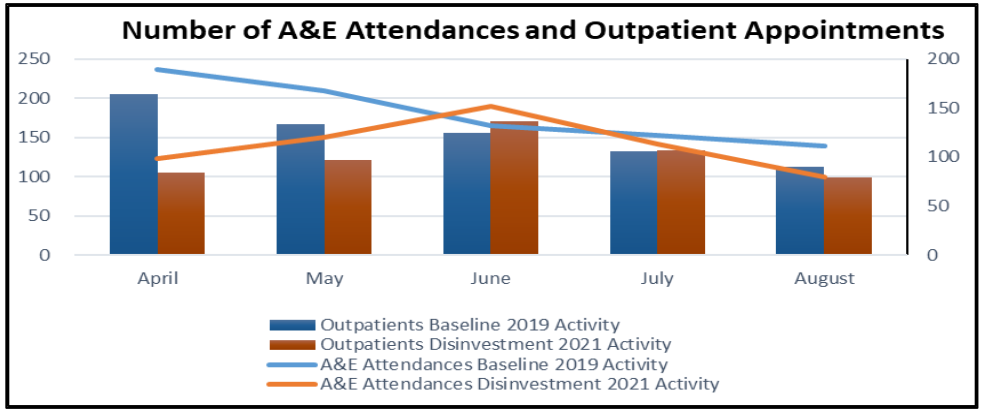


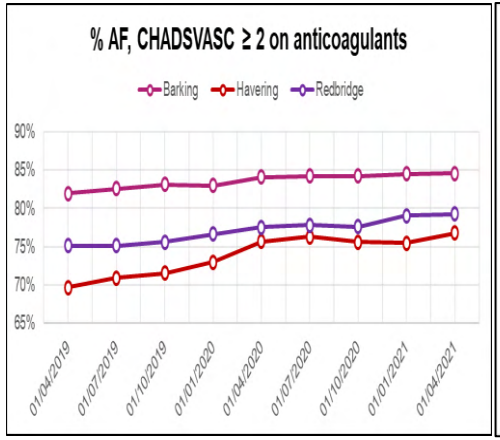
Key Notes

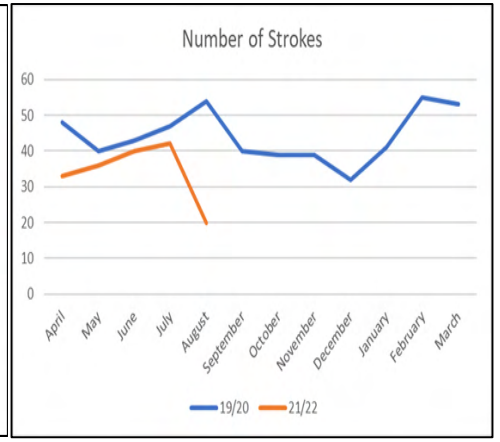
- Due to the impact of covid, the 20/21 position have been skewed and therefore, the 21/22 position have been compared to the 19/20 pre-covid levels.
- The YTD (Q2) level of A&E attendances, for patients aged 65+, is currently 15% (4,167 attendances) lower than the comparable period in 19/20.
- However, the spike in the level of over 65+ admissions in recent months indicates that older patients presenting to Hospital are more complex and with a higher acuity of their condition, in part driven by Covid.
- The Queens Frailty Unit, which was launched in May-21, incorporating the previous ‘ED Front Door’ and ‘Home is Best’ services, is starting to impact on the admission rates through a more dedicated and integrated Frailty service aimed at assessing and supporting patients to be cared for in an appropriate setting where an admission is not required. In August-21, there were 24% (258) less admissions than in August-19.
- The Falls Strength and Balance service was impacted during covid due to social distancing measures and the move to virtual sessions. However, despite a spike in June-21, the 21/22 position shows a 10% reduction in falls equating to 14 less falls by August-21 compared to the same period in 19/20.
- As the Strength and Balance classes resume face to face sessions, it is expected that the number of falls will decrease further in future months.

Long Term Conditions Transformation Board Impact Achievements





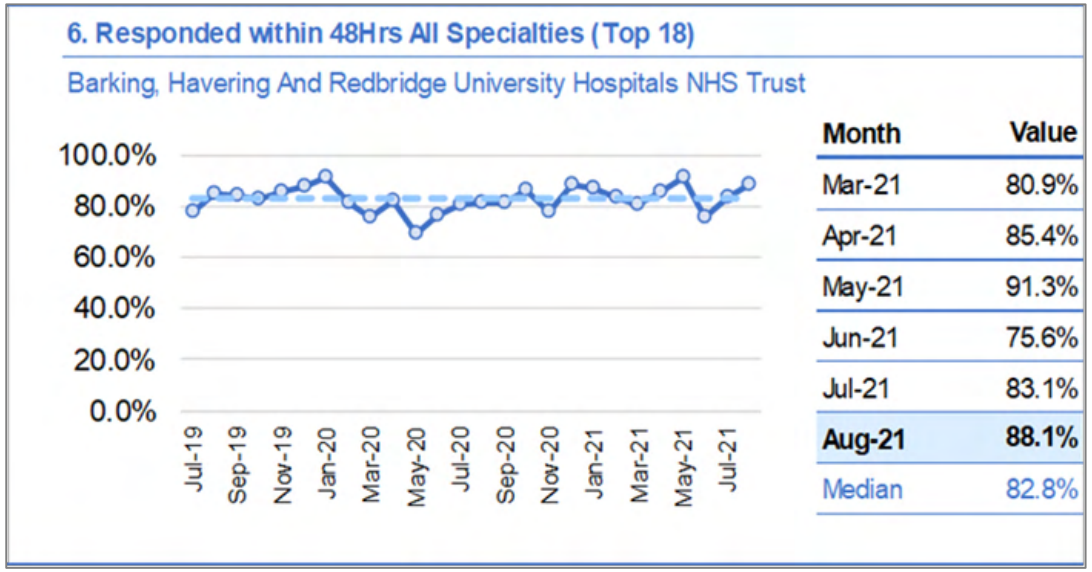




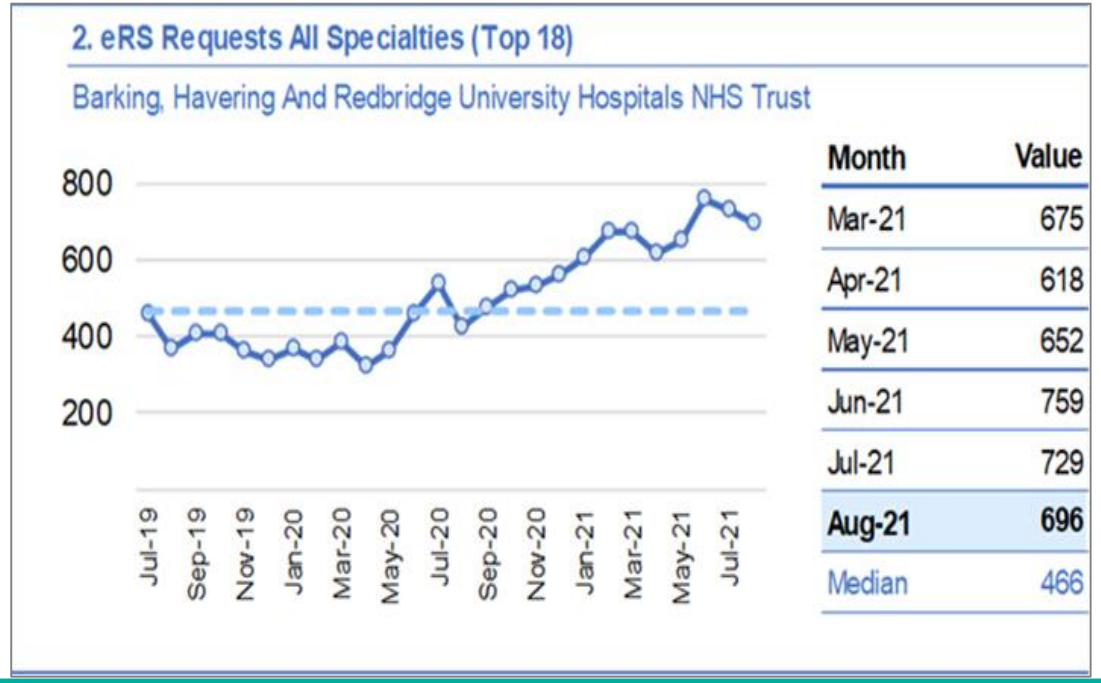
Key Notes

- The LTC Asthma and COPD LIS was implemented prior to Covid, with the purpose of shifting routine spirometry tests, for diagnosis of COPD/asthma, from an Acute setting into Primary Care, and to support patients through the development of care plans to better manage their condition and reduce presentations to Secondary Care.
- Since April 2021, there have been 159 less respiratory related A&E admissions compared to the same period in 19/20.
- COPD and asthma related admissions remain on a downward trajectory, and despite a post-covid surge in admissions in June-21, at Quarter 2, admission remain below the 19/20 position.
- The shift in setting for the delivery of routine Spirometry testing, has resulted in 77% less spirometry activity (reduction of 610 tests between April-21 to August-21) taking place in secondary care. As the Tests are performed in an Outpatient setting, this has resulted in the freeing up of 610 outpatient appointments at BHRUT.
- Since the implementation of the Atrial Fibrillation LIS in 19/20, 93 out of 116 GP practices have had their AF registers reviewed for high-risk patients (CHADVASc >2) who are not on anticoagulation treatment. This review of 769 patients has led to over 200 patients being anticoagulated.
- Due to early detection and intervention, this has contributed to 27% (61) less strokes in 21/22 (to August-21), compared to the same period in 19/20.

Planned Care Transformation Board Impact Achievements



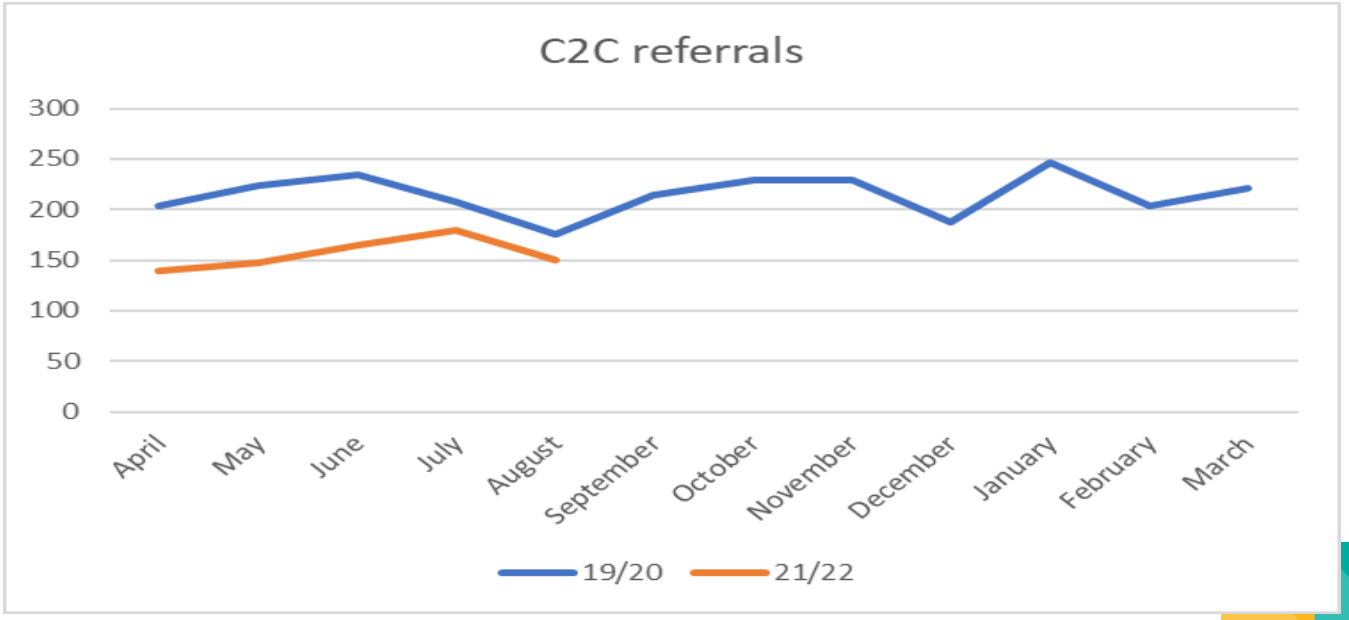
Month	Value
Mar-21	80.9%
Apr-21	85.4%
May-21	91.3%
Jun-21	75.6%
Jul-21	83.1%
Aug-21	**88.1%**
Median	82.8%



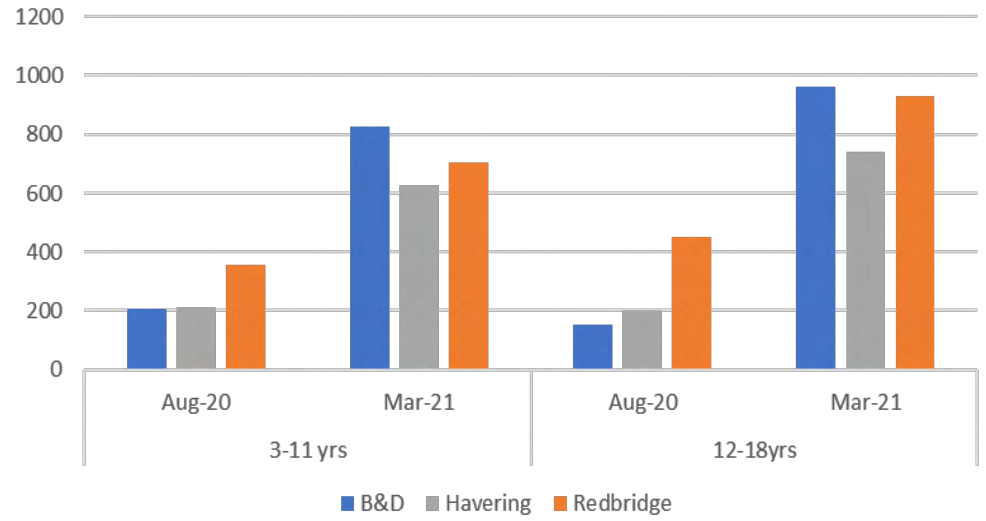
Month	Value
Mar-21	675
Apr-21	618
May-21	652
Jun-21	759
Jul-21	729
Aug-21	**696**
Median	466

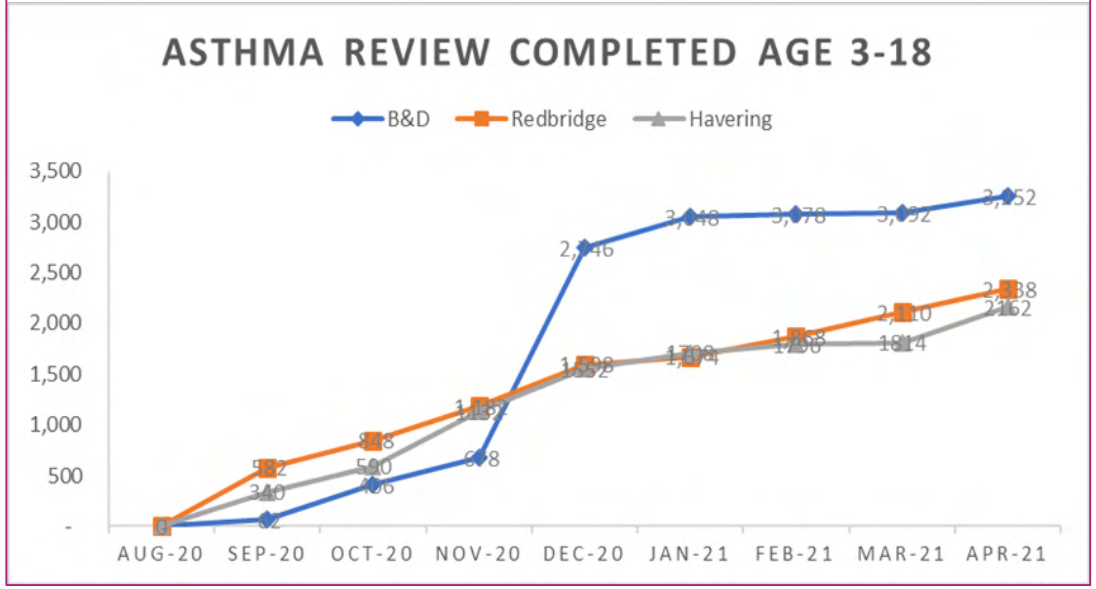
Key notes

- The Advice & Guidance service has continued to improve with an increase in the number of requests for Advice & Guidance on e-RS, whilst maintaining a 83% response rate within 48 hours.
- The improvements in the Trust Directory of Services and combined with the roll out of the Triage/RAS systems, has contributed to a 25% reduction (265 attendances) in the level of Consultant to Consultant (C2C) referrals.
- The C2C policy, following system agreement, is currently suspended and further communication and engagement is ongoing within the Trust to ensure that the legacy processes are reversed to support the reduction in demand on Primary Care.
- The Patient Initiated Follow Up (PIFU) pathways have been piloted in Neurology and the pathway will be rolled out to 4 further Specialties (Trauma & Orthopaedics, ophthalmology, gastroenterology and Prostate Stratified Pathways) in the next few months. The PIFU is aimed at empowering patients, with clinical oversight, to manage their own follow-up pathways based on their condition and requirements. This in turn is expected to reduce the number of unnecessary follow-up attendances going forward.



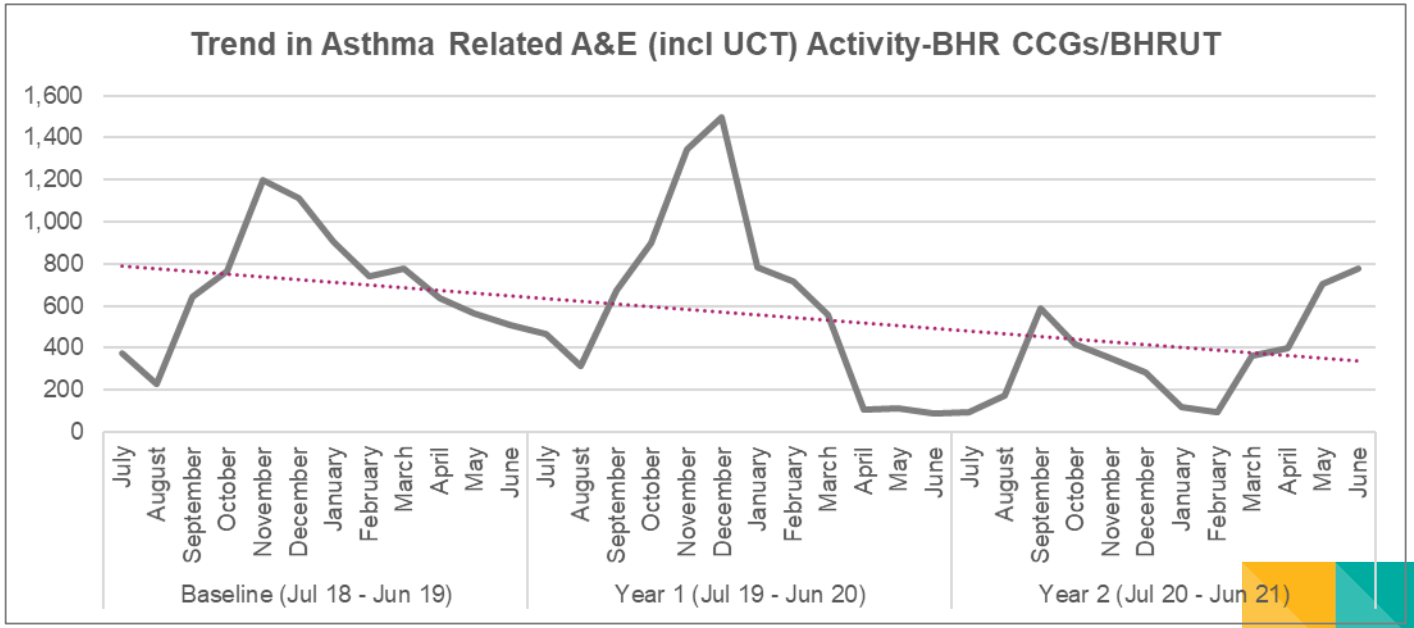
Children and Young People Transformation Board Impact Achievements



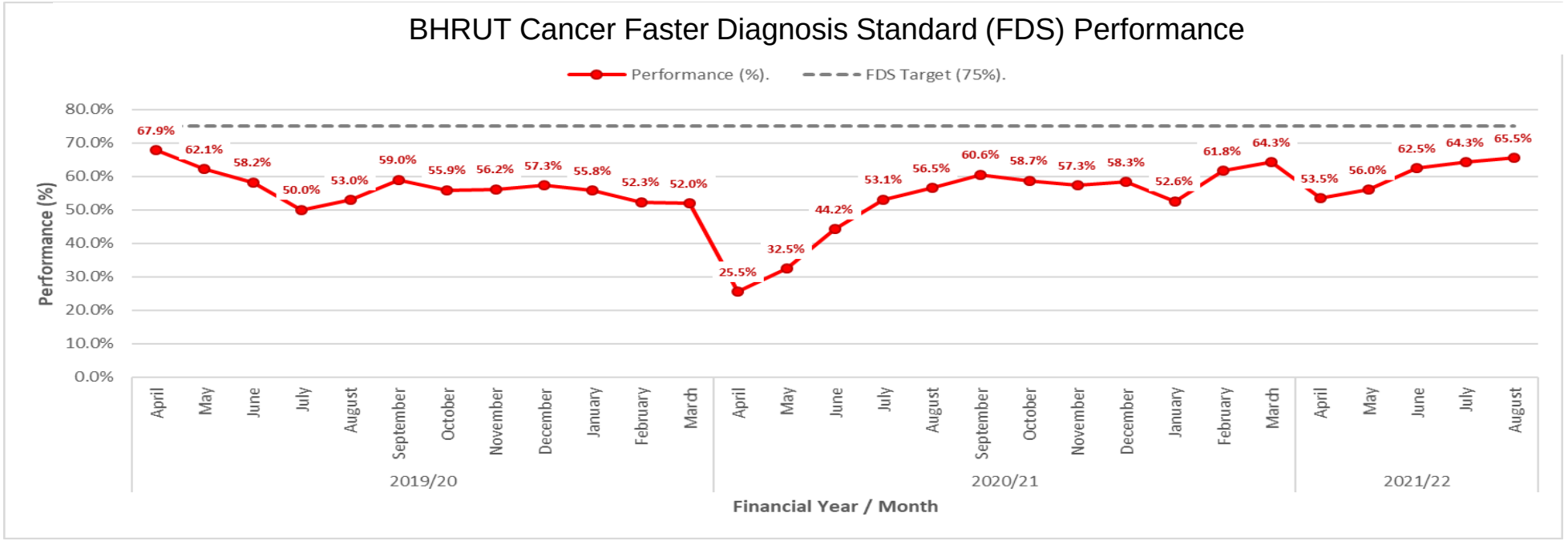


Key notes

- The Sustainable Asthmas LIS, which was implemented in 19/20 in response to the Regulation 28, focuses on providing education and support to children and their families to help manage the Asthma condition through the implementation of Care Plans. The service is an integrated service between Primary Care and Community services.
- The Sustainable Asthmas LIS, has resulted in a 200% increase in the number of care plans issued since its implementation (from 1,574 in August 20 to 4,790 at the end of March 21), with the impact of the care plans seen in the following months and years.
- The implementation of the LIS has contributed to a 48% reduction in Children's Respiratory related A&E/UCC attendances across BHR, (from 8,462 attendances (pre-LIS) to 4,360 over the past year)
- Paediatric Emergency admissions, which are directly attributable to minor Asthma conditions, has also reduced by 48% across BHR, from 405 admissions pre LIS (Baseline Year), to 208 admissions in year 2 of the scheme. Whilst some of the reduction can be attributed to the impact of Covid, admissions have not reached pre-covid levels, in part, driven by the increase community base care provided by the LIS.



Cancer Transformation Board Impact Achievements



Key notes

- Significant work has been undertaken by the Trust to improve the Faster Diagnosis times including:
  - Dedicated clinical review clinics established with consultant time to sign patient off pathway
  - Local process agreed with Primary Care on endoscopy sign off process to support FDS compliance
  - Clinic capacity increased to reduce median waits
  - Clinical triage team booking directly onto Endoscopy list
  - Increased Radiology scanning capacity to support delivery of FDS and resource has been allocated to support Gynae and Urology specifically.

- This work has resulted in the current performance being back at pre-covid levels. The FDS August-21 Published information indicates a performance of 65.50% (+1.30%) from previous month against the 75.0% Target.

- There has also been an improved position for the 28 Day FDS in Gynaecology and Upper GI seen in September 2021.

BHR Integrated Care Partnership Board

25 November 2021

Title of report	BHR community phlebotomy update
Author	Jeremy Kidd, Deputy Director of Transformation - Planned Care, BHR ICP
Presented by	Jeremy Kidd, Deputy Director of Transformation - Planned Care, BHR ICP
Contact for further information	Tracy Rubery, Director of Transformation, NEL CCG (BHR ICP)
Executive summary	The new pilot model for community phlebotomy provision commenced on 1st July 2021. The chosen service model is being piloted to ensure that we are able to "test" ideas in an agile way and adapt the service as necessary to meet emerging demands as nationally we move out of the lockdown. The implementation is going well: in all but one site patients can be bled in a maximum of one day. Patients report very high levels of satisfaction with the service with 93% reporting that they found the service good, or very good.
Action required	Noting
Where else has this paper been discussed?	n/a
Next steps/ onward reporting	Planned Care Transformation Board (for operational oversight)
What does this mean for local people? **How does this drive change and reduce health inequalities?**	The new service model is designed to ensure that patients/residents are able to access blood testing in a timely manner, closer to home and without the need to travel to an acute hospital site (in most cases).

	Through the use of bookable appointment slots and extended hours, it should also mean that services are more convenient and accessible to all, including those how require carer/family support to attend.
Conflicts of interest	Dr Jyoti Sood is a member of the Executive Phlebotomy Steering Group which has inputted into the development of this model. Dr Sood is a member of a PCN which has been delivering phlebotomy testing as part of the recovery work and is now delivering as part of this pilot.
Strategic fit	Care closer to home
Impact on finance, performance and quality	• Increased financial requirement to fund "gap" identified between existing service model and proposed new service model. • Improved performance in terms of waiting times (for urgent and routine bleeds). • Improved quality – fewer complaints due to increased bleed times and more convenient provision.
Risks	A full project risk register is held by the Executive Phlebotomy Steering Group. The following risks are taken from that register. • There are risks as a result of covid impacting staffing, for which a plan is in place. NELFT have a mitigation plan in place to safeguard delivery of their services • In addition, there is a risk of sample delays, which could require patients to require a second bleed. A mitigation plan is in place: transport runs are now aligned to the sites and a pilot for centrifuges is taking place.
Equality impact	There are no equalities implications arising from this report. A full Equality Impact Assessment will be completed as part of the implementation of this new service (pending agreement) and there will be the opportunity through the pilot to adapt as necessary to mitigate any identified issues.

1. Purpose of the Report

1.1. To provide an update on progress of the Community Phlebotomy pilot.

2. Background/Introduction

2.1. The new pilot model for community phlebotomy provision commenced on 1st July 2021.

2.2. The pilot is designed to deliver a service which meets the needs of BHR patients, more broadly however it is recognised that the challenge in developing a new model for the delivery of phlebotomy in the community is the absence of empirical evidence upon which to base a model. As a result, the chosen service model needed to be piloted: this ensures that we are able to "test" ideas in an agile way and adapt the service as necessary to meet emerging demands as nationally we move out of the lockdown. The effectiveness of the pilot is being closely monitored by the Executive Phlebotomy Steering Group

3. Pilot Update

3.1. There are four NELFT sites in each borough in BHR. In addition, four PCNs in Redbridge are delivering phlebotomy as part of this pilot under a Local Incentive Scheme (LIS).

3.2. NELFT provide weekly and monthly data on the volume of bleeds carried out in BHR sites (including GP sites). Table 1 below sets out the bleeds by month for all sites using the 10to8 online booking system (note: this includes PCN sites).

Borough	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
B&D	8,541	8,270	8,632	11,168	8,846	9,477
Havering	7,814	7,930	8,275	13,153	10,778	11,033
Redbridge	6,291	5,843	5,834	7,377	5,630	5,496
Total	**22,646**	**22,043**	**22,741**	**31,698**	**25,254**	**26,006**

Table 1 - Bleeds per month - Source 10to8 Booking System

3.3. The latest bookings on the 10to8 booking system are set out in table 2 below. Note that this splits the bookings by those who have booked to be bled in the cohorts of 0-2 weeks, 2-4 weeks and over 4 weeks. This does not reflect availability of bleeds: some patients like to book ahead, potentially for example if they require regular tests to inform medication reviews.

Timeframe	W/C 11th Oct 2021	W/C 18th Oct 2021	W/C 25th Oct 2021	W/C 1ST Nov 2021
0-2 weeks	3169	3311	3561	3687
2-4 weeks	132	17	9	16
4 weeks+	5	4	4	3

Table 2 - Bookings by week/period, source 10to8 booking system on 01.11.21

Borough	W/C 11th Oct 2021	W/C 18th Oct 2021	W/C 25th Oct 2021	W/C 1ST Nov
B&D	1045	1095	1214	1342
Havering	1328	1354	1365	1367
Redbridge	796	862	982	978

Table 3 Bookings in the next 0-2 weeks, by borough

3.4. Table 4, below sets out the wait to the next bleed by site (for comparative purposes the data for the last 4 weeks is included). It is presently possible to be bled the same day as booking in each borough and the maximum wait for a bleed at any site is two days at Barking Community Hospital

Clinic	Next available date	Wait period w/c 11th October	Wait period w/c 18th October	Wait period w/c 25th October	Wait period w/c 1st November
B&D					
Barking Community Hospital	3rd November	1 day	1 day	1 day	2 Day
Chadwell Heath HC	1st November	Same day	Same day	Same day	Same day
Thames View HC	1st November	Same day	Same day	Same day	Same day
Porters Ave HC	2nd November	1 day	1 day	1 day	1 day
Havering					
Cranham HC	1st November	Same day	Same day	Same day	Same day
Elm Park Clinic	2nd November	1 day	1 day	1 day	1 day
Harold Hill HC	1st November	Same day	Same day	Same day	Same day
Raphael House	1st November	Same day	Same day	Same day	Same day
Redbridge					
Barley Court	1st November	Same day	Same day	Same day	Same day
Loxford Polyclinic	2nd November	Same day	Same day	Same day	1 day
Hainault HC	2nd November	Same day	Same day	Same day	1 day
Seven Kings HC	2nd November	1 day	1 day	1 day	1 day

Table 4 Date of next available bleed by site - source 10to8 booking system (data as at 01.11.21)

3.5. The blood bottle shortage experienced during August and September has not impacted on the delivery of the pilot.

3.6. The services provided by Barts Health are not part of the current Phlebotomy pilot, however for completeness these are provided at Appendix 1.

3.7. In addition to the quantitative performance data above, a survey of patients' response to the service was developed by the Executive Phlebotomy Steering Group. Data from the latest reporting period (August – September 2021) is set out below, this includes over 7,000 responses. During this reporting period patients gave favourable responses to the service; 93% of service users reported that their experience of the service was very good, or

good as is show in figure 2 below. Figure 5 demonstrates that nearly 98% of patients were happy with the distance travelled to the clinic that they used.

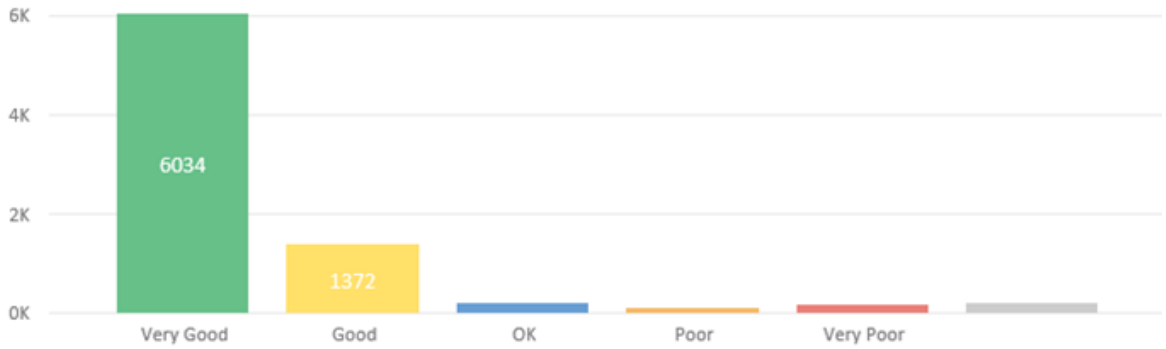


Figure 1 Overall Experiance of the Service

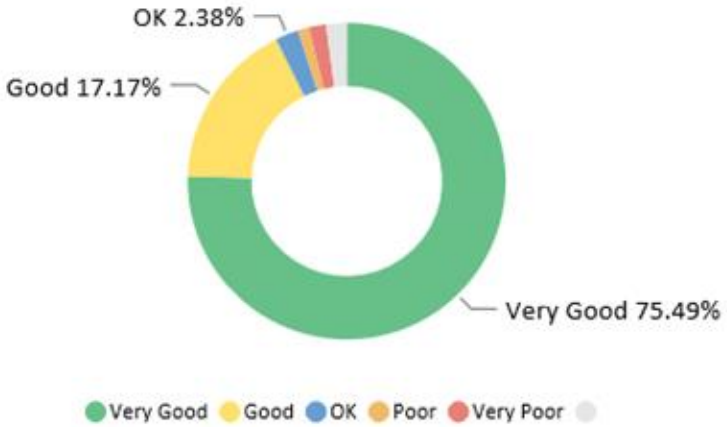


Figure 2 - Overall Experience of the service (%)

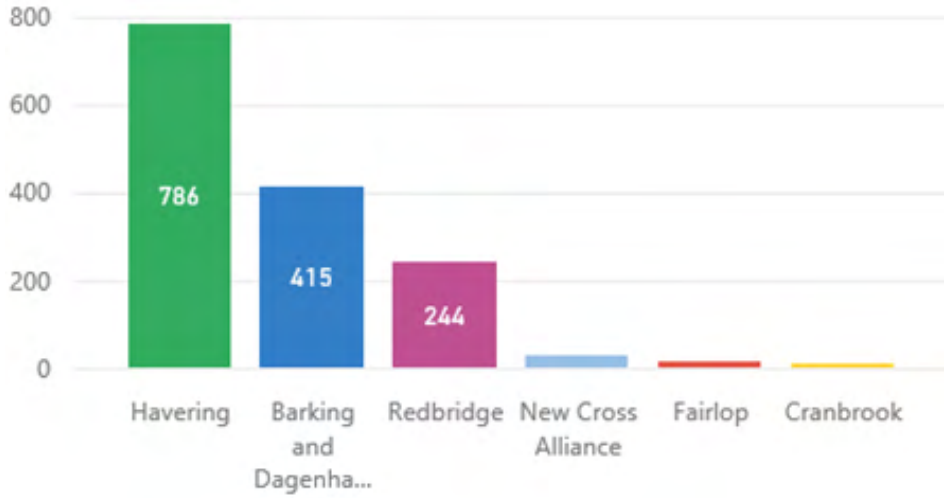


Figure 3 Positive Experience Reported by area

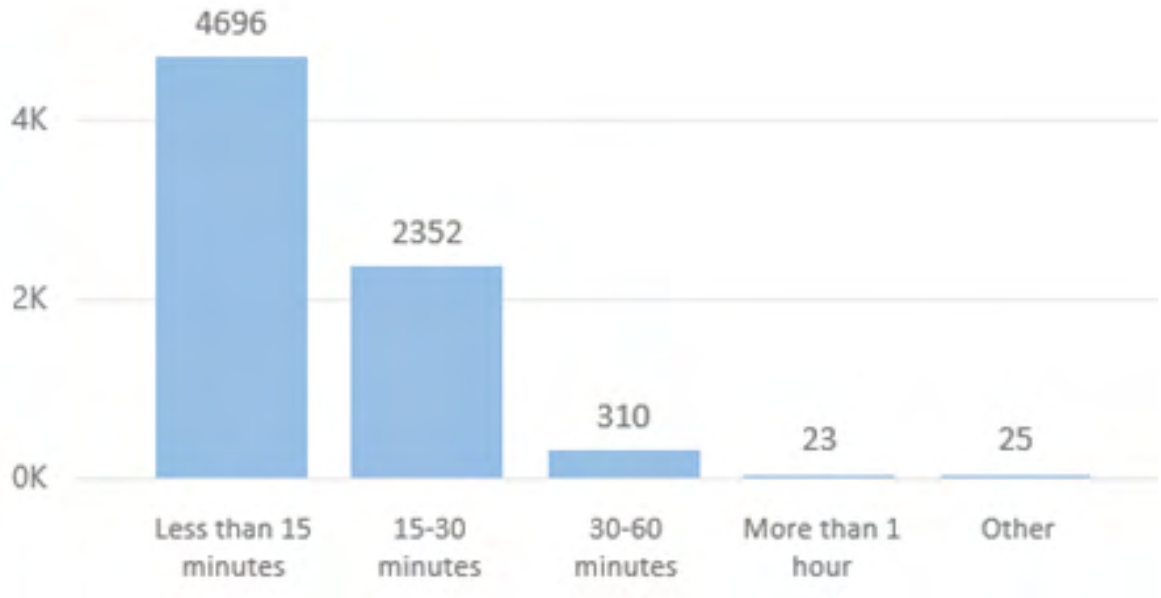


Figure 4 Time to reach the clinic

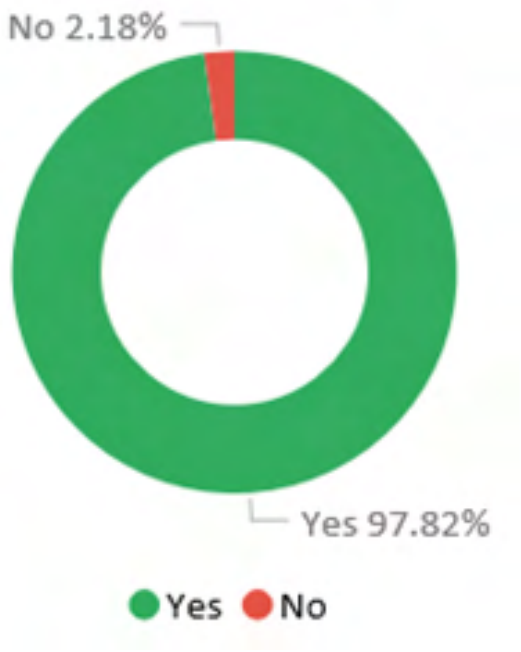


Figure 5 Are you happy with the distance travelled to reach the clinic?

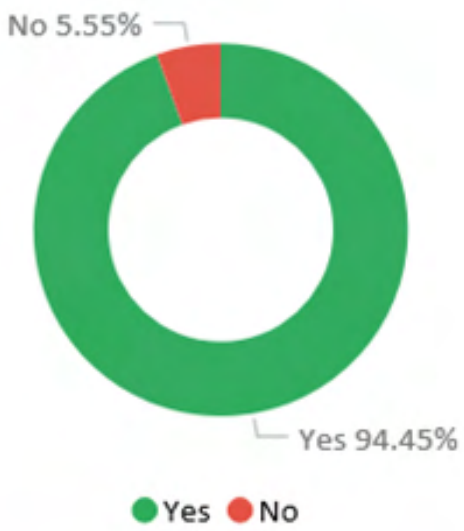


Figure 6 Were you seen at your scheduled time?

4. Equalities

4.1. There are no equalities implications arising from this report.

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

5. Risks and mitigations

5.1. A full risk register is held by the Executive Phlebotomy Steering Group. Risks to note include:

5.2. There is a risk that front line staff are impacted by the new wave, leading to delays and cancellations for patients. In mitigation NELFT have high levels of staff vaccination take up, clinics are covid secure (patient flow, PPE use), patient messaging is in place. Additionally, NELFT use of bank and floating staff and only cancel clinics as a last resort

5.3. Late Samples - There is a clinical risk of incorrect potassium readings in late sample caused by transport delays. Mitigating actions are now in place: Transport runs now align to current sites. Centrifuge are in place in pilot sites. Continue to monitor while new sites come online. Centrifuge working group to be formed to address the transport issue.

Jeremy Kidd
Deputy Director of Transformation - Planned Care
03.11.2021

Barts Health Community Phlebotomy

Barts Health provide phlebotomy in three sites which are predominantly utilised by Redbridge patients. Table 1a below sets out the volume of bleeds at all three sites, table 2a sets out the total percentage of capacity utilised. Barts' sites also utilise online booking.

Attendances	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
OPD Wanstead	2651	2266	2463	2032	2031	2059

Table 1a - Bleeds in Barts sites (all sites)

Booking %	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
OPD Wanstead	65%	75%	81%	89%	89%	87%

Table 2a - Barts phlebotomy capacity utilisation (all sites)

Table 3a sets out the waits by Barts site. Barts advise that waits have not been over two days at any point while they have been collecting data.

Clinic	Next available date	Days waiting
Whipps Cross Adults	26/10/2021	1
Whipps Cross - Paeds	26/10/2021	1
Wanstead – Adults only	27/10/2021	2

Table 3a Waits by Barts site

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

BHR Integrated Care Partnership Board

25 November 2021

Title of report	BHR Priority actions progress update
Author	Emily Plane, Programme Lead, BHR System Development
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 our key priority areas
Where else has this paper been discussed?	This is a recurring report which will be shared with ICPB members at each meeting
Next steps/ onward reporting	N/A; this report is intended to update members of the BHR Integrated Care Partnership Board on progress of our key priority areas
What does this mean for local people? **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.
Conflicts of Interest	There are no conflicts of interest arising from this report
Strategic Fit	All areas of progress noted in this report align with national, North East London Integrated Care System, and BHR Integrated Care Partnership strategy
Impact on finance, performance and quality	There are no direct finance, performance and quality impacts from this report at this stage
Risks	Capacity, in the context of transitioning to an ICS from April 2022 and establishing our Borough Partnerships, alongside continuing to deliver transformation, is an ongoing risk, which is being mitigated by bringing in additional resource where required, e.g. funding to support Borough Partnership development
Equality Impact	Not applicable at this stage

Attachment:

- BHR Priority actions progress update - November 2021

Emily Plane
Programme Lead, BHR System Development
November 2021

BHR Integrated Care Partnership

Better care, better lives, together for all

BHR Integrated Care Partnership

Key Priority Areas – PROGRESS UPDATE

Last updated: November 2021






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 April 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.
October 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
- 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
- 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 April 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: Oliver Shanley
SRO: Steve Rubery
with SOCG

2021/22 Aims

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

2021/22 Key Workstreams

Restoration and Recovery

BHR Recovery and Restoration plan first draft May 2021	Complete
Review and inclusion of Social Care Provider Recovery and Restoration into the master BHR Plan June 2021	Complete
BHR Recovery Summit – 6th July 2021	Complete
BHR Recovery Summit action plan developed	Complete
Ongoing review and update of the Recovery and Restoration plan via SOCG fortnightly	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	In progress

Surge planning, and meeting demand and unmet need

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

Staff Wellbeing

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

Service Changes

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

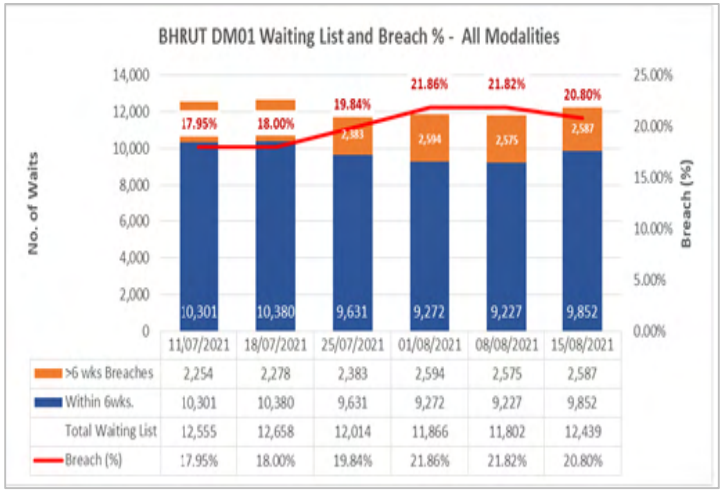
BHR ICP Priority – RECOVERING WELL

Elective Position

BHRUT overall RTT Trajectory	Jun-21	Jul-21	Aug-21	Trend
18 weeks + - Actual	15,594	16,316	15,478	↘
Waiting list – Actual	49,683	50,981	51,074	↑
RTT performance % - Actual	68.6%	68.0%	69.7%	↗
52 weeks + - Actual	1,291	1,266	1,257	↘

- The overall number of patients on the waiting list has continued to increase based on the latest provisional data to w/e 15th August.
- However, the growth in the waiting list relates to 'new' referrals (<18 weeks).
- The level of patients waiting 18+ weeks saw an increase in July (based on provisional data), however this has reduced over recent weeks.
- The 52+ week waiters are continuing to see a week on week reduction.
- However, the level of 40 week waiters has remained consistently around c3.5k each week
- In the last 2 weeks in August, c60% of Elective activity (Ordinary Elective and Day Cases) continues to relate to patients on the P1-4 list. This is consistent with previous months trends.

Diagnostics



- Despite a reduction in the number of patients on the waiting list in July, the waiting list has increased in August, with c12.5k currently on the list.
- The number of 6> week breaches has increased over recent months with c2.5k breaches per month between June and August, compared to c600 in April.
- The deterioration in performance and increase in breaches is reflected in all Modalities
- Challenges remain in Imaging Modalities which are reporting the following for the week ending 15/08/21 (unvalidated current data) :
  - MRI 36.37%
  - CT 26.67%

Referrals

- GP Referrals into BHRUT has been increasing with the current referral rates (w/e 15/08), more than 10% above the 12 week average levels.
- Consultant internal referrals have also slightly increase above the 12 week average.
- A&E and 'Other' referrals have slightly reduced over the same period.
- The reported level of Outpatient activity for August (to 8th August) indicates that activity is at 82%, which is significantly below the 95% Operating Plan target. There is a risk that an increasing rate of referral (demand) will exceed capacity resulting in increased pressures on the growing waiting list.

BHR ICP Priority – ADDRESSING INEQUALITIES AND PREVENTION

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

Overall Objective

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

SRO / Sponsor

Sponsor: 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

Supporting key priorities from each of our Borough Partnerships

2021/22 Key Workstreams

Develop an approach to population health management in BHR

Seek to learn from Care City's work on inequalities and to involve Care City in the work of the BHR Prevention Group	In progress
BHR Prevention Group established, led by BHR Public Health leads, with a focus on: ○ Diabetes/obesity ○ Hypertension / CVD ○ Atrial Fibrillation ○ Physical and Mental Wellbeing ○ Social Isolation ○ Falls prevention ○ Dementia ○ Cancer From October 2021, this group will report directly into the BHR Health and Care Cabinet	In progress
Borough Partnerships have submitted expressions of interest to take part in a Population Health management programme – process being led at a NEL level. Meeting towards the end of July to identify the successful areas.	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	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	In progress
Recruit to Borough Director role for Havering	In progress
Borough Partnerships to take forward Operationalisation of their Roadmaps	In progress
NEL to draft a framework for Borough Partnership development within ICS, with BHR input	In progress
26th Jul – 2nd Borough Partnership development workshop	Complete
3rd Borough Partnership Workshop arranged 7th September	Complete
4th Borough Partnership Workshop arranged November	In progress
5th Borough Partnership Workshop being arranged Jan 22	In progress

BHR ICP Priority – ANCHOR ORGANISATIONS

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

Overall Objective

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

SRO / Sponsor

Sponsor area 1: Oliver Shanley / Kathryn Halford
Sponsor/SRO area 2: 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	In progress
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	In progress

Long COVID

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

BHR ICP Priority – LEADERSHIP, CULTURE, AND LEADING CHANGE

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

Overall Objective

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

SRO / Sponsor

Sponsor: Ceri Jacob
SROs: As set out below

2021/22 Aims

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

2021/22 Key Workstreams

BHR Integrated Sustainability Plan

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

Lead: Mark Eaton/Steve Rubery

Supporting PCN Development

Engagement with PCN CDs to design an approach to development and support	Complete
NHS Elect Commissioned to undertake initial PCN interviews – end May 2021 – 10 interviews	Complete
Outputs from NHS Elect interviews reviewed and developed into a proposal for ongoing PCN Development	Complete
PCN Development session – 27th July – to review next steps for PCN development	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
Further session on PCN development to be held August/September 2021	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, Jacqui Van Rossum, Lee Basso, Barbara Nicholls

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

Integrated Care Partnership Board

25 November 2021

Title of report	BHR Winter Plan 2021/22
Author	Kirsty Boettcher
Presented by	Kirsty Boettcher – Deputy Director of Transformation: Urgent Care
Contact for further information	Kirsty Boettcher – Deputy Director of Transformation: Urgent Care
Executive summary	• Winter 2021/22 is likely to be extremely challenging and this paper summaries the actions that we are taking in line with the NHSE ten point plan for urgent care. • Funding • The Committee are asked to note the content of the report
Action required	Note
Where else has this paper been discussed?	SOCG UEC Transformation Board Discharge Improvement Working group ICEG Finance Committee
Next steps/ onward reporting	Submit to NEL CCG as part of winter plan submission to NHSE
What does this mean for local people? **How does this drive change and reduce health inequalities?**	This highlights the areas that we need to work on to ensure that services meet the needs of patients across winter 2021/22. The plan is for all patients.
Conflicts of interest	There are no conflicts of interest
Strategic fit	• High quality services for patients • Put patient experience at the centre of our delivery • Ensure the best use of resources
Impact on finance, performance and quality	The winter plan will require finance and this will be discussed at the Finance Committee on 30/9/21. The plan aims to improve ED performance and reduce length of stay.
Risks	The risks are highlighted in the document

Equality impact	An Equality Impact Assessment has not been completed and there are no known implications for equalities

Introduction/ Context/ Background/ Purpose of the report
The ongoing pandemic, and the risk of a concurrent flu outbreak, increase in respiratory presentations for 0-3 year olds and an increase in people seeking urgent care mean that this winter is bringing unprecedented challenges. A BHR system wide winter plan has been developed, to recognise the actions required to manage the winter and mitigate risks.

This paper is being brought to the Committee to confirm the action that is being taken, and the additional services and capacity that are being put in place to try and reduce these risks.

The Committee are asked to note the report.

Key messages
There are significant risks in managing through winter 2021/22 based on staffing, demand and capacity.

Body of report
The paper follows the 'ten point plan' that has been developed by NHSE and details the actions that we are taking in each area and the risks that we aim to address. The plan has been developed across the BHR system with all partner involvement.

The Ten Points are:

1. Supporting 111 and 999 services
2. Supporting primary care to manage same day primary care demand
3. Promoting greater use of UTC
4. Increasing support for CYP
5. Using communications to help people use/ choose services wisely
6. Improving in-hospital flow and discharge
7. Supporting adults and children's MH needs
8. Reviewing IPC to ensure a proportionate response
9. Review staff COVID isolation rules
10. Ensuring a sustainable workforce

Additional investment has been agreed for this winter and the additional capacity in 2021/22 is highlighted in green in the main report. The table below is a summary of the key investments and bed/ performance impact.

Scheme	Service	Duration	Impact
1	Therapy assessment in ED	19 weeks	5 beds
2	IRS	22 Weeks	6.8 beds
3	Queens beds	12 weeks	30 beds
4	Nursing home rehab beds	18 Weeks	6 beds
5	EOL residential beds	18 Weeks	4 beds
6	Weekend nursing home discharges	18 weeks	0.5 bed
7	HALO	21 Weeks	1820 ED atts avoided
8	PELC – increased capacity	22 Weeks	3% improvement in 4 hour performance

Risks and mitigations
The paper details the risks and mitigations and the BHR winter plan will provide further details on the mitigations and impact.

Conclusion / Recommendations
The Committee is asked to note the content of the paper.

Attachments
BHR Winter Plan 2021/22 v6

Kirsty Boettcher – Deputy Director of Transformation: Urgent Care
8/11/2021

DRAFT 6.0: 8th November 2021

BHR TEN POINT PLAN FOR URGENT CARE - WINTER 2021/22

10 POINTS	NARRATIVE	RISKS	PROPOSED ACTIONS	LEAD
Supporting 111 and 999 services	Demand has increased significantly for 111 and 999. we need to consider how this can be reduced and other options for management of the activity.	• As activity increases for 111 they require more staff. They increase rates and this takes staff from local services - this is affecting PELC being able to fill shifts	HALO based at Queens and KGH to maximise use of ACPs and possible redirection (ED attendance reduction 1820) - funded and due to start 15/11/21	K Boettcher/ B Evans
			111 increase redirection to pharmacy	LAS
			Additional £1.9M above contract base line for 111 to support recruitment of additional staff (20% increase).	S Graham
			CAS overflow commissioned and mobilised from Sep - Mar 22, additional extended access hubs funded through to Mar 22	S Graham
			Working with SEL and NWL to rebase 111 contracts and manage system clinical and financial risks for 111/999 at ICS level.	S Graham
			Confirm arrangements for PLE cover support 111 requirements in light of primary care direct booking	J Hamberger
Supporting primary care to manage same day primary care demand	Primary care demand has increased but capacity hasn't increased in line with demand. 111 and UTCs are seeing significant increases in primary care patients who either haven't tried or cannot access their practice at a time suitable for them.	• Currently not clear what will be different/ additional in primary care to manage demand • Workforce and capacity issues across BHR • Competing demands from vaccination programme • Ability for patients to access practices through phone lines leading to frustration and seeking support from other services	Increase use of/ signposting to pharmacy and network support posts	Primary Care
			Increase in 2 hour response through CTT - starting from September 2021. Work with primary care to ensure appropriate use of CTT.	T Fowler/ R Dicaprio
			Increase GP hub capacity to further support 111 - NEL funded	C Morgan
			Full release and utilisation of 1 slot per 3000 for 111 booking.	
			Pilot the 'prioritisation list' method for 111 to book into practice slots.	J Hamberger
			BHR summit suggestion of practices joining phone answering capacity to better meet patient demand	TBC
			24/7 primary care pathway being developed across NEL	S Graham / J Lindon
			Development of duty doctor LIS	R Shine
Promoting greater use of UTC	Our UTCs are already fully integrated with direct booking from 111	• Clinical staff groups utilised within UTCs are being offered increasing rates by other providers including for remote working. This is affecting PELCs ability to fill shifts • Changes in leadership for PELC at CEO and Director of Nursing/ Ops level • Funding for additional staff over and above current contract model to meet expected demand and IPC requirements	Need to reintroduce 'telephone first' before attendance for 111 activity. This is dependent on workforce and funding and requires further work	C Morgan/ C Whitton
			Change in UTC space at Queens to better manage flow and reduce queues	L Crees/ S Elliott
			Confirmation of NEL finance agreement to continue funding 'covid' staff increases (20% increase).	
			Additional staffing funded to respond to modelling of 25% increase in demand.	C Whitton/ C Morgan
			Demand will be monitored against the model throughout winter and adapt capacity if required.	

			Working with BHR GP federations to implement electronic re-directions from UTC. Discussions between providers to expand hub capacity to receive additional re-directions from the UTC at a cost.	C Morgan/ C Whitton
			Managing demand and queues - (website/App access, remote devices for staff managing the queues, pilot of the ticket machines at KGH)	C Morgan/ C Whitton
			Logistical support – strengthening project management, IT and Estates capability	
			PELC application to be part of a national pharmacy pilot	S Munshi
			PELC access to CMC and process for use	S Munshi
			Plan in development to establish wound clinics in the UTCs to move that activity from the UTC flow	S Khatoon
			UTCs to support unregistered patients to register with a GP	K Manhertz
Increasing support for CYP	RSV risk and general increase in paediatric attendances across primary and urgent care	• What do primary care need to support management of activity at a practice/ network level • Funding for additional staff over and above current contract model • Training issue and purchase and roll out of equipment for pulse oximetry • Large volume of mild to moderate acuity CYP cohort requiring 0-1 day LoS • Supporting primary care with management of respiratory illness	Demand modelling by practice for primary and ED activity for 0-3 year olds to understand demand and where additional support is required	K Boettcher
			Increase/utilise GP hub capacity and ensure children are seen face to face	K Boettcher/ C Morgan
			National funding for pulse oximetry in primary care - clinical pathway and roll out programme in development for NEL	TBC
			Proposed roll out of Hospital at Home service - paediatric nursing assessment and support , with paediatrician oversight in childs own home	G McNeice
			Circulation to GPs of NHSE bronchiolitis pathway with support training document and PTI sessions to follow	K Boettcher
			Increased inpatient CYP capacity of 6 beds from 4/10/21	N Abbott
			BHRUT - full RSV management plan in place	L Hassell
Using communications to help people use/ chose services wisely	Comms plan in development across NEL	• Accurate data not available to enable planned targeting of messages and activity, reducing effectiveness of campaign. • Partners do not align messages and activity, reducing effectiveness through lack of consistency • Patients continue to demand face to face consultation and lack confidence in virtual/ digital services, resulting in high levels of attendance at UTCs and other services	Use insight and evidence to develop a targeted approach and campaign for NEL (align to national campaign, due to launch mid September) Develop own campaign visual identity and assets to reflect NEL communities in the visuals and languages, to localise, and begin to use materials with public and stakeholders sooner. Develop a central campaign microsite to direct eligible cohorts to targeted messaging building on national messaging. Work together collaboratively as a system to pool resources, amplify, and share key messaging and assets across all available channels.	NEL CCG led, with support from all system partners

		• Funding not identified for targeted work. Reliance on traditional channels and approach, reducing effectiveness and impact • More virtual access is now available at primary care and other urgent care services. However not all of the public are	Develop own campaign visual identity and assets to reflect NEL communities in the visuals and languages, to localise, and begin to use materials with public and stakeholders sooner. Focused paid-for intervention in identified geographic locations (and the communities and cohorts within those areas) where uptake is consistently low / hesitancy groups higher.	
Improving in-hospital flow and discharge	maximise the options to manage patients differently at the front door and minimise LOS to maintain flow given the bed gap which is worsened by COVID	• SDEC currently only has 10 spaces - can't maximise impact and no space to move the service to or to expand to receive referrals from primary care. Also only on Queens site • BHR LA funding position • Essex ability to commission care packages due to capacity issues • COVID vaccination rules impact on care home staff and capacity • Home care provider vaccination rates • COVID contact and impact on discharge to care homes • Increased demand for packages of care in the community puts pressure on LA authority commissioned services and generates additional costs that LAs are unable to fund - blocking flow into community at times of high pressure • Homeless/ no recourse to public funds and Afghan resettlement programmes - significant demand and pressures for this group and not clear pathways out of secondary care	SDEC implemented on Queens site - limited capacity of 10 spaces. Expansion plan will require additional space and staffing Republicise hot clinics to all practices ED advice line - republicise to practices ED directory of community services Confirm outcome of Medical referral line pilot and roll out plan Concept paper developed for virtual ward - awaiting confirmation of funding and then project team to be set up Frailty units in place on both on the Queens and KGH sites - performance and flow review to maximise impact Therapy assessment at RAFTing for all appropriate patients over 18. service will run 7 days from 10am to 10pm and will commence therapy process and complete Peach form before patients enter ED Daily conference calls in place led by Red2Green team with LA's, CCG, NELFT, Matrons/discharge co-ordinators Follow up call with brokerage teams in the pm Board round reviews and electronic flow board deployment at Queens with plan for KGH in next 3 months Focus will be on improving EDD's and planning of discharges, refocus on red2green and safer principles following pandemic and staff changes – with clear escalation processes Hospital Flow programme with divisional teams restarted Focus work to improve: - Pre 12 discharges - Pre 5 pm discharges - 7-day LoS - 21 days LoS 7 day LoS reviews bi weekly	B Graham/ S Elshowaya G Barrett/ D Patel G Barrett/ D Patel C Morgan S Elshowaya/ G Barrett K Ahmad/ G Barrett/ K Boettcher P Thorp R Bagtharia/ R Green BHRUT/ K Peters BHRUT / K Peters BHRUT / K Peters BHRUT R2G

Recruitment of additional therapy resource, for inpatient wards, approval of 10 posts and currently being recruited	Lisa Lomas
Review of internal equipment ordering process. Streamlining equipment ordering process- trial in progress in palliative care to reduce LoS	BHRUT R2G
Business case in development for 30 additional beds on the Queens hospital site	BHRUT
Business case for 6 nursing home beds to be used for step down with therapy support	K Boettcher
Permanent fully staffed HDS service in place from Oct 2021. HDS will merge into the SPA from Jan 2022.	D Feetham
External consultancy support to review 1 to 1s and D2A pathways to maximise use and cost effectiveness	K Boettcher/ P McDonnell
Pilot for 1 Saturday/Sunday discharge per weekend to a Havering care home	P McDonnell/ C White
Band 7 nurse recruitment to support 1:1 review on wards and alternative plan development	D Monie
Additional capacity in IRS from November 2021 to support: discharge from acute, flow out of Meadow Court and the IRS back log post COVID. Discharge to assess Havering: Pilot to be extended until March 22. Permanent Therapy Support commissioned from Sept/Oct 21. B&D: Block bed pilot (8 beds from Oct 2021)	D Feetham
Redbridge will continue to support the D2A pathway from hospital under the current arrangements. Following the Havering pilot Redbridge will be looking at developing the D2A model further to ensure people receive support to promote their independence, health and wellbeing following discharge from hospital.	P McDonnell
Home First - slots per day: B&D 2 (subject to recruitment); Havering 7-8; Redbridge 3-4	P McDonnell
4 beds to be commissioned @ Kallar Lodge residential Care Home to offer a 3-4 week bed base for palliative patients supported by SFH	C Alexander
4 beds have been commissioned from Springfield care home in Redbridge for COVID positive cases. Other capacity can be stepped up if required.	LBR
Use of Hospital discharge fund for 4x weeks D2A. Review of model of care & decision on funding of the final 2x weeks D2A to be agreed by end October	S Morrow
Homeless - NEL funding for 1 discharge co-ordinator and 2 support workers (Havering and Redbridge). Aim to have these in place by end of October 2021.	TBC

			Session to confirm pathways for homeless and NRPF	C Morgan / K Peters
			Review end Oct recruitment progress for key roles (therapists, discharge co-ordinators).	DWIG
			Stroke ward plan - joint development between BHRUT and NELFT next steps to be agreed	J Van Rossum / H Coffey
Supporting adults and children's MH needs	Need to ensure that we have sufficient capacity and clear escalation processes for management and flow of adult MH and CAMHS presentations	• Increased MH presentations across all age groups affecting health, social care and housing	The need to provide a family therapy element to the HTT offer to deal with patients for whom relationships are a key element Service would operate 9am-5pm Monday to Friday	O Johnson / A Domitri
			HUB established in Goodmayes to receive walk in, ambulance and police transfers with MH crisis (patients 18+) with no physical health presentation. This acts as a diversion from A&E and walk-facility (crisis), safely staffed. Also allows for reduction of ambulance conveyance to and waits for S136 in ED. Service operating 7 days - 9-5pm	O Johnson / A Domitri
			Core 24 in psychiatric liaison fully implemented on both sites.	O Johnson / A Domitri
			Additional 18 beds have been commissioned in Picasso Ward and these are in place and operating as part of CDU. Direct agreement fully established between NELFT and ELFT to utilise additional capacity in ELFT beds.	O Johnson / A Domitri
			Mental Health Alternative Care Pathway in place	O Johnson/ T Wishart
			CAMHS beds - Provider collaborative now responsible for tier 4 bed management.	D Tanner
			High level pan London provider led work to review existing CAMHS caseloads for crisis risk and to apply high level actions to reduce activity. Increased C2C contacts around use of IP beds and CAMHS reassessments. Increased partnership working on escalation pathways to reduce LOS.	D Tanner
			Plan to increase CAMHS capacity by 8 places by December - subject to confirmation of works and funding	D Tanner
			Additional investment from the Provider Collaborative has allowed recruitment of an additional 2 Band 7 clinical staff into the BHR Interact Team	D Tanner
			Work continues to establish additional Paeds IP capacity at KGH for 24-48 hour NICE compliant stays	D Tanner
			24/7 advice line (MH hotline) readvertised to GPs	D Tanner

Reviewing IPC to ensure a proportionate response	The provision of effective, timely researched based IPC support is key to ensuring and effective response to Covid 19 and other patient related bacteraemia. IPC Basic Principles training has recently been offered to staff across NEL and provided by the University of East London.	There is a risk of outbreaks and poor management of bacteraemia outbreaks leading to poorer patient outcomes, extended lengths of stay and delayed discharges if there is not a proportionate IPC response.	NEL IPC Leds to continue to meet regularly as a point of sharing of best practice, updates on current guidance, discussion of system-wide IPC issues, and to agree escalations to the regional and national teams, BHR and NEL SMT's. Further cohort of IPC Basic Principles training in late September aimed specifically at staff working within mental health settings.	M. Gilbey-Cross M. Gilbey-Cross
Review staff COVID isolation rules	Staffing number could be reduced where it is identified that NHS staff have been 'pinged' or have been in contact with a known positive case of Covid 19. This would have a detrimental effect on the quality and safety and delivery of care services.	Staffing levels could be impacted as a result of staff contacts with positive cases and by being 'pinged' via the NHS Covid App.	To continue to follow the NHSE national guidance on exemptions from isolation: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/08/C1381-Updated-guidance-on-NHS-staff-and-student-self-isolation-return-to-work-following-COVID-contact.pdf System partners to escalate where staff absence is having an impact on service provision with a view to agreeing mutual aid arrangements.	M. Gilbey-Cross M. Gilbey-Cross
Ensuring a sustainable workforce	Therapy remains high risk but there are significant issues for all services in recruiting and retaining staff as well as UTCs and 111 filling shifts to support urgent care	• Rate for clinical staff is increasing - staff are difficult to get and higher rates being paid. This is affecting PELC ability to fill shifts		

Additional capacity in winter 2021/22

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BHR Integrated Care Partnership Board

25 November 2021

Title of report	Finance Report, month 7 (October 2021)
Author	Julia Summers, Head of Finance, BHR ICP
Presented by	Steve Collins, Acting Chief Finance Officer, NEL CCG
Contact for further information	Robert.adcock@nhs.net
Executive summary	**Key issues** The CCG have 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 is showing a break-even position. The BHR H2 plan is a balanced plan and does not rely on non-recurrent mitigations, except where they have been agreed to fund non-recurrent investments, for example the integrated sustainability plan. At month 7 (period to end of October 2021), BHR ICP and each of the ICPs in NEL CCG have reported a break-even position across core budgets. However, delivery of the break-even position is reliant on the use of non-recurrent balance sheet accruals, totalling £8.7m**.** This relates to H1 pressures and BHR ICP is expecting to manage H2 within budget. 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. **Recommendations**

	BHR ICPB is asked to note the contents of the attached presentation. BHR ICPB is asked to note the BHR ICP H2 and full year budgets.
Action required	Note
Where else has this paper been discussed?	N/A
Next steps/ onward reporting	Monthly updates to ICEG, BHR ICP Finance Group, 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 7 Finance Overview Report 21/22

Meeting name: BHR Integrated Care Partnership Board
Presenter: Steve Collins
Date: 25 November 2021

Finance Report Month 7

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Month 7 (October 2021) 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 £1,259m, which is part of the total NEL CCG budget of £3,917m.**

- **The CCG plan and ICP plans are part of the NEL system plan which is showing a break-even position**.

- The BHR H2 plan is a balanced plan and does not rely on non-recurrent mitigations except where these have been agreed to fund non-recurrent investments, for example the integrated sustainability plan.

- A level of financial risk has been identified from a commissioning perspective within the financial plan. If this materialises it will be mitigated through appropriate actions and non-recurrent measures. As discussed in H1 reports, **the CCG needs to be aware of its recurrent underlying position moving into 22/23 and be aware of the impact of this on the ICB and providers.**

- A full review of financial information has been undertaken for Month 7. The financial position has been prepared along the same lines as H1. Therefore, with the exception of the hospital discharge pathway (HDP), Covid and elective recovery fund (ERF), 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.**

- As reported in previous months, the H1 position required **the use of non-recurrent mitigations totalling £7.8m and accessing CCG Covid contingency funds (£0.9m). The BHR H2 plan assumes that spend will remain within plan.** However, this is not the case across the whole of NEL CCG where the level of non-recurrent mitigations has increased and now total £57.1m for the full year.

- As previously reported, budgetary pressures continue with Independent Sector (IS) contracts, prescribing and NEL corporate budgets. The IS planned budget was increased in H2 to reflect the increase in expenditure seen in H1. There is continued pressure over and above this funding increase as a result of the transfer of activity from Barts Health to the independent sector. The current forecast is based on the maximum planned activity and the associated ERF income that this will attract . Further work is being undertaken to fully understand the impact of independent sector activity as well as the overall corporate budget position as we move into the Integrated Care Board and system.

- The table below highlights the level of mitigation required for BHR ICP and the other NEL ICPs **to deliver the breakeven forecast position.**

Month 7 (October 2021) Executive Summary

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown				
	BHR £m	C&H £m	TNW £m	Non ICP £m	NEL £m
TOTAL EXPENDITURE	**11.7**	**0.5**	**50.8**	**16.3**	**79.4**
Revenue Resource Limit Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
In Year (Surplus) / Deficit Before Mitigation	**11.7**	**0.5**	**50.8**	**16.3**	**79.4**
Retrospective Funding expected for HDP/Covid & ERF	-3.0	0.0	-3.0	-16.3	-22.3
Adjusted (Surplus) / Deficit after NHSE expected top up	**8.7**	**0.5**	**47.8**	**0.0**	**57.1**
Covid Contingency	-0.9	0.1	-4.2	0.0	-5.0
Non Recurrent Mitigation	-7.8	-0.7	-43.6	0.0	-52.0
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

- The Month 7 forecast **assumes that all SDF, MHIS and other specific transformation funds are fully spent**. However, there remains a risk of slippage against a number of these investments as mobilisation in some cases has taken longer than anticipated.

H2 and full year plan – *BHR ICP*

- Block arrangements continue with NHS providers with an expectation that contractual arrangements will resume in 22/23
- Financial uplift for H2 NHS contracts is 1.16%, including a tariff efficiency of 0.82%. There is also a 1.75% uplift for H1 pay award impact.
- System funding envelopes include CCG allocations, system top up funds and a reduced Covid allocation.
- ICS to deliver the tariff efficiency, Covid funds reduction and a system wide efficiency ask. **Excluding the 0.82% efficiency ask the funding reduction is £17m to £18m for NEL.**
- Small amounts of growth funds to cover price and activity pressures in prescribing, CHC, non NHS contracts.
- **The CCG has identified financial risks over and above those identified in the system plan**. These relate to independent sector activity, CHC, prescribing and NEL corporate costs. The mitigations outlined in H1 will continue. The CCG expects that non-recurrent mitigations will fully mitigate the financial risk in H2.
- **The CCG needs to be aware of its recurrent underlying position moving into 22/23 and be aware of the impact of this on the ICB and providers**
- Planning guidance for 22/23 is expected in mid-December. Further updates on this will be given to future committees.
- Part of of non ICP budget relates to SDF. This will be delegated to individual ICPs in future months
- **H1 and H2 will be treated as a single financial period.** The budget by ICP is shown in the table below (detail at a functional area is shown in the next slide). **BHR ICP has a 21/22 planned budget of £1,259m**.

	BHR ICP	CH ICP	TNW ICP	Non ICP	Total NEL
Total H1 & H2 budget 21/22 (£m)	1,258.6	505.6	1,516.5	636.5	**3,917.3**

Month 7 Position – *BHR ICP*

- The position before CCG mitigations and after NHSE anticipated top-ups shows **a full year pressure of £8.7m. This relates to the pressure seen in H1. BHR ICP expects to manage H2 within the budget allocated.**
- **Non-recurrent balance sheet mitigations and covid contingency** have been released into the position to offset CCG overspends.
- This has been necessary to **meet budgetary pressures with the acute independent sector, prescribing and corporate costs.** Other Primary care pressures, i.e. hub arrangements, have been mitigated through the use of covid contingency funds and expected NHSE funding.
- **The use of non-recurrent mitigations and the anticipated NHSE top-up means that the revised CCG position for H2 is break- even.**
- Appendix 1 includes NEL CCG level information and central ICS funds.

BHR ICP Financial Summary H2 2021-22	Month 7				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	384.3	388.5	4.2		659.1	664.7	5.6	
Mental Health & LD	75.4	75.1	-0.3	3	125.1	125.0	-0.1	3
Community Health Services	58.3	58.3	0.0	3	100.3	100.2	-0.1	3
Continuing Care	45.0	45.9	0.9		79.0	78.8	-0.2	3
Other Programme	22.2	23.3	1.0		38.1	39.3	1.2	
Prescribing	61.1	62.3	1.2		103.8	105.0	1.2	
Primary Care Services	11.4	11.9	0.5		19.0	20.0	0.9	
Primary Care Co-Commissioning	71.6	71.6	-0.0	3	122.5	122.5	-0.0	3
Running Costs	8.7	8.7	-0.0	3	15.0	15.0	-0.0	3
Central Reserves & Efficiency Requirement	-0.5	0.0	0.5		-3.2	0.0	3.2	
TOTAL EXPENDITURE	**737.5**	**745.6**	**8.0**		**1,258.6**	**1,270.3**	**11.7**	
Revenue Resource Limit Total	**-737.5**	**-737.5**	0.0	3	**-1,258.6**	**-1,258.6**	0.0	3
In Year (Surplus) / Deficit Before Mitigation	**0.0**	**8.0**	**8.0**		**0.0**	**11.7**	**11.7**	
Retrospective Funding expected for HDP/Covid & ERF		-3.0	-3.0	3		-3.0	-3.0	3
Adjusted (Surplus) / Deficit after NHSE expected top up		**5.0**	**5.0**			**8.7**	**8.7**	
Covid Contingency		-0.5	-0.5			-0.9	-0.9	
Non Recurrent Mitigation		-4.6	-4.6			-7.8	-7.8	

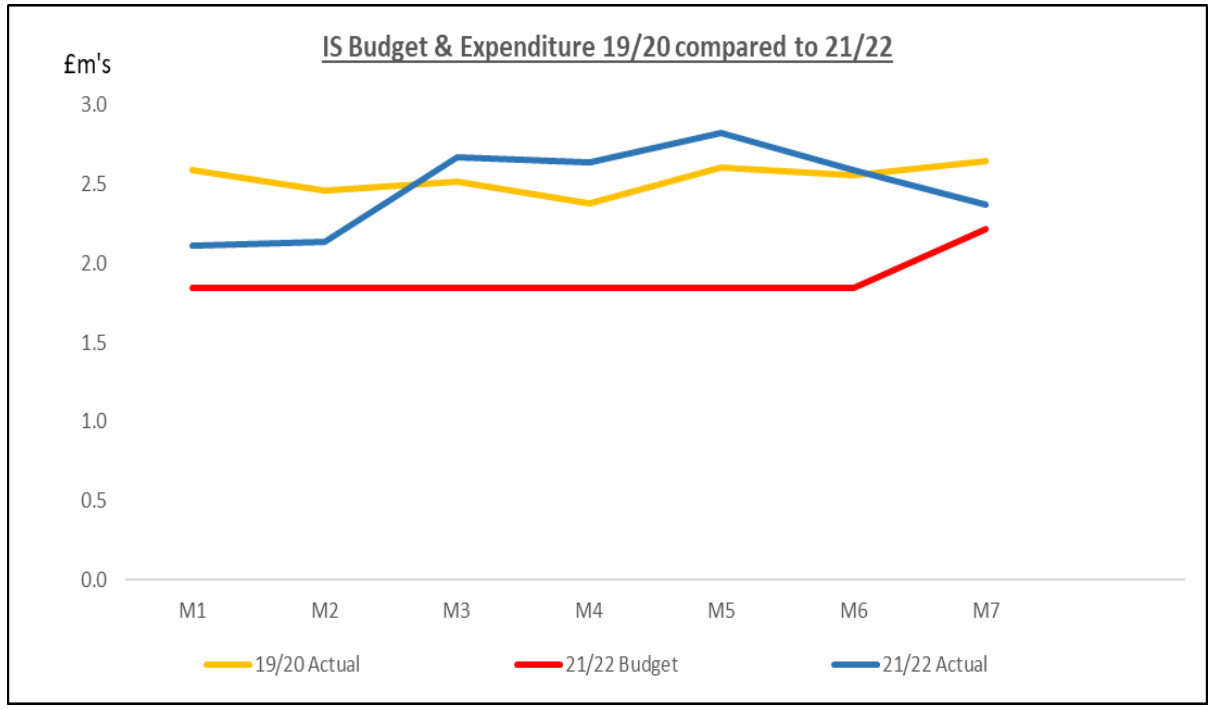
21/22 full year variances – *BHR and NEL Breakdown*

- 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, prescribing and other programme pressures.**
- NEL CCG is expecting an additional £22.3m of funding (forecast position) mainly relating to the Hospital discharge programme (£15.3m) **This is reported as a pressure in the Community Health Services line.**
- 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	5.6	15.3
Mental Health & LD	-0.1	-0.1
Community Health Services	-0.1	16.2
Continuing Care	-0.2	-2.6
Other Programme	1.2	3.4
Prescribing	1.2	3.0
Primary Care Services	0.9	6.1
Primary Care Co-Commissioning	-0.0	-0.0
Running Costs	-0.0	0.0
Central Reserves	3.2	38.0
TOTAL EXPENDITURE	**11.7**	**79.4**
Revenue Resource Limit Total	**0.0**	**0.0**
In Year (Surplus) / Deficit Before Mitigation	**11.7**	**79.4**
Retrospective Funding expected for HDP/Covid & ERF	-3.0	-22.3
Adjusted (Surplus) / Deficit after NHSE expected top up	**8.7**	**57.1**
Covid Contingency	-0.9	-5.0
Non Recurrent Mitigation	-7.8	-52.0
In Year (Surplus) / Deficit	**0.0**	**0.0**

BHR ICP key variances - *Acute*

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown	
	BHR £m	NEL £m
Acute	5.6	15.3



- **BHR ICP have an acute forecast overspend of £5.6m.** This increases to £15.3m at a NEL level.
- NHS block contracts are reported as breakeven.
- Forecast overspends are reported on BHR ICP **against urgent care (£0.3m), non contract activity (£1.3m) and independent sector (IS) providers (£4m).**
- The independent sector graph shows that the H2 budget for 21/22 has been uplifted to cover the run rate of expenditure in H1. However, spend in Month 7 is slightly in excess of the budget set which is driving a further overspend in H2.
- The current forecast includes the transfer of Barts Health activity to the IS. The current forecast is based on the maximum planned activity. However, actual activity may not continue at these levels. ERF estimated funding of £3m for BHR ICP is expected against this but to note lower activity rates will mean that the ERF funding will reduce.
- The IS position is still being worked through by the NEL team so this position may be subject to change. Further updates will be given in Month 8.

BHR ICP key variances – *Continuing Healthcare*

NEL CCG Financial Summary H2 2021-22	Forecast Variance - ICP Breakdown	
	BHR £m	NEL £m
Continuing Care	-0.2	-2.6

BOROUGH	ANNUAL BUDGET £m	FORECAST OUTTURN £m	FORECAST VARIANCE £m
BARKING AND DAGENHAM	18.6	18.2	-0.5
HAVERING	27.9	28.7	0.7
REDBRIDGE	32.4	32.0	-0.5
BHR ICP	**79.0**	**78.8**	**-0.2**

BHR ICP Packages		
	Package Numbers Per Month BHR	Movement Month on Month BHR
M2	1,581	
M3	1,613	32
M4	1,660	47
M5	1,651	-9
M6	1,687	36
M7	1,721	34
Packages Mvmt M2 to M6 =		**140**

ICP → BHR M7				
CHC Type	Start of Period Packages	New Packages	Removed Packages	End of Period Packages
Adults	682	228	203	707
Children	74	6	8	72
FNC	931	53	42	942
Total =	**1,687**	**287**	**253**	**1,721**

- **BHR are reporting a full year forecast underspend of £0.2m**. The NEL forecast underspend is £2.6m
- BHR H2 budgets have been set using the run rate of H1 spend. The forecast outturn spend for BHR is in line with this, which means that the H1 overspend has been fully funded in H2. The BHR position is driven by increased costs in **Havering where there has been an increase in both the number of packages and the costs associated with the packages**.
- The information on packages of care shows a month on month increase in the number of packages. This is 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	1.2	3.0
Primary Care Services	0.9	6.1
TOTAL PRIMARY CARE	**2.1**	**9.1**

- **The BHR forecast variance on primary care and prescribing is £2.1m**. This increases to £9.1m across NEL.
- The prescribing forecast variance is based on the latest available data (month 5).
- The driver behind the overspend is the increased number and in some cases, cost of prescriptions.
- Primary Care Services show a forecast overspend of £0.9m and includes a forecast for reclaimable covid costs of £0.7m.
- The main drivers of the remaining 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 7 there is no reported variance against mental health. The MHIS plan has been set for the full financial year and the Month 7 return to NHSE assumes that spend is in line with plan. Analysis of the BHR section of the plan shows that spend is broadly in line with the plan. The CCG has recently carried out a re-categorisation exercise to refine the split of mental health category information provided to NHSE. It is expected that reporting against the new categories will start later in the financial year.

2. **Central reserves** – there is a reported overspend in BHR of £3.2m on central reserves which relates solely to H1 (increases to £38m forecast overspend across NEL). The driver of this variance relates to a planned efficiency target. This has been fully mitigated by the planned use of non-recurrent resources. The forecast assumes that all ICP/CCG Covid contingencies are fully utliised.

3. **Corporate Pressures** – there is a reported overspend **in BHR of £0.9m against the NEL corporate budgets**. This is associated with business intelligence software and service arrangements that are no longer being funded from central NHSE resources.

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. Month 7 year-to-date and the forecast position suggests that NEL CCG will be within the cap.

- **BHR ICP expenditure is £7.1m year-to-date and a forecast of £11.4m.** At month 7 NHSEI have reimbursed £15.3m across NEL. **Therefore, at month 7 there is an additional HDP year-to-date claim of £2.4m**, with £15.3m expected for forecast costs.

- The HDP scheme covers the costs over and above that normally commissioned by the CCG and Local Authorities on post discharge recovery and support services/rehabilitation and reablement care following discharge from hospital and designated care settings.

	LA YTD M7 £m	CCG YTD M7 £m	Total YTD M7 £m	LA FOT £m	CCG FOT £m	Total YTD £000s
BHR ICP	5.2	1.9	7.1	7.0	4.3	11.4
CH ICP	1.0	0.2	1.1	1.5	0.3	1.8
TNW ICP	3.3	6.1	9.4	7.6	9.8	17.4
Total	**9.5**	**8.2**	**17.6**	**16.2**	**14.4**	**30.6**
HDP Funds received Q1&2			-15.3			-15.3
Outstanding HDP claim			**2.4**			**15.3**

Other Covid

- Other than HDP, the majority of Covid costs are funded within the CCG baseline.

- **BHR ICP has a forecast claim of £0.7m in relation to vaccination costs**.

Elective Recovery Fund

Elective Recovery Fund	Total ERF H1 £m
BHRUT	7.5
Barts Health	12.1
Homerton	3.4
NEL CCG	3.5
Total ERF	**26.4**
Funding distributed - Trusts	-22.9
Funding distributed - NEL CCG	-3.5
Outstanding ERF claim	**0.0**
H2 CCG IS forecast	6.0
Total expected H2 ERF	**6.0**

- ERF plans submitted to NHSE/I captures information from NHS and non-NHS providers. The H1 position resulted in a claim of £24.9m which has been fully reimbursed.
- £22.9m of the total £26.4m 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.
- In Month 7 activity at the independent sector has increased as a result of a transfer of activity from Barts Health. From a system perspective this means that the expected ERF income expectation in H2 is £6m. **At month 7 BHR ICP are expecting £3m of these funds**.
- This expectation is based on the latest assumptions about IS activity data. The NEL team are working on this and assumptions may be refined in future months. Any changes to activity data will impact the expected ERF income. Further updates will be given to committee as the information becomes available.

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 AP7 - OCT 21		2021/22 AP7 - SEP 21		2021/22 Year to date		2020/21 Outturn	
	Number	£000	Number	£000	Number	£000	Number	£000
Non-NHS Payables:								
Total Non-NHS trade invoices paid in the year	6,510	70,078	6,131	78,394	43,481	463,520	89,808	865,136
Total Non-NHS trade invoices paid within target	6,235	68,197	5,984	76,749	41,072	445,692	85,961	824,785
Percentage of non-NHS trade invoices paid within target	96%	97%	98%	98%	94%	96%	96%	95%
NHS Payables:								
Total NHS trade invoices paid in the year	246	248,373	415	259,185	2,176	1,638,429	12,449	2,407,453
Total NHS trade invoices paid within target	245	248,222	412	258,432	2,085	1,632,327	11,472	2,395,694
Percentage of NHS trade invoices paid within target	100%	100%	99%	100%	96%	100%	92%	100%
Combined non NHS and NHS:								
Total Non-NHS trade invoices paid in the year	6,756	318,452	6,546	337,579	45,657	2,101,949	102,257	3,272,589
Total Non-NHS trade invoices paid within target	6,480	316,419	6,396	335,180	43,157	2,078,019	97,433	3,220,479
Percentage of all trade invoices paid within target	96%	99%	98%	99%	95%	99%	95%	98%

- The BPPC targets were met for both NHS and Non NHS in October.
- Appendix 2 shows the balance sheet position of the CCG.

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. BHR ICP have set a H2 budget that does not rely on the use of non-recurrent mitigations. Across NEL non-recurrent mitigations have been required to balance the H2 plan.

- At Month 7 NEL CCG has reported a break-even position on the core budgets, with a reported variance as a result of the outstanding NHSE/I retrospective top-up for HDP, claimable Covid and ERF. The break-even position in BHR ICP have been achieved using non-recurrent mitigations (forecast £8.7m). This relates to the overspend reported in H1. BHR are expecting to manage the H2 position within budget.

- 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.

- BHR ICP and NEL CCG has received funding for transformation areas. Plans are being developed by transformation leads. At month 7 it is assumed that the funds are fully committed.

- Although the CCG is seeing run rate pressures, these are currently being mitigated by non recurrent resources. This will continue to be updated and further updates will be given to Finance Committee.

- ICPB is asked to note the BHR ICP H2 and full year budgets, in line with the planned system submission.

Appendix 1 – NEL Funds

NEL CCG Financial Summary H2 2021-22	Month 7				Forecast			
	Budget £m	Actual £m	Variance £m	RAG	Budget £m	Actual £m	Variance £m	RAG
Acute	1,276.1	1,285.6	9.5		1,966.4	1,981.7	15.3	
Mental Health & LD	232.1	231.9	-0.3	3	397.4	397.4	-0.1	3
Community Health Services	205.5	209.0	3.5		320.6	336.9	16.2	2
Continuing Care	95.9	94.6	-1.3	3	165.1	162.5	-2.6	3
Other Programme	81.8	84.0	2.2		133.4	136.8	3.4	
Prescribing	145.5	148.5	3.0		250.1	253.2	3.0	
Primary Care Services	46.9	50.4	3.5	2	79.0	85.1	6.1	2
Primary Care Co-Commissioning	198.1	198.1	0.0	3	339.0	339.0	-0.0	3
Running Costs	22.4	22.4	0.0	3	38.5	38.5	0.0	3
Central Reserves	0.4	19.2	18.8		227.7	265.8	38.0	
TOTAL EXPENDITURE	**2,304.8**	**2,343.8**	**39.0**		**3,917.3**	**3,996.7**	**79.4**	
Revenue Resource Limit Total	**-2,304.8**	**-2,304.8**	0.0	3	**-3,917.3**	**-3,917.3**	0.0	3
In Year (Surplus) / Deficit Before Mitigation	**0.0**	**39.0**	**39.0**		**0.0**	**79.4**	**79.4**	
Retrospective Funding expected for HDP/Covid & ERF		-9.5	-9.5	3		-22.3	-22.3	3
Adjusted (Surplus) / Deficit after NHSE expected top up	**0.0**	**29.5**	**29.5**		**0.0**	**57.1**	**57.1**	
Covid Contingency		-2.6	-2.6			-5.0	-5.0	
Non Recurrent Mitigation		-26.9	-26.9			-52.0	-52.0	
In Year (Surplus) / Deficit	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	

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

Agreed minutes - Integrated Care Executive Group

16 September 2021 at 3.30pm – 5.00pm

Via MS Teams

Members:

Oliver Shanley (OS)	Chief Executive, NELFT – **Deputy Chair**
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Caroline Allum (CA)	Medical Director, NELFT & Health & Care Cabinet Chair
Matthew Trainer (MT)	Chief Executive, BHRUT
Barbara Nicholls (BN)	Director of Adult Services, LBH
Matthew Cole (MC)	Director of Public Health, LBBD
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation
Diane McKerracher (DM)	Interim Chief Executive, Redbridge GP Federation

Attendees:

Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Mark Eaton (ME)	BHR System Recovery Adviser
Emily Plane (EP)	Programme Lead, BHR ICP
John Craig (JC)	Chief Executive, Care City
Anna McDonald (AMc)	Business Manager, BHR ICP
Hanh Xuan-Tan	Deputy Director, Recovery Planning, BHR ICP
Kirsty Boettcher (KB)	Deputy Director, Un-planned Care, BHR ICP
Hannah Coffey (HC)	Director, Strategy & Partnership, BHRUT
Mark Ansell (MA	Director of Public Health, LBH
Wassim Fattahi-Negro (WF)	Performance & Intelligence Unit, LBBD
Amanda Flower (AF)	Local Area Co-ordination Lead, LBH
Rachel Penney (RP)	Learning Disabilities and Autism Strategic Lead, BHR ICP
Jane Leaman (JL)	LBBD

Apologies/not present:

Ceri Jacob (CJ)	Managing Director, BHR ICP
Henry Black (HB)	Acting Accountable Officer, NEL CGG
Ahmet Koray (AK)	Director of Finance, BHR ICP
Magda Smith (MS)	Chief Medical Officer, BHRUT
Adrian Loades (AL)	Director of People, LBR
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Craig Nikolic (CN)	Chief Operating Officer, B&D GP Federation
Carrie-Anne Wade (CW)	Strategic Communications Leader, NELFT

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 19 August 2021 were agreed as an accurate record.	
1.3	**Action log/matters arising**	
	The actions log was noted and updated accordingly.	
2.0	**Local area co-ordination review**	
	Local area co-ordination is being piloted in four wards in Havering. The report provided an update on the implementation and outcomes achieved and included case studies which reflected on the work being undertaken in the community. An external evaluation will be taking place during September and October and the plan is to roll the service out across the whole borough, subject to funding. DM referred to the cost implications across the wider system when other services such as 'Looked After Children' (LAC) need to be involved and asked how they will be to taken into account as part of the evaluation. BN responded that the formula has been tried and tested in the neighbouring borough of Thurrock where the service has been implemented and a well-established network is in place. AF gave an overview as to how the co-ordinators link in with others services such as LAC when required. SC commented that all the evidence shows this is the right way forward but flagged that the challenge for the local system is how this can be prioritised as there are many conflicting priorities and agreeing what the key priorities are will be one of the challenges in taking this forward. UB commented that Havering primary care is in full support of Local area co-ordination and suggested the evaluation report is taken to the Havering Borough Partnership Board before it comes back to ICEG to ensure there is a unified voice and that the evaluation is robust. ME referred to the original business case and recommended re-visiting that in order to ensure continuity of funding from the NHS. JC referred to gap that will be left following the recent decision taken by 'Independent Age' and highlighted the need to consider the data gathered by Care City in regard to social isolation health costs as part of this. BN and AF to link in with JC outside of the meeting. ICEG members: • Noted the progress of the Local Area Co-ordination pilot. • Agreed to receive the evaluation report in November and discuss options for further funding.	BN BN BN/AF/ JC BN

3.0	Transformation	
	3.1 Integrated Sustainability Plan ME presented the final draft of the Integrated Sustainability Plan (ISP) and recapped that the focus of the ISP is on transforming outcomes, tackling inequalities and inequities and on ensuring the BHR system can sustainably deliver on its commitments. It is a five-year plan, with the aim of reducing secondary care excess spend by £70m per year by 2025/26, of which, £35m will be re-invested in order to deliver care differently, improve outcomes and invest in prevention which will all benefit our local population. It has been necessary to make assumptions on the income that the BHR system will receive which will need to be reviewed when the finances for 2022/23 are confirmed. HC emphasised the need to focus on outcomes; for ICEG to be able to see the translation of the plan into the Transformation Boards and the need to be clear that they are delivering and ensure there is collective ownership. Assurance will also be needed that the system has the right resources and capabilities in place to support clinical and operational teams to deliver on the significant agenda. BN asked for clarification as to how Local Authorities will receive funding for any new proposals they put forward. ME clarified that there are two routes for Local Authorities to access funding - the first is by submitting new business cases to the relevant Transformation Board and once submitted and approved, the impact will be monitored at ICEG - the second is by way of the prevention funds. UB referred to being mid-way through 2021/22 and asked if the evidence is showing that the re-purposing is realistic. ME explained that some of the Transformation Boards have plans and schemes that are in excess of their target for this year, some are under their target and some have no schemes at present and a that a due diligence exercise is currently being undertaken. A series of workshops with the Transformation Boards are also planned which will be in the format of a 'Star Chamber'. OS reiterated the need for the ISP to be brought back to ICEG for regular review to ensure the Transformation Boards are delivering what is expected. ME added that decisions may need to be made going forward in regard to decommissioning schemes and moving the investment elsewhere. ICEG members:- • Approved the ISP ahead of it being presented to the ICPB at its September 2021 for final approval. **3.2 Cancer Transformation Board update** MC presented the update and advised that the Cancer Transformation Board is on target to deliver as per the agreed scheduled. ICEG members were alerted to one issue relating to data on colposcopy in Barking and Dagenham which MC explained is being followed up. ICEG members: • Noted the update.	

	3.3 LD & Autism Transformation Board update RP presented the update and talked through the main areas of the programme. Two key areas were flagged; the development of the BHR in-patient offer at Goodmayes Hospital and the slightly higher number than usual of long-stay patients who have been in hospital for more than five years who are ready for discharge. In terms of the latter, a complex case manager has been recruited to oversee the discharge of the patients and it is hoped they will all be on track for discharged by the end of this financial year. HC advised that BHRUT is undertaking an internal review of this cohort of patients who have been particularly affected by Covid-19 and suggested that it would be helpful for RP to be involved to ensure the review aligns with the broader work being undertaken by the Transformation Board. HC to link RP in with Magda Smith. CA emphasised the importance of the LeDeR programme and asked that the learning resulting from the reviews is fed into the mortality review groups within each organisation, noting that historically the learning has not been shared due to confidentiality issues. JC advised that Care City is working with on two innovative projects, one in partnership with NELFT and the other in partnership with Redbridge Local Authority and they need to learn from and build on the work that the Transformation Board is doing. JC to liaise with RP outside of the meeting. OS asked whether BHR has any residents placed in the Independent Sector. RP confirmed there are seven 'out of area' placements for the whole of NEL and apart from one, they are BHR patients. OS asked for an update on the seven patients at the next meeting. RP referred to a relevant report written by Diane Jones, NEL Chief Nurse and agreed to share the report with ICEG members. BN noted that the focus is on in-patient care and said she is keen to think much more about moving people out of in-patient care. ICEG members: • Noted the update. • Requested an update on the seven out of area patients at the next meeting. *RP left the meeting.*	HC RP JC/RP RP RP RP
4.0	**Winter plan assurance**	
	KB presented the draft assurance template and explained that it considers risk across five key areas; demand; capacity; workforce; exit flow; external events. The risk ratings for BHR show mostly amber/red and KB gave an overview of the reasons for the ratings. A winter plan is being developed in collaboration with all system partners in order to respond to the risks. NHSE has looked at a 10-point plan that particularly focuses on urgent care and a draft of the BHR 10-point plan will be presented to the ICPB on 30 September 2021. BN flagged that risks relating to capacity in primary care and Local Authorities were not included in the assurance template. KB confirmed that	

	the winter plan itself does highlight those risks including funding and added that the plan has been circulated to all system partners asking them to review it and advise KB on what else needs to be included. KB to liaise with BN outside of the meeting. HC asked where the senior leaders across the system will come together to make collective decisions. SR fed back on a suggestion put forward at a recent meeting of the BHR System Operational Command Group (SOCG) for the collective responsibility of the winter plan to sit with SOCG. KB summed up the different forums where the winter plan has been reviewed and discussed to date including the Discharge Working Improvement Group (DWIG) and OS asked KB to map out the route it has taken in order to ensure full system oversight and contribution and share it with ICEG members. ICEG members: • Noted the update.	KB/BN KB
5.0	**ICS development**	
	5.1 Developing our Barking and Dagenham, Havering and Redbridge partnership within the NEL Integrated Care System context EP presented the update and summarised the key work that is being progressed. Following agreement at the last meeting on a process for agreeing what our vision is on the things we will continue to collaborate on at a multi-borough level, meetings are being set up with individual organisations and collective discussions will also be held with each of the Borough Partnerships. Following this, it is expected that by November 2021, we will be in a position to present a strong vision that everyone has signed up to in terms of what we will continue to collaborate on from April 2022. This will include a much clearer idea of what will sit at each level of the system and an indication of what the Borough Partnerships will lead on. Borough Partnership development workshops continue to be held bi-monthly and are progressing well with good engagement. In regard to Anchor Organisations, all NEL system partners have signed up to a charter and BHR system partners will be coming together at a workshop on 20 October where opportunities for Anchor Organisations in BHR will be identified in relation to procurement processes. OS suggested that more time should be allocated on the agenda for the November meeting to discuss and reflect on what has been agreed. ICEG members:- • Noted the update. • Supported and agreed to engage with the process that is underway to articulate our local BHR vision for multiborough collaboration within the wider ICS context. **5.2 Delivering NEL's Integrated Care System (ICS)** HC explained that the report included a high- level view of the workplan in terms of the design of the ICS together with a high-level detailed presentation on NEL ICS development that has been shared with system partners for information including the Joint Overview and Scrutiny Committee. There are three key elements that Chris Cotton is leading on in	EP/AMc

	his role as Director of Integrated Care System Transition for NEL CCG; strategy and transformation; system design; organisational transition. A number of different working groups have been established; senior leaders' group; thematic working groups; ICS strategy group; ICS transition delivery group. HC offered to feed any comments back to Chris Cotton and JC gave his view that the focus is currently on process and structure rather than on ICS outcomes which the ICS is responsible for. He suggested the presentations need to reflect more of the substantive discussion alongside how processes and structures will change. OS flagged the upcoming NEL ICS partnership workshop scheduled for 6 October and suggested it would be good to ensure that ICEG will be represented at the workshop. HC to feedback the comments to CC. ICEG members: • Noted the update.	HC
6.0	**BHR JSNA**	
	MA explained that the delivery of the JSNA is progressing well despite the challenges posed by the pandemic. The next stage of the delivery will concentrate on the introduction of a new assessment of needs relating to public health protection where impacts of unforeseen circumstances such as the Covid-19 pandemic will be addressed and assessed at a local level. There is an expectation at a NEL ICS level that going forward there will be a needs assessment in some form and this will be proposed as a three-borough approach. The BHR JSNA steering group will engage with Locality / PCN and transformation teams to ensure the 2021 JSNA includes key intelligence where data is available. WF gave a demonstration of the updated tool which is based on google maps. All the information is in the public domain. PCN level profiles are being developed and the BHR Health & Wellbeing Boards are responsible for ensuring that Local Authorities and the CCG work together to deliver the JSNA. ICEG members:- • Noted the update. • Agreed to receive a final draft in December 2021. • Agreed to allocate more time on the agenda.	MA/WF EP/AMc
7.0	**ICP performance**	
	6.1 Exception report SR recapped that constitutional standards are monitored by the BHR Quality & Performance Oversight Group and as previously agreed, an exception was presented giving an update on the two areas of concern relating to the A&E 4- hour standard and Cancer waiting times (62 days). In regard to the A&E issue, SR advised that this is going to be a 12 -24 months piece of work to sustainably turnaround and improve ED performance. The Trust has appointed an Improvement Director, Karim Ahmad who is an ED Consultant from Barts Health and as part of the partnership working, he will be leading on ED improvement at BHRUT. In	

	addition, the Trust has appointed a senior nurse, James Avery who will be working with Karim Ahmad and the General Manager for ED, Scott Chandler. SR advised that following a discussion with MT, it is proposed that going forward, a highlight report on the work being achieved in ED will be presented to ICEG instead of ED being included in the current exception report and explained the reasons why. In regard to Cancer, SR advised that the numbers of long waiters is decreasing and the PTL is decreasing and it is expected that this will no longer need to be included in the exception report. MT expressed his view that it is likely to be a two-year recovery programme for ED. He added that there are some clear priorities about patient experience and safety in the short term whilst the longer-term changes to patient flow across the whole hospital are made. A number of key tasks have been set for the senior team over the next few months which include a stronger focus on patient experience and safety over the winter period. The CQC has published its patient survey results for ED and BHRUT is the worst in the country in terms of patient experience, mainly relating to waiting times and the lack of dignity & privacy. The highlighted issues are primarily at the Queen's hospital site rather than KGH. OS thanked MT for sharing his views and added that as system partners, each organisation is willing to support MT and his team. OS also commented that the exception report tends to focus on BHRUT and asked for consideration to be given to the wider system challenges when compiling the exception report going forward so that it is a system report rather than its focus being on a particular organisation. ICEG members: • Noted the update. • Agreed to accept a highlight report going forward on the improvements being made in ED and the impact of the improvements.	SR SR
8.0	**Any other business**	
	There were no additional items for discussion. It was noted that this was the last ICEG meeting for HC and OS thanked her for all her help and support.	
9.0	**Items for noting**	
	8.1 BHR Quality & Performance Oversight Group minutes ICEG members noted the minutes of the meeting held in August 2021.	
	Date of next meeting – 21 October 2021	

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

Agreed minutes - Integrated Care Executive Group

21 October 2021 at 3.30pm – 5.00pm
Via MS Teams

Members:

Ceri Jacob (CJ)	Managing Director, BHR ICP - chair
Oliver Shanley (OS)	Chief Executive, NELFT
Steve Collins (SC)	Acting Chief Finance Officer, NEL CCG
Caroline Allum (CA)	Medical Director, NELFT & Health & Care Cabinet Chair
Magda Smith (MS)	Chief Medical Officer, BHRUT
Barbara Nicholls (BN)	Director of Adult Services, LBH
Matthew Cole (MC)	Director of Public Health, LBBD
Adrian Loades (AL)	Director of People, LBR
Craig Nikolic (CNi)	Chief Operating Officer, B&D GP Federation
Urvashi Bhagat (UB)	Chief Executive, Havering GP Federation
Ross Arnold (RA)	Chief Executive, Redbridge GP Federation

Attendees:

Lee Basso (LB)	Director, Strategy & Partnership, BHRUT
Emily Plane (EP)	Programme Lead, BHR ICP
John Craig (JC)	Chief Executive, Care City
Anna McDonald (AMc)	Business Manager, BHR ICP
Hanh Xuan-Tan	Deputy Director, Recovery Planning, BHR ICP
Jane Leaman (JL)	Interim Consultant, Public Health, LBBD
Carrie-Anne Wade (CW)	Strategic Communications Leader, NELFT
Umesh Gadhvi (UG	Director of Healthcare Informatics, NELFT & BHRUT & BHR Digital Lead
Martin Wallis (MW)	NELCCG Digital Programme Manager
Niall Canavan (NC)	CIO, NEL ICS and Homerton Hospital
Chris Cotton (CC)	Director, ICS Transition, NEL CCG
John Flood (JF)	Head of Provider Performance Improvement, NEL CSU
Carla Morgan (CM)	Senior Programme Manager, BHR ICP

Apologies/not present:

Matthew Trainer (MT)	Chief Executive, BHRUT
Chris Naylor (CNa)	Chief Executive, LBBD
Henry Black (HB)	Acting Accountable Officer, NEL CGG
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Ahmet Koray (AK)	Director of Finance, BHR ICP
Jacqui Van Rossum (JVR	Executive Integrated Care Director, NELFT

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

	The group welcomed Ross Arnold who joined ICEG for the first time in his role as Redbridge GP Federation Chief Executive.	
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 16 September 2021 were agreed as an accurate record.	
1.3	**Action log/matters arising**	
	The actions log was noted and updated accordingly:- **Estate prioritisation –** added to ICEG forward plan for December meeting. **Local care co-ordination review** – UB advised this was discussed briefly at the Havering Borough Partnership Board but no decision was made. BN to take it back to the next meeting of the Havering Borough Partnership Board and provide an update to ICEG in November. **LD & Autism Transformation Board update –** LB to follow-up on the actions relating to Hannah Coffey and Rachel P.	EP/AMc BN LB
2.0	**ICS development**	
	2.1 BHR – developing our BHR partnership within the NEL Integrated Care System context From April 2022 Place Based Partnerships will be key entities, with delegated authority from the NHS Commissioning Board for the North East London ICS for key decisions. There is however an appetite to ensure that we do not lose the good partnership work that we have built across BHR in this transition period and as Place Based Partnerships are given time to mature. The process previously endorsed by ICEG members to consider and articulate the key areas that will continue to be collaborated on at a BHR level is underway and involves a series of interviews with partner organisations, alongside discussions with Borough Partnerships as a group, seeking views on key areas of ongoing collaboration at a multiborough level. The outputs from the discussions will be developed into a proposal which will be reviewed by Place Based Partnership Boards in the first instance and then presented to ICEG and ICPB members in November. Once endorsed, the proposal will be shared with NEL colleagues to feed into and shape the framework that is being developed for the NEL Integrated Care System. BHR partner organisations held a procurement workshop on 20 October 2021 to identify opportunities for BHR Anchor Organisations to seek to embed social value in our local procurement processes. BN chaired the workshop which was well attended by leads from across the health and care system. A follow-up workshop will be held in December 2021. In the meantime, colleagues in LBH are leading the action to look at ways in which We can support local businesses to be able to collaborate to bid for health	CJ/EP

	and care tenders. OS advised that NELFT will be undertaking partnership working in regard to the 'Levelling up Health' campaign in order to identify where there are gaps in NELFT regarding inequalities. OS to provide an update on this at a future ICEG meeting as it links to the wider Anchor Organisations inequalities work. BN referred to the BHR Academy and flagged that there is a gap in regard to the wider care workforce which needs a greater focus. OS fed back on a recent discussion he has had with Alison Crewe (AC) about the possibility of extending the Academy out more broadly, which will also include a stronger focus on primary care following feedback from our primary care stakeholders. CJ agreed to follow this up with AC at their next meeting. An update on Organisational Development (OD) work streams was provided including Primary Care development, Borough Partnerships development and Transformation Boards. CNi suggested it would be helpful to have an update on the work of the B&D Borough Partnership that links into the overall update given by CJ. CJ welcomed the offer but due to time constraints CJ suggested it would be best to add the update to the next agenda. ICEG members: • Noted and commented on the detail in the paper and the next steps to articulate multi borough collaboration and key elements of our BHR partnership within the wider context of the developing North East London Integrated Care System. • Agreed to continue to support and engage with the process that is underway to articulate our local BHR vision for multiborough collaboration within the wider ICS context. • Considered the OD programme approach, and the next steps for this. **2.2 NEL – Delivering North East London's Integrated Care System (NEL ICS)** The paper presented by CC provided an update on the strands of work involved in the formation of NEL ICS as well as an update on the many priorities for the ICS. The structure of the new transition programme was included together with the leadership and design approach being taken as the new forums and roles within the ICS are put in place. Information on NEL-level work in regard to resident engagement and clinical leadership was given and CC advised this complements the work being done at borough and multi-borough level. A helpful summary on NEL's provider collaboratives was included and CC advised that acute and mental health collaboratives are mandated by NHSE and consideration is being given to establishing a community collaborative and a primary care collaborative. A working group session on delegation to place-based partnerships in NEL is scheduled for 28 October 2021 and it is hoped that will bring a greater degree of clarity. CNi referred to the 'leadership and design approach' slide and commented that he would like to see primary care provider professional managers included on some of the groups mentioned such as the ICS strategy group. CC to liaise with CNi outside of the meeting.	OS CJ EP/Ni CC/CNi

	ICEG members were asked to give their views as to the level of detail they would like included in the NEL ICS development updates at ICEG going forward. CNi gave his view that as much information as possible should be shared as this is going to shape the future and members can then decide what they want to focus on. OS referred to the guidance on 'thriving places' and suggested it would be helpful to have a mini deep dive on each one which would help to inform the thinking at borough level. CC thanked ICEG members for their feedback. ICEG members noted the update. *Chris Cotton left the meeting.*	CC
3.0	**Digital update**	
	UG talked through the supporting papers for this item which provided an overall update on the programmes of work taking place across the ICS with particular focus on the BHR digital strategy which supports the overarching NEL digital/data strategy. It was noted that the following documents were shared outside of the main meeting papers pack for information; NELFT ITT for digital strategy, BHRUT strategic outline business case ITT, NELFT and BHRUT digital programmes. UG advised that a number of items were being presented for approval including the Terms of Reference for the BHR Digital and Data Steering Group and explained the need to ensure that there is representation from all BHR partners on the group. UG referred to the NEL data strategy programme and advised that he is liaising with BHR colleagues to support the development of the data analytics element noted within the NEL digital strategy. Workshops will be held looking at things such as how data is processed. BN asked whether there is good engagement from the Local Authority leads and UG confirmed there is with LBBD and LBH but he will soon be liaising with LBR. ICEG members: • Noted the updates across the different strategies • Approved the Terms of Reference for BHR Digital and Data Steering Group. **3.1 NEL digital strategy** MW presented the key points in the slide set and summarised the four strategic levels, advising that the biggest is infrastructure. This strategy is a work in progress and will be subject to additions and amendments as it is reviewed by a wider group of stakeholders. The strategy will demonstrate how patients will be enabled to be more empowered in their health and care and how professionals will have access to the information they need to plan and deliver seamless care. Clinicians and managers will have access to information and systems that will improve their ability to treat individual patients, cohorts and the entire ICS population. CNi referred to business intelligence and explained that the B&D GP Federation undertakes its own business intelligence as it is not possible to access NEL CCG's intelligence. He expressed his view that business intelligence should be delegated to providers. BN added that Public Health	

	Teams in Local Authorities have not been able to access health data historically. BN flagged that social care is more than just care homes and suggested the impact will be far greater if the 'digital offer' is extended to all social care providers so that peoples' health can be maintained in the community. BN explained that virtual reality technology is an area being looked at to support people being monitored in their own homes and gave an overview of a pilot that is about to get underway with 'My Sense'. UG assured ICEG members of the planned approach to work in partnership to utilise the skills and expertise in analytics across the system in order to devise the strategy collaboratively. UG to liaise with CNi and BN outside of the meeting in regard to business intelligence and virtual reality technology. AL commented that he found the strategy document difficult to follow from a Local Authority perspective and suggested it would be helpful to have a summary of the 'ask' of Local Authorities to get a fully coherent picture. MW agreed that the document currently has an NHS focus and explained that the original audience was NHSE. CJ requested that a summary of the Local Authority 'ask' is added. Support for the strategy was expressed by CA and others. JC suggested that more could be included on what happens in hospitals and what happens in individual patients' homes and out of hospital services overall. UG and MW to liaise with JC outside of the meeting. SC welcomed all the feedback and added that input from system colleagues on how the work can be prioritised would be welcome. ICEG members: • Approved the NEL digital strategy **3.2 Personal Health Record** MW explained that a process has been undertaken with colleagues in North West London CCG (NWL CCG) in regard to 'Patient Knows Best' which has been in place in NWL CCG for a number of years. MW recapped that the Personal Health Record business case had recently been approved by the NEL CCG Finance & Performance Committee and MW explained that it was being presented to ICEG to ensure that system colleagues are sighted on the implementation. ICEG members: • Supported the business case. **3.3 Digital process – including NEL Primary Care Digital First highlight report** The highlight report provided information on the projects across the Primary Care Digital First Programme to sight ICEG members on developments and progress. NC advised that NHSE asked the CCG to outline how digital maturity as an ICS will be achieved. The 'patient knows best' software provides different opportunities for communicating with patients and for transforming hospital services and it was noted that addressing some areas of clinical resistance to change will be one of the challenges. CJ asked when and how change to clinical practice will happen. MW confirmed that a list of the clinical teams keen to be involved is included as part of the Personal	UG/CNi /BN UG/MW UG/MW UG/MW

	Health Record business case. UG added that the main focus of attention for the digital process will be the Transformation Boards. ICEG members: • Noted the update. *Umesh G, Martin W and Niall C left the meeting.*	
4.0	**ICP performance**	
	4.1 Exception report JF recapped that routine performance reporting across BHR has primarily been focused on healthcare, NHS constitutional standards and key metrics associated with the NHS Long Term Plan and these metrics do not necessarily support an integrated view of the whole health and care system. ICEG members were asked to consider three possible reporting options and structures for future reporting and agree an approach to allow the initial scoping phase to start. CJ asked members to consider the Placed Based Partnerships as the building blocks in the first instance. OS gave his view that 'option 2 - Integrated NHS Constitution led report' would be appropriate if the reports included additional Public Health data. This would avoid duplicating reports reviewed and discussed at other forums such as the BHR Quality & Performance Oversight Group. OS suggested setting up a small working group to discuss the options in more detail and agree the way forward. MC agreed to be included in the working group and JF agreed to send an e-mail to other members after the meeting asking for nominations to be part of the small working group to develop a more comprehensive ICEG report. ICEG members noted the update. **4.2 UEC pathway improvement report** CM presented the update which summarised the work of the Urgent & Emergency Care (U&EC) Transformation Board. There are three subgroups; pre-hospital group; operational working group; secondary care sub group and CM gave an overview of each. BN recapped on what she had mentioned earlier in the meeting in regard to discussions that have started about the use of virtual reality technology and reiterated the need to include virtual technology in the digital programme for BHR going forward. SC referred to the significant pressures that continue to be seen in the U&E care pathway and asked if the U&EC Transformation Board is confident that the outcomes detailed in the report will be delivered. CM clarified that there is a huge amount of work that supports the ED work and underpins the U&EC Transformation Board and the team works closely with other Transformation Boards, particularly Older People, Children and Primary Care. MS stressed the need to have absolute focus and support the teams on the delivery and added that the system must deliver on the agreed actions with absolute rigour rather than switch direction at this point in time. It was noted that there are significant levels of engagement with all health and social care settings and also with the LAS.	JF

	ICEG members noted the update. *Carla Morgan left the meeting.* **4.3 BHR ICP priorities update** CJ advised that the progress report was being presented for information and suggested that going forward, a report focussing on one of the priorities in more detail is presented rather than including all four. ICEG members: • Noted the progress to take forward our key priority areas. **4.4 Finance overview** SC advised that going forward the finance update will focus more on transformational benefits and development and on value for money and sustainability. The key messages in the report were given and SC advised that the existing mechanisms will broadly continue into the second half of the year. The CCG is waiting for re-imbursement in regard to the hospital discharge programme and SC clarified that hospital discharge programme will continue into the second part of the year. In regard to the Elective Recovery Fund (ERF), some recompense was received in the first quarter but no ERF will be earnt in the second quarter. An overview of the Transformation Investment Fund (TIF) was provided. On the whole, the pressures remain as previously reported and include activity and cost assumptions with independent sector plans, prescribing increases, continuing healthcare (CHC) package costs and NEL corporate costs associated with business intelligence software and service arrangements that are no longer being funded from central NHSE resources. The pressures are being covered from balance sheet accruals set aside at year-end in anticipation of pressures and in particular those associated with acute activity and CHC budgets in 2021/22. AL flagged that children's services and adult services in LBR are currently overspent by a significant margin. He stressed that the situation is unsustainable and that the council has to deliver a balanced financial position at the end of the year and will need to take action to achieve this. CJ confirmed that a similar conversation has been held with BN in regard to LBH and options are being worked up which will be followed up outside of the meeting. *Ceri Jacob left the meeting.* SC acknowledged that the finance report is currently a health orientated finance view and suggested the need to look at what the options are for addressing the system wide pressures. ICEG members were advised that a meeting of all the finance leads including Local Authorities is being scheduled for the end of November/early December 2021. All local authority partners agreed that the situation in relation to their finances is significant and requires a joint approach. It was noted that the situation will seriously impact on the ability to work as a system. It was agreed that an urgent impact assessment on this is needed. UB added that we need to understand what the high-level risks are for the system and what the interdependencies are. CNi pointed out that demand is high in all areas and questioned if anyone is looking at what the impact of this is on our residents. OS asked	CJ/EP CJ/SC SC

	SC to follow this up with CJ as a matter of urgency outside of the meeting and include the concerns flagged by CNi and UB. ICEG members noted the update.	SC
5.0	**Any other business**	
	5.1 New cycle of reporting for Transformation key milestones and ISP impact update HX advised that a new routine reporting process has been developed in BHR to monitor the impact of transformation and map it against the requirements set out in the integrated Sustainability Plan (ISP). Key milestones that enable delivery will also be included along with any issues that need to be escalated. The first bi-monthly report will be presented to ICEG at the November meeting.	TR
6.0	**Items for information**	
	8.1 BHR Quality & Performance Oversight Group minutes ICEG members noted the minutes of the meeting held in September 2021.	
	Date of next meeting – 18 November 2021	

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

Health and Care Cabinet

Thursday 9 September 2021
(via MS Teams)

Members:

Dr Caroline Allum (CA) – Chair	Medical Director, NELFT
Debbie Smith (DS)	Director of Nursing, NELFT
Chris Tuckett (CT)	Associate Director of AHPs, NELFT
Gladys Xavier (GX)	Director of Public Health, LBR
Heather Noble (HN)	Medical Director, Whipps Cross Hospital, Barts Health
Dr Shanika Sharma (SS)	Clinical Director, B&D PCN (Network West One)
Dr Adedayo Adedeji (AAd)	B&D GP Federation
Dr David Derby (DD)	Havering GP Federation
Dr Jyoti Sood (JS)	HEE representative
Janaka Perera (JP)	Community pharmacy representative

Attendees:

Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Dr Ramneek Hara (RH)	B&D Clinical Lead, NEL CCG
Dr Fawad Hussain (FH)	Medical Director (KGH), BHRUT for Magda Smith
Elaine Greenway (EG)	Public Health Consultant, LBH for Mark Ansell
Gary Etheridge (GE)	Director of Nursing, BHRUT for Kathryn Halford
Keeley Chaplin (KC)	Minute taker, BHR ICP, NEL CCG
Sultana Choudhury (SC)	Public Health Principal, LBR – for item 2
Rebecca Nunn (RN)	Public Health Consultant, LBBD – for item 2
Jack Davies (JD)	Public Health Specialist, LBH – for item 2
Peter McDonnell (PMcD)	Lead Commissioner Older People and Frailty, BHR ICP, NEL CCG – for item 4.1
Solma Khatoon (SK)	Senior Project Manager, BHR ICP, NEL CCG – for item 4.2
Rachael Shine (RSh)	Primary Care Delivery Manager, BHR ICP, NEL CCG – for item 4.3

Apologies:

Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Magda Smith (MS)	Medical Director, BHRUT
Leila Hussein (LH)	Social Care representative, LBR
Kathryn Halford (KH)	Chief Nurse, BHRUT
Rahul Singal (RS)	Pharmacy Lead, NELFT
Matthew Cole (MC)	Director of Public Health, LBBD
Mark Ansell (MA)	Director of Public Health, LBH
Norah Rao (NR)	Practice Nurse representative
Remi Odejinmi (RO)	BHRUT inequalities lead
Kate Dempsey (KD)	Social Care representative, LBH
Claire Bailey (CB)	Divisional Director of Healthcare Professionals, BHRUT
Susanne Knoerr (SK)	Social Care representative, LBBD
John Craig (JC)	CEO, CareCity

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

1.1	Declaration of conflicts of interest	
	None declared.	
1.2	Minutes of the meeting held on 12 August 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 164	
2.0	**Obesity Session**	
2.1	The chair welcomed Rebecca Nunn, Sultana Choudhury and Jack Davies to the Health and Care Committee to lead the presentation and discussion on tackling obesity in BHR. This part of the meeting was run as a workshop style discussion.	
2.2	Current obesity needs, service provision and key challenges in BHR	
	• The percentage of adults classified as overweight or obese are LBBD 65%, LBR 61%, LBH 67.3%. These are significantly higher than the London average of 56%. The England average is 63%. • For reception age children (age 4-5), which is taken from the national childhood measurement programme (NCMP), the figures are: LBBD 24.6%, LBR 22.3% and LBH 21.6% with the London average being 21.6% and England 23% • The year 6 prevalence (age 10-11) data shows this has increased to LBBD 44.7%, LBH 38.1% and LBR 39.6% - London is at 38.2% and England 35.2% • Latest draft data suggests the prevalence is now even higher, possibly due to the effects of lockdown. • Obesity is caused by a number of factors including dietary habits, physical activity, long term conditions and mental health. • The impact of obesity can increase risk of premature mortality, chronic conditions, poorer maternity outcomes and higher risks from Covid-19. • Each borough is focusing on tackling obesity in slightly differing ways but have the same goals and follow national guidelines. • There are common areas of concern across Barking and Dagenham, Havering and Redbridge, such as staff confidence to raise weight management issues with people as well as knowing the most appropriate referral pathways. There are gaps around maternal obesity support so this is an opportunity to build on links across maternity and health visiting services. There are also gaps around childhood obesity and this is an opportunity to review and address these.	
2.3	The cabinet then discussed the following areas: 1. Work across BHR to clarify and improve the offer to overweight and obese women in Maternity (all providers) 2. Work with BHR local authority obesity leads to improve links between maternity and health visiting to support Maternal obesity and infant feeding 3. Commission a comprehensive Tier 3 children's specialist weight management service for BHR 4. NELFT to work with LA obesity leads to strengthen health visiting & school nursing offer for obesity prevention, identification and support. 5. Assess staff ability to broach the subject of weight and supporting people to access the right services	

	6. Map Obesity Clinical Pathway - develop feedback loop between obesity treatment tiers and primary care 7. Review clinical pathway protocols – update with lifestyle services regularly 8. Explore the opportunity for better links between children's height & weight measurements and GP referral 9. Children's Social Care –Explore opportunity to identify and escalate cases of childhood obesity and to treat as a safeguarding issue 10. Support for adolescent weight management –age 11-15 11. Strategies to better support LD patients through weight management Members discussed each item in detail to identify gaps and priorities and highlighted: • Potential health inequalities and access to services should be considered when planning e.g. it can be more difficult to provide comprehensive support to people with learning disabilities (LD) and serious mental illness (SMI). • RSh offered to link in with the primary care health inequalities work which includes looking at pre-conception care. • Engage with staff / local population / parents / service users on how to approach discussions on tackling weight management • Primary care can make 'every contact count' • DS offered to link in with the NELFT CYP group • Include social prescribing in plans and provide up to date information for health professionals and residents. • GE to provide link with the Director of Midwifery • Explore what opportunities are available for obesity prevention at 1 & 2½ years old health check • Proposal for the tier 3 children's specialist weight management service to be brought to the Health and Care Cabinet for endorsement. • CT offered to signpost Public Health (PH) colleagues to tools available to help staff with conversations with patients and residents. • GX to raise with PHE if data sharing agreement can be developed between GPs and provider re NCMP data • Consider the LD and SMI annual health checks as tool to consider weight issues and management Members agreed that the top priorities will have a focus on actions relating to pre-conception through to early years.	
2.4	Next steps	
	The health and Care Committee **endorsed** the obesity actions discussed at today's meeting, and noted that an action plan with priorities will be developed which will be circulated to members, and taken forward by named leads. The next meeting will review the outcomes from this discussion, and a more in-depth discussion will take place in six months' time to review process	RN/SC/JD On Oct agenda March agenda
3.0	**Phlebotomy – lessons learnt as an integrated care system**	
	Not discussed due to apologies received from presenter and will be brought forward to the next meeting.	

4.0	**Transformation boards concept plans**	
4.1	Home First concept and business case	
	PMD presented the proposal for Home First which is the key to support people to be discharged from hospital sooner, with the opportunity to return to their original place of residence. The 2019/20 pilot went well and there was an average reduction of 2.7 in length of stay (LoS) per patient (equating to 11k bed days) with a reduction in clinical time, therapist workloads and equipment ordered. The proposal is: In Havering: • will continue with the standalone service with Essex Cares for both the care element and Occupational Therapy band 7 overview and assessment. • Senior Care workers will continue to provide a Trusted Assessor mode for assessing small equipment at the patients' home. Seven discharge slots a day will be provided In LBBD and Redbridge: *Care:* LBBD will utilise the Crisis Intervention care agencies they already commission for the care element. LBR will utilise NELFT who deliver the care element of reablement. *OT therapy and equipment:* NELFT will deliver a single OT, rehab assistant and trusted assessor model across both boroughs. EG queried if there will be an impact on beds in adult social care. PMD advised that there will be an impact on reablement due to an increase in hours but the CCG will partially fund this. Once the concept is agreed, further discussions will take place with the local authorities on its potential impact. JP queried if there are any issues arising from access to medication upon discharge. PMD advised the *red to green* process will be managed from the hospital into the service and that there are no apparent issues around access to medication as part of this process at this stage HN advised that key to the success of this will be trust between the organisations and that should be included within the business case. Requests for equipment or wheelchair services should be completed by the Home First team and not come via the GP. CA noted the comment that these forms are lengthy to complete from a staff perspective and will take this back to the service. The Committee **supported** the concept plan for Home First.	
4.2	Diabetes Psychiatric Service	
	JS presented the concept paper seeking the opportunity to develop a diabetes psychiatry service for the most vulnerable people within the diabetes services. This service would be for patients who struggle to consistently attend 'ordinary' services, e.g. not attending clinic, struggling with their diabetes and who have admissions to hospital in BHRUT. The proposal will be to fund a 0.6 WTE consultant to provide a diabetes psychiatry service in BHRUT, reduce recurrent readmissions to Diabetes	

	Keto Acidosis (DKA), improve patient's HbA1c levels and improve the overall patient's experience. EG queried if the psychiatrist will be linked to the local substances misuse team as patients requiring this can be complex to manage. JS advised the care requirements of the individual will determine who will be involved in the MDT which could include this team if required; this will be considered as part of the planning/design of the service. The Committee **agreed to support** this proposal for the Diabetes Psychiatric Service.	
4.3	Duty Doctor Scheme	
	RS presented the concept to commission a duty doctor scheme to allow healthcare professionals access to a GP during core hours (8am-6:30pm; Monday-Friday). The scheme will run in each borough starting in October 2021 and ending in March 2022. The scheme will initially be run as a pilot, with a review taking place at the end of the pilot period. This will enhance the urgent primary care response for patients during core hours. Funding from primary care budgets has been accrued to support this pilot scheme and will be staffed by GPs recruited by the Federation. Data will come from the Business Intelligence (BI) team as well as from the call centre and Federation. CA added this will need to include the origin of the patient. DD added that he had been involved in discussions regarding the formation of scheme. The duty doctor will be an experienced GP with access to the patient record to help with care for the patient. The Committee **approved** the concept for the duty doctor scheme.	
5.0	**Any other business**	
5.1	BHR Partnership Priority – Inequalities and Prevention	
	EP provided an update on the inequalities and prevention priority which The Health and Care Cabinet are the sponsors for. Dr Remi Odejinmi is the lead SRO for this. The Borough Partnership continue to meet monthly to review progress. The CCG has identified CCG director support to each borough partnership; Sharon Morrow for B&D, Tracy Rubery for Redbridge and Sarah See is supporting for Havering until a borough director role is recruited to.	
5.2	BHR Recovery Summit Progress against action plan	
	EP presented the progress report against the action plan following the recovery summit held in July. Actions are being progressed and are now RAG rated. Leads will be invited to the next meeting to update on their respective areas, with the opportunity to discuss any issues with Cabinet members, and the opportunity to consider if the cabinet can offer any support to improve progress actions if needed.	On Oct agenda

5.3	Chair	
	CA noted that the chair role is on a rotation and that the next meeting should consider who will be next to chair.	On Oct agenda
6.0	**Date of next meeting**	
	14 October 2021 at 1:30pm-3:30pm	

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

Health and Care Cabinet

Thursday 14 October 2021
(via MS Teams)

Members:

Caroline Allum (CA) – Chair	Medical Director, NELFT
Jagan John (JJ)	NEL CCG Chair / B&D Clinical Chair
Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Rahul Singal (RS)	Pharmacy Lead, NELFT
Magda Smith (MS)	Medical Director, BHRUT
Gladys Xavier (GX)	Director of Public Health, LBR
Leila Hussein (LH)	Social Care representative, LBR
Mark Ansell (MA)	Director of Public Health, LBH
Kate Dempsey (KD)	Social Care representative, LBH
Susanne Knoerr (SK)	Social Care representative, LBBD
John Peters (JP)	Acting Medical Director (Whipps Cross), Barts Health
Shanika Sharma (SS)	Clinical Director for B&D PCN
David Derby (DD)	Havering GP Federation
Janaka Perera (JP)	Community pharmacy representative
John Craig (JC)	CEO, CareCity
Jyoti Sood (JS)	HEE representative

Attendees:

Ramneek Hara (RH)	B&D Clinical Lead, NEL CCG
Remi Odejinmi (RO)	BHRUT inequalities lead
Tha Han (TH)	Public Health Consultant, LBH
Uzma Haque (UH)	B&D Clinical Lead, NEL CCG
Keeley Chaplin (KC)	Minute taker, BHR ICP, NEL CCG
Umesh Gadhvi (UG)	Director of IT, BHRUT - item 2
Melissa Hoskins (MH)	Head of Communications and Engagement, BHR ICP, NEL CCG - item 2
Carrie-Ann Wade (CAW)	Communications, NELFT - item 2
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG - item 2
Hanh Xuan-Tang (HXT)	Deputy Director of Recovery Planning, BHR ICP, NEL CCG - item 2
Sherine Howell (SH)	Children and Adolescent Mental Health (CAMHS) Commissioner, BHR ICP, NEL CCG - item 2
Kirsty Boettcher (KB)	Deputy Director of Transformation – Urgent Care, BHR ICP, NEL CCG - item 2
Julia Corey (JC)	BHR ICP, NEL CCG - item 2
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT - item 2
Peter Tanner (PT)	Consultant Histopathologist and Lead Medical Examiner, BHRUT - item 3
Len Kemp (LK)	Head of Pathology, BHRUT – item 4
Sultana Choudhury (SC)	Public Health Principal, LBR – item 5
Eric Ayesu-Boapeah (EAB)	Public Health Consultant, LBBD – item 5
Jack Davies (JD)	Public Health Specialist, LBH – item 5
Lydia Freeman (LF)	Public Health, LBBD – item 5
Shivani Choudhary (SC)	Primary Care Improvement Lead, BHR ICP, NEL CCG - item 6
Peter McDonnell (PMD)	Lead Commissioner Older People and Frailty, BHR ICP, NEL CCG – item 6

Apologies:

Emily Plane (EP)	Programme Lead, BHR System Development, NEL CCG
Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Kathryn Halford (KH)	Chief Nurse, BHRUT
Claire Bailey (CB)	Divisional Director of Healthcare Professionals, BHRUT
Norah Rao (NR)	Practice Nurse representative
Matthew Cole (MC)	Director of Public Health, LBBD
Debbie Smith (DS)	Director of Nursing, NELFT
Chris Tuckett (CT)	Associate Director of AHPs, NELFT

<table>
<tr><td>1.0</td><td colspan="2">Welcome, introductions and apologies</td><td></td></tr>
<tr><td></td><td colspan="2">The Chair welcomed all to the meeting and apologies were noted as listed above.</td><td></td></tr>
<tr><td>1.1</td><td colspan="2">Declaration of conflicts of interest</td><td></td></tr>
<tr><td></td><td colspan="2">None declared.</td><td></td></tr>
<tr><td>1.2</td><td colspan="2">Minutes of the meeting held on 9 September 2021</td><td></td></tr>
<tr><td></td><td colspan="2">The minutes of the last meeting were agreed.</td><td></td></tr>
<tr><td>1.3</td><td colspan="2">Matters/actions arising</td><td></td></tr>
<tr><td></td><td colspan="2">The updated action log was noted and it was agreed to close action 172</td><td></td></tr>
<tr><td>2.0</td><td colspan="2">Review of progress on the Recovery Summit actions</td><td></td></tr>
<tr><td>2.1</td><td colspan="2">Key areas were discussed and updates recorded by the SROs as follows:</td><td></td></tr>
<tr><td>2.2</td><td colspan="2"><table>
<tr><th>Key area/ SRO</th><th>Update</th></tr>
<tr><td>Communications – Melissa Hoskins</td><td>• Comprehensive comms plan is in place and includes explaining the primary care offer to patients. FAQs to be shared with patients on how services are delivered and reiterating there are f2f appointments with GPs and healthcare practitioners.
• NEL-wide comms and engagement plan for winter is being developed between all health and social care partners
• Scoping the nudge theory - looking at resources needed
• The LGA is supporting a behaviour insight project that all boroughs are involved in – MA suggested all partners are involved</td></tr>
<tr><td>Care Navigation – Sharon Morrow</td><td>• Steering group is set up to progress actions and to maximise opportunities for social prescribing and what tools are available
• NEL enabler group to roll out social prescribing across all boroughs.
• B&D are performing well and is the most developed. Havering has variation in PCNs with some more advanced. Redbridge is least developed but has good engagement.</td></tr>
<tr><td>Discharge Hub – Kirsty Boettcher</td><td>• BHRUT virtual ward identified linked to front door and part of back door discharge. The ward links in for MAU and ED and clinicians see patient in either service and can refer for diagnostics.</td></tr>
</table></td><td></td></tr>
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		• SOP has been developed for virtual ward and awaiting sign off. This will clarify what should go back to primary and clear patient communications. • The virtual ward in ED has seen a 30% increase in referrals and initial feedback is this is working well. • A concept paper will be prepared and presented to the cabinet. • KB and JP to discuss discharge medicines service.	
	Advice and Guidance - Sherine Howell	• Four areas under Mental Health A&G have now gone live across BHR. Adults MH, Older Adults inc memory service, LD and CAMHS. • Havering has commissioned A&G and is live from NELFT. B&D and Redbridge are looking for consultant cover. • It was suggested briefings are given at the GP education events to advertise A&G	
	Clinician to Clinician Referrals – Richard Pennington	• BHRUT are developing a telephone line for patients and clinicians to enquire where they are in the referral process. • C2C referral measures are being tracked through the internal outpatient group and the planned care transformation board. • Changes are being embedded though there are still some consultants that direct to the GP for referral as they cannot refer. • A&E cannot refer to rapid chest pain clinic and may require additional ECG. AA suggested the referral form specifies the date the ECG was taken in A&E to reduce wait time for patient. • RP and JVR to make contact regarding NELFT to BHRUT and BHRUT to NELFT referrals.	
	Digital – Umesh Gadhvi	• NELFT digital strategy – this is out to procurement and to have in place by March 2022 • NEL digital strategy - being led by Martin Wallis and a draft is being taken to ICEG and will bring back to this group. • A BHR digital data steering group has been set up to oversee all digital development. • Additional support for the digital programme is being sought and will soon go out to recruitment. This role will help manage the strategies, the BHR digital roadmap as well as focusing on patient engagement. • There has been a lot of work across the system including an upgrade to the pathology system (central server for results across NEL). Primary care and social services are also included in the programme. • Rio and EMIS have the ability to switch on the shared care record portal (ELPR) but bilateral record sharing is still being scoped out.	

		• UG to feedback on the considerations being made by the primary care digital transformation group re digital inclusion /poverty.
	Understanding activity/ data – Hanh Xuan-Tang	• Members to feedback comments on the temperature report and the deep dive into issues and behaviours driving increased levels of activity that were circulated with papers.
2.3	Areas to be discussed at a future meeting: • Making best use of our resources in the community • Estates • Primary care access • Social care	
2.4	Actions arising from this discussion were: • UG to feedback on the considerations being made by the primary care digital transformation group re digital inclusion /poverty. • UG agreed to bring a highlight report to a future health and care cabinet meeting incorporating updates on the strategies as well as the governance process. • LK offered to bring an update on the pathology upgrade. • NEL digital strategy - being led by Martin Wallis and a draft is being taken to ICEG and will bring back to this group. • RP and JVR to make contact regarding NELFT to BHRUT and BHRUT to NELFT referrals • KB and JP to discuss discharge medicines service • Sharon Morrow to bring more detailed report on social prescribing to a future meeting • GX will share Redbridge Social Prescribing evaluation report by the East London University.	UG UG LK MW RP/JVR KB/JP SM GX
3.0	**BHR Medical Examiner**	
	Peter Tanner is the Lead Medical Examiner at BHRUT. This role will help to improve the entire death certification process and provides additional support to bereaved relates and clinical teams. This function also interacts with faith communities ensuring religious customs involving death and burial are abided by. This role is based in the Trust but will independently scrutinise medical notes, and discuss any issues or concerns that the bereaved may have following a death. PT has been able to adopt best practice from other London areas that already has this function in place. Support is provided from the London Medical Examiner Service but is locally managed. This role becomes a statutory function from March 2022 when all non-coronal deaths, including community, will be overseen by this service. It is estimated that there will be approximately 5000 deaths per annum at the Trust and in community settings. BHRUT will be aligning with Barts for support over weekends. The management structure has now been finalised and it is hoped that appointments to the team will be filled by the end of the year. MS added that they are keen to recruit from primary care and community care as well as in	

	secondary care and will notify members when the external advert is published. Members **noted** and thanked PT for his verbal briefing.	
4.0	**Phlebotomy – lessons learnt as an integrated care system**	
	LK presented the report which outlines the background to the Level 2 Serious Incident (SI) that was declared within Phlebotomy following the announcement of a national lockdown due to Covid-19. BHRUT closed the Community Phlebotomy Service it provided to all but high-risk patients. At the time the SI was declared there were 40,000 patients awaiting a community blood test. The report shares the learning from the SI to ensure that other services are made aware and that high quality, safe patient care remains safeguarded against any major incident. Communications was the main theme from the investigation and business continuity plans ensure that this is enhanced to ensure NELFT and the CCG are kept informed of any pressure in the system as they arise. Whilst there is no evidence that this caused clinical harm, it is acknowledged that these delays did cause stress and distress to the patients affected The BHR ICS came together to develop a recovery plan and redesign of the service. Improvements to the service has been made and listening to patient feedback and groups has been a key factor. This includes adopting a full appointment system, and services closer to home where appropriate. A one-year pilot has been agreed which will have 11 NELFT sites throughout the community which will take GP requested phlebotomy tests. This went live in July and patients can get an appointment within 1-3 days. It is planned this will move to an integrated care system that can be scalable to meet demand. Joint training has also been developed. Centrifuges will be introduced to all NELFT managed sites and to some GP practices. SS noted that some practices were providing phlebotomy services as part of the phlebotomy Local Improvement Scheme (LIS) and have continued to provide despite the LIS being discontinued. SS and LK and relevant parties will discuss this outside of the meeting. The phlebotomy SI working group will continue to meet monthly to ensure the successful delivery of this pilot. The Chair thanked all those that had worked so hard to resolve this SI and to make improvements to the phlebotomy service. Members **noted** the update and learning from the incident.	SS / LK
5.0	**Tackling Obesity in BHR action plan**	
	JD, SC and EAB presented the action plan following the focussed discussion on tackling obesity at the previous meeting which was led by the local authority public health leads. The action plan was reviewed and the short-term actions were discussed in detail.	

	• Maternity Services – contacts with midwifery team and maternity commissioners are being sought. GX agreed to link them with the NEL maternity group. • Pre-conception – SC is liaising with CCG primary care team regarding raising healthy weight for women planning to conceive. Suggestions included discussions held with the sexual health team, primary care and pharmacy and if training would be available. • Health visitors – an outline of current obesity prevention is being undertaken and will be reviewed for any potential improvements that are needed. • BCYP –Dale Greenwood is leading on engagement work for CYP at NEL level and suggested that he may have connections that can support this discussion. JD is reviewing the available services for obesity treatment and what is available and ensuring GPs can refer into it however requires some contacts. RH suggested JD link with the long-term conditions transformation board which has a sub-group on obesity with identified leads. • LD and Mental Health – review includes people with severe mental illness and would like to link in with the SMI annual health check. JD to contact JS and link with the LD partnership board. Members **noted** the review of the action plan and timeframes to complete actions and agreed that an update will be presented in 6 months.	GX JD JD
6.0	**Transformation boards concept plans**	
6.1	Local Improvement Scheme for Long Term Conditions	
	Currently primary care manages patients with long term conditions (LTC) which is contracted with the Federations through a LIS which had a three-year tenure. This concept paper proposes the development of a business case for an extension of the LTC LIS for a further three years. The LTC LIS contract will be revised to address and balance factors outlined in the plan in order to improve care, support organisational change and manage value from the investment. The BHR Health and Care Cabinet **supported** the concept to revise and continue the LTC LIS for a further three years.	
6.2	Community falls service for care homes	
	The BHR Community Falls Service expansion seeks to deliver an extension of the current BHR specialist multidisciplinary community falls service, providing more staffing resource for the team. Extra resource is needed as the pandemic has seen an increased number of deconditioned older people who are at greater risk of falling. The BHR Health and Care Cabinet **supported** the concept of an expansion of the NELFT community falls service.	
6.3	Community Complex Dementia (Havering)	
	The concept is to have a Havering focussed integrated community-based dementia service which will address existing challenges. The proposed community MDT team will work with people with dementia and their family to ensure better patient care, better carer support and effective utilisation of existing resources. The proposed service is expected to work collaboratively	

	to ensure streamlined pathways, improved the quality of care for patients and reduce unnecessary hospital admissions. The proposal will also promote much stronger links between the multi-disciplinary approach and acute and community frailty services and the voluntary sector. JC and PMD will link up to discuss possible options for remote support and training. The BHR Health and Care Cabinet **supported** the concept of the dementia pathway in Havering.	JC/PMD
7.0	**Any other business**	
7.1	Chair	
	Members nominated and **approved** Magda Smith as the next chair of the BHR Health and Care Cabinet.	
8.0	**For information**	
8.1	BHR Priorities Plan on a Page	
	The H&CC are the sponsors on workstreams addressing prevention and the update was **noted**.	
9.0	**Date of next meeting**	
	11 November 2021 at 1:30pm-3:30pm	

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

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 30 September 2021 – 11.00am – 12.10pm

Via Microsoft Teams

Minutes

Members:

Kash Pandya (KP)	Lay Member, Governance and Audit Chair, NEL CCG
Ahmet Koray (AK)	Director of Finance, BHR ICP
Ceri Jacob (CJ)	Managing Director, BHR ICP
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Caron Bluestone (CB)	Lay Member, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Jane West (JW)	Chief Operating Officer, London Borough of Havering
Philip Gregory (PG)	Finance Director, London Borough of Barking & Dagenham

Attendees:

Rob Adcock (RA)	Deputy Chief Finance Officer, BHR ICP
Mark Eaton (ME)	BHR System Recovery Adviser, BHR ICP
Michael Gilham (MG)	Director of Finance, BHRUT
Andrew Ringshaw (AR)	Associate Director of Finance, NELFT
Tracy Rubery (TR)	Director of Transformation, BHR ICP
Pete McDonnell (PMc)	Lead Commissioner for Older People and Frailty, BHR ICP
Hanh Xuan-Tang (HX)	Deputy Director of Recovery Planning, BHR ICP
Kirsty Boettcher (KB)	Deputy Director of Transformation: Urgent Care, BHR ICP
Keith Flaxman (KF)	Project Director, NEL CCG
Steve Downing (SD)	Deputy Head of Contracts, BHRUT
Marie Loizides (ML)	Therapy Manager, BHRUT
Katie McDonald (KMc)	Corporate and Governance Administrator, BHR ICP (minute taker)

Apologies:

Nick Swift (NS)	Chief Finance Officer, BHRUT
Malcom Young (MY)	Executive Director of Finance, NELFT
Ian Ambrose (IA)	Operational Director of Finance, London Borough of Redbridge

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	
1.1	**Declarations of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict. No additional conflicts of interest were declared.	
1.2	**Minutes of the meeting held on 26 August 2021**	
	The minutes of the meeting were agreed as an accurate record.	

1.3	**Actions log/ matters arising**	
	Members noted the actions taken since the last meeting and agreed to close ACT005 and ACT006.	
2.0	**Month 5 Finance Overview Report 21/22**	
	RA presented the report, highlighting that at Month 5 both NEL CCG and BHR ICP have reported a breakeven position across core budgets. Delivery of the position is reliant on the use of non-recurrent balance sheet accruals, £5.9m to Month 5 and £7.6m forecast. This is necessary in order to offset budgetary pressures in the independent sector contracts, prescribing and continuing healthcare. CB highlighted the prescribing overspend and shared concerns raised with the ICP's Chief Pharmacist regarding repeat prescribing. AA explained the difference between repeat dispensing and repeat prescribing, adding that the vulnerable cohort are those with dosette boxes as they are not monitored. KP suggested that prescribing is added to a future agenda as a deep dive discussion. KP shared concerns that reserve funds have been used to achieve the breakeven position, which could lead to difficulties later in the year. AK agreed that this is a concern and explained that the CCG is looking at an allocation adjustment for the Independent Sector and will be raising the matter with NHSE. KP suggested that the CHC budget for Havering is readjusted also as many patients from the other NEL boroughs are being placed in Havering care homes. AK agreed to discuss this further with Steve Collins. The Finance Sub-committee noted the report and associated risks.	KMc AK
3.0	**H2 update**	
	AK advised that the H2 guidance is yet to be received from NHSE, so planning assumptions have been made. The CCG is optimistic that the position can be managed. KP queried whether partner Trusts have received any indication from NHSE regarding H2. MG and AR confirmed that Trusts are in the same position as the CCG and are awaiting further information. The sub-committee noted the verbal update.	
4.0	**Provider updates**	
4.1	NELFT – Finance and Investment Committee update	
	AR presented the report, highlighting that NELFT has reported a breakeven position at Month 5 and has used £4m of top up funding. High levels of agency staff remain a cost pressure due to substantive posts being unrecruited to. There has been increased expenditure across Home Treatment Teams, which has led to additional pressures on the crisis team pathway. KP queried whether NELFT has the finances to deliver the Mental Health Investment Standard. AR explained that obtaining workforce is difficult so is a significant risk to the MHIS. There have been no Extra Contractual Referrals	

	(ECRs) and patients are able to remain in the patch, however this has created pressures on the crisis team. MG provided an update on BHRUT's financial position, explaining that the Trust is currently £1.2m off plan, however this is likely to increase to £3m by Month 6. This position is primarily driven through the number of hospitalised Covid-19 patients and bed capacity remains a challenge. Key areas of improvement include reducing the number of temporary staff and utilising theatres. *Jane West joined the meeting at 11:20.* CB highlighted that staffing issues is a key risk across the system and reminded members of the BHR Academy which can be utilised by Trusts and will help to lower costs in the longer term. The Finance Sub-committee noted the report.	
5.0	**Transformation**	
5.1	BHR Integrated Sustainability Plan	
	ME presented the report, noting that the plan has been reviewed by various committees and feedback has been incorporated into the final plan where appropriate. The five-year plan is based on assumptions; therefore, it will require further review once arrangements for H2 and beyond are confirmed. AK thanked ME for his work on the plan and recommended that the document remains agile going forward as pressures arise. CJ thanked system partners for their contributions to the plan, adding that this provides partners with the opportunity to work towards an Integrated Care System and offers transparency across the system. The plan should also improve patient outcomes. KP queried whether consideration could be given as to how Local Authorities can be incorporated into the plan once it receives final approval. ME explained that this had been explored previously but difficulties arose, however consideration could be given to include CHC alignment. The BHR ICP Finance Sub-committee approved the document and recommended it for NEL CCG Governing Body approval.	
5.2	Non-recurrent funding process	
	TR presented the report, explaining that the £20m non-recurrent funding is expected to support priorities set out in the transformation boards' plans which are linked to the Integrated Sustainability Plan. The rationale is that these areas will support a recurrent benefit which will improve patient outcomes and experience as well as financial sustainability of the system. Concept cases will be developed for schemes which are then presented to the Health and Care Cabinet, for clinical input, and Star Chambers prior to being developed into business cases. AA highlighted that this process demonstrates effective ICS working as there is a breadth of input and queried whether there is a clinical evaluator at the	

	Star Chamber sessions. TR explained that clinical evaluation is sought at the Health and Care Cabinet prior to Star Chamber sessions. The Finance Sub-committee noted the proposed process.	
5.3	BHR Transformation Board finance update	
	TR presented the report, noting the current financial position of schemes due to go live during 2021/22. CB highlighted the slippage in uptake of advice and guidance as GPs have reported that responses are not received in a timely manner. TR advised that 400 advice and guidance requests are made per month, which is behind plan. A local incentive scheme is being considered, however there has been positive feedback with the service. AA added that advice and guidance is well embedded in primary care, however there are issues regarding the transfer of work which is being considered at a NEL-level. JW indicated that Local Authorities have an interest in children and young people and questioned how LAs are incorporated into this work. TR explained that the LAs have representatives on all transformation boards and that Barbara Nicholls sponsors the Older People board. KP suggested that a deep dive into advice and guidance is brought back to the sub-committee in two months. *Steve Rubery joined the meeting at 11.45.* The Finance Sub-committee noted the current financial positions of the Transformation Boards in relation to the 2021/22 transformational schemes.	KMc
6.0	**NHSE Community Health Services (CHS) baseline exercise**	
	PMc presented the report, explaining that NHSE requested that all ICSs and ICPs conduct a community health services baseline audit of activity, workforce and costs for the last three years to provide an overview of 34 services. This was a high-level exercise, so it is likely that NHSE will request additional information in the coming weeks. KP questioned why BHR sexual assault services were not included in the exercise. PMc explained that in BHR the services fall under acute rather than community health, however this is different in TNW. AR added that further work is required before using the outcomes for benchmarking. The Finance Sub-committee noted the report. *Pete McDonnell left the meeting at 11.55.*	
7.0	**Business cases for investment**	
7.1	BHR winter plan	
	KB presented the report, highlighting that investment in schemes would help to reduce the bed gap, reduce hospital attendances and improve patient flow during the winter period. Funding priorities will be further developed during the coming weeks to finalise workforce, estate requirements and actual cost.	

	Individual business cases for schemes will be presented to the sub-committee for approval as they are developed. A separate primary care scheme has not been developed, however discussions remain open and the Duty Doctor Scheme is progressing which should ease pressure in primary care over winter. The proposed investment needed is a maximum of £2.9m. KP questioned whether the CCG has the budget for this proposal. AK confirmed that there is the budget for this year, however this will need to be included for next year's plans. CJ noted that primary care requires support on additional levels, such as staffing issues and handling an increase in abusive patients. MG queried whether the frailty unit at BHRUT is included within the winter plan or a separate budget. AK advised that this is not funded recurrently, however can be discussed separately. CJ added that the frailty unit is incorporated in the older people strategy, so mainstreaming for next year requires consideration. AA questioned how the success of schemes can be measured and attributed to individual business cases. KB acknowledged that this is a difficult task, adding that each scheme will outline key cohorts which will be monitored. The Finance Sub-committee agreed the funding priorities set out in the report and the financial budget, with a recognition that these may vary with further development.	
7.2	Contract award – Bearing Point	
	KB presented the report, explaining that the discharge to assess pathway supported the discharge of patients out of hospital, however it has driven cost pressures in adult social care which are not sustainable. Consultancy support has been secured to review the pathway and to support the action plan. The Finance Sub-committee approved the contract award.	
7.3	Hospital Ambulance Liaison Officer (HALO)	
	KB presented the report, highlighting that the three band 7 HALOs would work across Queen's Hospital and King Georges hospital sites too meet ambulance crews prior to checking in. The HALOs will review each conveyance with crews to determine whether alternative treatment could have been sought and explore possibilities for proactive redirection in order to reduce the pressures being faced by urgent care services. KP queried whether similar schemes have been implemented elsewhere in North East London. KB advised that this is unique within London and that London Ambulance Service (LAS) are very keen to implement this. SR added that Queens Hospital has had a HALO position previously, however there is not the same level of pressure at other Trusts. KP questioned whether the HALOs' working hours of 10am – 10pm are peak ambulance hours. KB confirmed that this is where the highest demand has been demonstrated.	

	The Finance Sub-committee approved the total investment of £105,212 (October 2021 – March 2022).	
7.4	Musculoskeletal (MSK) digital referral	
	ML presented the report, outlining that the digital referral tool will stream MSK referrals to the right clinician first time which will help to reduce waiting lists for secondary care services and therefore improve quality of care for patients. Clinicians in primary and secondary care will collaborate to build the clinical pathways which will include holistic approaches and consider health inequalities. It is estimated that GPs will save 3.5 minutes per referral and that £0.8m will be saved in the first year of implementation. TR advised that the proposal has been well supported by the Planned Care Transformation Board and if the tool is successful, it could be used with other specialities. AA added that he is highly supportive of the proposal and that the digital platform could have many applications in the future. CB noted that there has been issues regarding clinical coding not being used effectively and queried whether the tool uses updated coding. ML explained that this is an issue that primary and secondary care colleagues can evaluate when building the pathways, however service changes can be updated overnight on the tool. KP queried whether the CCG has the budget for this. AK confirmed that there is funding available. The Finance Sub-committee approved the total investment of £256,000 recurrently.	
7.5	St George's Health and Wellbeing Hub	
	SR presented the report, explaining that the St George's Health and Wellbeing Hub was granted approval as a NEL priority under the wave 4 capital programme in 2020 and the cost of development is £27.7m. In June 2021 NHSE had queries in relation to the draft outline business case (OBC) so the CCG requested that Carnall Farrar review the OBC. The OBC has since been refreshed and the revised version was submitted in September 2021. A round table event is scheduled on 4 October 2021 which will determine whether the proposal can be progressed into a business case. KF added that the draft OBC was subjected to great scrutiny and that plans must be completed by 2024. AA thanked KF and system partners for their input into the OBC, which is an incredible piece of work. KP echoed thanks to those involved and queried whether revenue funding has been incorporated from 2024. AK advised that there is an issue with gaps in funding across the system which will need to be addressed once the organisation becomes an ICS/ ICB. The Finance Sub-committee noted the report.	
8.0	**Key messages for the BHR ICPB and NEL Finance and Performance Committee**	

	An update report from the sub-committee Chair will be presented to the BHR ICPB and NEL Finance and Performance Committee for noting. The key messages to feed back this month include: • Receiving an update on the current financial position • Receiving an update on the Integrated Sustainability Plan and non-recurrent funding • Receiving an update on the Transformation Boards • Receiving financial position updates from provider colleagues • Approval of business cases for investment	
9.0	**Any other business**	
	There was no other business to note.	
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.	
10.3	Confirmation of virtual approval: Procurement of a Community MSK Physiotherapy Backlog Clearance Service	
	The sub-committee noted the virtual approval of the business case.	
	Date of next meeting – 28 October 2021	

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

BHR Integrated Care Partnership Finance Sub-Committee

Thursday 28 October 2021 – 11.00am – 12.30pm

Via Microsoft Teams

Minutes

Members:

Kash Pandya (KP)	Lay Member, Governance and Audit Chair, NEL CCG
Ahmet Koray (AK)	Director of Finance, BHR ICP
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
Ian Ambrose (IA)	Operational Director of Finance, London Borough of Redbridge

Attendees:

Stuart Greenacre (SG)	Associate Director of Finance, BHRUT
Linda Chapman (LC)	Associate Director of Finance, NELFT
Dean Musk (DM)	Head of Estates and Capital Programmes, NEL CCG
Brian Jopling (BJ)	Director of Mental Health, LD and Autism, NELFT
Pete McDonnell (PMc)	Lead Commissioner for Older People and Frailty, BHR ICP
Hanh Xuan-Tang (HXT)	Deputy Director of Recovery Planning, BHR ICP
Julian Buckton (JB)	Shared PMO Programme Lead, NEL CCG
Kirsty Boettcher (KB)	Deputy Director of Transformation: Urgent Care, BHR ICP
Jeremy Kidd (JK)	Deputy Director of Transformation: Unplanned Care, BHR ICP
Louise Brent (LB)	Planned Care Programme Manager, BHR ICP
Dr Ramneek Hara (RH)	Clinical Lead, NEL CCG
Dr Manoj Menon (MM)	Secondary Care Consultant, BHRUT
Dawn Gough (DG)	Transformation Project Lead, NELFT
Dr Adam Ainley (AAi)	Secondary Care Consultant, BHRUT
Katie McDonald (KMc)	Corporate and Governance Administrator, BHR ICP (minute taker)

Apologies:

Rob Adcock (RA)	Deputy Chief Finance Officer, BHR ICP
Dr Atul Aggarwal (AA)	Havering Clinical Chair
Ceri Jacob (CJ)	Managing Director, BHR ICP
Steve Rubery (SR)	Director of Planning & Performance, BHR ICP
Nick Swift (NS)	Chief Finance Officer, BHRUT
Michael Gilham (MG)	Director of Finance, BHRUT
Andrew Ringshaw (AR)	Associate Director of Finance, NELFT
Philip Gregory (PG)	Finance Director, London Borough of Barking & Dagenham

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting and apologies were noted.	
1.1	**Declarations of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict.	

	No additional conflicts of interest were declared.	
1.2	**Minutes of the meeting held on 30 September 2021**	
	The minutes of the meeting were agreed as an accurate record.	
1.3	**Actions log/ matters arising**	
	ACT008 – AK advised that an update will be brought back to the next meeting along with H2 plans, adding that a separate meeting has been arranged to discuss the additional overspends faced by Local Authorities. Members noted the actions taken since the last meeting and agreed to close ACT007 and ACT009.	
2.0	**Month 6 Finance Overview Report 21/22**	
	AK presented the report noting that at month 6 all ICPs in NEL CCG have reported a break-even position across core budgets. The delivery of the BHR position is reliant on the use of non-recurrent resources totalling £8m. Within this, an overspend in corporate costs for business intelligence service arrangements that are no longer funded by NHSE resources was reported for the first time this month. The position is being reviewed across NEL CCG to establish a recurrent funding source. KP highlighted that CHC remains a risk and welcomed the deep dive report scheduled for the November meeting. AK added that there is a £1.3m overspend, however this is a more manageable position that previous years. JW queried whether there is a single document which outlines budget plans and system recovery. AK explained that this information is within the BHR Integrated Sustainability Plan which was approved by the sub-committee. A budget plan is expected for next year; however, the allocations remain unknown. AK advised that H2 remains difficult as a full year cycle cannot be planned. CB questioned whether block contracts remain in place for H2. AK confirmed block contracting will remain, however guidance on 2022/23 is outstanding. The finance sub-committee noted the report.	
3.0	**Transformation**	
3.1	BHR Transformation Board finance update	
	HXT presented the report, highlighting the financial position for each Transformation Board. The Duty Doctor scheme has been paused in order to review whether the proposed model supports the new national guidance. KP raised concerns regarding the slippage and queried whether the budget will be impacted if schemes are not delivered. AK explained that the benefit of savings will not be seen this year due to block contracting arrangements. CB questioned which investments are delivered through the £21m non-recurrent budget. AK advised that all schemes in the report are funded through the Integrated Sustainability Plan monies.	

	KP queried whether clinicians are represented at the Star Chambers. HXT explained that clinicians are not at the chamber, however all concept plans are presented to the Health and Care Cabinet before reaching the start chambers. The finance sub- committee noted the current financial positions of the Transformation Boards in relation to the 2021/22 transformational schemes.	
4.0	**Estates delivery update**	
	DM presented the report highlighting the proposed disposal of the Harold Hill LTC centre, the Gants Hill Community Hub development as well as local estates developments in BHR. KP queried how the CCG can ensure that 50% of the sale of the Harold Hill site will be reinvested locally. DM explained that a formal declaration must be made to NHS Property Services and the CCG can then engage regarding a disposal receipt. CB questioned whether the £40k investment request for the Gants Hill Community Hub will be used to fund external management consultants. DM explained that the strategic outline case is worked up internally, however the level of detail needed requires a procurement for consultants which would be through competitive tender. JW queried whether a target has been set for savings in order to meet the budget gap. AK suggested that deep dives into individual schemes could be presented to the sub-committee in order to outline potential savings. DM explained that outline business cases contain this detail which can be presented to the sub-committee when developed. AK thanked DM and the estates team for their work and welcomed the monthly update reports going forward. The finance sub-committee: • Approved the handback to NHS Property Services of Harold Wood Long Term Conditions Centre. • Approved an investment of £40k to further progress the CCG's business case development regarding the Gants Hill Community Hub.	
5.0	**Provider updates**	
5.1	NELFT – mental health investment and performance update	
	BJ presented the report, noting that a three-year financial plan has been developed which reflects the clinical priorities agreed by NEL CCG and NELFT. A significant level of slippage has occurred on MHIS, SDF and SR funding due to difficulties to recruit, delays in business case approval and demand changes due to the pandemic. The total forecast overspend is £5.4m. AK noted that the governance and decision-making processes regarding MHIS requires review to ensure performance measures are delivered. MY agreed that this is important as some transformation groups believe they have the authority to approve schemes.	

	KP queried whether the additional government funding could be lost if not utilised. AK confirmed that the funding would not be lost, however the CCG would be criticised which is a reputational risk. CB questioned how waiting list sizes become cost pressures. MY explained that waiting lists create clinical risks which are not funded for. The finance sub-committee noted the report and proposed next steps. *Malcolm Young left the meeting at 12.00pm.*	
6.0	**Business cases for investment**	
6.1	COPD community service redesign	
	LB presented the report, explaining that the business case aims to transform the COPD element of NELFT's community respiratory service which has not been reviewed for ten years. The service will be equitable for all patients registered with a BHR GP and will align with the service offered to City & Hackney patients in Homerton Hospital. KP queried whether the CCG has funding available in the budget. AK explained that this will be incorporated into 2022/23 plans and highlighted the benefits to patient quality of care. KP questioned whether the workforce is available. DG explained that workforce transformation has been considered within this piece of work. RH and MM highlighted the potential benefits to patients and clinicians if the redesign is agreed. The finance sub-committee made a recommendation to the BHR Area Committee to approve the business case.	
6.2	Long Covid Service Extension	
	LB presented the report, highlighting that patient and staff needs have been reviewed following the business case in 2020 in order to establish what is required to run the service effectively now that more is known about long Covid. The proposed changes will provide dedicated leadership, enable better access to digital solutions, tackle inequalities and link homeless people into pathways. CB queried whether the workforce will be met by substantive or agency staff. LB explained that as the service is only until 2022 it will be for agency staffing costs. RH added that the LTC Transformation Board has a workforce subgroup, so partners are working together to fill the gaps. KP asked what will happen to the funding if it is not spent. LB advised that verbal assurance has been provided that funding can be carried into 2022/23, but a request for this in writing has been made. The finance sub-committee approved the business case subject to receiving approval from Managing Director, Ceri Jacob. *CJ approved the business case virtually by way of email on 29 October 2021.*	

6.3	HFrEF Community Service Redesign	
	LB presented the report, noting that business case aims to transform the HFrEF element of NELFT's heart failure service which has not been reviewed for ten years. It will provide an equitable service for all patients registered with a BHR GP and will enable patients to access wider services across NELFT in an integrated way. A subsequent business case will be developed to agree how this service can extend its operating hours to 8am to 8pm. RH highlighted that standardising services across BHR is very positive and addresses inequalities. KP questioned whether the CCG has the funding available. AK confirmed that this will need to be included in the budgets for 2022/23. AK queried whether this aligns with other community programmes and requested assurance that the CCG would not be double paying for services. JK advised that the business case has not been developed in isolation and is a vertically aligned pathway which is not a stand-alone service. The finance sub-committee made a recommendation to the BHR Area Committee to approve the business case.	
6.4	Winter capacity – IRS	
	KB presented the report highlighting that the scheme is part of the BHR winter plan which was agreed at the September finance sub-committee. The Intensive Rehab Service (IRS) is a major support to release bed capacity at Queens, King George and Whipps Cross Hospitals. The additional investment will partially address the bed gap, improve ED performance and reduce patients' length of stay. The finance sub-committee noted the scheme.	
6.5	Home First	
	PMc presented the report, explaining that Home First is a discharge model to support same day discharge. It enables a light touch rehab assessment in the acute setting, utilising a trusted assessor under the supervision of a senior Occupational Therapist to assess rehab, equipment and care in the person's home once discharged. KP queried whether this is a recurrent spend. AK confirmed it is a recurrent spend and budget will be allocated to it, however the scheme will essentially be self-funding. JW was supportive of the investment and highlighted that this will reduce other cost pressures. KP questioned whether medication services are aligned with Home First. PMc confirmed that they are aligned and that patients are not discharged unless medications are available. The finance sub-committee approved the business case subject to receiving approval from Managing Director, Ceri Jacob. *CJ approved the business case virtually by way of email on 29 October 2021.*	

6.6	Better Care Fund (BCF) update	
	This item was deferred to the meeting on 25 November 2021.	
6.7	Proposal to Extend BHR's Community Ophthalmology Service (Evolutio)	
	JK presented the report, explaining that the community ophthalmology service provided by Evolutio was awarded a three-year contract with the option to extend for a further two years in December 2018, therefore an extension is now due. The contract has overperformed and has exceeded planned budgets and activity. Evidence has shown that Evolutio receives positive patient and GP feedback as well as delivering a good quality service. Entending the contract will continue to assist with diverting outpatient activity from BHRUT which will help address the RTT pressures being faced. 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. The finance sub-committee made a recommendation to the BHR Area Committee to approve the business case.	JK
7.0	**Key messages for the BHR ICPB and NEL Finance and Performance Committee**	
	An update report from the sub-committee Chair will be presented to the BHR ICPB and NEL Finance and Performance Committee for noting. The key messages to feed back this month include: • Receiving an update on the current financial position • Receiving an update on the Transformation Boards • Receiving an update on estates delivery • Receiving financial position updates from provider colleagues • Approval of business cases for investment	
8.0	**Any other business**	
	There was no other business to note.	
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 – 25 November 2021	

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

BHR Health System Quality and Performance Oversight Group
2 September 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
Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT
Caron Bluestone (CB)	Associate Lay Member for Quality, Performance & Finance, BHR ICP, NEL CCG

Attendees

Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
John Flood (JF)	NEL Provider Performance Director, NELCSU
Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Tracy Rubery (TR)	Director of Transformation, BHR ICP, NEL CCG
Jeremy Kidd (JK)	Deputy Director of Delivery (Planned Care), BHR ICP, NELCCG
Keeley Chaplin (KLC)	(Minute taker) Governance Team, BHR ICP, NEL CCG
Carol White (CW)	Integrated Care Director (Havering), NELFT
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Fawad Hussain (FH)	Medical Director (KGH), BHRUT - for Magda Smith
Christine Kane (CK)	CHC Quality & Safety Lead, NELCSU
Kirsty Boettcher (KB)	Deputy Director of Transformation – Urgent Care, BHR ICP, NEL CCG

Apologies

Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Dr Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG
Diane Jones (DJ)	Director of Nursing & Quality – NEL CCG
Jacqui van Rossum (JvR)	Executive Integrated Care Director (London), NELFT
Dr Ramneek Hara (RH)	Deputy Barking & Dagenham Chair, NEL CCG
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG
Aleks Hammerton (AH)	Acting Chief Operating Officer, BHRUT
Sue Elliott (SE)	Director of Nursing, Quality and Governance, PELC
Justin Roper (JR)	Acting Deputy Director of Quality & Safety, TNW ICP, NEL CCG
Chetan Vyas (CV)	Director of Quality & Safety, TNW 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 5th August 2021
	The minutes of the BHR Health System Quality and Performance Oversight Group held on 5th August 2021 were duly **noted and approved**.
1.3	Matters/actions arising
	The actions log was reviewed and the following was discussed. ACT012 – discussion on Barts Health issues is still required with attendance from the TNW quality leads. RP added issues relating to consultant to consultant referrals has been raised at the BHRUT Planned Care Board and it has been agreed that a working group will be set up to look at streamlining processes. The actions log was **noted** and members agreed to close ACT010.
2.0	**Performance**
2.1	System performance report
	JF provided updates by exception on performance against constitutional standards highlighting the following: • BHRUT's performance in A&E and the cancer 62-day pathway remain of concern. There is a winter-level number of attendances into the Emergency Department (ED). • BHRUT's 52+ week wait position has significantly improved and the referral to treatment patient treatment list (PTL) remains stable. • Diagnostics remains a challenge with issues with imaging. • In NELFT the IAPT access is 30% up on the previous month • The number of children accessing the Children and Young People (CYP) service has increased significantly. • Serious Mental Illness (SMI) physical heath checks under performance is mainly relating to the hard to reach client group who need all five elements of their checks to be completed. The group **noted** the content of report and actions being taken to address risks.
2.2	BHRUT performance challenges and recovery
	RP updated members on operational performance in BHRUT and actions being taken to reverse downward trends. Key highlights from the report include: • There continues to be a high number of attendances in ED but they are seeing an improvement in Type 3 performance with the continued collaboration with PELC and CCGs to improve front door processes by reducing demand and optimising referrals to the ED. • The Children and Young People's Assessment Unit (CYPAU) is in place and making an impact but the Trust has set further improvement targets for paediatric performance. • Success of the Frailty Unit at King George Hospital (KGH) is continuing with a pilot at Queens Hospital (QH) • The Same Day Emergency Care (SDEC) facility is now in place at QH. • Focussed work on discharges is being planned and will involve the whole system in this.

No.	Agenda item and minute
	• 52 week wait (ww) performance is ahead of plan for admitted and non-admitted but is expected to plateau over August due to leave. In September the numbers are expected to reduce again. The overall plan is to have nil 52ww by May 2022. • MRI equipment breakdowns have reduced available capacity and a replacement and upgrade programme is underway in radiology. • As part of the mutual offer to support Barts Health, some endoscopy patients have been transferred from Barts and offered to be examined at BHRUT • Cancer 2ww performance is consistently meeting the standard despite growing demand • The Cancer 62 days backlog is reducing. Radiology issues has caused pathways to slow down in July but plans are in place to increase capacity for CT and MRI. SH thanked RP for the report and noted the good news for endoscopy unit. SH asked if GPs should refer to BHRUT rather than Whipps Cross Hospital. RP advised this may need to be discussed with the clinical lead if this is appropriate and viable to do this as well as for areas such as gastroenterology and cardiology. RP will look into this. **Action RP** SH asked if there has been any impact on the Cancer 2ww position since GPs have started to use the 'C the signs' diagnostic tool. RP agreed to look into this. **Action RP** CB asked if there any provision across NEL organisations to see where there is less stress in the system to work together to share capacity where needed the most. RP advised there are conversations held where work can be redirected but there are some practicalities with the electronic systems across the organisations. The BHRUT IT team is working to ensure redirection for patients from Whipps Cross becomes smoother. The long term will be to have a NEL waiting list view. SH suggested Medefer are also notified of where there are stresses in the system. The Group **noted** the content of the report and actions being taken to address risks.
2.3	NELFT performance challenges and recovery
	JH presented the NELFT performance report for August 2021. • Proposing new KPIs and indicators to fine tune the reporting for this group. • The number of users of the Care Programme Approach (CPA) discharged from inpatient care and are followed up within 7 days did not reach 100% in July as there were four that had not been seen in 7 days • Safeguarding supervision dropped slightly in July but has picked up again in August. • Maternal mood review by 8 weeks is reaching 80% which is above target • The Crisis/PLA assessments in A&E seeing patients within 4 hours of the service being notified has consistently met the target of 95% • Early Intervention in Psychosis (EIP) has been well above the 56% target of seeing the patient within 2 weeks of referral • The IAPT targets for 6 and 18 weeks have been met. CB noted a few anomalies between the IAPT waiting times and the BHR MH performance report that don't seem to compare like for like and asked to understand the difference as there is a high number of patients waiting for the second appointment. JH can include the data on follow up from first to second appointment in the next report. JF added that there is a difference in reporting as the data produced for BHR is on constitutional standards and does not cover all of the activity that is recorded in BHR.

No.	Agenda item and minute
	JF drew attention to the elective position within the Whipps Cross data included in item 2.1. This indicates the 18ww and 52ww position are challenged. The Elective Alliance and NEL are working on looking at pressure points across the NEL system and how they can tackle these. JF will include Whipps Cross data at the next meeting. SH asked if is there an issue with IAPT reporting and if patients choose the online module are they recorded and followed up with how they get on with the modules. CW will look into this. JH and CW will provide a presentation to a future meeting on the IAPT model as well as more detail on the waits from first to second appointments. **Action CW/JH** The Group **noted** the contents of the report.
2.4	PELC performance report
	The Group **noted** the contents of the report.
3.0	**Quality**
3.1	BHR System Quality and Safeguarding Report

	MGC provided an overview of quality and safeguarding issues and risks across the BHR system.
	• BHRUT
	  • Since the previous report, no Never Events have been declared.
	  • The outcome from the external review of all BHRUT's Serious Incidents (SI) over the previous two years will be presented to the next meeting.
	  • There have been no Regulation 28 Reports issued since the previous report.
	• NELFT
	  • Since the previous report, no Never Events have been declared.
	  • An audit of Initial Health Assessments (IHAs) will be conducted by a specialist in IHAs from the Royal College of Paediatrics and Child Health and an independent deep-dive review into IHA's has been commissioned. CW advised that several actions have already been completed. The transformation board will look at the service model and ensure actions are progressing to the timeframe. MGC has received an update on the Looked After Children Quality Improvement Programme Progress Report from JVR which will be circulated with the minutes. **Action MGC**
	  • Potential issues with community patient investigations have been raised regarding the ability of community-based doctors and nurses to directly book investigations for patients and review results. CW advised that all paediatricians have the ability to order tests via Cyberlab but they would like to have an alert added to the system that would flag back to them when results are made available. The IT director is working on this. MGC suggested communications on the process is sent out to community clinicians to ensure they are aware of the process and a regular update to this group would be useful. CW confirmed that the process is being conveyed out.
	• There were no Regulation 28 Reports issued in primary care since last reported.
	
	The Group **noted** the detail of the report and actions being taken to date to mitigate the identified risks.

3.2	Level 3 Independent investigation
	CK briefed members on the investigation following the death of person with learning disabilities. The investigation has taken a system review of the events, using

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	methodology prescribed by the Social Care Institute for Excellence for Safeguarding Adult Reviews. LB noted that there were a number of elements that had impacted on their care. The report includes learning and recommendations and an action plan has been developed. CB noted that there had been procedures in place when this occurred and asked how the organisations involved will ensure these are followed so this does not happen again. LB and MGC will bring an update back to the October meeting. SH suggested the learning from this case is brought to the GPs learning events to ensure they are all made aware. MGC will ensure this is included in the learning for primary care. CW suggested the learning is also shared with safeguarding adult partnerships. Members thanked CK and colleagues for their work into the report which was duly **noted**.
3.3	BHRUT Quality Report
	LB presented the group with the 'flash' report to provide assurance on the Trust's most up to date Quality and Safety data for July 2021 and highlighted the following: • The Trust is taking part in the NHSE Test & Trace Lamp Testing program for Covid-19 in asymptomatic Healthcare Workers which is being rolled out across the organisation. If the pilot is successful the Trust will use this for certain patient cohorts such as patients with learning disabilities as this is less invasive. • Planning for RSV is ongoing and includes an increase of inpatient children's capacity by 10 beds. • ED has seen a significant deterioration in overall positive experience feedback. The majority is regarding the increased waiting times to be seen in ED. The patient experience team will continue to work closely with the service to identify initiatives, which ensure patients are kept informed of increased waiting times as a result of service pressures. • The vulnerable young person programme is a 6-month programme to support local vulnerable young people who are at disadvantage due to their personal circumstances. The aim of the programme is to provide them to learn new skills and possible future employment with the Trust. • The new MRI modular scanner is now fully operational, halving MRI scanning time from 30mins to 15mins, increasing diagnostic capacity. • National reporting for mixed sex ward breaches was paused due to the response to Covid-19 however the Trust continues to report internally on this. CB noted that 100% of complaints are acknowledged within 3 days however only 64% were responded to within the agreed timescales and asked if the number of complaints being received are significant and responding to these not achievable. LB advised that the delay is often caused by the department not providing an adequate response and having to redraft the letter. The Head of Complaints is now providing some focussed work on quality of complaint responses and an update will be provided in the next report. The Group **noted** the report.
3.4	NELFT Quality Report
	The NELFT quality and safety summary report and risk exceptions was presented and the Group **noted** the content of the report.

No.	Agenda item and minute
3.5	PELC Quality Report
	The Group **noted** the content of the report.
4.0	**Other issues**
4.1	Barts Health issues
	This item was not discussed due to apologies from the leads.
4.2	Barts Health Diabetic footcare service
	Diabetic footcare services outside of BHR are geographically bounded. It is not confirmed if this is due to pressures on staff relating to Covid-19 or if this is broader. This represents a risk to rapid access. JK has contacted the NEL diabetes group to engage with colleagues to understand what is available for patients in each borough, identify potential problems and gaps in the service. JK noted that GPs in Redbridge are able to refer patients into the BHRUT service as well as the foot protection service that is being commissioned. SH would like to know if the NELFT podiatry service link into this and added podiatrists often request GPs to prescribe antibiotics for foot problems with no other advice for the GP. CW will look at this. **Action CW** SR noted the health inequalities for the population which is dependent upon the provider they reside near, not only for the diabetic foot care but areas such as access to endoscopies and planned care procedures. Members **noted** the verbal update and that a further report will come back once the initial review has been conducted.
4.3	RSV surge planning
	KB provided a verbal report on the planning for a potential RSV surge. KB is the urgent care lead for RSV in NEL and reported that there has been excellent co-operation across NEL. BHRUT have done a large amount of preparation and link in with the NEL intensive care network. They are providing additional paediatric beds at King George Hospital. The 111 service are recruiting paediatric nurses to support a separate streaming line for babies and young people. There has been a change in policy for 999 calls to convey all under 1s to hospital (from the under 3s) and London Ambulance Services (LAS) are reviewing the impact of this. Primary care data analysis is being conducted across NEL, looking at the winter period October 2019 to March 2020. This includes A&E attendances by practice, by hospital for both in and out of hours and primary care attendances. The data will be broken down to GP network level to review demand. Assurance that all NEL practices are seeing 0-5-year olds face to face is being sought. A NEL clinical sub group has been set up with a GP representative from each of the boroughs. National policy suggests that pulse oximetry should be in place and a solution to this is being looked at for NEL. Members asked if there is any RSV data which could be shared. KB confirmed there is a trend report and will look at sharing this. Communications is an important issue especially for parents to help identify the differences in childhood illnesses. KB will circulate the local authority communication that has been circulated out to schools and nurseries for information. SH noted there

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	was a service at Whipps Cross Hospital called Paediatric Pearls. KB will look into this and will provide the traffic light document. KB will also find out if paediatric hot clinics will be recommencing at Whipps Cross and BHRUT. **Actions: KB** The Group **noted** the verbal update.
5.0	**Annual Reports**
5.1	Adults safeguarding annual report 2020/21
	The Safeguarding Adults' annual report provides an update on safeguarding adult activity for the period 2020/21 and highlights key priorities for 2021/22. Members **noted** the report and that it will be presented to the NEL Quality, Safety and Improvement Committee for approval.
5.2	Safeguarding children annual report 2020/21
	The Safeguarding Children's annual report provides an update on safeguarding children activity for the period 2020/21 and highlights key priorities for 2021/22. Members **noted** the report and that it will be presented to the NEL Quality, Safety and Improvement Committee for approval.
5.3	Looked After Children annual report 2020/21
	The Looked After Children's Annual Report provides an update on looked after children activity for the period 2020/21 and highlights key priorities for 2021/22. Members **noted** the report and that it will be presented to the NEL Quality, Safety and Improvement Committee for approval.
5.4	Child Death Overview Panel (CDOP) annual report 2020/21
	The Child Death Overview Panel's Annual Report provides an update on CDOP activity for the period 2020/21 and highlights key priorities for 2021/22. Members **noted** the report and that it will be presented to the NEL Quality, Safety and Improvement Committee for approval.
6.0	**Any other business**
6.1	CQC Maternity Update
	Following the CQC unannounced inspection of BHRUTs maternity services on 10 June, the final report or ratings have not yet been received. Once they have KH will bring this back to the group. KH clarified that no concerns had been raised during the inspection.
6.2	Future QPOG meetings
	Following CJ suggestion of themed items at future meetings it was agreed the next meeting would focus on how the trusts are tackling their long waiting lists. Members of the clinical/surgical team from BHRUT and Barts will be invited. CB suggested they could raise theatre time lost due to Covid. CB suggested that key lines of enquiries are developed to focus the discussion to include patient communications with a suggested helpline for patients to query their referrals.
7.0	**Date of next meeting**
	7 October 2021

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

BHR Health System Quality and Performance Oversight Group
7 October 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
Lorraine Bess (LB)	Director of Nursing (Quality & Patient Safety), BHRUT
Caron Bluestone (CB)	Associate Lay Member for Quality, Performance & Finance, BHR ICP, NEL CCG
Dr Magda Smith (MSm)	Chief Medical Officer, BHRUT
Dr Anil Mehta (AM)	Redbridge Clinical Chair, NEL CCG

Attendees

Dr Atul Aggarwal (AA)	Havering Clinical Chair, NEL CCG
Dr Jagan John (JJ)	NEL Chair and B&D Clinical Chair, NEL CCG
Ceri Jacob (CJ)	Managing Director, BHR ICP, NEL CCG
John Flood (JF)	NEL Provider Performance Director, NELCSU
Debbie Smith (DS)	
Carol White (CW)	Integrated Care Director (Havering), NELFT
Richard Pennington (RP)	Acting Chief Operating Officer, BHRUT
Hilary Shanahan (HS)	Interim Head of Quality & Clinical Governance, BHR ICP, NEL CCG
Tracey Thorne (TT)	Director of Nursing – Cross Divisional Programmes, BHRUT
Margaret Heraghty (MH)	Deputy Director of Nursing Mental Health Inpatients, NELFT
Keeley Chaplin (KLC)	(Minute taker) Governance Team, BHR ICP, NEL CCG

Apologies

Kathryn Halford OBE (KH)	Chief Nurse, BHRUT
Jacqui van Rossum (JvR)	Executive Integrated Care Director (London), NELFT
Dr Vincent Perry (VP)	Deputy Medical Director, NELFT
Sue Elliott (SE)	Director of Nursing, Quality and Governance, PELC
Diane Jones (DJ)	Director of Nursing & Quality, NEL CCG
Sharon Morrow (SM)	Director of Integrated Care, BHR ICP, NEL CCG
Tracy Rubery (TR)	Director of Transformation, BHR ICP, NEL CCG
Mark Gilbey-Cross (MGC)	Deputy Nurse Director, BHR ICP, NEL CCG
Susan Smyth (SuS)	Director of Nursing (Clinical Effectiveness), NELFT
Jacky Hayter (JHa)	Director of Performance and Business Intelligence, NELFT
Dr Ramneek Hara (RH)	Deputy Barking & Dagenham Chair, 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 2 September 2021
	The minutes of the BHR Health System Quality and Performance Oversight Group held on 2 September 2021 were duly **noted and approved**.
1.3	Matters/actions arising
	The actions log was reviewed and the following was discussed. The actions log was **noted** and members agreed to close ACT014, ACT019, ACT020.
2.0	**Access to elective services**
2.1	Members had a focussed discussion on access to elective services in BHRUT. Representation from Barts Health was not available to join the meeting however they sent some data which had been circulated on 6 October 2021. A number of questions were detailed in the agenda to help form the discussion. RP gave an overview on managing long waits. The patient treatment list (PTL) waiting list is now at 53k, which has increased by 2k in the last 6-8 weeks from a combination of staff leave and increased referrals which are now higher than at pre-Covid levels. For medium waits there are some areas that are doing well and are starting to see a reduction in waiting times such as gastro, endocrine, cardiology and respiratory. Waiting times to first clinical contact in other specialities are 6 weeks for ENT, 10 weeks for Ophthalmology, 12-16 weeks for general surgery, urology, trauma & orthopaedics and 14 weeks for gynaecology. As referrals are received they are scanned by the specialty service and anyone they identify as urgent are prioritised. The number of pre-Covid virtual appointments was at 8-10% and are now averaging at 36%. However, there is variation between specialties. It is expected that a third of first appointments will continue to be virtual. Overall activity numbers in outpatients are around 94% of pre-Covid activity and there is a variation in specialties. Changes made during Covid to help with non-elective flow and change in use of clinical space had implications on registrar streams and some equipment. Infection, Prevention and Control (IPC) constraints also reduced the number of patients seen per clinic but changes made will now have a positive impact. AA noted the increase in referrals for some specialties are back to pre-Covid levels but highlighted a possible risk for patients in the specialties that are not yet back to pre-Covid levels. MS advised that there have been some pathway changes that have redirected patients elsewhere and the planned care oversight board are monitoring this work. MS clarified that the clinical lead and the specialty has responsibility of the patient for clinical oversight once the referral has been received. Specialties are scanning referrals as they come in to manage the risk of patients in the pathway. A harm risk programme has been set up that highlights patients that may be at higher risk of harm. MS will bring the harm review approach that manages the risk of harm to patients to a future meeting. **Action MS and added to forward planner.**

No.	Agenda item and minute
	Patients that are on admitted waiting lists are categorised into a priority level in line with NHS England. SH asked what learning can be garnered from specialties that are managing their lists effectively. MS gave some examples of good practice and advised that they are shared between specialties. RP added that clinical leads in all specialties are focused and engaged in the process. SH asked when 'blitz' clinics are arranged who would be responsible to request diagnostics. **Action: RP will look into this to clarify.** CB asked why paediatric waits in some specialities are much longer. RP advised that these waits are for surgical specialties which had been difficult to restart due to availability of paediatric consultants or surgical paediatric beds. MS advised the numbers are small but have long waits. JJ asked if communications can be sent to patients outlining A&G as a clinical option and what to expect. **Action: MS/RP** AM noted that the urology service does not appear to be improving. RP advised that this is an area that requires face to face appointments therefore there are lower levels of activity due to ensuring IPC guidance is followed. RP will explore options that can address this. SH noted disappointment that Barts Health were not available to attend as this would have been an opportunity to share good practice as their urology service works well. They could also share information on their Access Issues Resolution Service (AIRS). BHRUT are developing a similar system and will strengthen the appointments system until it is in place. AA advised he has been working closely with colleagues in BHRUT and they have been very responsive to working together to resolve issues. RP suggested some support from the group on how to change the narrative with local stakeholders to emphasise the pressures the hospital and health services are under and realities of the waiting list. RP noted that deep dives have been held as an ICS but these could be refocussed with additional primary care input to look at urology and gynae. MS added there is a need to review the A&G process and the amount of work that is going back into primary care and how this could be shared out and confirmed BHRUT are accepting referrals from other practice healthcare professionals, under the supervision of their practice, which will help to stop duplication. SH concluded that the next step will be on how we can engage better with Barts Health. SH noted that in the Barts Health data they have stated that once the patient has been referred to them and on the waiting list there is joint responsibility for the patient between Barts Health and primary care. JJ advised that GPs are not made aware of this and a clear view is needed on this. SR added they also have a different approach to reviewing patients on the waiting list. A letter will be sent to the Barts Health Medical Director from the chair to highlight concerns raised and engagement by Barts Health. **Action SH**
3.0	**Assurance**
3.1	Phlebotomy SI close down report
	The report was presented to members to provide an update on progress against actions from the BHR system-wide phlebotomy SI.

No.	Agenda item and minute
	Members noted the actions taken to mitigate the identified risks and agreed that the monitoring of the phlebotomy SI action plan can be closed down. The Chair thanked everyone involved for the hard work that went into this and that is was a fantastic demonstration of collaborative working to resolve the problems.
4.0	**Quality**
4.1	BHR System Quality and Safeguarding Report

	HS provided an overview of quality and safeguarding issues and risks across the BHR system highlighting:
	• BHRUT
	  • Since the previous report, no Never Events have been declared.
	  • There have been no Regulation 28 Reports issued since the previous report.
	• NELFT
	  • Since the previous report, no Never Events have been declared.
	  • There have been no Regulation 28 Reports issued since the previous report.
	• BHR Primary Care
	  • There were no Regulation 28 Reports issued since last reported.
	
	The Group **noted** the detail of the report and actions being taken to date to mitigate the identified risks.

4.2	BHRUT Quality Report
	LB presented the group with the 'flash' report to provide assurance on the Trust's most up to date Quality and Safety data for August 2021 and highlighted the following: • There was a Covid outbreak during August which resulted in the closure of two wards and this reflects the importance of continued screening and IPC to reduce the risks. • The maternity CQC report has now been published and the Trust are working through actions on the six 'must do's' they must take as set out in the report. The response will be submitted to the CQC by 26 October and an update for members will be included at the November meeting. MS advised that the Trust is cognisant of the effect the report may have on staff and are ensuring they are being supported. MS added that the report also details areas of good practice found during the inspection. The Group **noted** the report.
4.3	NELFT Quality Report
	The NELFT quality and safety summary report and risk exceptions was presented. The Chair suggested that the next meeting should have a focus on Mental Health Services and CW will ensure that the information provided will include a flow chart on what to do when a patient is in crisis. CB noted that the DNA rate was high and queried if this could be related to patients having long waits and asked if this could be answered at the next meeting. AA advised he had been promoting the advice and guidance (A&G) for mental health services though had experienced a delay in receiving a response. CW will investigate this. **Action CW** The Group **noted** the content of the report.

No.	Agenda item and minute
4.4	PELC Quality Report
	The Group **noted** the content of the report.
5.0	**Performance**
5.1	System performance report
	JF provided updates by exception on performance against constitutional standards highlighting the following: • The BHRUT Referral to Treatment (RTT) performance improved slightly and a slight increase in PTL. The 52ww in July saw a slight reduction. Cancer 62-day pathway remains a challenge and the recovery plan is under review. Meeting the A&E 4-hour national standard remains a concern with the main reason due to waiting for first clinician appointment and bed management. • In NELFT there is pressure in both community and mental health services and the focus is now on recovery from Covid. The physical health checks for people with SMI is a priority however due to infection control risks face to face checks are constrained but solutions are being sought to tackle this and reduce health inequalities. It was noted that nursing rates are at very low levels especially in Redbridge. There are concerns regarding priorities for practice nurses who are prioritising Covid and Flu vaccinations and the ability to provide additional services. • It was agreed that a wider discussion will be made at the next meeting 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
	JH presented the NELFT performance report for August 2021 which was duly **noted**.
5.4	PELC performance report
	The Group **noted** the contents of the report.
6.0	**Any other business**
6.1	**Third Covid Vaccine dose** MS reported that they are looking at how they manage the approach of third doses of vaccines for patients who were compromised between the first and second dose. They are not able to book on the national system if they are within 6 months since the second dose. The initial message for patients will be to go back to their GP therefore the Trust are working collaboratively with the CCG to manage this and ensure primary care do not receive a large number of requests from these patients.
7.0	**Date of next meeting**
	4 November 2021

NHS
North East London
Clinical Commissioning Group

Integrated Safeguarding Assurance Board Meeting
Wednesday 27 October 2021 @ 09:30 – 12:00: MS Teams / Room 7BC North House

Minutes

Present	Initials	Title
Eve McGrath	EM	Designated Nurse Adult Safeguarding Havering
Gillian McNeice	GM	Project Lead PINS Children's Commissioning
Jeanette Ford	JF	Child Death Overview Panel (CDOP) Manager (BHR ICP)
Jessica Barlow	JB	Child Death Overview Panel (CDOP) Co-Ordinator (BHR ICP)
Jo Wingrave	JW	Business Manager Safeguarding (BHR ICP) - **Minutes**
Liz Adamson	DrLA	Designated Dr Safeguarding Children Havering
Mark Gilbey-Cross	MGC	Deputy Nurse Director (BHR ICP) **– Chair**
Paul Archer	PA	Designated Nurse Safeguarding Children & LAC Havering
Richard Burack	DrRB	Named GP Safeguarding Children (B&D and Havering)
Ruth Rothman	RR	Nurse Consultant Safeguarding Children & PC Redbridge
Sophie Naill	DrSN	Designated Doctor for LAC (BHR ICP)
Stephen Hynes	SH	Designated Nurse Adult Safeguarding Redbridge
Sue Nichols	SN	Designated Nurse Safeguarding Children & LAC Redbridge
Apologies / Not present		
Ceri Jacob	CJ	Managing Director (BHR NEL CCG)
Doug Tanner	DT	Children's & Maternity Commissioning Lead
Hilary Shanahan	HS	Interim Head of Quality & Clinical Governance
Jig Tailor	JT	Senior Commissioning & Contract Manager BHR
Kate Byrne	KB	Designated Nurse Safeguarding Children & LAC B&D
Maggie Jeffrey	MJ	Deputy Head of Commissioning & Contract Management
Ronan Fox	RF	Joint Children's Commissioner B&D
Sarah Luke	DrSL	Designated Dr Safeguarding Children B&D and Redbridge
Vikki Gatley	VG	Designated Clinical Officer for SEND

No	Agenda Item & Minute
1.	i. **Welcome, introductions and apologies:** Due to the restrictions during Covid-19 the meeting took place via MS Teams with some members joining from room 7B/C North House. MGC welcomed everyone to the meeting and apologies were noted ii. **Declaration of conflict of interest** ***(Types of interest - financial, non-financial professional, non-financial personal, indirect)*****:** MGC invited attendees to express any conflicts of interest. None were expressed

2.	**Minutes of previous meeting and matters arising:** Minutes of the last meeting held on Wednesday 22 September 2021 were reviewed and agreed
3.	**Action Log:** The Action Log was reviewed and updated accordingly
4.	**Children's Commissioning Assurance Report:** GM presented the report, highlighting the following: • ASD/ADHD and Challenging Work behaviour workstream: The business case has been slowed as there is an urgent requirement for external Business Intelligence (BI) support. This has now been escalated to ICEG as a system risk, CYPTB taking risk forward to ensure issues are overcome and funding is delivered • SEND: One issue relating to disinvestment to SALT DCO trying to work and bring the parties together. Some work on recruitment and retention of AHP's identified as a serious issue and taken forward to the workforce academy • RSV: Anticipated surge remains an issue, RSV activity is not very much higher than the seasonal norm but there are a lot of sick children and large numbers of under 5s attending ED – related to difficulty with seeing GP f2f. Primary Care (PC) are very busy and the UEC team are working with DrRB around this. There is additional inpatient capacity at King George's along with establishing a Paediatric Assessment Unit there • CAMHS crisis with ED: Additional inpatient capacity and various workstreams looking at "cooling-off "models • Vaccinations of 12-15-year-olds group have been predominant. Have not had any negative issues escalated to CYP as PC CCG are dealing with most of the planning. However, it is reported that there is low uptake across NEL. Lots of work done with Comms to ensure CYP and families have pertinent information, and that they also have the facility to discuss with a trusted clinician, if they wish to do so • CETRs: A business case is being put together for a dedicated commissioner across NEL - to be submitted in November • NELFT request to reduce the KPIs, now a working party reviewing this to work towards satisfactory KPIs • MGS raised CAMHS children issues: 2 with lengthy delays in obtaining a bed. Quality leads are working on all Q&S KPIs across NEL, requesting appropriate information and that KPIs are appropriate
5.	**Barking and Dagenham Safeguarding Assurance Report – Children:** Apologies received for KB**,** SN highlighted the following: • Greenwich Safeguarding Children Partnership is undertaking an LCSPR in relation to the murder of a 15-year-old boy in Woolwich on 5th July. Five boys have been arrested and all have been charged with either the murder and/or attempted murder. Four of the five are Kent young people and the 5th appears to have been residing in Kent but it is understood that he is a B&D child allocated to YOS. The first panel meeting has taken place with representation from B&D YOS • Demand and capacity were discussed at the October LAC Zoning meeting, as there are currently 12 slots per months for IHAs, however more children than that come into care per month. NELFT have agreed to offer extra slots to attempt to meet demand, however this is not a long-term solution. It was requested that this concern be reflected in the ongoing LAC review currently underway across NELFT • The designated nurse has been informed of four child deaths (240, 241, 242, 243) in this reporting period. Baby 240 died in GOSH with known mitochondrial disorder. Baby 241 died at NUH NICU with extreme prematurity. Baby 242 died at St Marys Hospital aged 3months of sepsis - unexpected. Baby 243 died at GOSH aged 18 months old of sepsis and RDS, requiring inotropes, ECMO etc. • B&D were successful in their bid to work with the Centre of Excellence for Child Sexual Abuse, chosen as one of three pilot sites (Bristol and Lincolnshire) to take forward pathway and strategy

	development. On 12 October members of the CSA working group met with the Centre of Excellence for module 1 on the Theory of Change model, with good engagement and participation from across the partnership to develop the CSA response pathway. It is noted that with the development of the CSA service, pathway and strategy there may be unidentified financial resource implications moving forward • With the development of the CSA service, pathway and strategy there may be unidentified financial resource implications moving forward • MGC updated on Section 2.1 SI 2020/1027: SI declared by BHRUT in Jan 2020 – now identified an independent investigator for the Level 3 Independent Investigation
6.	**Havering Safeguarding Assurance Report – Children:** PA presented the report, highlighting the following: • Most risks remain the same. The CCG has now reached 92% compliance re safeguarding children training. Only one member of staff is non-compliant and PA is following -up • NELFT re SG and LAC: compliance regarding training, supervision, IHAs and RHAs is still unknown due to the data being unvalidated. The CCG has been assured that validated data will be provided from September 2021 onward which should identify areas of compliance/risks • Child Deaths: ➢ 1 year 11 months old baby boy sadly found deceased face-down on his mattress, the death was unexpected but deemed not suspicious ➢ Stabbing of 2 x 16yrs old boys both from Havering, a 3rd boy is being treated for stab wounds in The Royal London Hospital under police protection. All three boys are known to NELFT and social services • SIs: Most of the SIs relate to maternity services at BHRUT. PA plans to meet with HS to determine if any of the SIs have been closed down • Training sessions re CSA Hub with the local authority with the aim to improve compliance of referral into that service and raise awareness. Clarity is needed regarding the referral pathway as it is unclear of health services can refer directly into the hub • Investigation of historical abuse in a residential school: The CCG has been contacted by the Designated Nurse for Safeguarding Children in Waltham Forest. One former resident of the school is now in a care home in Havering, contact has been made with family. GP is aware but this is for information only at the present time. • PA confirmed for DrSN that the boys involved in the stabbing are not LAC and that the CSA Hub training being offered is to raise awareness and improve referrals • MGC suggested comms work for wider NEL colleagues, and PA agreed **ACTION: PA to arrange BHR-wide communication on the CSA Hub Training to include Primary Care, Health Visitors, Early Years etc, wherever appropriate** • A discussion followed around referrals of abuse of children, including that the police and Health are now able to make direct referrals **ACTION: PA to ask Anna Redel for clarification on the process of child abuse referrals**
7.	**Redbridge Safeguarding Assurance Report – Children:** SN presented the report, highlighting the following: • Section 3.2 SI 2020/3265: 21-month-old boy attended ED on 13 January 2020 with injury to his right leg. Dr Sarah Luke contacted Paediatricians at Queens Hospital. Report of February last year has been shared and hopefully dealt with • Large number of SIs with lots awaiting further information requests or stop clock. • Section 3.14 2020/1171 – raised by Whipps Cross death of mother in labour in Jan 2021. Report shared in Sep 2021 with MGC and HS

	• Child deaths since 1st April: 8 for Redbridge, being dealt with appropriately • LADO: GP working for NELFT still not back in the country • Compliance training figure up to 97% • 1st quarter for IHAs at 81.2% and 85% for RHAs • MGC updated on the significant increase in FIRs. Once the SI has been investigated and the report submitted, it then goes through CSU colleagues to undergo quality assurance review. If any elements are missing or are not covered enough, then the information is sent back. There is currently lots of work around improving SI reporting, but quality is now diminishing with issues raised around the time taking to them to be returned. MGC will circulate a very helpful report on what the key trends are around FIRs, including attention to details using correct gender, poor grammar, incorrect dates. Full discussion scheduled for next week with BHRUT • MGC added that with emerging changes to the way SIs are managed, the focus will fall onto provider organisations to decide which incidents will be investigated going forward. Expectation that patient strategies will change but NEL need to have an oversight **ACTION: MGC to circulate a copy of the report on FIRs with members of ISAB**
8.	**Designated Doctor for LAC BHR IHA Report:** DrSN added her reflection to the minutes from the last ISAB meeting of 22 September, where she was not in attendance: • HCSA situation discussed around LAC; DrSN stated it is nationally accepted that children do disclose sexual abuse in their LAC health assessments. Quality audits demonstrate that in a sample of ten IHAs, usually one of two CYPs will disclose sexual abuse, more often than not referral to the police/SW would not be appropriate, however, referral to the HCSA service would be required and it is DrSN's understanding that referral pathways were reviewed to ensure acceptance of referrals from other health services a number of years ago. Clarity on the referral pathway is required. • Very clear in IHA concerns meetings "only designated doctors and doctors disagreed with me about the IHAs" • A discussion ensued around the phrase in DrSNs ISAB report stating that, "...it is hard to imagine that this issue could have existed for the number of years that it has without anyone (other than DrSN) rasing this….". DrSN clarified that in the IHA concerns meetings, chaired by MGC and attended by directors from both the CCG and NELFT, the latter had stated that only DrSN had concerns around quality of the IHA service and that their doctors disagreed. This does not align with DrLA's report or comments that concerns have been raised by other doctors. DrLA clarified that this was not the quality of the IHAs being highlighted specifically, but doctors had been raising their concerns. • DrSN commented the raising of those concerns and the recognition from NELFT that there were elements for improvement following the publication of JH's study. • MGC clarified that doctors have been raising concerns in NELFT. We recognise long standing issues that have been raised. There is ongoing Quality and Improvement work, to ensure effective assurance and oversight. Diane Jones is taking a suggestion to SMT for a request for an independent commission to carry out work to oversee quality assurance • MGC asked members if they know of any doctors who have experience and understanding of LAC to forward their details to MGC • MGC reported that the Q&S team are having discussions with the Children's Commissioning team to ensure we have the correct picture across the service
9.	**Barking & Dagenham Adults Safeguarding Assurance Report:** EM presented the report highlighting the following: • Section 5.0 Learning Disabilities Mortality Reviews: Across NEL there have been a total of 40 LeDeR reviews since the transferral to the NHS England LeDer Platform web-based system

	• Section 8.0 SARs: On 20/10/21 at the LBBD Safeguarding Adult Board meeting SAR Alice case was discussed. This young lady had been moved to multiple borough accommodation, and was taken into care at 10-years-old and diagnosed with Autism, mild learning disabilities, ADHD and signs of personality disorder. Sadly, Alice died of a drug overdose in July 2018 at the age of 18. EM added that there appears to be an increase in the number of cases that slip through the net once vulnerable young people reach 18-years-of-age. EM reported that this matter is to be taken to the Children's SG Committee for further discussion • A man who died in October last year had multiple pressure areas despite being under the care of community nurses. This incident was not referred as a potential SAR until after the SI report had been completed by NELFT. Further details to follow, but the case is to be considered at the next meeting of the SAR Committee
10.	**Havering Adults Safeguarding Assurance Report:** EM presented the report highlighting the following: EM reported no update with staff adult training compliance as no figures received from NELFT since Q1 2021/22. There has been no update on amendments to the current Safeguarding Adult training framework at NELFT despite confirmation from them that they would use the nationally agreed SG L1 L2 & L3 training framework as of 1st April 2022 **ACTION: MGC to have conversation with Ruth Blackburn at NELFT regarding progress on the safeguarding training reviews** • Section 4.0 Care homes with Nursing: The next LQSG meeting is scheduled for 2 November. EM attended the City & Hackney equivalent meeting on 20th Oct meeting hoping to see how other care home assurance monitoring and SG concerns are shared. EM is currently working with the designated nurse from City & Hackney who is attending the next LQSG meeting and EM will be attending their equivalent meeting at City & Hackney going forward • Section 6.0 LeDeR: The delays in the roll-out of the platform have now been addressed. All Local Area Co-Ordinators have access to the system. Received 5 cases for Learning Disability Death Reviews, and all cases have been allocated and are either in progress or completed • MGC reported additional resources for LeDeR may be available as a result of the consultation. • Section 9.0 SARs: A new referral received in relation to a 31-year-old female with Unstable Personality Disorder under the care of a number of agencies between November 2002 and April 2016. She attempted suicide by hanging and was taken to Queens Hospital where she sadly passed away on 02/11/2020. In June 2020, a Serious Incident was declared by NELFT in relation to the deceased and the final report has now been issued. A SAR Panel meeting was held on 14 October and currently awaiting outcome of the chairs' decision if to progress as a SAR • PA updated that there was a dispute if this suicide was a result of self-neglect so a final decision is to be made
11.	**Redbridge Adults Safeguarding Assurance Report:** SH presented the report, highlighting the following: • Section 2. Assurance Report: Absence of Named Dr Safeguarding Adults for Redbridge, B&D and Havering now transferred onto NEL corporate register in Q2. CCG Training Q2 data demonstrates compliance. Prevent 98.97 % and Safeguarding Adults (Level 1) 95.36%. • P3: Supervision policy and framework, Diane Jones confirmed waiting until staff consultation is completed until shared so currently on hold • 2.2 NELFT Training Compliance: Unable to obtain Q2 data. Remains an issue and discussed and raised at numerous meetings • Section 3: Care Homes with Nursing • 3.2 Springfield Care Centre: Concerns raised in relation to an alleged incident involving a staff member who is alleged to have physically and emotionally abused a resident. Strategy meeting held on 18/10/2021. The decision made was to progress the anonymous concern as an individual safeguarding enquiry as it had been found that there was only one resident requiring

	assisted feeding. Thematic issues identified from safeguarding concerns involving Springfield will be addressed through the quality assurance and contracts monitoring process and the service improvement plan that is in place • Vi and John Rubens House (Jewish Care): In addition to the above there remains to be an open Section 42 Enquiry in relation to a resident who sustained a pressure ulcer to a heal. The LA progressed the concern to a Section 42 Enquiry and a convened virtual strategy meeting on 13/10/2021. Actions arising from this meeting will be reviewed at a review strategy meeting scheduled for 10/11/2021 • Greenmantle Care Home (Woodford): A concern was raised by Essex NHS Foundation Trust in relation to alleged financial abuse. LBR reviewed the case and concluded that the LA would not be making any further enquires as other agencies are carrying out reviews. SH was asked by the referring organisation to challenge this with the LA but was informed that the matter is closed from an LBR perspective and SH has relayed this information • Section 4.0. Primary Care SG Adults training: RSAB are facilitating a series of training events, details within SH report. All events have been circulated to Redbridge GPs via the GP Newsletter • Section 5.0 Prevent: Recent data contained within SH report. SH highlighted information on the new National Referral Form (NRF). LB Redbridge has not confirmed adopting this form and discussions are in place. MET Police want to be informed of any concerns and after deconfliction information is sent to LA MASH Teams • Section 7.0 LeDeR: 3 reviews in Redbridge in progress; one allocated to a reviewer that started last week and the family have recently decided to support the review process • Section 8.0 Liberty Protection Safeguards: Implementation timetable remains unchanged for April 2022. SH & EMG supported BHR CCG CHC Team Manager with the NHSEI 1ST Readiness Audit and SH and EMG continued to support the NEL Task and Finish Group • Section 8.8: Free webinar “Approaching the Court of Protection for Medical Decisions” on 22 October 2021 for Social Workers was shared with LBR LA. This was cascaded to all SWs in Redbridge • Section 10: Domestic Homicide and SARS: 10.2 One SAR action plan in place “SAR George “. Domestic Homicide review LM/ RM in August 2019 - DHR report V6 recently submitted to the Coroner. Verbal update provided by SH since writing SH report; inquests were due to be heard at Walthamstow Coroners Court on 23/24/25 November 2021. Potential for update at next ISAB meeting • Section 11: Legislation Updates/ National Updates / Events • 11.22 (1) September SCIELine video produced for Liberty Protection Safeguards. This video is short and informative, and to be used in training going forward • (2) London Adults SG Adults Annual Conference scheduled for 16 November 2021 • (3) National Safeguarding Adults week 15-21 November 2021. SH to draw up information and forward to NEL CCG COMS team for cascading and for inclusion in the GP bulletin. EM and SH have scheduled a session with GPs in Redbridge. A presentation and resource pack have been developed for the event
12.	**Designated Doctor Safeguarding Assurance Report (Havering):** DrLA presented the report, highlighting the following: • DrLA reported interviews taking place in November for consultant with Named Doctor responsibilities for Havering. 2 candidates with one who is understood to be known to the service and of good standing

	• Doctors come back to discrepancies in paediatric staffing and this remains an issue. Discussed at Paediatrician meeting last Friday 22 October re getting more trainees into post so being actively addressed within the organisation and DrLA to monitor progress • Designated Doctor role still not advertised with no imminent possibility of appointing to this role
13.	**Named GP Safeguarding Assurance Report (Havering and Barking & Dagenham):** DrRB presented the report, highlighting the following: • RR and DrRB have organised a section 11 Audit with a template set-up by London named GPs, in particular in Ealing. DrRB reported that this is quite a good tool that is amendable and online There are approximately 60 questions that we are looking at to modify to be more focused on BHR, and looking to see if NEL would undertake this also from a corporate point of view • GPs are currently under immense pressure, with concerns that now may not be a good time to request completion of the audit DrRB is hoping to meet with Dr Jagen John the NEL and B&D Chair of the Clinical leads and CCG re B&D Iris Adults SG Programme for Domestic Abuse. 6 practices have not engaged but over 75 engaged practices which is good in comparison to other areas in NEL. Great programme and offer within B&D • MGC: P4. LIZ – work is progressing and at speed. Primary Care – SH understood Professional Nurse Advocate Course to be opened up further
14.	**Designated Doctor Safeguarding Assurance Report (Redbridge and Barking & Dagenham):** Apologies received for DrSL, no update report submitted
15.	**Redbridge Nurse Consultant Safeguarding Children Assurance Report:** RR presented the report, highlighting the following: • RR reported still awaiting figures from Social Care on Child Protection conferences and being carried through as a Local Incentive Scheme (LIS)
16.	**Child Death Overview Panel (CDOP) Update:** JF presented the report, highlighting the following: • JF reported that Barts has nobody in post to deal with Child Deaths. DrSL and JF met with Lead Nurse, and also met with MGC and SN to discuss this as a cross-borough issue • 2 boys stabbed – CDOP look at themes and this is the 3rd death caused by stabbing in Havering in one year • MGC – CDOP are directly unaffected by the consultation but there will be some change of line management. MGC has put forward recommendation to Diane Jones that line management is delegated to the Deputy Chief Nurse. as CDOP sits within the Quality arena but has strong links to Safeguarding and works closely with the Designated Nurses
17.	**GP Practice Training Feedback:** DrRB/RR gave feedback highlighting the following: • RR reported that following a conversation with London GPs and MGC, this conversation has been superseded by the Section 11 work that is ongoing
18.	**Escalations:** • DrSN and PA amendments to the Risk Register – MGC is awaiting confirmation of agreement of the amendments. Quality meeting scheduled for 5 November. DrSN would like to see a copy of the agreed Risk Register. MGC added that currently awaiting updates from City & Hackney but happy for all to see the final version
19.	**AOB:** • MGC reminded all that the consultation deadline closes today

	• RR asked about plans to replace SN who retires on 31 December. MGC is working on the assumption that nothing is happening yet due to the consultation, being that a colleague across NEL may wish to move over to Redbridge or once the consultation is concluded the post will go to advert internally, and if no interest internally then national advertising via NHS Jobs • JB updated all on the team catch-up date. Most chose Friday so a discussion took place on which date in November. All agreed Friday 26 November for a team day in the office for Christmas, cakes and coffee. MGC reminded all to book a desk on the 7th Floor. JB to book 7A/7B meeting room for team lunch
18.	**Date of next meeting:** Wednesday 24 November 2021 @ 10:00 – 12:00