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Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD
## AGENDA

| 1.00 pm | Wednesday, 27 January 2021 | Virtual Meeting |
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Members: 16, Quorum: 6

**BOARD MEMBERS:**

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| Elected Members: | Cllr Robert Benham<br>Cllr Jason Frost (Chairman)<br>Cllr Damian White<br>Cllr Nisha Patel |
| Officers of the Council: | Andrew Blake-Herbert, Chief Executive<br>Barbara Nicholls, Director of Adult Services<br>Mark Ansell, Interim Director of Public Health |
| Havering Clinical Commissioning Group: | Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG)<br>Ceri Jacob, BHR CCG |
| Other Organisations: | Anne-Marie Dean, Healthwatch Havering<br>Jacqui Van Rossum, NELFT<br>Fiona Peskett, BHRUT |

**For information about the meeting please contact:**
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## What is the Health and Wellbeing Board?

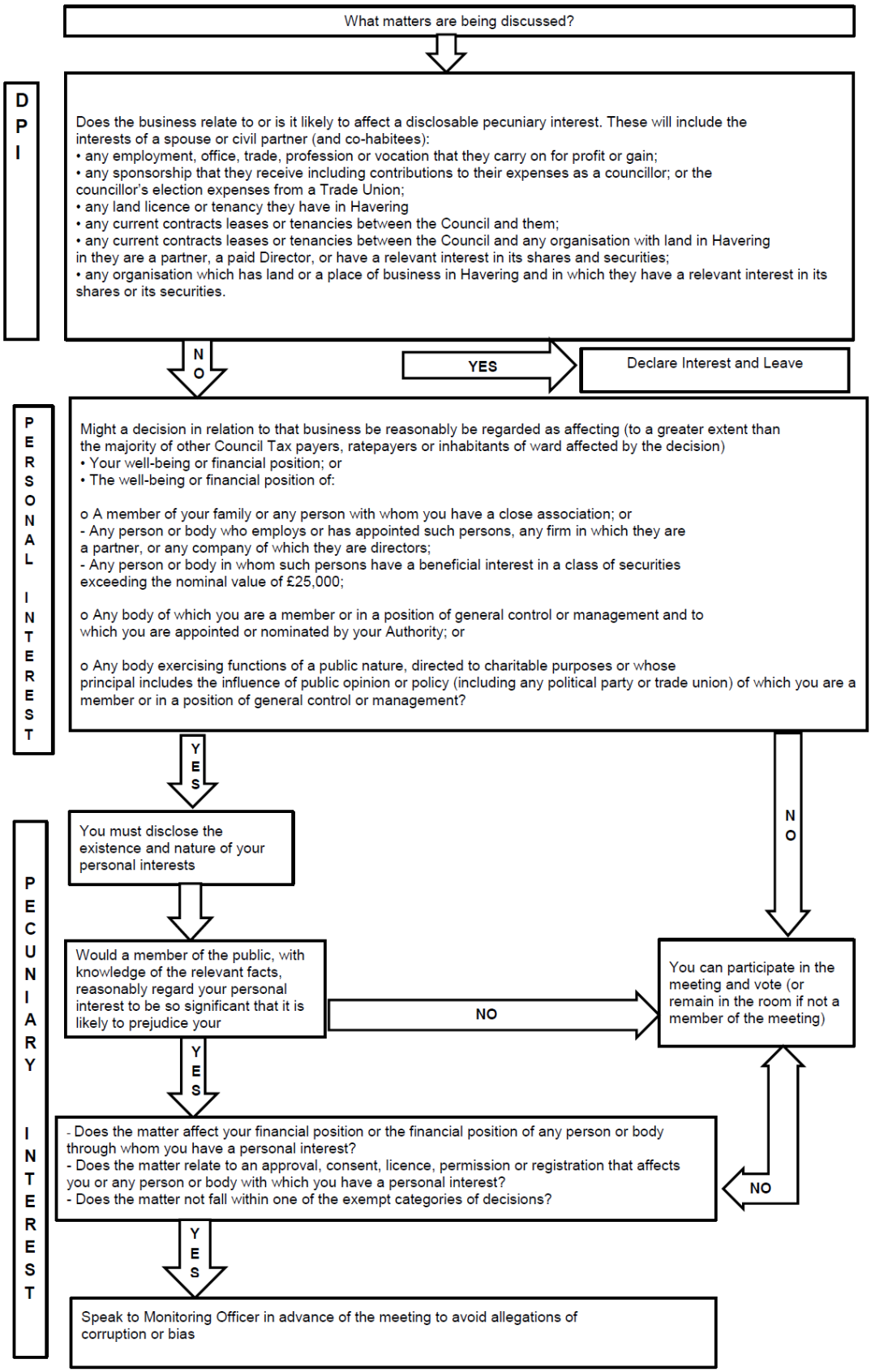
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

## What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information

## DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



## AGENDA ITEMS

**1 CHAIRMAN'S ANNOUNCEMENTS**

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

**2 APOLOGIES FOR ABSENCE**

(If any) – receive

**3 DISCLOSURE OF INTERESTS**

Members are invited to disclose any interest in any of the items on the agenda at this point of the meeting.

*Members may still disclose any interest in any item at any time prior to the consideration of the matter.*

**4 MINUTES** (Pages 1 - 4)

To approve as a correct record the minutes of the Committee held on 25th November 2020 and to authorise the Chairman to sign them.

**5 MATTERS ARISING**

To consider the Board's Action Log

**6 ANY OTHER BUSINESS**

**7 UPDATE ON DEVELOPING GOVERNANCE ARRANGEMENTS FOR INTEGRATED CARE SYSTEM** (Pages 5 - 30)

Report and appendices attached.

**8 COVID-19 UPDATE** (Pages 31 - 38)

Repot and appendices attached

## 9 DATE OF NEXT MEETING

The next meeting is to be held on 24th February 2021 at 1pm via Zoom.

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**MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD**
**Virtual Meeting**
**25 November 2020 (1.05 - 3.00 pm)**

**Present:**

**Elected Members:** Councillors Jason Frost (Chairman), Damian White and Nisha Patel

**Officers of the Council:** Barbara Nicholls (Director of Adult Services) and Mark Ansell (Interim Director of Public Health)

**Havering Clinical Commissioning Group:** Dr Atul Aggarwal (Chair, Havering Clinical Commissioning Group (CCG))

**Healthwatch:** Anne-Marie Dean (Healthwatch Havering)

BHRUT: Fiona Peskett (BHRUT)

**Also Present:** Elaine Greenway, Gill Butler, Kevin Engstrom, Paul Rose**,** Paul Walker**,** Sarah See**,** Ratidzo Chinyuku**,** Luke Phimister

All decisions were taken with no votes against.

20 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman reminded Members of the action to be taken in an emergency.

21 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Andrew Blake-Herbert and Robert South.

22 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

23 **MINUTES**

The minutes of the meeting of the Committee held on 21 October 2020 were agreed as a correct record and, due to COVID-19, will be signed by the Chairman at a later date.

24 **UPDATE ON COVID-19**

The Board was given a verbal update by Mark Ansell, Director of Public Health on the Borough's COVID-19 figures.

Board members noted that incidence rates for London and England had started to fall but the Havering rate had continued to increase although at a slower rate. Assuming benefits of second lockdown continue rates in Havering are likely to peak around 400 cases per 100,000 people - higher than in many areas previously put into tier 3 / very high alert level. Rates amongst working age adults had decreased with lockdown but rates in school aged children and young people had continued to increase quickly with no sign of it slowing. Early years children had low rates with the main increase coming from secondary school ages. It was noted that on some days almost half of all secondary school pupils were not attending school due to either being cases or close contacts of cases. Members noted that Havering schools import children and young people from adjoining authorities and a joint approach would be necessary.

Further work is underway to understand why rates were higher amongst Asian residents. No clear pattern was evident - with high rates across the borough as a whole and particularly hotspots appearing at different locations at different points in time with no obvious relationship to levels of disadvantage as had been reported elsewhere.

It was noted by the Board that as of the 20th November 2020, BHR hospitals had 245 inpatients testing positive for coronavirus, occupying more than 25% of beds and 18 such patients had died in the preceding week. It was noted that a quarter of deaths had COVID as a contributing factor.

Members were updated on the new tier system and it was explained that London as a whole was expected to be put in Tier 2 when lockdown ended. It was noted that Tier 2 restrictions had not stopped cases increasing in Havering prior to lockdown but there had been some tightening up to further help control the spread of COVID. Board members were advised that if the borough remained in Tier 2 that additional intervention (and funding) would be needed focused on older teenagers and working age adults.

Members were then updated on the contact tracing by Kevin Engstrom. There had been challenges due to delays in accessing the national database, duplicate records and the time delay between testing positive and records being updated. The Board was advised that the activity based on advice from NHS Test and Trace was expected to be 10 per week had grown to 20-30 cases per day, often received four or more days after testing positive. It was also noted that some records had incomplete information and some cases in the same households had been contacted on multiple times days.

The Board was then updated by Elaine Greenway on asymptomatic testing using lateral flow devices. It was noted that NHS staff were processing their own tests but LFDs weren't currently approved for use in this way in the community. In the community, people self-swabbed but tests had then to be processed by a trained operative. Results could be given in 30 minutes but a dedicated testing team was needed. It was explained that the sensitivity of LFDs was lower (50-70%) vs PCR tests (+98%) so that a proportion of

positive cases would be missed. Nonetheless introduction of LTDs was progress as currently asymptomatic cases weren't tested at all. A number of pilots were being planned including the self-employed, day-care providers and commuters.

The Board **noted** the COVID-19 and contact tracing updates.

## 25 DEVELOPMENT OF HOUSING STRATEGY

The report presented to the Committee outlined Havering 2021-2026 housing strategy.

Board members noted that the Council was still aiming to deliver 12 new estates in the Borough. Members noted that the strategy was in the consultation phase which would end in November 2020 with a plan for cabinet approval in March-May 2021 for implementation starting June 2021. It was described that the strategy would consider the new domestic abuse, and building safety bills and would work towards the commitment of ending rough sleeping by 2024.

The Board were concerned that the growth in housing development may stretch services that the public may perceive to be already stretched. A proposal was put forward to determine the capacity and or increased pressure on primary care services as a result of the housing development.

The Board **noted** the report.

## 26 ANY OTHER BUSINESS

Paul Rose advised the Board of a three-fold increase in the number of calls regarding mental health issues that required greater resilience and deployment of new staff to handle care calls and befriending in the voluntary sector. A proposal was put forward to have a joint conversation between NELFT representatives and voluntary sector to assess capacity needs for public mental health.

The Board requested an update on the immunisation of care home staff against seasonal flu in the context of usual efforts to manage winter pressures and in preparation for the COVID Vaccine

## 27 DATE OF NEXT MEETING

The next meeting of the Board would be held on Wednesday 27 January at 1.00 pm.

**Chairman**

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

**To:** Havering Health and Wellbeing Board

**From:** Alison Blair, Director of Transition

**Date:** 27 January 2021

**Subject:** Barking & Dagenham, Havering and Redbridge Integrated Care Partnership (BHR ICP) Governance

**Summary**

This report provides an update on the development of the governance arrangements of the Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership (ICP) in the context of the wider north east London (NEL) Integrated Care System development.

The BHR CCGs' governing bodies in common held on 24 September received an update on the proposal to merge the seven north east London CCGs into one CCG from April 2021 and approved the submission of a single CCG application to NHSEI on 30 September 2020; and taking the proposal to merge to a vote of GP members in October 2020.

The outcome of the vote was declared on 20 October 2020 with members of the seven north east London CCGs supporting the merger to form a new, single North East London CCG. The applications to NHSEI was conditionally approved in November 2020. This outcome allowed the three systems across north east London to further develop local integrated care partnerships.

NHSE/I have also confirmed that North East London has been designated as an Integrated Care System (ICS). This follows an application process in November and a follow-up discussion with the regional team before a plan was submitted to the national team for a decision. North East London had originally been aiming for April 2021 in line with the Long Term Plan, but due to the progress made over recent months and the strong history of collaborative working in NEL, we were in a position to apply earlier and gives us the momentum to move forward to the next stage of our ICS development. The ICS designation will really strengthen our ability to collectively address health inequalities and ultimately improve the health and wellbeing of our local population.

There is a commitment from North East London CCG colleagues that the 80/20 principle of subsidiarity will apply in the future whereby the majority of functions and resources will be delegated to the ICP. From 1 April 2020 the BHR integrated care partnership board will have delegated responsibility for functions as set out in the attached terms of reference. There will be occasions where decisions will be reserved for only members of the CCG, the terms of reference set out how these decisions will be taken which will ensure that other members of the ICPB will continue to be present subject to the management of any conflicts of interest**.**

Further development of the structures to support the ICP at a borough partnership continue and partners will want to explore further delegation at this level. Borough Partnerships will be a key element of the BHR Integrated Care Partnership bringing together delivery of health and care services around the needs of local people. This will include input around the wider determinants of health, at a community/place-based level. Borough Partnership development will be led by the respective Local

Authority Chief Executives in each area, who will also link them into the work of the Health and Wellbeing Boards to deliver the aspirations of more integrated care, closer to home, supporting local people to remain well for as long as possible, and drawing in support for the wider determinants of health (e.g. housing, debt management, employment) as required.

The BHR ICP has significant and strong clinical and professional leadership with the views of clinicians and professionals represented at every level. Clinical and professional leaders work across the system focussing on what is best for residents, improving outcomes, assimilating evidence and solutions workable for practitioners. Borough members forums supports the work of the BHR ICP and will be led by each of the borough clinical directors (current BHR CCG Chairs) of the north east London CCG governing body.

The three main bodies of the BHR ICP will be:

- The Integrated Care Partnership Board (ICPB) – the ICPB will deliver on the expectations of population and patients for their health and care services and provide strategic leadership for, and delivery of, the overarching strategy and outcomes framework for the ICP; it will also provide oversight and facilitation of the transformation and design of the health and care in BHR, in particular facilitating the establishment Borough Partnerships and the Primary Care Networks (PCNs).
- The Integrated Care Executive Group (ICEG) – the ICEG will support the ICPB in its decision making by providing a forum for emerging ideas and proposals to be tested, ensure early engagement and involvement of key senior leaders from across the health and care system in the development of the BHR ICP and build collective understanding of important strategic issues so as to take such knowledge and insight into statutory organisations at the highest level.
- The Health & Care Cabinet (H&CC) – the H&CC will provide health and care clinical and professional leadership to the BHR ICP, ensuring that transformation boards develop robust proposals that are safe and effective and that the reasons underpinning financial assumptions are appropriate in terms of health and care. The H&CC will make decisions and at times, recommendations to the ICPB.

All partners have contributed to the development of the proposed governance arrangements of the BHR Integrated Care Partnership, including the Integrated Care Partnership Board, the BHR system leaders, BHR system governance leads and legal advisors Browne Jacobson. The ICPB terms of reference will be reviewed in the autumn 2021 to ensure they are fit for purpose for April 2022, when the national model for integrated care is expected to commence.

The attached slides set out:

- Governance structure
- Terms of reference for the Integrated Care Partnership Board

An OD programme is being planned for the ICPB to be delivered by legal advisors, Browne Jacobson during February and March, which will cover

- Scene setting: ICS and ICP
- The ICPB – its function and role
- Statutory vs policy decision-making
- Decision-making scenarios.

**Recommendations**

The Health and Wellbeing Board is asked:

- to note and comment on the update
- to approve the Integrated Care Partnership Board Terms of Reference

**Appendices:**

- BHR ICP governance structure
- BHR Integrated Care Partnership Board Terms of Reference

Author: Anne-Marie Keliris, BHR ICP Governance programme lead
Date: 12 January 2021

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

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

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

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| | 6. The ICPB is established and constituted in accordance with the Codes of Conduct: code of accountability in the NHS (July 2004) and the UK Corporate Governance Code (June 2010).<br><br>7. The BHR ICP will operate within the NEL ICS/CCG reporting to the NEL ICS/CCG in relation to the exercise of its functions. These terms of reference will be reviewed in 2021/22 in line with developing national guidance and legislative framework. |
| **Part 1: Terms of Reference for the ICPB** | |
| **Status** | 8. The ICPB is a non-statutory partnership body, that brings together representatives from across the ICP area to make decisions on policy matters relating to the ICP and on matters that the Member organisations have asked it to manage on its behalf.<br><br>9. It also incorporates Partner Organisation-specific structures that have been established in order to enable statutory decisions to be taken within the ICPB structure, to the extent permitted by law. These are set out in Part 2.<br><br>10. The ICPB is founded on the basis of a strong partnership with representation from across the BHR health and care system, including from the CCG, local provider trusts, local authorities and primary care providers.<br><br>11. The ICPB will be supported by the ICP Executive Group, which will lead on the delivery of the ICP strategy and vision agreed by the ICPB, and by the Health and Care Cabinet, which will have responsibility for the development and review of pathways, as well as being the primary forum for the provision of health and care expertise and advice to the other parts of the ICP governance. Both the ICP Executive Group and the Health and Care Cabinet are non-statutory partnership bodies, like the ICPB.<br><br>12. The ICPB will formally commence its operation on 1 April 2021. |
| **Principles** | 13. The ICPB and its Members agree to abide by the following principles:<br><br>13.1. Encourage cooperative behaviour between ourselves and engender a culture of "Best for Service" including no fault, no blame and no disputes where practically possible.<br><br>13.2. Ensure that sufficient resources are available, including appropriately qualified staff who are authorised to fulfil the responsibilities as allocated.<br><br>13.3. Assume joint responsibility for the achievement of outcomes.<br><br>13.4. Commit to the principle of collective responsibility and to share the risks and rewards (in the manner to be determined as part of the agreed transition arrangements) associated with the performance of the ICP Objectives. |

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| | 13.5. Adhere to statutory requirements and best practice by complying with applicable laws and standards including EU procurement rules, EU and UK competition rules, data protection and freedom of information legislation.<br><br>13.6. Agree to work together on a transparent basis (for example, open book accounting where possible) subject to compliance with all applicable laws, particularly competition law, and agreed information sharing protocols and ethical walls. |
| **Role** | 14. The ICPB will seek to act in the best interest of residents in the BHR health and care system as a whole, rather than representing the individual interests of any of its members.<br><br>15. The role of the ICPB is as follows:<br><br>15.1. to oversee delivery on the expectations of population and patients for their health and care services;<br><br>15.2. to provide strategic leadership for, and delivery of, the overarching strategy and outcomes framework for the ICP;<br><br>15.3. to provide oversight and facilitation of the transformation and design of the health and care in Barking & Dagenham, Havering and Redbridge, in particular facilitating the establishment Borough Partnerships and the Primary Care Networks (PCNs);<br><br>15.4. to provide collective accountability for delivery to the partner organisations, through its membership and reporting arrangements;<br><br>15.5. take collective decisions on matters that it has been asked to manage on behalf of one or more partner organisation;<br><br>15.6. along with the ICP Executive Group, to be the forum within which, to the extent permitted by law, Members take reserved statutory decisions;<br><br>15.7. take collective decisions on the use of any ICS funding allocated to the ICP;<br><br>15.8. promote and model partnership working within the ICP;<br><br>15.9. negotiate and robustly manage any actual or potential conflicts of interest, in accordance with applicable guidance and legal requirements.<br><br>16. Where a Member organisation has asked the ICPB to manage functions on its behalf, these are set out in Part 2 to these ToR. The ICPB may in turn ask that these management functions are devolved to another part of the ICP governance structure, provided that it ensures appropriate oversight and reporting arrangements are in |

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| | place so as to meet its own obligations, as set out in Part 2 to these ToR. |
| **Duties** | 17. The ICPB's duties shall include:<br><br>17.1. producing and championing a coherent vision and strategy for health and care for the ICP;<br><br>17.2. developing and describing the high-level strategic objectives for the system that are related to health and wellbeing;<br><br>17.3. producing an outcomes framework for the whole of the ICP to deliver increasing healthy life expectancy, address local variation and seeking to reduce health inequalities;<br><br>17.4. undertaking stakeholder engagement which will include engaging with staff, patients and the population;<br><br>17.5. developing a coherent approach to measuring outcomes and strategic objectives within the framework;<br><br>17.6. ensuring the delivery of high-quality outcomes, putting patient safety and quality first;<br><br>17.7. having oversight and management of the ICP financial resources, reporting to the ICS and to Member organisations as appropriate;<br><br>17.8. having responsibility for the collective delivery of those responsibilities that the ICPB is asked to manage on behalf of one of its Members. |
| **Geographical Coverage** | 18. The ICPB shall cover the Barking & Dagenham, Havering and Redbridge area. |
| **Membership** | 19. ICPB members are selected so as to be representative of the constituent organisations, but attend to promote the greater collective endeavour.<br><br>20. ICPB members are expected to make good two-way connections between the ICPB and their constituent organisations, modelling a partnership approach to working as well as listening to the voices of patients and the general public.<br><br>21. The membership of the ICPB shall include those individuals listed below:—<br><br>**North East London CCG**<br>Accountable Officer<br>Chief Finance Officer<br>Lay member |

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

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

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

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

**Part 2**

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

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

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| | *Commissioning Strategy: the Committee will have lead responsibility for the CCG's commissioning strategy in the ICP area. This includes exercising the following specific functions in this context:*<br><br>56.1. overseeing the health and care needs assessment process within the ICP area and supporting the CCG in the overall health and care needs assessment process in the ICP;<br><br>56.2. overseeing the development of the commissioning vision and outcomes setting, and supporting the CCG in the development of the overall commissioning vision and outcomes setting, within the ICP area;<br><br>56.3. overseeing the development and implementation of service specification and standards within the ICP area, ensuring that these are consistent with the overarching principles agreed by the CCG;<br><br>56.4. overseeing the development and implementation of a decommissioning policy within the ICP area, ensuring consistency with the overall policy agreed by the CCG.<br><br>*Population health management: the Committee will have lead responsibility for population modelling and analysis within the ICP area, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality. This includes exercising the following specific functions in this context:*<br><br>56.5. ensuring appropriate arrangements are in place to support the ICP to carry-out predicative modelling and trend analysis;<br><br>56.6. overseeing and implementing information governance arrangements within the ICP area;<br><br>56.7. overseeing the development and implementation of system incentives and re-alignment in order to deliver a response population health driven system.<br><br>*Market management: the Committee will work the ICPB, asking it to manage aspects of market management as appropriate, as part of its overall role in relation to this function, as follows:*<br><br>56.8. working with the ICPB to evaluate health and care services in the ICP area;<br><br>56.9. working with the ICPB to design and develop health and care services;<br><br>56.10. agreeing the strategic market shape for the ICP area, ensuring consistency with the overall objectives and principles agreed by the CCG for the ICP;<br><br>56.11. leading on horizon scanning within the ICP area. |

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

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

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| | • Section 223G – Means of meeting expenditure of CCGs out of public funds<br>• Section 223H – Financial duties of CCGs: expenditure<br>• Section 223I: Financial duties of CCGs: use of resources<br>• Section 223J: Financial duties of CCGs: additional controls on resource use<br>59. Annex 2 sets out which of the above Delegated Functions are Reserved Functions, to be exercised by the Committee only.<br>60. In performing its role, the Committee will exercise its functions in accordance with its Terms of Reference; the terms of the delegations made to it by the North East London CCG Governing Body and the financial limit on its delegated authority, which shall be the total budgeted resource allocated to the Committee.<br>61. Where there is any uncertainty about whether a matter relates to the Committee in its capacity as a decision-making body within the CCG governance structure or whether it relates to its wider local system role as part of the ICPB, the flowchart included in Annex [3 to these Terms of Reference will be followed to guide the Chair's consideration of the issue. |
| **Geographical Coverage** | 62. The geographical area covered will be the same as the ICPB. |
| **Membership** | 63. There will be a total of seven members, as follows:<br>**NEL CCG**<br>• Accountable Officer or nominated deputy<br>• Chief Finance Officer or nominated deputy<br>• Governing Body Lay Member (Chair)<br>• 3 x Clinical Directors (CCG Borough GPs)<br>• BHR ICP Managing Director<br>64. Any member of the ICPB will have a standing invite to attend all meetings of the Committee.<br>65. Although attendees will not have a formal decision-making role in relation to the Delegated Functions and will not be entitled to vote on such matters, they will be encouraged to participate in discussions and to contribute to the decision-making process, subject always to the Committee operating within the CCG's governance framework, including in relation to managing actual and potential conflicts of interest. |
| **Chairing Arrangements** | 66. The role of Chair of the Committee will be performed by the Governing Body Lay Member who is also a member of the Committee. |

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

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| | 79. Where confidential information is presented to the Committee, all members will ensure that they comply with any confidentiality requirements.<br><br>80. The Committee will meet [bi-monthly]. The frequency of meetings may be varied to meet operational need, with the Chair determining this as necessary and in accordance with the provisions for meetings set out above. |
| **Accountability and Reporting** | 81. The Committee shall be directly accountable to the North East London CCG Governing Body.<br><br>82. The Committee will ensure that it reports to the North East London CCG Governing Body on a bi-monthly basis and that a copy of its minutes is presented to the North East London CCG Governing Body, for information.<br><br>83. In the event that the North East London CCG Governing Body requests information from the Committee, the Committee will ensure that it responds promptly to such a request. |
| **Sub-committees** | 84. In order to assist it with performing its role and responsibilities, the Committee is authorised to establish sub-committees and to determine the membership, role and remit for each sub-committee. Any sub-committee established by the Committee will report directly to it.<br><br>85. The terms of reference for any sub-committee established by the Committee will be incorporated within the CCG Governance Handbook.<br><br>86. The Committee may decide to delegate decision-making to any of its sub-committees duly established but, unless this is explicitly stated within the terms of reference for the relevant sub-committee, the default will be that no decision-making has been delegated. Where decision-making responsibilities are delegated to a sub-committee, these will be clearly recorded in the Committee's SoRDM, which shall be maintained by the Secretariat to the Committee and incorporated within the CCG Governance Handbook.<br><br>87. The Committee may delegate funds from its overall budget to a sub-committee, provided that appropriate accountability and reporting arrangements are agreed and that these reflect the Committee's own financial reporting requirements. |
| **Monitoring Effectiveness and Compliance with Terms of Reference** | 88. The Committee will carry out an annual review of its functioning and provide an annual report to the North East London CCG Governing Body on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. |

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| **Review of Terms of Reference** | 89. The terms of reference of the Committee shall be reviewed by the North East London CCG Governing Body at least annually. |

**Annex [1]: Functions that the ICP Board will manage on behalf of the Committee**

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

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

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

    (a) service evaluation; and

    (b) service design and development.

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

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

    (a) community-based assets identification and integration;

    (b) integrated pathway-design;

    (c) service and care coordination;

    (d) place-based planning;

    (e) evidence-based protocols and pathways;

    (f) cost-reduction and demand management;

    (g) workforce strategy.

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

    (a) contract management and monitoring;

    (b) promoting continuous quality improvement;

    (c) safeguarding interventions and learnings;

    (d) regulatory liaison and relationship;

    (e) regular public outcome reporting.

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

    (a) political engagement;

    (b) clinical and professional engagement;

(c) public and community engagement;

(d) provider relationship management;

(e) strategic partnership management.

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

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

8. The ICPB will report to the Committee on a [monthly] basis.

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

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

**CCG Reserved Functions**

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

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

- *(a) by each of the CCG Governing Body ICP Area Committees established by the NEL CCG Governing Body; and/or*
- *(b) by individuals with delegated authority to act on behalf of the CCG and within the scope of such delegated authority.*

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

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

**Annex 3: Decision-Making Flow Chart**

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

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

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

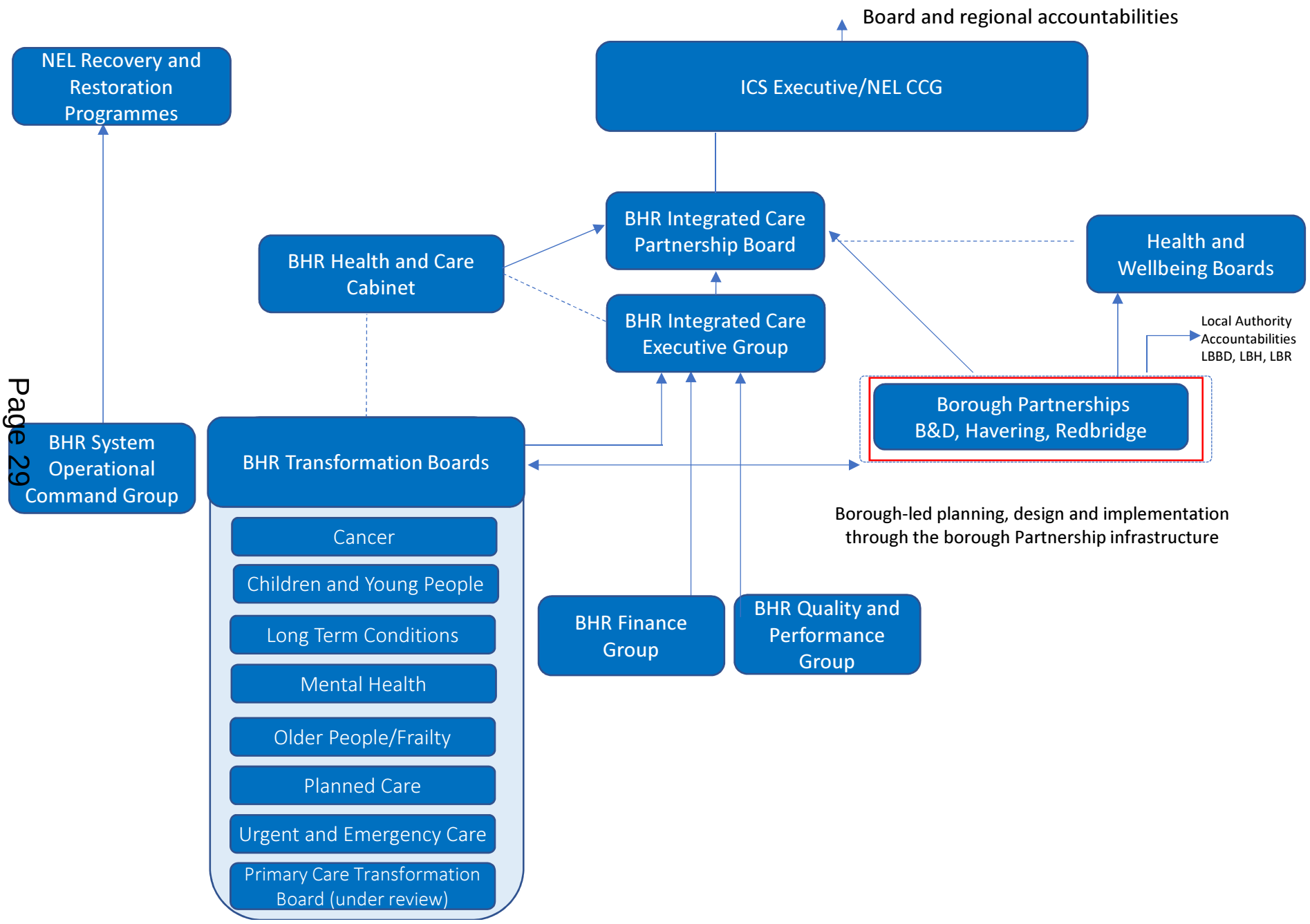
   [If it is then the matter should go to the proper part of the ICS governance for determination.]

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

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

4. Does the issue in question cover decisions that may fall for determination in both statutory forums and the ICPB? If the split in decision making is apparent then that should be followed, otherwise the matter should be referred to [the ICP Executive Group for agreement on the approach to be followed].

# Governance arrangements – April 2021



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Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

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| **Subject Heading:** | Update on Testing Strategy |
| **Board Lead:** | Mark Ansell, Director of Public Health |
| **Report Author and contact details:** | Elaine Greenway, Consultant in Public Health<br>Elaine.greenway@havering.gov.uk |

**The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy**

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| ☐ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
| ☐ | Lifestyles and behaviours<br>• The prevention of obesity<br>• Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups<br>• Strengthen early years providers, schools and colleges as health improving settings |
| ☐ | The communities and places we live in<br>• Realising the benefits of regeneration for the health of local residents and the health and social care services available to them<br>• Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem. |
| ☐ | Local health and social care services<br>• Development of integrated health, housing and social care services at locality level. |
| ☐ | BHR Integrated Care Partnership Board Transformation Board<br>• Older people and frailty and end of life<br>• Long term conditions<br>• Children and young people<br>• Mental health<br>• Planned Care<br>Cancer<br>Primary Care<br>Accident and Emergency Delivery Board<br>Transforming Care Programme Board |

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| SUMMARY |
| --- |
| Testing for Covid-19 is an essential tool in reducing risks of transmission of infection. The attached presentation is an update on the local approach to testing, as requested by the Health and Wellbeing Board. |
| **RECOMMENDATIONS** |
| To note the content of the presentation. |
| **REPORT DETAIL** |
| No further detail. |
| **IMPLICATIONS AND RISKS** |
| Not yet fully assessed. |
| **BACKGROUND PAPERS** |
| None |

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# Health and Wellbeing Baord

## Update on progress of Havering Testing Strategy

# Background

Aims and purposes of testing are:

- Diagnosis: Confirmation of diagnosis in clinical management (pillar 1)
- Detection: Identification of cases of Covid-19 for purposes of specific action to prevent viral spread (pillars 1 & 2)
- Surveillance: to determine circulating disease levels and inform policy decisions for population health measures (pillars 3 and 4)

# Progress of Havering Testing Strategy: Background

- **In scope:**
  - Ensuring good access to Pillar 2 testing (symptomatic and asymptomatic) across the Borough
  - Local approach to asymptomatic testing

- **Out of scope**
  - CQC-registered care homes testing
  - Schools based testing
  - Other national testing programmes (employers 250+, statutory organisations)

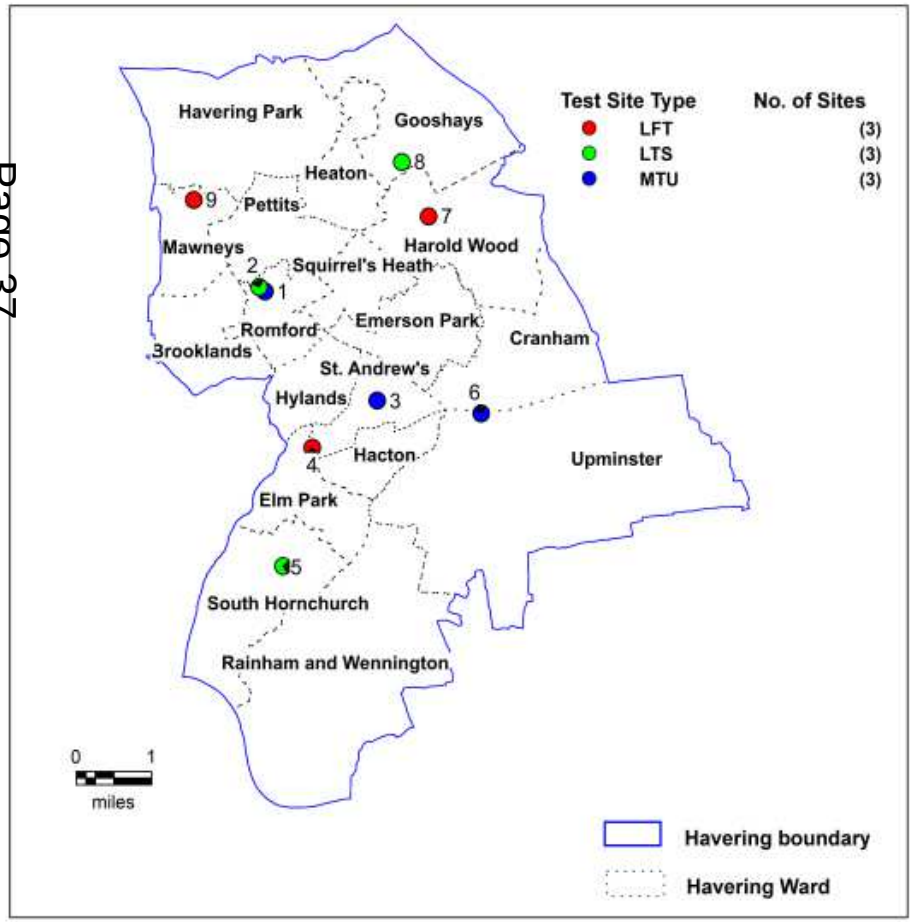
- **Limitations**
  - Home testing: awaiting decision from DHSC on home testing
  - Smart testing: awaiting national policy changes (serial testing, test to release, etc)

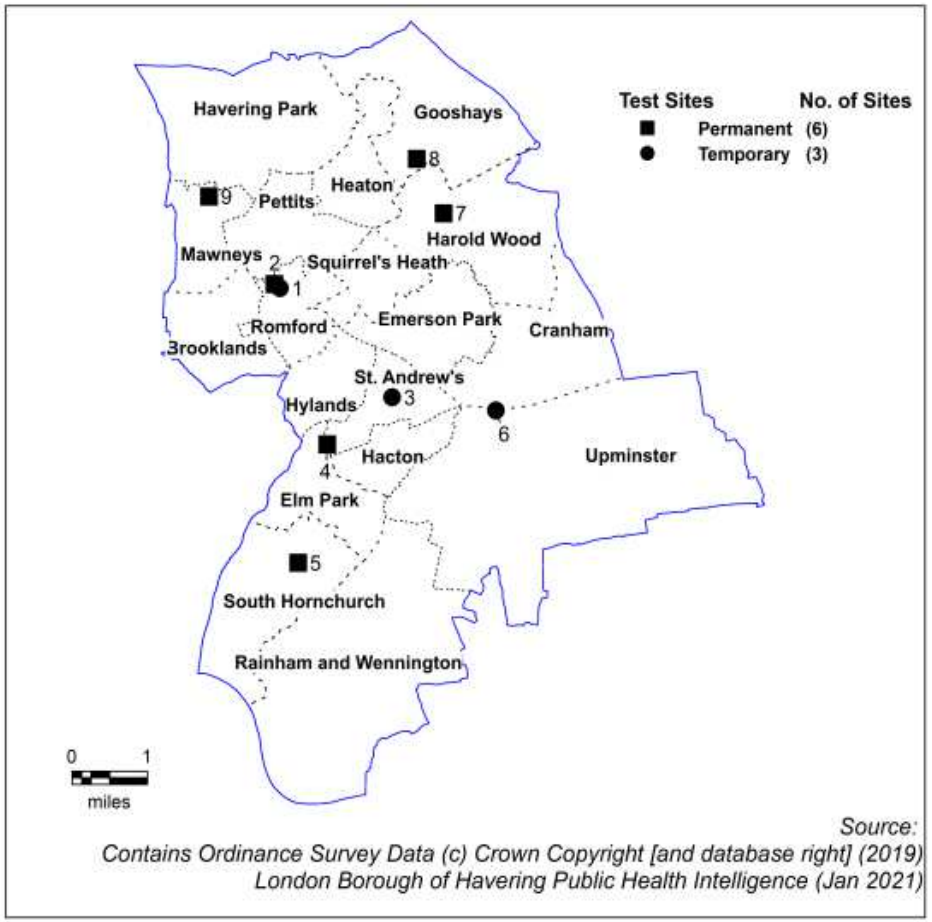
# Progress of Havering Testing Strategy: Content

- **Focus:**
  - Priority for LFT: the working population (paid and volunteers) who are unable to work from home, noting that
    - priority groups may alter as restrictions change
    - anyone not in a priority group may obtain a PCR test (currently asymptomatic as well as symptomatic)
- **Community LFT Sites (for priority groups):**
  - Currently 3 community testing sites in the borough: Elm Park library, Harold Wood library, Collier Row library
  - Expansion on community testing subject to agreement of Annex A (to be submitted to DHSC)
- **Non-public LFT Sites**
  - To date
    - Adult day care settings
  - In development
    - Non-CQC registered housing locations (for vulnerable residents)
    - Council services
- **Partners**
  - Local authorities requested to work with statutory partners and infrastructure to collaborate on asymptomatic testing

## LB Havering Covid-19 Test Sites

| ID | Site Type | Site Name | Site Address | Postcode | Permanent / Temporary |
|---|---|---|---|---|---|
| 1 | MTU | Romford Town Hall | Havering Town Hall, Romford | RM1 3BB | Temporary |
| 2 | LTS | Romford Town Hall Rear car park | Romford Town Hall Park End Road, Romford | RM1 4AU | Permanent |
| 3 | MTU | Dorrington Gardens | Dorrington Gardens, Hornchurch | RM12 4HX | Temporary |
| 4 | LFT | Elm Park Library | Elm Park Library, St Nicholas Avenue, Elm Park | RM12 4PT | Permanent |
| 5 | LTS | Cherry Tree Lane | Cherry Tree Lane, Rainham Road, Rainham | RM13 7RJ | Permanent |
| 6 | MTU | Upminster Station | 70 Station Rd, Upminster | RM14 2TD | Temporary |
| 7 | LFT | Harold Wood Library | Harold Wood Library, Arundel Road, Harold Wood | RM3 0RX | Permanent |
| 8 | LTS | Dagnam Park Drive | Central Park Leisure Centre, Harold Hill | RM3 9LB | Permanent |
| 9 | LFT | Collier Row Library | 45 Collier Row Road, Romford | RM5 3NR | Permanent |

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