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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 22 September 2021	Council Chamber, Town Hall

Members: 24, Quorum: 9

BOARD MEMBERS:

Elected Members: Cllr Jason Frost (Chairman)
Cllr Robert Benham
Cllr Damian White
Cllr Nisha Patel

Officers of the Council: Andrew Blake-Herbert, Chief Executive
Barbara Nicholls, Director of Adult Services
Robert South, Director of Children Services
Patrick Odling-Smee , Director of Housing Services
Neil Stubbings, Director of Regeneration Services
Mark Ansell, Interim Director of Public Health

North East London Clinical Commissioning Group (NEL CCG)
(Dr Atul Aggarwal and Sarah See)

Havering Primary Care Networks (PCNs) represented by the Clinical Directors:

- Havering Crest – Dr Asif Imran, Dr Narinder Kullar
- North – Dr Jwala Gupta, Dr Gurmeet Singh
- South – Dr Nik Rao, Dr John O'Moore
- Marshall – Dr Sarita Symon, Dr Ian Quigley

Other Organisations:

- Healthwatch Havering (Anne-Marie Dean, Executive Chairman)
- BHRUT (Mehboob Khan, Non-Executive Director)
- NELFT (Carol White, Integrated Care Director)

- Voluntary and Community Sector (Paul Rose, Compact for Havering Chairman)

For information about the meeting please contact:
Luke Phimister 01708 434619 01708 434619
luke.phimister@onesource.co.uk

What is the Health and Wellbeing Board?

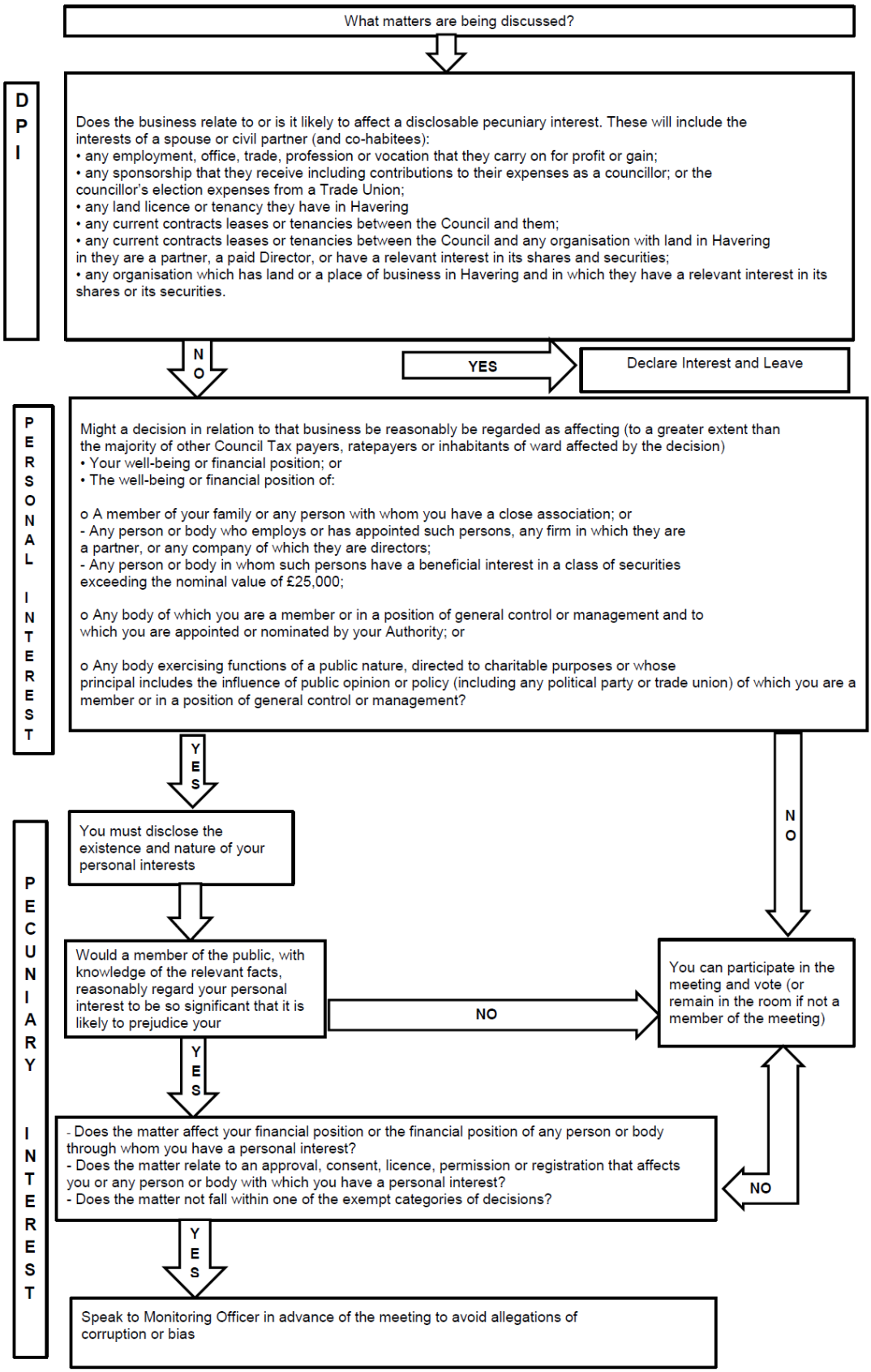
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities 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 - 6)

To approve as a correct record the minutes of the Board held on 23 June 2021 and to authorise the Chairman to sign them.

5 MATTERS ARISING

To consider the Board's Action Log

6 BHRUT CLINICAL STRATEGY (Pages 7 - 16)

Report attached.

7 BHR INTEGRATED SUSTAINABILITY PLAN (Pages 17 - 56)

Report attached.

8 PHLEBOTOMY PILOT (Pages 57 - 76)

Report attached.

9 BOROUGH PARTNERSHIP UPDATE

Board to receive update.

10 DATE OF NEXT MEETING

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Council Chamber - Town Hall
23 June 2021 (1.10 - 3.15 pm)

Present:

Elected Members: Councillors Robert Benham, Jason Frost (Chairman) and Nisha Patel

Officers of the Council: Mark Ansell (Director of Public Health)

North East London Clinical Commissioning Group: Sarah See

Havering Primary Care Networks: Dr Daniel Weaver (Havering Health) and Dr Asif Imran (Havering Crest)

Other Organisations: Anne-Marie Dean (Healthwatch Havering)

Also present (via videoconference):
Andrew Blake-Herbert (Chief Executive)
Barbara Nicholls (Director of Adult Services)
Carol White (NELFT)
Councillor Damian White (Leader, LBH)
Mehboob Khan (Non-Executive Director, BHRUT)
Nick Swift (Chief Financial Officer, BHRUT)
Remi Odejinmi (Director for Equality, Diversity and Inclusion, BHRUT)
Alan Wishart (Inclusion Interim Director of Workforce, BHRUT)
Anthony Wakhisi (Principle Public Health Specialist, LBH)
John Green (Head of Joint Commissioning Unit, LBH)
Ratidzo Chinyuku (Public Health Practitioner, LBH)

All decisions were taken with no votes against.

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

1 **APOLOGIES FOR ABSENCE**

Apologies for absence from the meeting room were received from Councillor Damian White who was present via videoconference.

Apologies were also received from Dr Atul Aggarwal (Havering CCG), Jacqui van Rossum – NELFT (Carol White substituting)

2 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

3 **MINUTES**

It was noted that the list of apologies at the previous meeting was not complete.

It was clarified that the report on the Communications Strategy had been brought in response to a request from a Board Member.

The minutes of the meeting of the Board held on 28 April 2021 were otherwise agreed as a correct record and would be signed at a later date.

4 **MATTERS ARISING**

There were no matters arising.

5 **BHR JSNA 2021 DEVELOPMENT**

It was explained that the development of the Joint Strategic Needs Assessment was one of the statutory duties of the Board. The Board received a demonstration of the local insight tool; a tool which provides up to date local population health intelligence across BHR.

Members were advised that summary reports of key indicators could be produced by locality and also be compared with local and national comparators. Members noted that input from clinical, social care and community partners was needed to capture representation across the entire spectrum of health and wellbeing. The Board welcomed the tool feeling it was very clear and deliver improvements to population health management systems within the developing BHR Integrated Care System. Members agreed that whilst primary care networks did have a data sharing agreement, an agreement within the systems at BHR and North East London was also needed. Summarising the discussion, Members supported an exploration into an assurance agreement for data sharing between primary care networks and wider partners.

Members were advised that open-source data was uploaded continuously by the software and was the most accurate in the public domain. Members were informed that the insight tool supported the uploading of supplementary reports and evidence from partners. The Director of Public Health suggested and encouraged that partners of the Board contribute to the insight tool by providing supporting evidence, reports or commentary.

Members were advised that the JSNA would feed into the next iteration of the Joint Health and Wellbeing Strategy. Moving beyond, a representative from BHRUT put forward (the view that) an intervention dashboard would assist in raising awareness, reducing duplication, synergising efforts, monitoring of health inequalities, and in the evaluation of health programmes / services at place level. It was noted that the steering group would be advised of the need to link data with the various equalities interventions that were taking place locally.

The Board noted that the perspectives from the Transformation Boards were to be included in the reiteration of the JSNA. Details of the work with partners to refresh the JSNA would be brought to a future meeting of the Board.

The Board noted the position.

6 HAVERING BOROUGH PARTNERSHIP ROAD MAP

It was noted that the final sentence of the 'implications and risks' section of the cover report had been printed incorrectly and should be disregarded.

Members were advised that the place-based partnership was still in its infancy. Members were advised that the partnership would implement aspects of the Joint Health and Wellbeing Strategy, and would receive oversight from the Health and Wellbeing Board to support this work. Members were also advised that a programme manager had been recruited to support the partnership development, but more resources would be needed.

The principles for the partnership were outlined and included having a shared local vision, supporting asset based community development and resilience, and investing in a multi-agency partnership. Other principles included strengthening the role of health and care providers, enabling effective place-based leadership and jointly planning & coordinating services. Priorities for the partnership included healthy living, reducing social exclusion, and action on homelessness, mental health and joblessness.

It was highlighted that it was important that the partnership had sufficient resources and that data was shared in a timely manner. In terms of decision making, Members commented and proposed to a 'collective responsibility' approach as an alternative to the proposed 'disagree and commit' style. It was also pointed out that IT systems could be used to assist with social prescribing. Primary Care Networks raised aspirations for collaboration across organisational boundaries, for example, by ensuring a standardised delivery of service by link workers in the borough.

A representative from BHRUT stated that the Trust fully supported the roadmap and wished to participate in the partnership arrangements. This commitment was also re-iterated by a representative from NELFT. Members noted that the Borough Partnership presented a window of opportunity to share understanding of local population needs in the shaping and improvement of population health management at place-based level. It was acknowledged that the JSNA and Health & Wellbeing Board would complement this work. It was accepted that The Board, as a Committee of the Council, and through its strategic leadership, support the operational deliverables of the Borough Partnership.

It was noted that there had been a lot of good partnership work seen during the pandemic. The Council Chief Executive added that workforce health and wellbeing should also be considered. It was suggested that consideration be given to what representatives would be needed on the partnership from each body. Members considered the implications regards to representation and governance of the Borough Partnership in advance of the promised Integrated Care System legislative proposals.

It was noted that Terms of Reference would be prepared to set out the working arrangements for the Borough Partnership.

7 UPDATED TERMS OF REFERENCE AND WORK PROGRAMME 2021-22

It was explained that the Flexibility Regulations which permitted remote meetings had now came to an end, and that the Terms of Reference and work programme had been reviewed to accommodate and ensure representation and in-person attendance by the Board's key partners. Members noted that the ToR would be reviewed at the material time and in accordance with the anticipated legislative promises as set out in the white paper for health and social care.

The revised ToR before the Board suggested that the Board should meet quarterly.

Members received an overview of the proposed work programme, which included elements that supported the Board in undertaking its statutory obligations and aspirations beyond the statutory core. As part of the key aspirations, Members were informed that the Board would appraise significant health considerations identified from key policy and strategy across the Council. Members were subsequently informed that the Board provided an opportunity for wider partners to influence Council strategy, policies and plans impacting on health and the wider determinants of health.

Members were in favour of widening participation or membership to the Board, and suggested representation from young people, head-teachers and allied-health professionals. A Healthwatch representative felt that the Board should have greater engagement with dentists and opticians who could assist in articulating the barriers in access to care as reportedly experienced by vulnerable groups and local residents in the borough. Clinical officers volunteered and agreed to make contact with the dental and ophthalmology committees for North East London and consider how engagement could be carried out.

It was suggested that membership of the Board be kept under review.

Subject to the comments above, the Board **ADOPTED** the draft Terms of Reference.

8 LONDON AMBULANCE SERVICE LETTER

The Board considered a recent letter from London Ambulance Service NHS Trust detailing plans for a new ambulance dispatch centre covering Havering. Whilst no representative from London Ambulance Service had been able to attend the meeting, it was clarified that the new centre was not in Romford but in Dagenham Road.

It was **AGREED** that London Ambulance Service should be asked to attend the September 2021 meeting of the Health and Wellbeing Board. Questions on the subject could be compiled in advance if this would assist.

9 COVID-19 UPDATE

It was **AGREED** that a Covid-19 update item should be put on each Board agenda going forward.

The Board was advised that there would be no progression to step 4 of the easing of lockdown restrictions until 19 July at the earliest. The number of cases in Havering was on an upward trajectory and was doubling every 7 days (from a low base). Cases in Havering remained below the London and England averages.

Members were advised that cases of the Delta variant were rising more among younger adults. There was a risk of a renewed surge in hospital admissions but this was uncertain at this stage. Members were informed that deaths from Covid-19 in Havering remained low and hospital admission numbers were fairly stable. It was explained that two doses of the vaccine reduced the risk of developing serious illness by 90% and was highly effective against hospitalisation. Havering had seen a good uptake of the vaccine overall.

It was explained that the Delta variant was dominant nationally and was more transmissible but two doses of the vaccine remained very effective against it. There would now be a 5 week vaccination 'sprint' to maximise the numbers of people vaccinated before restrictions were removed. It was also important to continue with as many protection controls as possible.

Members were informed that walk-in vaccination clinics being established at Victoria Hospital and South Hornchurch library. Vaccinations for 16-18 year olds were being discussed but the Joint Committee on Vaccinations and Immunisations felt that there would only be a small benefit to young people's health of doing this. There had not been any data provided as yet from BHRUT as regards hospitalisation trends.

10 **DATE OF NEXT MEETING**

The next meeting of the Board was scheduled for 22 September 2021.

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Chairman

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	BHRUT Clinical Strategy update
Board Lead:	Hannah Coffey, Director of Strategy and Partnerships
Report Author and contact details:	John Mealey, Senior Communications Officer, 01708 504 135, john.mealey@nhs.net

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

☒	The wider determinants of health • Increase employment of people with health problems or disabilities • 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. • 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 • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☒	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • 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 • Development of integrated health, housing and social care services at locality level.
☐	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY
In 2019/20, BHRUT started on the development of a ten-year clinical strategy to determine how it deliver services across its hospitals to provide the very best care for our communities. The Trust undertook a huge amount of work in the year before Covid-19, however, completion of the strategy was paused at the start of the pandemic. BHRUT has restarted the work to complete the strategy, while also considering the impact of Covid-19, and would like to update the Health and Wellbeing Board on the work it is currently undertaking to ensure the strategy is informed by the needs of our population and the views of patients and partners.
RECOMMENDATIONS
To note the progress of BHRUT's clinical strategy and engagement opportunities.
REPORT DETAIL
Attached presentation providing an update on BHRUT's clinical strategy.
IMPLICATIONS AND RISKS
None
BACKGROUND PAPERS
None

BHRUT CLINICAL STRATEGY UPDATE

Havering HWBB

September 2021

Hannah Coffey

Director of Strategy and Partnerships

We're reviewing what your hospitals should look like in the future...

HAVE YOUR SAY

...and it's vital we hear from our local communities.

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

BACKGROUND

- In 2019/20, we started on the development of a ten-year clinical strategy to determine how we deliver services across our hospitals to provide the very best care for our communities
- We undertook a huge amount of work in the year before Covid-19, including a number of engagement events with staff, stakeholders, partners and members of our community across BHR
- The pandemic hit when we were working on the final phase of the strategy, so plans were paused abruptly while we turned our focus and efforts to managing the virus
- The world has since moved on and we want to take stock and refresh our strategy, as we consider the impact of Covid-19 and legislative developments, as well as incorporating what we have collectively learned over the last year
- As before, we must ensure the strategy is informed by the needs of our population and the views of our patients and partners, as well as recognising our wider role as an anchor organisation

WHERE WE GOT TO IN THE DEVELOPMENT OF THE STRATEGY

Case for change

Identified the **major opportunities for improvement and transformation** across BHRUT including:

Managing demand

- Demand for acute services is growing
- Some demand could be better served in alternative settings of care

Access, quality and safety

- Access across many services is poor
- Better use of capacity
- The quality and safety of services have been improving over time

Enablers

- Workforce constraints
- More efficient use of current estate assets
- Improved use of technology and digital innovations
- Challenges have impacted the financial position

The three pillars of the clinical strategy

The clinical strategy rested on three pillars, which were underpinned by recommendations to transform care models and organise services more effectively as well as deliver more care in community settings and virtually:

- **Running highly reliable hospitals**
- **Accelerating integrated Borough-based partnerships**
- **Collaborating with NEL partners**

Central to the clinical strategy are **five transformative care models**: (1) Urgent and emergency care; (2) Planned care; (3) Maternity; (4) Cancer; and (5) Anticipatory care for people with complex needs

A review of the evidence base and benchmarking analysis informed the assessment of impact of the strategy for each model

Two site identities

A core objective of the clinical strategy was to **develop a clinical identity for each of our two main sites,** setting out the services where there would be benefit in delivering them from one site along with the benefits and supporting evidence for this approach

OUR CLINICAL STRATEGY REFRESH

- We now feel it is the right time to revisit and refresh our clinical strategy to best meet the needs of our local population

- This means greater emphasis on equality, diversity and inclusion, as well as more detailed clinical pathway design with our partners to ensure we improve health and deliver integrated care for our communities

- The Clinical Strategy has three distinct and refreshed pillars:
  1. Running reliable hospitals
  2. Collaborating with health partners across NEL
  3. Our role in 'place', as we root ourselves in our local community and work with our partners in the Borough Partnerships

- The strategy refresh will run in parallel with the work around our proposed collaboration with Barts Health and the wider development of the NEL integrated care system

OUR APPROACH

- The development of the strategy will again be clinically led
- Clinical leaders will engage with partners, patients, stakeholders and our communities to get their views to shape our plans
- Our ambition is to have a draft plan ready by the end of 2021, and will engage on this draft with patients, residents, partners, stakeholders and staff before it is finalised
- We will continue to work with, and listen to, our partners, particularly in advising how and who we engage with throughout this process
- Due to the ongoing demands of the pandemic and anticipated surges, we are taking a digital first approach to engagement, including virtual public listening events, and are engaging with partners to help access our harder to reach communities

CORE ELEMENTS

Input into strategy	Description
Lessons learned from the initial clinical strategy development	Although there were a lot of positives to the initial development of the clinical strategy, there were some clear lessons learned about how to approach a similar process in the future: 1. While the Carnell Farrar (CF) team worked in an integrated manner with BHRUT, there is a need to foster broader ownership of the work within the Trust, throughout the process 2. Engagement with patients and the public should be central to the process, not peripheral or subsequent to it 3. More can be done to involve other system partners in the development of care models, in particular involving public health directors and NELFT 4. A greater focus on inequalities and some proposed solutions is required. This is a very central feature of the population and needs to have greater consideration
Impact of Covid-19 and associated ways of working	The impact of the pandemic has meant that some of the above elements have been thrown into sharp relief. In addition the developments during the pandemic require consideration. 1. The pandemic has highlighted the importance of inequalities and population health 2. Some of the service changes that occurred during the pandemic need to be evaluated eg the changes to emergency general surgery and the 'elective hub' 3. The last 15 months have also shown the need to balance a flexible workforce with one that has a sufficient mix of specialism
Policy developments	Partly driven by the pandemic and the need for recovery, there have been a number of policy developments that should also feed into the clinical strategy refresh 1. The DHSC white paper has emphasised the need to develop ICSs and borough partnerships ('place') 2. The collaboration work between BHRUT and Barts Health has initiated and will have implications about the shape and nature of services delivered within both trusts

ENGAGING TO UNDERSTAND OUR CURRENT STATE

- Engaging with patients, stakeholders, communities and staff to garner information to refresh the care models; these will be engaged on through a series of virtual public listening events in October
- Patient partners involved throughout to ensure the patient voice is always present
- Working closely with the borough partnerships

Engaging externally

- **Residents' survey**
  - Seeks to understand access to a range of healthcare services both in and out of hospital, and before and during the pandemic.
  - At the mid-way point, more than 370 respondents which exceeds the previous survey work. Thank you to our patient partners for helping develop the survey and partners for promoting
  - Continue to liaise with local authorities and Healthwatch to understand how they can help us to access hard to reach groups, for both the survey and for those unable to attend the listening events, to ensure their views inform the strategy development
  - Continue to liaise with faith leaders, chaplains and system colleagues to help support promote our survey and public listening events
  - Targeted social media posts to ensure residents across our three boroughs are aware of the survey
- **Stakeholder survey and interviews:** Undertaken by a range of executives, divisional directors and Carnell Farrar
- **Borough partnership workshops:** Further workshops will take place before the draft strategy is finalised

Engaging internally

- Staff survey
- Attendance at Patient Partnership Council
- Internal stakeholders interviews
- Current state and inequalities workshop

NEXT STEPS

- Over the coming months, we will continue to engage internally and externally to ensure different views shape the plans for the refresh, before updating our clinical strategy. These include:

September 2021
• Borough Partnership workshops • Working with partners to maximise survey response rates and ensure responses are reflective of local communities • Ongoing promotion, engagement and subsequent analysis of residents' and staff surveys, alongside external stakeholder survey and interviews • Residents' and staff surveys to close • Current state and inequalities Internal workshops • Continue to work with local authorities, Healthwatch and faith leaders to help access hard to reach residents and garner feedback on the care models • Strategy update to be shared with Health and Wellbeing Boards
October 2021
• Refreshed draft care models developed and engaged through virtual public listening events. Events to be held per borough • Series of public listening events to review care models • BHRUT and Barts Health collaboration workshop and care model design workshops will also take place
November 2021
• Borough Partnership and care model impact workshops • Care model impact to be confirmed • Draft clinical strategy to be finalised by the end of the month and taken to Trust Board
December 2021
• Engagement to start on the draft strategy with internal and external stakeholders • Seek views of stakeholders, residents and staff through a wide range of mechanisms and platforms

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LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading: BHR Integrated Sustainability Plan

Board Lead:

Report Author and contact details: Mark Eaton Mark.eaton1@nhs.net
07841-464916

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • 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. • Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.
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SUMMARY
The focus of the ISP is on transforming outcomes, tackling inequalities and on ensuring we can sustainably deliver our commitments.
RECOMMENDATIONS
The HWBB **is asked to:** • **DISCUSS** any changes/additions or clarifications required. **APPROVE** the paper to proceed to final approval or note any additional steps required.
REPORT DETAIL
IMPLICATIONS AND RISKS
BACKGROUND PAPERS

North East London Health & Care Partnership

NHS
North East London
Clinical Commissioning Group

Barking & Dagenham, Havering and Redbridge (BHR) Integrated Sustainability Plan (ISP)

2021/22

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BHR Integrated Sustainability Plan (ISP) Executive Summary

The NHS services covering the London Boroughs of Barking & Dagenham, Havering and Redbridge System (BHR) have seen declining financial performance since at least 2012 and possibly even earlier. These financial challenges are linked closely to negative changes in the outcomes for our population. The drivers of the challenges are related to a historic and chronic under-investment in Out of Hospital Support for patients with a lack of focus on prevention and early intervention. This has driven a significant increase in Non-Elective Admissions particularly for Older People and those with one or more Long Term Condition. In turn this rapid increase has led to change of the elective casemix in NHS hospitals in BHR which is a significant contributor to the overall financial problems we face.

In 2018/19 the NHS partners in BHR agreed London's first integrated Financial Recovery Plan (FRP) and in the first year of operation saw a significant improvement both in system finances and the start of changes and improvements in outcomes for our population.

This Integrated Sustainability Plan (ISP) resets the previous FRP and expands the scope to include redressing historic under-investment in Primary Care and to a lesser degree Mental Health Services. The aim of the ISP is to reduce secondary care activity by a recurrent £70m per year by 2025/26 which would leave the BHR System at slightly better than the equivalent to our peers. Of this £70m we would reinvest £35m/year by 2025/26 in delivering care differently, improving outcomes and investing in prevention.

To enable our partners to prepare for the changes we have also identified a £20m non-recurrent investment that will derisk years 1 and 2 of the ISP (2021/22 and 2022/23).

The challenges set out in this document should not be approached lightly and will require consistent system wide working for 5 years irrespective of individual personalities and agendas. However, the benefits include transforming outcomes for our population whilst returning BHR to financial balance.

Due to the absence at the time of writing of guidance for 2022/23 the values stated within the document should be deemed indicative and will need to be reset when substantive guidance (including sight of allocations) is available.

We commend this plan to you and ask for your on-going support to transforming how we support our population.

1.0 Introduction to the BHR Integrated Sustainability Plan (ISP)

In 2018/19 the NHS Partners in the London Boroughs of Barking & Dagenham, Havering & Redbridge (BHR) produced London's first Provider & Commissioner integrated Financial Recovery Plan (FRP). This was approved by NHS England and NHS Improvement (NHSE/I) at the end of 2018/19 and the initial implementation during 2019/20 showed that it was possible, through focused actions, to reduce non-elective admissions, change referral behaviours and improve outcomes whilst at the same time impacting positively on finances.

As we will show later in this document, the finances for the BHR System had been getting progressively worse since 2012. We can show that as finances got worse several important outcomes for our population also started to get worse including Healthy Life Expectancy and Years Living with Disability. The impact of this was that the system saw a significant increase in spend in secondary (hospital) care, peaking in 2018/19 at £106m/year above the average for similar populations in London. During the first year of implementation of the previous FRP we saw this excess drop from £106m to £96m with a corresponding reduction in non-elective admissions for Older People, an increase in people at the end of life who died in their preferred places rather than hospital, reductions in MSK related activity and a shift in referral patterns so that more activity was sent to local NHS hospitals (and therefore closer to home). These changes all corresponding with the system transformation schemes that were being implemented.

With the need to respond to the COVID Pandemic, work on the FRP was rightly paused through 2020/21 and into the first part of 2021/22. At the end of 2020/21 it was recognised that we would need to refresh and relaunch the FRP as we exited the COVID period and work was undertaken to revisit the drivers of the deficit to ensure these remained valid and also to reset the activity and finance numbers required to drive the system improvements. This work has been undertaken within the BHR Integrated Care Partnership (ICP) in collaboration with the NHS Partners; NELFT (North-East London NHS Foundation Trust), BHRUT (Barking & Havering University Hospitals NHS Trust) and the NEL CCG (North-East London Clinical Commissioning Group). In addition, the work has been widely shared with system partners as we will see through the ICPB (Integrated Care Programme Board), ICEG (Integrated Care Executive Group) and HCC (Health & Care Cabinet).

As part of refreshing the FRP we have also included a plan for correcting the historic under-investment in Primary Care and Mental Health. To reflect this expanded brief and the continuing focus on improving outcomes as the only true way of achieving financial sustainability over the longer term the previous Financial Recovery Plan has been renamed an Integrated Sustainability Plan (ISP). The BHR Integrated Sustainability Plan (ISP) is a key strategy for the BHR ICP and the three borough partnerships, working within the overall North-East London (NEL) Integrated Care System (ICS) Financial Strategy. Implementation will be tracked locally through the ICP structures, noting these will adapt as we move to an ICS in April 2021 and will also be monitored at a NEL level through the Finance Committee.

2.0 Population Health Outcomes for BHR

Whilst the implementation of the FRP was driven primarily by declining finances the solution was driven by the need to improve outcomes as many of the financial problems for BHR are driven by poor outcomes. Before we explore the drivers of the deficit that underpin the ISP it is worth reviewing the underlying outcome challenges that we face based on the latest data we are able to access.

Table 1 below summarises a series of public health outcomes relevant to the BHR population showing where the three BHR Boroughs are worse than the London average (or national average if no London average exists).

Table 1: Public Health Metrics (Source: PHE Fingertips 2021)

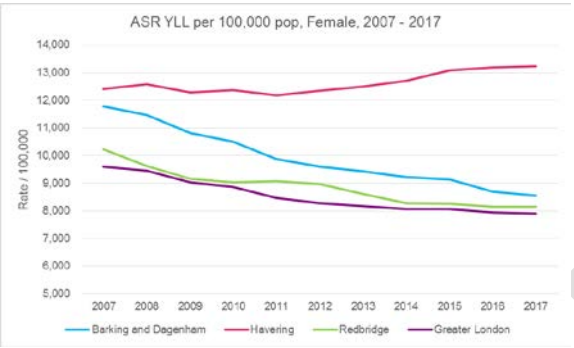
Area	Metric	B&D	H	R	Worst 3 in London (Not in Order)		
Diabetes	Type 1 Receiving All 8 Care Processes				Newham	Enfield	Waltham Forest
	Type 2 Receiving All 8 Care Processes				Waltham Forest	Enfield	Hounslow
	Major Diabetic Limb Amputation				Newham	Tower Hamlets	Redbridge
COPD & Respiratory	Emergency Hospital Admissions				Southwark	Tower Hamlets	B&D
	<75 Mortality Rate Respiratory Disease				B&D	Tower Hamlets	H&F
	65+ Mortality Rate Respiratory Disease				Tower Hamlets	Lewisham	B&D
Cancer	% Diagnosed at Stage 1 and 2				Brent	City of London	Newham
MSK	% Reporting Long Term MSK Problem				Enfield	Bexley	Havering
Cardiology	CHD Admissions (All Ages)				Hounslow	Ealing	Hillingdon
	Heart Failure Admissions (All Ages)				Lambeth	Brent	City of London
	Coronary Heart Disease Mortality (<75)				Newham	Hackney	Tower Hamlets
	Mortality Rate 65+ Cardiovascular Disease				Enfield	Hounslow	Haringey
Life Expectancy	Life Expectancy at Birth (Male)				Lambeth	B&D	Lewisham
	Life Expectancy at Birth (Female)				Islington	B&D	Greenwich
	Healthy Life Expectancy at Birth (Male)				Newham	B&D	Hackney
	Healthy Life Expectancy at Birth (Female)				Tower Hamlets	Croydon	Hillingdon
	Life Expectancy at Age 65 (Male)				Lewisham	B&D	Havering
	Life Expectancy at Age 65 (Male)				Islington	B&D	Greenwich
Deprivation	% of People 16-64 in Employment				Hackney	B&D	Redbridge
	Deprivation Score (2019)				Newham	B&D	Hackney
	Children <16 in Low Income Families				Camden	Islington	Tower Hamlets
Mental Health	Prevalence of Common MH 16+				Islington	Hackney	Newham
	Prevalence of Common MH 65+				Islington	Newham	Hackney

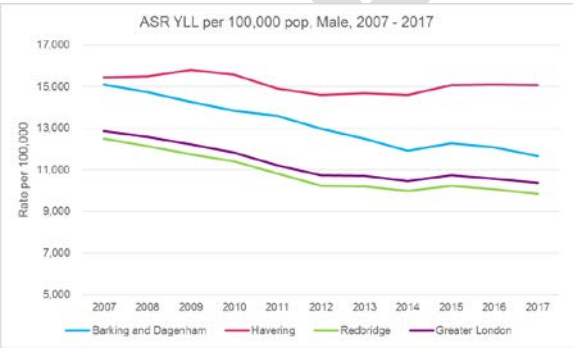
From Table 1 we can see that the three Boroughs, and B&D in particular, regularly appear in the 'top 3' Boroughs for having the worst outcomes across a range of metrics. We can also show a direct link between some of the poor outcomes above and excess non-elective admissions.

For example, we see Havering has issues with people living with long-term MSK problems and at the same time we have a significant excess of Trauma and Orthopaedics (T&O) related Non-Elective Admissions as well as excess activity in related specialities such as Rheumatology and Pain. Also, we see two of the three Boroughs have issues with CHD Admissions in Table 1 and this corresponds to excess non-elective activity we see across a range of specialities including Cardiology and Vascular Surgery.

Particularly noticeable is the relatively poor outcomes concerned with Healthy Life Expectancy at Age 65+. This corresponds to the significant excess of non-elective activity we see in Older People. For example, in Geriatric Medicine alone we see an annual excess of non-elective admissions of more than 3,000 per year at a total annual excess cost of £18m above the average for equivalent populations.

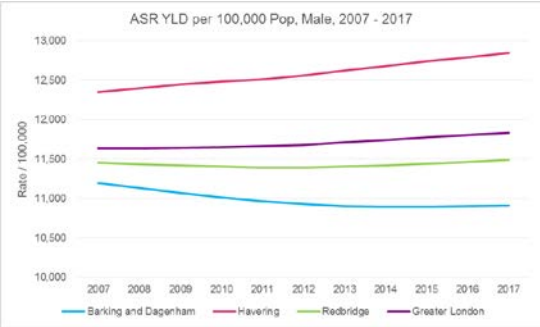
Graph 1 & 2 Showing Years of Life Lost (due to conditions amenable to healthcare) 2007-2017

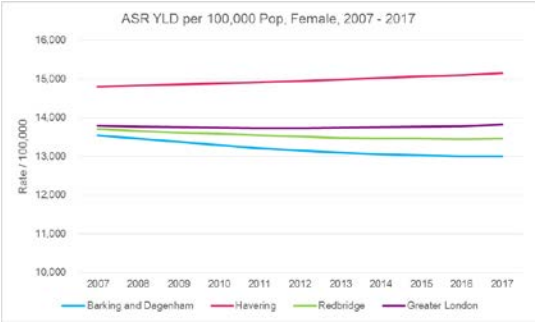




The two graphs above go some way to show how outcomes for the population of BHR are not as we would wish them to be. These graphs show the YLL (Years of Life Lost due to conditions amenable to healthcare) and apart from for males living in Redbridge, the whole of BHR tracks above the London average (ie worse) with Havering showing particularly poor outcomes. Again, we see this directly translating into hospital activity with increased numbers of the elderly frail population arriving in hospital non-electively and a corresponding increase in the costs of long-term care. Given the relative affluence of Havering (and to a lesser degree Redbridge) as a Borough compared to many other London Boroughs we cannot make a strong link between deprivation and YLL but can make the link between the historic under-investment in Primary Care and an under-investment in areas such as Dementia Care and the Prevention & Early Intervention in Frailty.

Graph 3 & 4 Showing Years Living with Disability (YLD)





Graphs 3 and 4 also show that our population are spending more years living with disability and ill-health which increases pressures and costs for both health and care. Whilst some of this is related naturally to the overall increase in life expectancy seen in the UK the fact that BHR has historically not invested in Prevention means we are not proactively addressing the onset of long-term conditions. Although evidence varies there is clearly an increasing impact on health and social care brought about by increased years living with disability and we see this in health in the form of excess activity and spend in such areas as Nephrology, Respiratory Medicine and across a range of specialities arising from people suffering the long-term impacts of Diabetes and various comorbidities.

What this section aims to show is the scale of the opportunity to improve outcomes for our population by increasing our Out of Hospital care including investing in prevention and early intervention. This in turn will reduce non-elective activity and pressures, allowing BHRUT to reshape its workforce as well as reduce the longer-term costs and burden on both the health and social care system.

This sets the scene for the triple-aim of the Integrated Sustainability Plan (ISP) which is that:

We will improve the medium to long-term outcomes (physical and mental health) for our population and through this **reduce the pressure on our health and care system** and therefore achieve **long-term financial sustainability.**

3.0 Demographic Comparisons

Later in the ISP we make the statement that demographics are not a major driver of the problems faced by BHR over the last decade. The following tables are included to show comparisons for the BHR Population to the other London Boroughs. What Tables 2-4 show are that whilst B&D in particular has issues with Mortality Due to Preventable Causes and Healthy Life Expectancy (Male & Female) these are not as extreme in comparison to Boroughs such as Islington, Hackney and Tower Hamlets, all of whom have lower levels of non-elective admissions per thousand population and a lower excess spend in secondary care.

Tables 2-4 (Mortality Due to Preventable Causes and Healthy Life Expectancy) – 2019/20 Data

Mortality Due to Preventable Causes	
England	**181**
London region	**161**
Islington	210
Hackney	207
Tower Hamlets	202
Barking and Dagenham	201
Lambeth	199
Greenwich	196
Lewisham	191
Southwark	190
Hammersmith and Fulham	190
Hounslow	173
Newham	173
Ealing	169
Hillingdon	167
Havering	167
Wandsworth	167
Waltham Forest	166
Haringey	163
Bexley	162
Croydon	159
Camden	157
Brent	154
Merton	150
Enfield	149
Sutton	149
Kingston upon Thames	144
Kensington and Chelsea	138
Richmond	136
Redbridge	134
Bromley	132
Westminster	126
Barnet	124
Harrow	121

Healthy Life Expectancy (Female)	
England	**63.9**
London region	**64.4**
Richmond	69.7
Brent	68.9
Harrow	67.8
Camden	67
Kingston upon Thames	67
Bromley	66.8
Kensington and Chelsea	66.6
Southwark	66.3
Haringey	66.3
Havering	65.9
Wandsworth	65.8
Sutton	65.6
Westminster	65.6
Waltham Forest	65.3
Lewisham	64.7
Barnet	64.7
Bexley	64.5
Enfield	63.8
Ealing	63.3
Redbridge	62.9
Hammersmith and Fulham	62.8
Lambeth	62.8
Barking and Dagenham	62.5
Greenwich	62.4
Hounslow	62.2
Merton	62.1
Hackney	62
Islington	61.7
Newham	61.4
Hillingdon	61
Croydon	59.5
Tower Hamlets	56.6

Healthy Life Expectancy (Male)	
England	**63.4**
London region	**64.2**
Richmond	71.9
Wandsworth	68.9
Harrow	68.5
Kingston upon Thames	67.9
Redbridge	66.5
Hillingdon	65.9
Bromley	65.8
Bexley	65.5
Haringey	65.3
Merton	65.2
Sutton	65.2
Croydon	65
Havering	64.2
Brent	64
Enfield	63.9
Barnet	63.8
Kensington and Chelsea	63.8
Ealing	63.8
Camden	63.5
Hammersmith and Fulham	63.5
Hounslow	63
Westminster	62.9
Waltham Forest	62.7
Southwark	62.7
Islington	62.6
Greenwich	61.3
Lambeth	60.9
Lewisham	60.6
Tower Hamlets	60.5
Barking and Dagenham	60.1
Hackney	58.6
Newham	58.4

Tables 5-8 show some additional population health data relevant to BHR. Given the association between deprivation and inequalities in health outcomes these table show the economic pressure on our local population. Again, whilst this does show B&D and, in one category, Redbridge as being worse than the rest of London the variation is not extreme and certainly does not explain why our populations have a greater chance of being admitted non-electively than other parts of London to such a large extent.

Tables 5-8 (Financial Comparisons for the BHR Population) – Data from 2020

Gross Annual Pay (Median)	
Barking and Dagenham	23,900
Newham	24,100
Brent	24,700
Waltham Forest	25,500
Enfield	26,300
Hounslow	26,400
Ealing	26,700
Bexley	26,900
Haringey	27,100
Hillingdon	27,100
Lewisham	27,300
Croydon	27,500
Greenwich	27,600
Harrow	27,600
Havering	27,900
Redbridge	28,000
Sutton	28,200
Barnet	28,700
Hackney	29,400
Southwark	29,400
Lambeth	29,900
Merton	30,200
Tower Hamlets	30,200
Bromley	32,000
Kingston-upon-Thames	32,400
Hammersmith & F'm	33,200
Islington	33,400
Wandsworth	34,500
Richmond	36,100
Camden	37,300
Westminster	39,700
Kensington & Chel	40,400

% Earning Less than Min Wage	
Redbridge	48.7
Sutton	44.1
Enfield	40.9
Waltham Forest	39.7
Harrow	38.4
Brent	36.9
Barnet	36.3
Bexley	35.3
Merton	35.1
Newham	33.8
Bromley	33.5
Havering	32.8
Ealing	30.2
Hillingdon	29.1
Haringey	28.6
Croydon	28.5
Kingston upon Thames	27.9
Hounslow	26.6
Barking and Dagenham	25.8
Greenwich	25
Lewisham	23.6
Richmond	23.4
Wandsworth	22.3
Hackney	22.1
Kensington & Chel	21.2
Lambeth	20.8
Southwark	14.1
Islington	13.3
Camden	13
Westminster	12.4
Hammersmith & F'm	12.2
Tower Hamlets	11.7

Employed Population %	
Barking and Dagenham	67.3
Camden	69.6
Enfield	69.8
Brent	70.4
Waltham Forest	71.5
Kensington & Chel	72.2
Hackney	72.5
Newham	72.7
Harrow	73.6
Redbridge	74
Tower Hamlets	74.4
Hillingdon	74.8
Islington	75
Hounslow	75.2
Haringey	75.3
Barnet	75.6
Greenwich	75.6
Ealing	75.7
Croydon	76.7
Hammersmith & F'm	76.8
Kingston upon Thames	77.2
Bromley	77.4
Lambeth	77.4
Sutton	77.4
Havering	77.5
Bexley	78.7
Merton	79.1
Southwark	79.4
Richmond	80.1
Lewisham	80.8
Wandsworth	84.9
City of London	100

Unemployment Rate %	
Westminster	12.3
Waltham Forest	10.2
Barking and Dagenham	9.6
Lambeth	9.1
Hillingdon	8.7
Southwark	7.9
Hammersmith & F'm	7.7
Harrow	7.5
Newham	7.3
Ealing	6.9
Sutton	6.3
Greenwich	6.2
Merton	6.2
Croydon	5.9
Enfield	5.8
Kensington & Chel	5.7
Tower Hamlets	5.7
Haringey	5.3
Hounslow	5.3
Lewisham	5.3
Camden	5.2
Islington	5.2
Barnet	4.9
Bexley	4.8
Hackney	4.8
Kingston upon Thames	4.7
Havering	4.2
Brent	3.6
Bromley	3.4
Wandsworth	2.7
Richmond	2.1
Redbridge	1.9

4.0 Drivers of the Deficit

In producing the original FRP in 2018/19 we were asked by NHSE/I to explore the underlying reasons for the deficit in BHR. As part of refreshing the FRP and transitioning to the Integrated Sustainability Plan (ISP) we reviewed the original drivers to confirm that these were still the main reasons for the on-going outcome and financial issues within BHR. The result of this review shows that the original drivers of the deficit identified in 2018/19 remain the main drivers in 2021/22 and these are summarised in Table 9 below.

Table 9: Summary of the Drivers of the BHR System Deficit

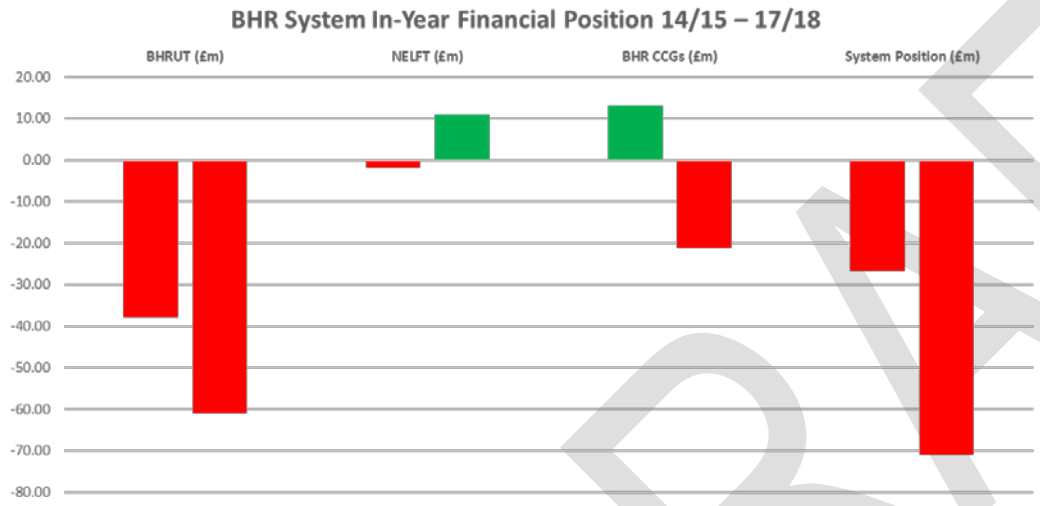
Driver	Deficit Impact	Narrative
Demographics	**Low to Medium**	Whilst there are demographic challenges within BHR (most notably within B&D) they cannot explain the variance in spend compared to areas such as Tower Hamlets, Waltham Forest and Enfield where, across a wide range of public health metrics, the BHR population are not substantially different to populations in these other areas.
Primary Care	**Very High**	Historic under-investment in Primary Care resulting in high clinician to patient ratios (for both GPs and Practice Nurses) and the excessive use of Locums is a significant driver of the system deficit. The under-investment limits the care available for the frail elderly and those with one or more Long Term Condition (LTC) resulting in higher non-elective activity and the lack of options for Out of Hospital elective care results in elevated elective referrals.
Community Services	**Unknown but possibly Medium/High**	The amount invested by BHR on a 'per head' population appears to remain at the average for the rest of NEL and NCL but given problems with comparing Community Services across areas it was unclear whether or not this is a driver of the deficit. However, based on feedback and a review of the available data (without comparisons) does suggest this is a significant driver of the deficit.
Excess Low Acuity Care in a Secondary Care Setting	**Very High**	BHRUT's market share of Outpatient Activity for BHR had consistently increased over a period of at least 4 years whilst the BHRUT share of higher acuity care (Daycase/Elective) had consistently fallen (data to 2019/20). This was a significant driver of system deficit and the BHRUT deficit. For the system the higher acuity care was occurring in higher cost settings (such as the Independent Sector and at trusts with higher Market Force Factor (MFF) Rates) whilst for BHRUT it was limiting the 'earnings per clinical hour'.

The impact of these drivers cannot be over-stated. Collectively they have created a destructive cycle involving an ever increasing spend in secondary care (peaking at £106m/Year above the average) therefore limiting available finances to invest Out of Hospital to tackle prevention and early intervention which in turn drove poor outcomes and ever more activity flowing into secondary care.

This position for BHR is neither sustainable nor desirable.

5.0 The Financial Impact on BHR

The financial challenges faced by the BHR have existed since at least 2012. As can be seen from earlier in the ISP there is a correlation to a declining financial position and worsening health outcomes for the population. Graph 5 charts the financial impact of these declining outcomes between two points in time (from 14/15 until 17/18). This shows that the system financial position worsened from around £27m deficit in 2014/15 to £72m deficit in 2017/18. Concurrently the excess spend in secondary care increased from <£80m to over £100m.



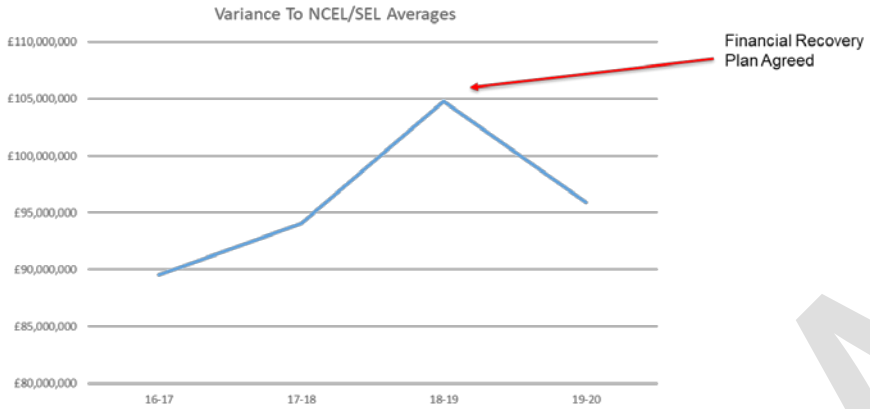
Graph 5: Financial Position within the NHS in BHR 2014/15 to 2017/18

There is an important message in this data. The system increased its excess spend in secondary care by £20m per year between 2014/15 and 2017/18 and yet, despite this massive increase in annual spend the financial position of BHRUT worsened from ~£38m deficit to £62m deficit. This clearly indicates the need to reshape the casemix within the hospital by reducing pressure on the Urgent & Emergency Care (UEC) Pathway and repatriating higher value add elective care (Daycase and Elective) that currently flows out of the system to higher cost settings, which when combined with the elective recovery work over the first two years of the ISP will significantly reshape the casemix within BHRUT.

The work undertaken during 2019/20 shows that we can both respect patient choice and at the same time increase the % of referrals seen at our local NHS hospitals and therefore can be assured that the assumptions about repatriation that exist within the ISP can be delivered.

The impact of working together to deliver the aspirations within the FRP is even more clearly seen in Graph 6 below that shows how the excess spend for the BHR System changed over time from 2016/17 to 2019/20.

Graph 6 – BHR Secondary Care Spend Variance compared to NEL, NCL and SEL



What Graphs 5 and 6 really show is that failing to address increasing non-elective admissions at the expense of elective admissions and daycase procedures is a key driver of the worsening financial performance in BHR as well as signalling the poor outcomes experienced by our population.

The reductions seem in Graph 6 of nearly £10m/year were driven by reductions in admissions for the Frail Elderly, increased numbers of Older People being able to die in their preferred place of death, reductions in the number of falls and improved outcomes for people with COPD as well as a new model of care for MSK. These positive improvements in outcomes will not be seen in public health data for another 1-2 years but if we improve support for people with (say) COPD then the frequency of them requiring urgent care will reduce and this can only be better for the individual and better for the system as a whole (both health and care).

6.0 Aims & Objectives of the ISP

As already mentioned earlier within this document the triple-aim of the Integrated Sustainability Plan (ISP) is stated below:

We will improve the medium to long-term outcomes (physical and mental health) for our population and through this **reduce the pressure on our health and care system** and therefore achieve **long-term financial sustainability.**

The objectives for the Integrated Sustainability Plan (ISP) build on those from the original Financial Recovery Plan (FRP) and are:

- Improve outcomes for Older People and people of all ages with 1+ Long Term Condition (LTC);
- In line with 21/22 Planning Guidance and our own aspirations we will focus our Out of Hospital investments on tackling inequalities and inequities that are a contributor to poor health outcomes;
- Reduce the amount of low acuity care undertaken in a secondary care setting, where appropriate and safe to do so;
- Achieve financial balance across the system by 2024/25;
- Reduce the excess spend in secondary care in all areas amenable to transformation to zero by 2024/25 and to exceed this by 15% in 2025/26. This will see a recurrent reduction in secondary care spend of £70m/year by 2025/26.
- Reinvest 50% of this reduction to reshape our model of care and in particular to grow our investments out of hospital. This will mean that we will recurrently invest £35m/year by 2025/26 in delivering care differently for our population.
- Maintain the financial integrity of BHRUT by repatriating care and reversing the decline in market share of higher value-added activity. This will be achieved whilst respecting patient choice;
- Work together through our System Wide Transformation Boards to shift activity into the most appropriate setting (whilst respecting patient choice where appropriate). This includes supporting our NHS Acute Partners (Barts Health and BHRUT) to achieve their elective recovery targets by supporting the move of care that can be provided in other settings to free up their clinical capacity.

- Monitor progress toward our aims and as a system make collective decisions about where we may need to change or adapt our focus to ensure we achieve our aims;

- Work together to ensure that no partner is disadvantaged in the long-term journey whilst recognising that there will be a need to take difficult decisions (particularly financial ones) in the short to medium term.

- The financial sovereignty of each organisation will be maintained and we will not be seeking to transfer deficits or surpluses between partners.

This will not be an easy journey and is a challenge for every partner. The benefits are significant with improved long-term health outcomes for our population and a sustainable financial position for all our partners.

7.0 Focusing Our Transformation Programme

The focus of our Transformation Programme through the ISP will mean addressing four priority areas:

1. Improving outcomes for Older People and those with complex needs and/or 1+ LTC and through this reduce the pressure on Urgent & Emergency Care services.

2. Reshape our Outpatient Services to reduce inappropriate attendances and activity and therefore release clinical resource for higher acuity care.

3. Reduce the excess daycase (and some elective) activity but simultaneously ensure that more of this care is delivered in our local NHS hospitals whilst respecting choice.

4. Address the historic under-investment within Primary Care and Mental Health.

For Priority 1, Table 10 below shows the priority specialities with significant excess non-elective activity where there are opportunities to intervene, change our model of care and therefore reduce excess activity. A full list of specialties to be focused on can be found listed later in this document and found in detail within the accompanying Modelling Document.

Table 10: Focus areas for non-elective activity reduction

Specialty	Conditions with High Levels of Non-Elective Admissions	Reduction to Reach Peer Average
Geriatric Medicine	Pneumonia, Asthma, Lower Respiratory Infections, COPD, Heart Failure, Arrythmia, Gastrointestinal Infections, Falls, Diabetes, Kidney/Urinary Tract Infections, AKI, Iron Deficiency, Sepsis	3088 Admissions/Year
MSK	Falls (reflected in Very Major & Major Hip Procedures)	350 Admissions/Year
General Surgery & Gastro	Gastrointestinal Tract Disorders, Skin Disorders & IBD	2187 Admissions/Year
Urology	AKI, General Renal Disorders	531 Admissions/Year
Respiratory	Pneumonia, COPD, Heart Failure, Sepsis	647 Admissions/Year
Stroke Medicine	Strokes/TIAs	256 Admissions/Year
Nephrology	CKD/AKI and related disorders	870 Admissions/Year

Table 10 shows not only the priority specialities but also how many non-elective admissions BHR would need to reduce by to reach the average number per thousand population achieved by our peer group.

For Priority 2, Table 11 shows where we need to focus our efforts to reduce Outpatient Activity. It should be noted that the Outpatient Reductions stated are based on the 19/20 Baseline and have not been reset following the COVID Pandemic due to the extreme variations in elective activity seen as the system responded to the crisis.

Table 11: Main focus areas for elective outpatient reductions

Specialty	Outpatient Reductions To Reach Peer Group Average	Outpatient Procedure Reductions To Reach Peer Group Average
Trauma & Orthopaedics	~23,000/Year	~6,000/Year
General Surgery	~11,000/Year	~3,500/Year
Ophthalmology	~11,000/Year	~1,500/Year
Cardiology	~7,000/Year	-
Respiratory	-	~2,000/Year
Nephrology	~3,000/Year (Follow Ups Only)	-
Pain Management	~5,000/Year	~2,000/Year
Rheumatology	~8,000/Year	~500/Year

The detail for all of Priorities 1-3 are provided later in this document. For Priority 4, the original FRP did not consider the Mental Health investment required to improve outcomes within BHR yet we can see from Table 1 (see earlier in this paper) that two of the three BHR Boroughs are above the London average for Mental Health prevalence. The historic underinvestment in Mental Health Services means we have failed to tackle the inequalities that exist such as the poor long term health outcomes and often shortened life expectancy of people with Serious Mental Illness (SMI) and those with Learning Disabilities (LD).

Whilst the original FRP did consider increased funding for Primary Care, the work undertaken to evaluate spend across NEL has identified there is a need to increase the investment even above the levels within the original FRP to achieve equity with other parts of North East London. Therefore, the ISP now includes the finance plans required to redress the under-investment in both Mental Health and Primary Care.

8.0 Delivering the Transformation

The establishment of the system wide Transformation Boards provides the infrastructure for agreeing and delivering the changes needed within BHR.

Currently, against the ~£95m/Year excess spend there is ~£35m/Year that is unlikely to be able to be addressed through transformation. Some of these areas are because they are purely coding artifacts (for example, the recurrent £7m/Year excess for Sports and Exercise Medicine which is actually related to excess costs for Older People based on an analysis of HRGs) and some are in areas not conducive to transformation such as Maternity/Obstetrics, Clinical Oncology etc.

Of the residual £60m/Year excess spend in Secondary Care the ISP aspires to reduce this to zero by 2024/25 and to exceed it by 15% in 2025/26. This would make a recurrent reduction in secondary care spend of ~£70m/Year.

Of this, we would reinvest 50% of the sum back into providing additional services Out of Hospital and reshaping how and where secondary care services are delivered. For example, in reducing non-elective admissions for Older People we may want to invest more money electively in providing a Frailty Hub in the Community staffed by BHRUT to provide a rapid access to Comprehensive Geriatric Assessments.

We will use the reprovision as follows:

1. Transformation Boards will be given an indicative budget based on the assumed activity changes they will need to drive. The aim is not to have rigid targets for Boards but to steer them toward the areas that will have the biggest impact on improving outcomes and reducing excess secondary care activity. However, the only way to release funding for investments is through reshaping secondary care services.

2. There is an indicative expectation of how this reprovision budget will be spent between different organisations (but not a formal requirement) as summarised below:

    a. BHRUT 30%
    b. Barts Health 5%
    c. NELFT (Community) 15%
    d. Primary Care 40%
    e. Local Authorities 5%
    f. VCS/Other 5%

3. To access this indicative budget the Transformation Boards will produce Business Cases effectively 'drawing down' from this budget (an outline of how this will be provided is summarised later in this document) with Business Cases going to ICEG for noting and ICPB (and potentially the NEL Governing Body) for approval as needed. This allows partners to 'test' whether the proposed transformation programmes will have the desired financial impact.

4. Delivery of the schemes will be monitored via the Transformation Boards with oversight from BHR Finance Sub-Group and the Integrated Care Programme Board to enable decisions to be made about changes, expansion and/or cessation of schemes. As the system migrates into an Integrated Care System (ICS) and as the BHR Plan becomes more aligned to the North-East London (NEL) Plan, this approval process may change.

Overall, if we achieve our aspirations by 2025/26 we will have achieved a significant improvement in outcomes, the reshaping of secondary care (mainly reducing non-elective activity and increasing the % of daycase and elective activity) and through this we will have delivered a recurrent £35m/Year reduction in spend that will ensure a sustainable financial position for the BHR System. Whilst these changes will have a significant positive impact on Local Authority finances we are not currently making any assumptions about the ISP being fully integrated across Health and Care.

9.0 ISP Financial Assumptions & Risks

In producing the ISP at a time when there is limited guidance beyond 21/22 there has been a need to utilise a series of assumptions within the modelling. In addition, the utilisation of assumptions means that there are inherent risks if any of the main assumptions used turn out to be materially different. The Assumptions are summarised in Section 9.1 and the associated Financial Risks are summarised in Section 9.2.

9.1 Financial & Activity Assumptions

1. The ISP ignores all one-off and other non-recurrent investments made in response to COVID to provide a 'clean' baseline for 2021/22 compared to the last pre-COVID year (2019/20). **Important:** This means the values in the ISP are indicative rather than based on actuals and a correction will need to be made when allocations are known beyond 21/22.

2. BHR will receive the Long-Term Plan Allocation Growth Assumptions until 2023/24 noting these are above the 2.3% Growth associated with Demographic & Non-Demographic Growth. This being 4.2% for 2022/23 and 4% for 2023/24.

3. For 2024/25 and 2025/26 BHR will see a 3% Allocation Growth in each year.

4. To enable us to compare what would happen in a 'Do Nothing' scenario the following assumptions are being made:

    a. Mental Health Investments and those for CHC will increase at the rate of Allocation Growth. By the end of the period of the ISP (2025/26) this means all providers in this category would have seen a 14.97% growth in income compared to the 2021/22 baseline.

    b. All other providers will see a growth in income equivalent to the 2.3% demographic/non-demographic growth. By the end of the period of the ISP (2025/26) this means all providers in this category would have seen a 9.52% growth in income compared to the 2021/22 baseline.

In terms of reducing secondary care activity, it is assumed that this will come from the following areas:

- **Non-Elective –** 70% from BHRUT, 20% from Barts and 10% from 'Other NHS' Acutes.
- **Elective –** 65% from BHRUT, 20% from IS/Other NHS Acutes and 15% from Barts.

9.2 Financial Risks & Mitigations

This section summarises the risks associated with the assumptions and also other external risks that might affect the financial plans outlined within the ISP along with any mitigations that may exist. Non-Clinical Risks mostly relate to perpetuating poor outcomes for our population and are therefore not included in this section but can be deduced from the Clinical Case made earlier within this document.

Risk	Description	Mitigation
Allocations are not at the level anticipated within the ISP.	The ISP assumes that allocation levels for the BHR ICP will return to the LTP Levels for 21/22 to 23/24 and then will be at a lower level of 3% for 24/25 and 25/26. This is yet to be tested.	There is a risk provision built into the ISP of a modest level but any substantial difference to the anticipated allocation above this level would need to be addressed through rephasing the ISP or increasing the rate of change.
The new costing formula and/or contract form may hinder the ability to move money around the system.	With the move away from Payment by Results (PbR) and the National Tariff Payment System (NTPS) toward the proposed Aligned Payment & Incentive (API) Contract could create issues with how funds are distributed and also the ease of moving money between partners.	Working together via the ICPB, ICEG and other Governance Structures within the BHR ICP would help to mitigate this especially if there continues to be a shared commitment to improving outcomes for our population as articulated within the ISP.
Specialist Commissioning devolution back to ICSs could bring additional cost pressures and complexity.	With the proposed devolution of Specialist Commissioning set to take place in March 2023 and a proposed move toward ICS Budgets based on a population/capitation rate the way funding flows into, through and out of the BHR ICP area could be affected.	Representatives from the BHR ICP need to be involved in the decision making processes associated with devolution and to assess any risks that this may cause to the delivery of the ISP.
Unexpected Cost Pressures could arise that eliminate any financial headroom.	It is quite common to have unexpected cost pressures that are driven by circumstances outside of the ability of planning teams to plan for or are driven by NHS Operating Plan requirements that place requirements on CCGs (and in the future ICSs).	As with the risk of allocation fluctuations there is a small amount of risk headroom built into the ISP that would be the first point of call for these unexpected pressures but this reserve may be exceeded if both allocation levels are lower than expected and excessive unexpected cost pressures occur concurrently.
Spending Review or other funds that are built into current investments turn out to be non-recurrent requiring replanning of investments with providers.	At present there is a risk that the Mental Health Spending Review money may not be recurrent. Post-COVID many other financial adjustments may also not be recurrent and these will create a potential financial risk to the system and the delivery of the ISP.	Obviously, as mentioned above there is a small risk provision built into the ISP but there are likely to be multiple calls on this arising from some of the other risks. Therefore addressing and responding to any changes to assumed income for existing services will need to considered by the BHR ICP as they arise.
The efficiency ask of ICSs (and of the BHR ICP in particular) may exceed the plans within the ISP.	The ISP assumes a year on year efficiency to bring the spend down to that of our peers and reshape our model of care. However, it could be that the efficiency requirement that appears for the future may exceed this level.	The ISP assumes a trajectory of reduction that is relatively modest. In the first instance the efficiency ask could be met by aiming for a more aggressive reduction trajectory or alternatively by slowing the investments into (say) Primary Care and Mental Health over and above ISP reprovision rates.

9.3 Overview of the ISP Assumptions

This section should be read in conjunction with the accompanying ISP Modelling Excel document and the associated Technical Guidance and discusses how the main assumptions detailed earlier within this document and expanded further here play through into the detail of the ISP.

9.3.1 Phasing of the ISP Reductions (Transformation Board Targets)

As stated previously the aim is to come close to the peer average of activity by 2024/25 and then to exceed the peer average in 2025/25. The current phasing of efficiencies assumes 6% will be delivered in 21/22 and the overall 5 Year Phasing will be as shown below in Table 12.

Table 12 – ISP Reduction Phasing (6% 21/22 Scenario)

ISP Reduction Phasing	TARGET REDUCTIONS	21/22	22/23	23/24	24/25	25/26
OPD Reduction %	**115%**	6%	26%	28%	30%	25%
DC/E Reduction %	**115%**	6%	26%	28%	30%	25%
NEL Reduction %	**115%**	6%	26%	28%	30%	25%

These are the current targets that are set for the five transformation boards directly affected by the ISP (Planned Care, Urgent & Emergency Care, Older People, Long Term Conditions and Cancer). At the time of finalising the ISP there is a due diligence process underway to assess the deliverability of current schemes and also work underway to improve the pipeline of efficiencies. To accommodate this a sensitivity analysis has been undertaken assuming the 6% delivery in 21/22 varies by 50% in each direction giving us the delivery profile shown in Tables 13 and 14 below.

Table 13 – ISP Reduction Phasing (3% 21/22 Scenario)

ISP Reduction Phasing	TARGET REDUCTIONS	21/22	22/23	23/24	24/25	25/26
OPD Reduction %	**115%**	3%	27%	30%	30%	25%
DC/E Reduction %	**115%**	3%	27%	30%	30%	25%
NEL Reduction %	**115%**	3%	27%	30%	30%	25%

Table 14 – ISP Reduction Phasing (9% 21/22 Scenario)

ISP Reduction Phasing	TARGET REDUCTIONS	21/22	22/23	23/24	24/25	25/26
OPD Reduction %	**115%**	9%	23%	28%	30%	25%
DC/E Reduction %	**115%**	9%	23%	28%	30%	25%
NEL Reduction %	**115%**	9%	23%	28%	30%	25%

We will see later how these different scenarios impact on the £20m Non-Recurrent Funding that is available to support and de-risk the first two years of the ISP (21/22 and 22/23).

9.3.2 Financial Impact of the ISP Reductions (including Reprovision)

This section focuses on how the 6% reduction scenario in 21/22 as described above plays out in terms of the expected reductions. These reductions are against the background growth and overall represent ~1.3% of the total system allocation by 2025/26.

Table 15 The proposed reductions by year across BHR compared to the 19/20 Baseline broken down by POD/Area and by Provider.

CUMULATIVE ISP REDUCTIONS	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)
OPD Gross Recurrent Reductions (£)	-£852	-£4,542	-£8,517	-£12,776	-£16,324
Daycase/Elective Gross Recurrent Reductions (£)	-£1,236	-£6,593	-£12,361	-£18,542	-£23,692
Non-Elective Gross Recurrent Reductions (£)	-£1,549	-£8,262	-£15,491	-£23,237	-£29,692
TOTAL ISP REDUCTIONS	**-£3,637**	**-£19,397**	**-£36,370**	**-£54,554**	**-£69,708**

CUMULATIVE REDUCTIONS BY PROVIDER	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)
BHRUT (70% of Non-Elective & 65% of Elective)	-£2,441	-£13,021	-£24,415	-£36,622	-£46,795
Barts (20% of Non-Elective & 15% of Elective) - WX is 52% of Elective & 58% of NEL	-£623	-£3,323	-£6,230	-£9,345	-£11,941
IS/Other Acute (10% of Non Elective & 20% of Elective)	-£572	-£3,053	-£5,725	-£8,587	-£10,972
TOTAL REDUCTIONS BY PROVIDER	**-£3,637**	**-£19,397**	**-£36,370**	**-£54,554**	**-£69,708**

Table 16 below shows the proposed reprovision and repatriation assumptions built into the ISP. This shows the £35m recurrent reinvestment that will be provided by 2025/26 to support the transformation in the BHR Model of Care.

Table 16 Reprovision & Repatriation Assumptions

CUMULATIVE REPROVISION COSTS BY PROVIDER	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)
BHRUT (30%)	£546	£2,910	£5,455	£8,183	£10,456
Barts (5%)	£91	£485	£909	£1,364	£1,743
NELFT (Community Services) (15%)	£273	£1,455	£2,728	£4,092	£5,228
Primary Care (40%)	£727	£3,879	£7,274	£10,911	£13,942
Local Authority Investments (5%)	£91	£485	£909	£1,364	£1,743
VCS/CVS & Other Investments (5%)	£91	£485	£909	£1,364	£1,743
TOTAL CUMULATIVE REPROVISION	**£1,818**	**£9,699**	**£18,185**	**£27,277**	**£34,854**

CUMULATIVE REPATRIATION ASSUMPTIONS	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)
BHRUT (BHR CCGs)	0.0	500.0	2,500.0	6,500.0	6,500.0
Barts	0.0	0.0	0.0	0.0	0.0
Independent Sector, NCA & Other Acute (Including NHS Other Acute)	0.0	-500.0	-2,500.0	-6,500.0	-6,500.0

The Repatriation Assumptions ignore the fact that on-average the cost of equivalent care in the Independent Sector is higher than that of BHRUT and Barts and therefore depending on where repatriation ultimately comes from there will be a further unstated efficiency to the BHR System.

Table 17 summarises the 'System Headroom' provision, this is effectively the 'Risk Reserve' detailed within Section 9.2 above and should not be used to fund recurrent or non-recurrent investments without careful planning and detailed guidance being available. This risk reserve is an important assumption and arises from the proposed allocations being in excess of the expected increase in costs and activity and may actually cease to exist if allocations are lower than expected.

Table 17 System Headroom

CUMULATIVE SYSTEM HEADROOM ALLOCATION	21-22 (£k)	22-23 (£k)	23-24 (£k)	24-25 (£k)	25-26 (£k)
BHRUT (1.75% from 22/23 Onwards)	£0	£6,768	£13,575	£20,450	£27,353
Barts (1.75% from 22/23 Onwards)	£0	£2,128	£4,263	£6,402	£8,555
Mental Health Equalisation Investment (Assumed 100% NELFT @1%/Yr)	£0	£1,063	£2,165	£3,301	£4,470
Primary Care Equalisation Investment (Assumed to Level of Tower Hamlets)	£0	£4,000	£7,500	£12,300	£12,300
Independent Sector, NCA & Other Acute (1% Growth 22/23 Onwards)	£0	£356	£719	£1,091	£1,472
Risk Provision	£19,790	£25,789	£33,341	£27,876	£27,605
CUMULATIVE IMPACT	**£19,790**	**£40,103**	**£61,564**	**£71,419**	**£81,755**

The “System Headroom” shown in Table 17 depends on the allocation assumptions arising and therefore, given the levels of uncertainty about the future, a large ‘Risk Provision’ is included. If these are realised then it allows for the following:

1. Over and above reprovision costs we would be able to fund some growth at BHRUT, Barts and with the Independent Sector.

2. As the reprovision assumptions for Primary Care are not sufficient to grow the investment to the same rate as Tower Hamlets, this would allow for the gap between the reprovision level and the rate required to reach the investment levels with Tower Hamlets. The rationale for choosing Tower Hamlets is that there are strong demographic similarities to that of the BHR System and they have a very minimal excess spend in secondary care which is the equivalent aspiration for the BHR System.

3. With Mental Health (MH) investments expected to increase at the same rate as allocation growth through the Mental Health Investment Standard (MHIS), this headroom also allows funding to accelerate the closing of the historic under-investment gap.

4. Lastly, there is a significant risk provision to allow for such things as excess efficiency requirements, allocation rates below plan and other unexpected costs.

All of the plan will need to be recast when we understand the actual financial landscape beyond 21/22.

10.0 De-risking 21/22 and 22/23

The NEL CCG has identified a £20m Non-Recurrent Fund that is available to de-risk the delivery of the first two years of the Transformation Programme outlined within the ISP. This eliminates the need to reduce the budgets for BHRUT and Barts Health to support investments Out of Hospital and at the same time provides the indicative budgets for the transformation boards most closely aligned to the ISP.

Table 18 summarises how the Non-Recurrent Fund will be utilised over the two-year period (2021/22 and 2022/23).

Table 18 Proposed Distribution of the Non-Recurrent De-Risking Funds

£20m NON-RECURRENT INVESTMENT FUND	21-22 (£k)	22-23 (£k)
Planned Care Transformation Board (ISP)	£1,011	£4,381
Urgent Care Transformation Board (ISP)	£62	£267
Older People Transformation Board (ISP)	£444	£1,926
LTC Transformation Board (ISP)	£271	£1,173
Cancer Transformation Board (ISP)	£31	£132
Mental Health Transformation Board	From Additional MH Investment	
Children's & Young People Transformation Board	£100	£150
Prevention Investment Fund (via Borough Partnerships)	£250	£750
BHRUT Adjustment (To Maintain Income)	£1,896	£2,844
Barts Adjustment (To Maintain Income)	£532	£710
Reserves	£1,000	£2,070
TOTAL	**£5,596**	**£14,404**

The main elements of Table 15 are explained below:

- For 21/22 and 22/23 we will be able to provide all of the Transformation Board that are identified within the ISP with indicative budgets without requiring this to be taken from the Acute Contracts. The assumptions for the indicative budgets and how these are worked out can be found in the accompanying ISP Model and ISP Technical Guidance.

- We will also be able to invest in the CYP Transformation Board and create a non-recurrent prevention fund (the latter managed via Borough Partnerships)

- We would be able to offset any additional reductions we would require in the BHRUT and Barts Health budgets in full in 21/22 and in part from 22/23. **IMPORTANT NOTE:** The investments shown above for BHRUT and Barts Health are not additional investments to the trusts but are provisions to the bottom line of the NEL CCG to offset the need to take money from the two providers to fund the transformation. This means that the NEL CCG will overspend unless these provisions are accounted for.

- We would have a (small) contingency still available to deal with unexpected emergencies and events.

The utilisation of this fund and ensuring it is retained for the sole purpose of de-risking the ISP in the first two years (allowing time for both Barts and BHRUT to undertake their own internal transformation programmes) will be overseen by a Non-Recurrent Investment Group chaired by the BHR ICP Representatives of the NEL CCG with input from partners. A further important note is that the budgets for transformation boards are indicative and can only be accessed by providing Business Cases that will be screened to ensure that they meet the aims and objectives of the ISP before funding can be released.

Table 18 is based on the assumption that 6% of the overall ISP Reduction targets are delivered in 2021/22. As mentioned earlier we are undertaking a due diligence exercise at the time of finalising this report to outline and therefore have undertaken a sensitivity analysis assuming that the actual delivery varies from the 6% by 50% in either direction. Details can be seen in Tables 19 and 20 below.

Table 19 Proposed Distribution of the Non-Recurrent De-Risking Funds (9% Delivery Scenario in 21/22)

£20m NON-RECURRENT INVESTMENT FUND	21-22 (£k)	22-23 (£k)
Planned Care Transformation Board (ISP)	£1,517	£3,876
Urgent Care Transformation Board (ISP)	£93	£236
Older People Transformation Board (ISP)	£667	£1,703
LTC Transformation Board (ISP)	£406	£1,038
Cancer Transformation Board (ISP)	£46	£117
Mental Health Transformation Board	From Additional MH Investment	
Children's & Young People Transformation Board	£100	£150
Prevention Investment Fund (via Borough Partnerships)	£250	£750
BHRUT Adjustment (To Maintain Income)	£2,844	£2,844
Barts Adjustment (To Maintain Income)	£798	£710
Reserves	£500	£1,356
TOTAL	**£7,220**	**£12,781**

Table 19 (9% Delivery) shows that the overall reserve levels are lower and that there is a much greater spend in 21/22.

Table 20 Proposed Distribution of the Non-Recurrent De-Risking Funds (3% Delivery Scenario 21/22)

£20m NON-RECURRENT INVESTMENT FUND	21-22 (£k)	22-23 (£k)
Planned Care Transformation Board (ISP)	£506	£4,550
Urgent Care Transformation Board (ISP)	£31	£278
Older People Transformation Board (ISP)	£222	£2,000
LTC Transformation Board (ISP)	£135	£1,219
Cancer Transformation Board (ISP)	£15	£138
Mental Health Transformation Board	From Additional MH Investment	
Children's & Young People Transformation Board	£100	£150
Prevention Investment Fund (via Borough Partnerships)	£250	£750
BHRUT Adjustment (To Maintain Income)	£948	£2,201
Barts Adjustment (To Maintain Income)	£266	£529
Reserves	£1,000	£4,713
TOTAL	**£3,473**	**£16,526**

Table 20 (3% Delivery) shows that there is a substantial risk that not all of the £20m funds will be spent in 22/23. This risk needs to be identified early and mitigations put in place including possibly rolling forward the residual budget into 23/24 if allowable by auditors.

11.0 Engagement

In this section we outline the dates in 2021/22 when the Integrated Sustainability Plan was discussed at system wide and provider specific meetings. The dates for the various meetings are shown in Table 21 below.

Table 21: Engagement with System & Partner in development of the ISP

Committee	Dates Presented (all in 2021)
ICPB (Integrated Care Programme Board)	27th May, 29th Jul & 30th Sep
ICEG (Integrated Care Executive Group)	20th May, 17th Jun, 15th Jul, 16th Sep & 21st Oct.
BHR Finance Sub-Group	1st Jul, 28th Jul & 26th Aug
NELFT Finance Committee	20th Jul, 21st Aug
NELFT Board	28th Sep
NEL Governing Body	27th Oct
BHRUT TEC (Trust Executive Committee)	24th Aug
BHRUT FIC (Finance & Investment Committee)	28th Jul, 25th Aug
BHRUT Board	13th Sep
HCC (Health & Care Cabinet)	13th May, 12th Aug & 14th Oct
Discussions with partners at Barts	5th Jul, 23rd Jul & 30th Jul
Discussions with partners at Waltham Forest	23rd Aug
BHR ISP Group	16th Apr, 14th May, 10th Jun, 9th Jul & 20th Aug

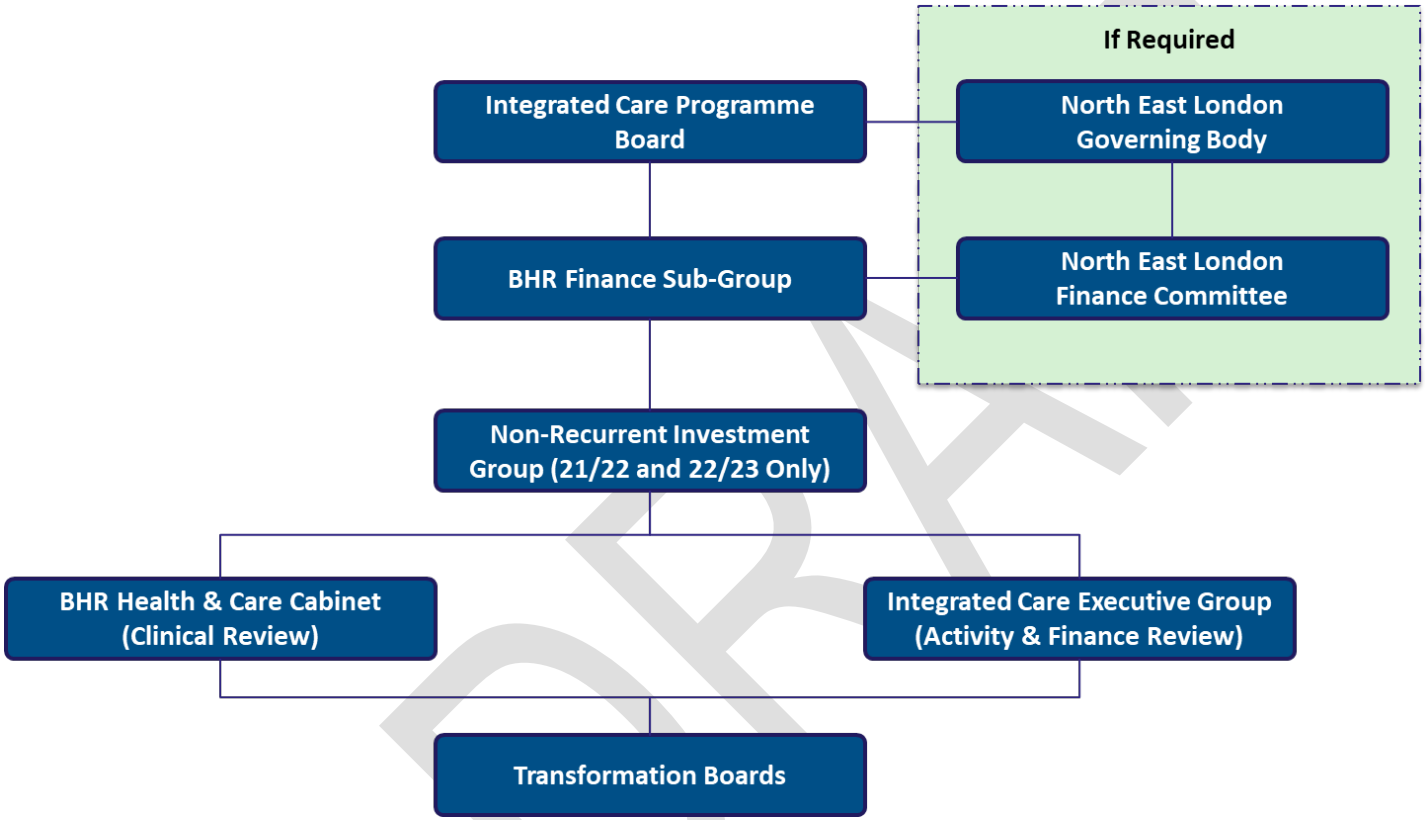
12.0 Enablers

The delivery of the ISP relies on multiple enablers that are summarised in this section along with the expected approach to how each Enabler will be managed to ensure the aspirations set out in the ISP are delivered.

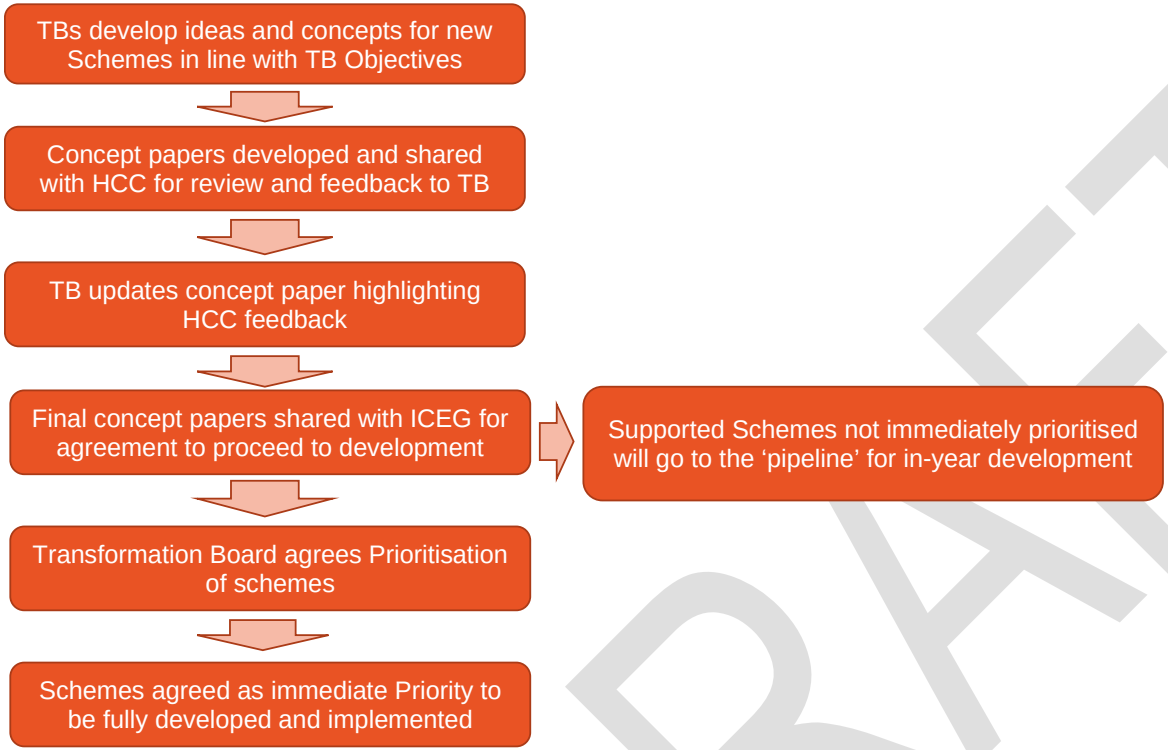
Enabler	Description	Expected Management
Workforce	Workforce is probably the biggest risk to the delivery of ISP with shortages of permanent staff across a wide range of settings. Staff shortages in Primary Care are unlikely to be delivered via substantial numbers of additional General Practitioners (GPs) but with new roles such via the ARRS (Additional Roles Reimbursement Scheme) will help change the workforce and therefore increase capacity.	Individual organisations will need to work on their own Workforce Plans. The financial plans and underlying expected activity changes set out within the ISP should provide a basis for calculating future workforce needs.
Communications	Ownership and delivery of the ISP is a 'whole system' matter and not confined to a few senior directors and clinicians. As such there is a clear need to have a robust communications and engagement plan with staff, and in due course, with the public.	We have already commenced producing a Communications & Engagement Plan for BHR that will need to be owned and led by Provider Partners as we progress with the ISP.
Capital Funding	There are already a range of actual and potential capital programmes underway (for example the St George's Hospital and the possible Barking Hospital). However, the ISP makes no assumption about the need for capital to deliver the changes proposed especially given the relatively modest changes that are proposed to be delivered over the period compared to the overall activity levels.	Any capital needs that do come to light relevant to the ISP will need to be addressed on an ad-hoc basis.
Contracts	The new contract forms are expected to be very different and based on different funding principles. It is important that the progress made in BHR over the previous years since the conclusion of the Expert Determination process between BHRUT and the BHR CCGs (as they were) and the agreement on adjustments and local pricing will need to be incorporated appropriately into future contracts and methods for adjusting contracts agreed collaboratively.	A working group needs to be set up to identify how we will translate the historic arrangements that existed pre-COVID in particularly the BHRUT Contract are translated into any new contract form.
Delivery of ISP	Delivery of the ISP lays very clearly with the system wide transformation boards but will need system wide support to progress changes at pace.	Governance of the ISP is proposed in Section 13 of this document.
Alignment of Plans	Individual organisations within the BHR System all have their own internal transformation and efficiency plans and aligning these around the aspirations set out within the ISP will be extremely important as this will impact on activity and workforce.	Plans will need to regularly reviewed and alignment is proposed to occur via ICEG and potentially ICPB and even the NEL ICS.
Relationships	A major part of the historic inability of BHR to improve was that relationships at a senior level was often not as it should have been. This prevented collaboration and bred a lack of trust.	The establishment of the ICS Structure along with local BHR Structures such as ICEG and the ICPB will support the maintenance of effective relationships.

12.0 Governance

The proposed Governance of the ISP is shown below. These arrangements will need to be reviewed in light of the transition to the ICS in 22/23 and should be kept under regular review.



The current root for approving Business Cases arising from the work of the BHR Transformation Boards is shown in the diagram below and again should be kept under review.


TBs develop ideas and concepts for new Schemes in line with TB Objectives
Concept papers developed and shared with HCC for review and feedback to TB
TB updates concept paper highlighting HCC feedback
Final concept papers shared with ICEG for agreement to proceed to development
Supported Schemes not immediately prioritised will go to the 'pipeline' for in-year development
Transformation Board agrees Prioritisation of schemes
Schemes agreed as immediate Priority to be fully developed and implemented

Abbreviations Used in the ISP

Abbreviation	Meaning
AKI	Acute Kidney Injury
B&D	The London Borough of Barking & Dagenham
Barts	A reference to Barts Health NHS Trust
BHR	Barking & Dagenham, Havering & Redbridge
BHRUT	Barking, Havering & Redbridge University Hospitals Trust
CCG	Clinical Commissioning Group
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CYP	Children & Young People
FRP	Financial Recovery Plan
HCC	BHR Health & Care Cabinet
HRG	Healthcare Resource Group
IBD	Irritable Bowell Disease
ICS	Integrated Care System
ICEG	Integrated Care Executive Group
ICPB	Integrated Care Programme Board
IS	Independent Sector
ISP	Integrated Sustainability Plan
LD	Learning Disability
LTC	Long Term Condition
MFF	Market Forces Factor
MH	Mental Health
MHIS	Mental Health Investment Standard
MSK	Musculo Skeletal
NEL	North East London or Non-Elective depending on context
NELFT	North East London NHS Foundation Trust
NHSE/I	NHS England/Improvement
OPD	Outpatients Department
SMI	Serious Mental Illness
TB	Transformation Board
TIA	Transient Ischemic Attack
T&O	Trauma & Orthopaedics
UEC	Urgent & Emergency Care
VCS	Voluntary & Charitable Sector
WX	Whipps Cross Hospital
YLL/YLD	Years of Life Lost and Years Living with Disability

Appendix 1 – Transformation Targets Required

The tables below show the required reductions that BHR would need to achieve to reach the weighted average for the remainder of North East, North Central and South East London. An explanation of how to read these tables can be found on the following page.

Specialty	POD	BHR Average Unit Cost	Gross Activity Reduction Required	% Correction Factor	Spend Reduction Required	Activity Reduction Required	Reductions Against 'Do Nothing'	% Barking & Dagenham	% Havering	% Redbridge
Trauma & Orthopaedics	OPFA	£186.67	8456	100%	£1,578,453	8456	23%	15%	46%	39%
	OPFU	£71.90	15344	100%	£1,103,204	15344	22%	14%	53%	33%
	OPPROC	£156.36	4115	100%	£643,344	4115	41%	22%	48%	30%
	ELECTIVE	£2,695.10	2524	100%	£6,803,082	2524	22%	12%	48%	40%
	NON-ELECTIVE	£4,363.25	280	125%	£1,525,075	350	17%	0%	100%	0%
General Surgery	OPFA	£197.12	5432	100%	£1,070,793	5432	33%	25%	47%	27%
	OPFU	£77.95	6534	100%	£509,301	6534	22%	22%	53%	25%
	OPPROC	£188.42	2737	40%	£206,274	1095	22%	24%	45%	31%
	ELECTIVE	£1,171.44	2599	100%	£3,045,106	2599	23%	18%	65%	17%
	NON-ELECTIVE	£2,457.06	1462	100%	£3,592,602	1462	19%	29%	56%	15%
Geriatric Medicine	NON-ELECTIVE	£3,041.53	6176	50%	£9,391,864	3088	29%	16%	58%	26%
Gastroenterology	ELECTIVE	£577.84	3953	100%	£2,284,291	3953	18%	7%	60%	33%
	NON-ELECTIVE	£3,312.82	919	80%	£2,434,726	735	41%	24%	45%	31%
Gynaecology	OPFA	£189.46	12216	100%	£2,314,380	12216	35%	32%	36%	32%
Ophthalmology	OPFA	£165.75	1762	125%	£365,037	2202	13%	4%	23%	72%
	OPFU	£69.84	7413	125%	£647,154	9266	20%	9%	59%	32%
	ELECTIVE	£902.41	1538	100%	£1,387,818	1538	18%	0%	0%	100%
Cardiology	OPFA	£133.94	5183	75%	£520,639	3887	27%	24%	74%	3%
	OPPROC	£181.07	2572	125%	£582,110	3215	15%	0%	100%	0%
	ELECTIVE	£1,748.38	158	100%	£277,071	158	7%	0%	55%	45%
	NON-ELECTIVE	£3,448.61	123	125%	£530,251	154	9%	0%	67%	33%
Urology	OPFU	£70.49	3467	100%	£244,406	3467	14%	0%	56%	44%
	OPPROC	£257.92	4033	100%	£1,040,254	4033	31%	10%	61%	29%
	ELECTIVE	£1,235.69	593	100%	£732,461	593	10%	0%	73%	27%
	NON-ELECTIVE	£2,597.58	425	125%	£1,379,818	531	23%	23%	46%	30%
ENT	ELECTIVE	£1,413.17	847	100%	£1,196,414	847	21%	26%	43%	32%
	NON-ELECTIVE	£1,252.08	415	100%	£520,144	415	25%	31%	46%	24%
Respiratory Medicine	OPPROC	£272.69	4335	50%	£591,013	2167	32%	32%	36%	32%
	NON-ELECTIVE	£3,538.32	647	100%	£2,289,463	647	26%	27%	66%	7%
Nephrology	OPFU	£152.23	2732	100%	£415,831	2732	20%	24%	15%	61%
	NON-ELECTIVE	£2,621.88	870	100%	£2,280,652	870	35%	34%	50%	15%

Specialty	POD	BHR Average Unit Cost	Gross Activity Reduction Required	% Correction Factor	Spend Reduction Required	Activity Reduction Required	Reductions Against 'Do Nothing'	% Barking & Dagenham	% Havering	% Redbridge
Rheumatology	OPFA	£302.16	856	125%	£323,356	1070	18%	0%	50%	50%
	OPFU	£104.38	7027	100%	£733,519	7027	21%	18%	52%	31%
	ELECTIVE	£1,026.96	367	100%	£376,463	367	24%	16%	75%	9%
Interventional Radiology	ELECTIVE	£1,048.35	2972	50%	£1,557,915	1486	25%	27%	46%	27%
	NON-ELECTIVE	£6,767.66	84	40%	£226,071	33	18%	18%	0%	82%
Breast Surgery	ELECTIVE	£2,103.95	218	100%	£459,466	218	19%	0%	71%	29%
Neurosurgery	OPFA	£249.05	2299	40%	£229,022	920	22%	24%	44%	32%
	ELECTIVE	£2,903.24	362	50%	£525,770	181	28%	22%	35%	43%
Pain Management	OPFA	£239.17	1334	100%	£318,938	1334	33%	22%	44%	34%
	OPFU	£83.50	4837	75%	£302,942	3628	29%	22%	52%	26%
	ELECTIVE	£841.40	1785	100%	£1,501,542	1785	31%	16%	51%	33%
Vascular Surgery	NON-ELECTIVE	£5,577.24	36	100%	£203,353	36	9%	28%	64%	8%
Stroke Medicine	OPFA	£506.18	450	100%	£227,568	450	28%	17%	50%	33%
	NON-ELECTIVE	£4,327.65	640	40%	£1,108,047	256	25%	15%	58%	27%
Gynaecological Oncology	OPPROC	£269.30	1127	75%	£227,553	845	34%	14%	79%	7%
	ELECTIVE	£1,277.81	889	40%	£454,386	356	24%	27%	43%	30%
Clinical Oncology	NON-ELECTIVE	£2,437.24	346	40%	£337,034	138	22%	25%	57%	18%

The headings for the tables above are summarised here:

- **Specialty –** This summarises the clinical specialty to which the reductions relate.
- **POD –** This summarises the Point of Delivery to which the reductions relate.
- **BHR Average Unit Cost –** This is a weighted average cost for each activity taking into account local tariffs for BHRUT and the actual costs incurred with other NHS and Independent Sector providers.
- **Gross Activity Reduction Required –** This states the total reduction required to reach the London Average.
- **% Correction Factor –** This corrects the reduction required based on an analysis as to whether the scale of reduction is appropriate or not. For example, reducing the excess activity for Stroke Medicine full would require a recurrent reduction of 640 Non-Elective Admissions and this is deemed excessive so we are only seeking to reduce the excess by 40% of this (256).

- **Spend Reduction Required –** This lists the value of the reductions we are planning to achieve and is calculated by multiplying the value in the *BHR Average Unit Cost* Column by the number in the *Activity Reduction Required* column.

- **Activity Reduction Required –** This is the actual target for reduction to be achieved recurrently by 2024/25 noting that we wish to exceed this target by 15% in 2025/26. This number is calculated by multiplying the number in the *Gross Activity Reduction Required* column by the *Correction Factor*.

- **Reductions Against 'Do Nothing' –** This lists the reduction the ISP is driving compared to what the scenario would have been by 2025/26 if we had not taken this approach. To remove the distortion caused by COVID this column takes the 2019/20 actual activity and adds 2.3% growth per year (for demographic and non-demographic growth) to give an expected value for 2025/26 had COVID not occurred. The reduction % shown here is the % represented by the *Activity Reduction Required* column number compared to 'Do Nothing'.

- **% By Borough –** The last three columns list the split of the required reductions by BHR Borough to help Integrated Care Partnerships (ICPs) and Borough Based Teams to focus their activity.

Appendix 2 – Transformation Board Targets

The reductions detailed in Appendix 1 have been aligned to Transformation Boards as shown below. Targets are shown either fully aligned to one Transformation Board or split across multiple Boards. The reason for this is that the underlying HRGs (Healthcare Resource Groups) associated with the activity reductions required have been used to target the reductions to the most appropriate transformation board.

		BHR Reductions		Transformation Board Alignment					
Specialty	POD	Spend Reduction Required	Activity Reduction Required	Planned Care Transformation Board	Urgent Care Transformation Board	Older People Transformation Board	LTC Transformation Board	Cancer Transformation Board	CHECK
Trauma & Orthopaedics	OPFA	£1,578,453	8,456	100%	0%	0%	0%	0%	100%
	OPFU	£1,103,204	15,344	100%	0%	0%	0%	0%	100%
	OPPROC	£643,344	4,115	100%	0%	0%	0%	0%	100%
	ELECTIVE	£6,803,082	2,524	100%	0%	0%	0%	0%	100%
	NON-ELECTIVE	£1,525,075	350	50%	0%	50%	0%	0%	100%
General Surgery	OPFA	£1,070,793	5,432	100%	0%	0%	0%	0%	100%
	OPFU	£509,301	6,534	100%	0%	0%	0%	0%	100%
	OPPROC	£206,274	1,095	100%	0%	0%	0%	0%	100%
	ELECTIVE	£3,045,106	2,599	100%	0%	0%	0%	0%	100%
	NON-ELECTIVE	£3,592,602	1,462	0%	50%	50%	0%	0%	100%
Geriatric Medicine	NON-ELECTIVE	£9,391,864	3,088	0%	0%	100%	0%	0%	100%
Gastroenterology	ELECTIVE	£2,284,291	3,953	100%	0%	0%	0%	0%	100%
	NON-ELECTIVE	£2,434,726	735	25%	0%	75%	0%	0%	100%
Gynaecology	OPFA	£2,314,380	12,216	100%	0%	0%	0%	0%	100%
Ophthalmology	OPFA	£365,037	2,202	100%	0%	0%	0%	0%	100%
	OPFU	£647,154	9,266	100%	0%	0%	0%	0%	100%
	ELECTIVE	£1,387,818	1,538	100%	0%	0%	0%	0%	100%
Cardiology	OPFA	£520,639	3,887	0%	0%	0%	100%	0%	100%
	OPPROC	£582,110	3,215	0%	0%	0%	100%	0%	100%
	ELECTIVE	£277,071	158	0%	0%	0%	100%	0%	100%
	NON-ELECTIVE	£530,251	154	0%	0%	0%	100%	0%	100%
Urology	OPFU	£244,406	3,467	100%	0%	0%	0%	0%	100%
	OPPROC	£1,040,254	4,033	100%	0%	0%	0%	0%	100%
	ELECTIVE	£732,461	593	100%	0%	0%	0%	0%	100%
	NON-ELECTIVE	£1,379,818	531	25%	0%	75%	0%	0%	100%
ENT	ELECTIVE	£1,196,414	847	100%	0%	0%	0%	0%	100%
	NON-ELECTIVE	£520,144	415	50%	50%	0%	0%	0%	100%
Respiratory Medicine	OPPROC	£591,013	2,167	0%	0%	0%	100%	0%	100%
	NON-ELECTIVE	£2,289,463	647	0%	0%	0%	100%	0%	100%
Nephrology	OPFU	£415,831	2,732	0%	0%	0%	100%	0%	100%
	NON-ELECTIVE	£2,280,652	870	0%	0%	0%	100%	0%	100%
Rheumatology	OPFA	£323,356	1,070	100%	0%	0%	0%	0%	100%
	OPFU	£733,519	7,027	100%	0%	0%	0%	0%	100%
	ELECTIVE	£376,463	367	100%	0%	0%	0%	0%	100%

		BHR Reductions		Transformation Board Alignment					
Specialty	POD	Spend Reduction Required	Activity Reduction Required	Planned Care Transformation Board	Urgent Care Transformation Board	Older People Transformation Board	LTC Transformation Board	Cancer Transformation Board	CHECK
Interventional Radiology	ELECTIVE	£1,557,915	1,486	100%	0%	0%	0%	0%	100%
	NON-ELECTIVE	£226,071	33	100%	0%	0%	0%	0%	100%
Breast Surgery	ELECTIVE	£459,466	218	100%	0%	0%	0%	0%	100%
Neurosurgery	OPFA	£229,022	920	100%	0%	0%	0%	0%	100%
	ELECTIVE	£525,770	181	100%	0%	0%	0%	0%	100%
Pain Management	OPFA	£318,938	1,334	100%	0%	0%	0%	0%	100%
	OPFU	£302,942	3,628	100%	0%	0%	0%	0%	100%
	ELECTIVE	£1,501,542	1,785	100%	0%	0%	0%	0%	100%
Vascular Surgery	NON-ELECTIVE	£203,353	36	0%	0%	0%	100%	0%	100%
Stroke Medicine	OPFA	£227,568	450	0%	0%	0%	100%	0%	100%
	NON-ELECTIVE	£1,108,047	256	0%	0%	0%	100%	0%	100%
Gynaecological Oncology	OPPROC	£227,553	845	0%	0%	0%	0%	100%	100%
	ELECTIVE	£454,386	356	0%	0%	0%	0%	100%	100%
Clinical Oncology	NON-ELECTIVE	£337,034	138	0%	0%	0%	0%	100%	100%

The reductions for each Transformation Board have been used to drive a financial and activity reduction target as shown in tables shown on the following pages. The explanation of how to reach each is given below:

- **OPD (Outpatient), DC/E (Daycase/Elective) & NEL (Non-Elective) Reduction %:** These rows show how the expected reductions required from the ISP will be delivered. This sets the previously stated aspiration of a 115% reduction of the excess activity in the areas amenable to transformation. This phasing can be adjusted and will feed through into the ISP Financial Modelling Page.

- **OPD, DC/E & NEL Reduction –** These rows take the overall target reductions for each Transformation Board and multiplies it by the expected reduction % (see above) to give an annual target.

- **OPD, DC/E & NEL Reduction (£) –** These rows multiply the reductions required in financial terms by the % to be delivered. These reductions relate back to the average unit cost calculated and explained earlier in Appendix 1.

- **Reinvestment –** This takes the total expected saving in each year and reallocates 50% back to the Transformation Board as an indicative budget to be used to drive the changes required.

The detail of the targets for each Transformation Board can be found in the accompanying ISP Model document.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Phlebotomy Pilot Update
Board Lead:	
Report Author and contact details:	Tracy Rubery (nee Welsh) Director of Transformation, NHS North East London Clinical Commissioning Group - Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership tracy.welsh1@nhs.net

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

☐	The wider determinants of health • Increase employment of people with health problems or disabilities • 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. • 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 • The prevention of obesity • Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups • Strengthen early years providers, schools and colleges as health improving settings
☐	The communities and places we live in • Realising the benefits of regeneration for the health of local residents and the health and social care services available to them • 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 • Development of integrated health, housing and social care services at locality level.
☒	BHR Integrated Care Partnership Board Transformation Board • Older people and frailty and end of life • Long term conditions • Children and young people • Mental health • Planned Care Cancer Primary Care Accident and Emergency Delivery Board Transforming Care Programme Board

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SUMMARY

1.1 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.

1.2 The new service model went live on 1st July 2021 and implementation is going well. All sites across Barking & Dagenham, Havering and Redbridge (BHR) are operational and patients are waiting less than five days for a routine appointment and 0-2 days for an urgent appointment.

1.3 Feedback has been received from 3,516 patients and 91% of respondents gave the service an overall experience rating of either 'very good' or 'good'.

1.4 Having fewer and larger sites has resulted in blood sample delays (upon arrival at the lab) dropping from its peak at 13% of all GP samples rejected in March 2021 to 4.4% in July 2021.

1.5 The new service model will 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).

1.6 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.

RECOMMENDATIONS

It is recommended that the Board:

• Notes the update of the BHR phlebotomy service one year pilot and its delivery so far.

REPORT DETAIL

2.1 During the first wave of the Covid-19 pandemic, in March 2020, Barking, Havering and Redbridge University Hospital (BHRUT) temporarily ceased to provide community-based phlebotomy as part of the initial Covid-19 response and focus provision of phlebotomy services for priority groups only.

2.2 The BHR CCGs and its community service and primary care providers worked closely together to restart community clinics (previously provided by BHRUT and North East London Foundation Trust (NELFT)), including the introduction of primary care provision of phlebotomy services.

2.3 Due to the lengthy waits experienced by BHR residents for a blood test, in October 2020, a system Serious Incident (SI) was declared. A successful recovery plan was put in place scaling up the provision and the SI has now been closed.

2.4 Subsequently, a new model of community provision was recommenced. It was agreed that multiple medium sized sites in each borough was pursued, as a starting point. This option provides a balance between distribution of sites to allow easy patient access and operational efficiency and service stability.

2.5 The chosen service model is being piloted: this ensures that we are able to "test" ideas in an agile way and refine it so that we can finalise the best model for the future, including, very importantly, obtaining patient/user input and feedback. The pilot model commenced on the 1st July 2021.

3. **Pilot Service Model - Update**

3.1 Delivery of the pilot model required engagement with NELFT and the Primary Care Networks (PCNs) as providers. The selection of the sites for the 11 NELFT and 4 PCNs has been approved by the Executive Phlebotomy Group. These are set out on the maps in Appendix 1. The full list of phlebotomy provision is listed in Appendix 2.

3.2 The sites have been selected based on dispersal across the boroughs, ease of access, availability of car parking and/or availability of sites.

3.3 The previous arrangements for the GP LIS and for Westlands Medical Centre came to an end on 30th June 2021. The service provided by the Hurley Group, situated in Havering, is in place until the end of September 2021.

3.4 BHR PCNs were given the opportunity to continue phlebotomy services under the new pilot model. No expressions of interest were received any of the Havering PCNs. Four Redbridge PCNs sent in their Expressions of Interest and are transitioning to the new system wide model. One PCN requested further time to train their staff onto the new 10to8 online booking system. One PCN's transport arrangements have been agreed and are preparing to be fully operational. Barking & Dagenham (B&D) PCNs requested more time to respond to the Expression of Interest and agreement was reached to extend their current GP Practice LIS until 16th August for those PCNs that submitted their expressions of interest by 30th June 2021, which subsequently was extended to 9th July. At the end of this process no B&D PCNs have yet signed up to the LIS.

3.5 NELFT sites are operational across BHR. In addition, there are now 2 extra weekend phlebotomy chairs at Elm Park (until 14th November 2021) as extra capacity was required to compensate for the lack of phlebotomy provision by Havering PCNs. This will be closely monitored.

3.6 Thames View are operating 1 phlebotomy chair instead of the 2 planned chairs due to issues with recruitment, annual leave and sickness. Recruitment is ongoing and the plan is to open the 2nd phlebotomy chair in September 2021. We have requested 2 new additional weekend chairs at Barking Community Hospital (until 14th November 2021) as extra capacity in

the absence of phlebotomy provision by B&D PCNs. This is being reviewed by NHS Property Services.

3.7 NELFT sites in Redbridge are operational. There are on-going estate queries regarding the extra space required at Loxford Polyclinic. Whilst agreement is being reached an extra chair will continue at Seven Kings Health Centre.

3.8 NELFT have increased their phlebotomy workforce from 20.71 WTE to 45.6 WTE, an increase of 45.4%. Recruitment and on-boarding of permanent staff is taking place. BHRUT laboratory staffing requirements had to be re-arranged and additional resources put in because of the increase in weekend and late evening working and some re-routing of drop offs has taken place to spread the work across the two BHRUT sites.

3.9 The Executive Phlebotomy Steering Group, which consists of members from NELFT, BHRUT, NEL CCG and the Clinical Lead, has created a patient survey that is available for patients to complete an hour after their appointment as patients get the link to the survey. Feedback was received from 3,516 patients, between the period 23rd June 2021 and 29th July 2021. 91% of respondents rated their overall experience of the service as 'very good' or 'good'.

3.10 The CCG will be working with local community groups and partners to reach out to those who do not have web/mobile phone access for their feedback to ensure that feedback is representative.

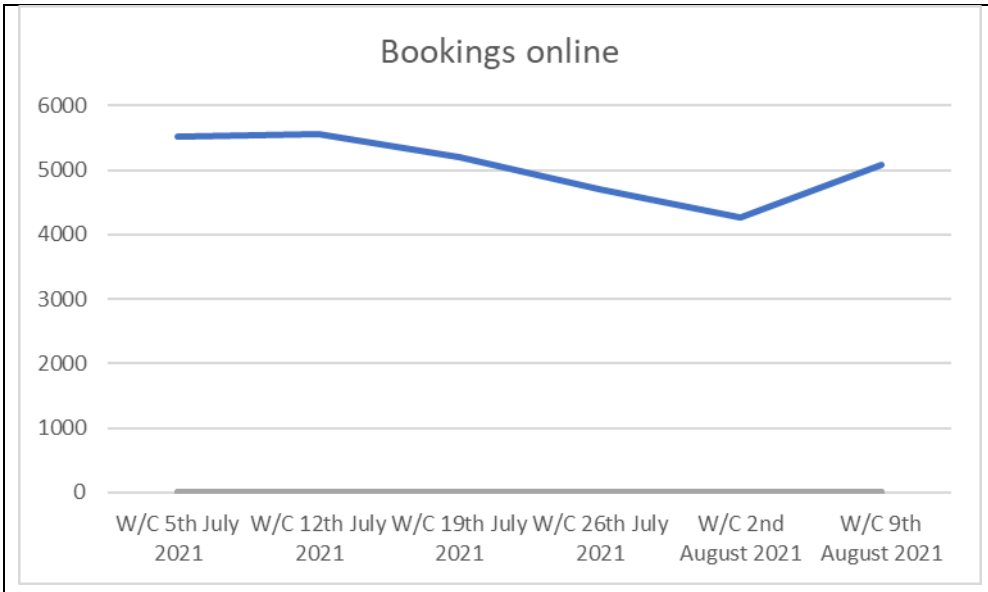
3.11 Transport runs from the blood collection sites to the laboratories have been reviewed and refined to ensure efficiency and blood sample integrity. Sample integrity starts to deteriorate after 4 hours (depending on storage conditions, etc). Samples that are tested more than 4 hours after the blood is drawn can affect results. In particular with potassium, there can be falsely elevated readings as samples get older. A high reading prompts an emergency call to the patient to come into the Emergency Department (ED). There have been examples of patients being called to ED unnecessarily because of delayed samples being tested. With the tweaks in transport and phlebotomy opening hours under this new model, the sample delayed rate dropped from its peak at 13% of all GP samples rejected in March 2021 to 4.4% in July 2021.

3.12 Centrifugation, which is a process that spins the blood test tubes to separate the components of the blood and increases the sample integrity time, is being piloted to determine feasibility.

3.13 Local and NEL wide stakeholder fortnightly updates are being provided to invite local feedback.

3.14 Waiting times for services are being closely monitored and currently stand at a maximum of five days wait for a routine blood test, many sites have slots available the same day. Urgent blood tests are taking place within two days.

3.15 On average 5,050 online appointments are made each week across BHR, as shown in the graph below:



IMPLICATIONS AND RISKS

BACKGROUND PAPERS

Appendix 1

Phlebotomy pilot model sites updated 2

Appendix 2

BHR-Pilot-where-to-go-to-have-a-blood-te

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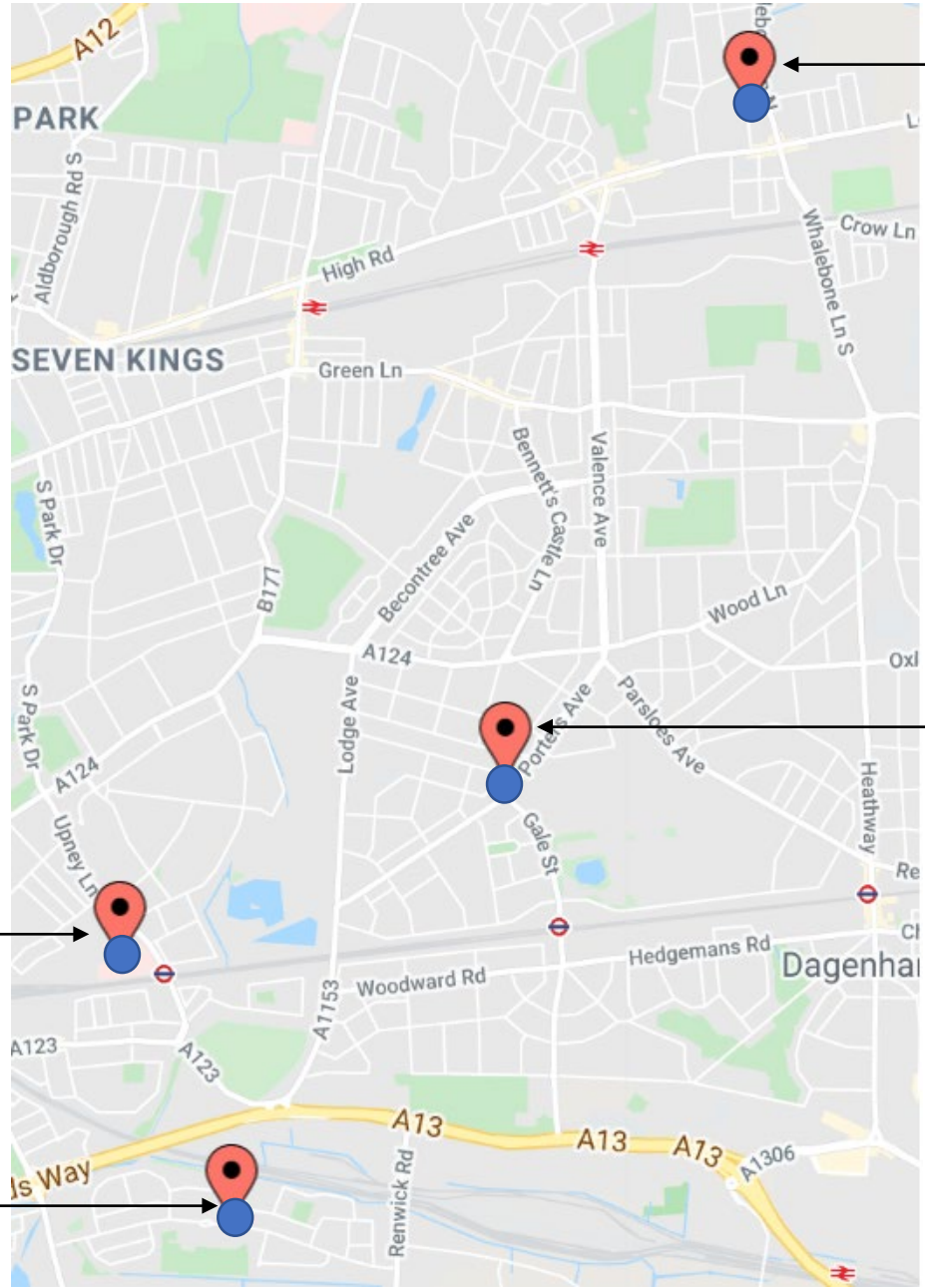
Barking and Dagenham



Chadwell Heath Health Centre

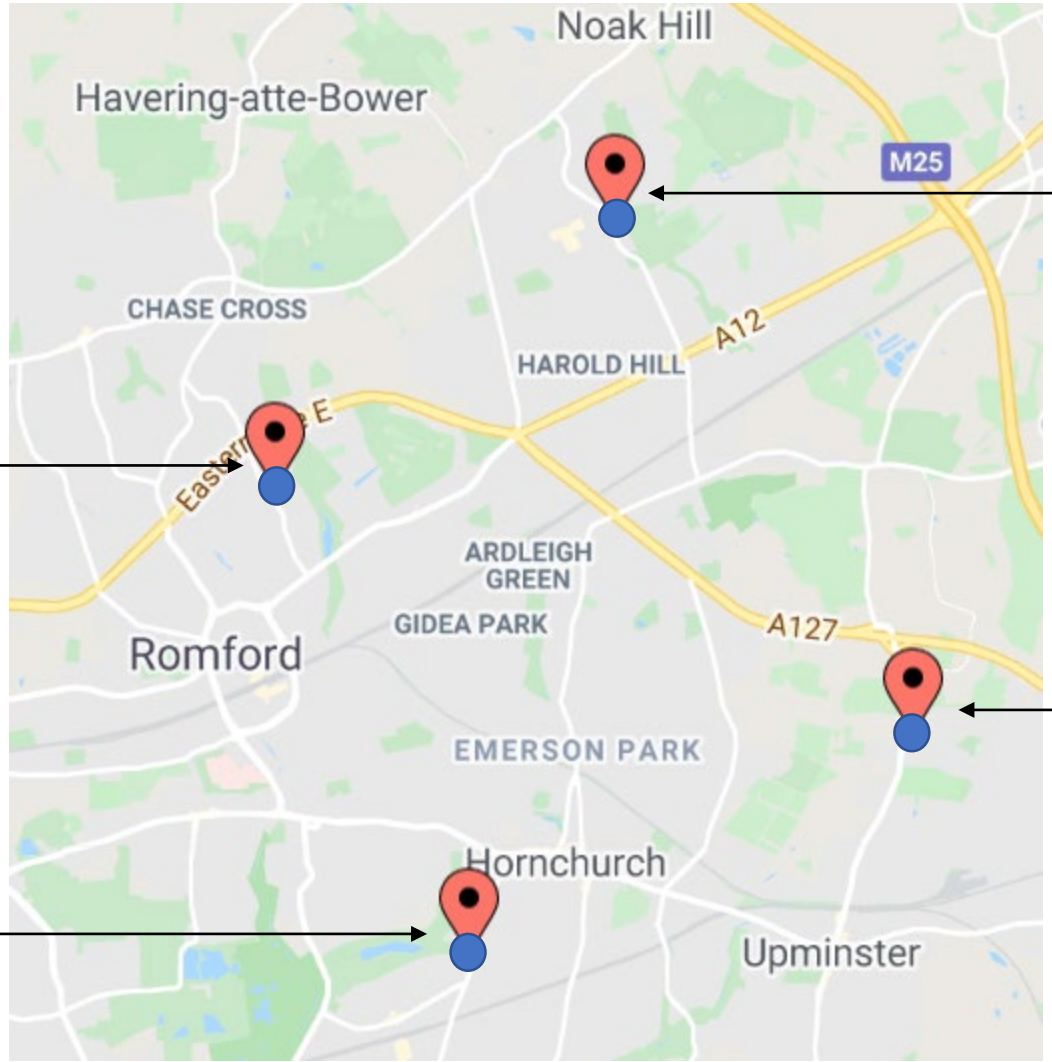
Porters Avenue

Barking Community Hospital

Thames View Health Centre

Key:
NELFT sites

Havering



Harold Hill Health Centre

Raphael House

Cranham Health Centre

Elm Park Clinic

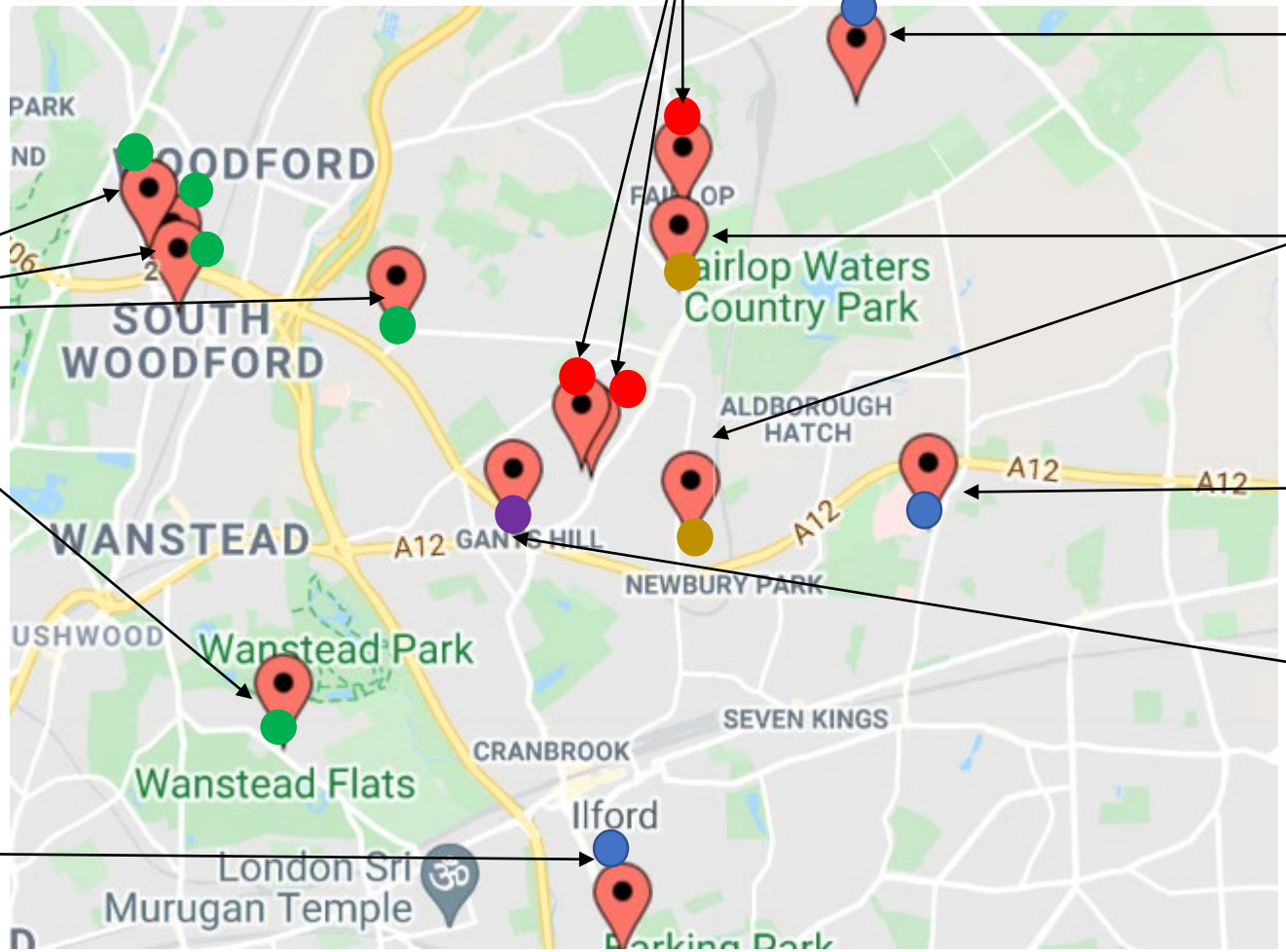
Key:
NELFT sites

Fairlop PCN:
Fencepiece Road Medical Centre
Kenwood Medical Centre
Eastern Avenue Medical Centre

Hainault Surgery

Wanstead and Woodford PCN:
Aldersbrook Medical Centre
Clayhall Clinic
Queen Mary Practice
Glebelands Practice
The Elmhurst Practice
The Shrubberies Medical Centre

New Cross Alliance:
Fullwell Cross Medical Centre
Newbury Group Practice



Barley Court

Cranbrook PCN:
Gants Hill Medical Centre

Loxford Polyclinic

Key:
- NELFT sites
- New Cross Alliance
- Fairlop PCN
- Cranbrook PCN
- Wanstead and Woodford PCN

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Where to go to have a blood test

Updated to reflect new pilot scheme w/c 28 June 2021

A pilot community blood testing service began w/c 28 June 2021 in Barking and Dagenham, Havering and Redbridge. It aims to continue to improve access to phlebotomy services across BHR, reduce waiting times and ensure urgent tests can be booked for the same or next day. Blood tests will be also be available at weekends at some sites. The target is for all patients to be able to have their blood test within seven days. All bookings and cancellations can be made online or by phone.

The pilot service is being developed by NEL CCG, North East London Foundation Trust (NELFT), Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and primary care providers, who have worked together to ensure that phlebotomy services meet the needs of local people throughout the pandemic.

The latest stakeholder update regarding this service can be found on our website.

If you have any comments or queries about this pilot, please email nelondon.bhrphlebotomyservice.nelccg@nhs.net

- There are currently **no walk-in services** available for Barking and Dagenham, Havering or Redbridge patients – all blood tests must be booked in advance.
- Blood tests for **children under 12** are carried out by appointment only by the BHRUT Children's Outpatient department.
- Always take your paper blood test form to your appointment as this is needed to process your blood test. If you have a blood test form from BHRUT, this can also be used at community sites.

Please note that this information is updated regularly and subject to change.
Updated 20.08.21

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Where to go to have a blood test

Updated to reflect new pilot scheme w/c 28 June 2021

Barking and Dagenham

Barking Community Hospital	Monday - Sunday 8AM – 4PM	**Upney Lane, Barking, Essex, IG11 9LX** **Appointment Only** **Book online at** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM – 4PM)** **Lines are very busy and it is recommended that patients book online.**
Chadwell Heath Health Clinic	Monday - Friday 8AM - 4PM By appointment only	**Ashton Gardens, Dagenham, Essex, RM6 6RT** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM – 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Porters Avenue Clinic	Monday - Friday 8AM – 4PM By appointment only	**234 Porters Avenue, Dagenham, Essex, RM8 2EQ** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**

Please note that this information is updated regularly and subject to change.
Updated 20.08.21

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University Hospitals
NHS Trust

Where to go to have a blood test

Updated to reflect new pilot scheme w/c 28 June 2021

Thames View Health Centre	Monday – Friday 8AM – 4PM By appointment only	**Bastable Avenue, Barking, IG11 0LG** **Appointment only.** **Book online at** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**

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Cranham Health Centre	Monday – Friday 8AM - 4PM By appointment only	**108 Avon Road, Cranham, RM14 1RG** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**

Please note that this information is updated regularly and subject to change.
Updated 20.08.21

NELFT NHS
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Best care by the best people

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

Where to go to have a blood test

Updated to reflect new pilot scheme w/c 28 June 2021

Elm Park Clinic	Monday – Friday 8AM - 4PM By appointment only Saturday – Sunday 8AM - 4PM (the Saturday and Sunday chairs will run from 10 July to 15 August)	**252 Abbs Cross Lane, Hornchurch, Essex RM12 4YG** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Harold Hill Health Centre	Monday – Friday 8AM to 4PM By appointment only	**Gooshays Drive, Romford, RM3 9SU** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Harold Wood Polyclinic	Monday – Friday 8AM – 12PM By appointment only	**St Clements Avenue, Off Gubbins Lane, Harold Wood RM3 0FE.** **Appointment only** **Phone: 020 3416 7711** **No children under 16.**

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Updated 20.08.21

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Raphael House	Monday - Sunday 8AM – 4PM By appointment only	**Raphael House, Pettits Lane, Romford, RM1 4HP** **Appointment only.** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **No children under 12.** **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Queen's Hospital	Blood testing services are available for patients under the care of the hospital. This includes oncology(cancer), maternity and haematology patients. If you are one of these patients, you will already have been informed how to have your blood test.	**Ground floor in the Main Entrance, Rom Valley Way, Romford, RM7 0AG** **Appointment only for patients over 12 yrs old** **Book via:** https://www.swiftqueue.co.uk/bhr.php If you do not have internet access, phone Queen's Hospital 01708 435498 **Booking for children under 12 years old:** • **Book via**: https://www.swiftqueue.co.uk/bhrpaeds.php • **Parents without internet access should call 01708 435289 (Children's OPD) to book a blood test for their child.** • If your child has special needs, please book on a **Monday ONLY**. If you are booking for genetic testing, this should be booked **before 11AM Mon-Thurs.** (Your paper form will state at the top whether you are booking for genetic/gene testing.)

Redbridge

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Barley Court Clinic (Goodmayes Hospital)	Monday - Friday 8AM - 4PM By appointment only	**Barley Court Clinic, Goodmayes Hospital, 157 Barley Lane, Ilford, IG3 8XJ** **Appointment only** **Book via** https://10to8.com/book/nelftbookabloodtest/ No children under 12. **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Eastern Avenue Medical Centre	Thursdays 8AM – 12PM Appointments available to patients across BHR and registered outside of this practice.	**737 Cranbrook Rd, Ilford IG2 6RJ** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Fencepiece Road Medical Centre	Tuesdays 8AM – 12PM Appointments available to patients across BHR and registered outside of this practice.	**83 Fencepiece Rd, Ilford IG6 2NB** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Fullwell Cross Medical Centre	Monday - Friday 8AM – 4PM Appointments available to patients	**1 Tomswood Hill, Ilford IG6 2HG** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)**

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	across BHR and registered outside of this practice.	**Telephone lines can get very busy and it is recommended that patients book online.**
Forest Medical Centre	Monday – Friday 8:30AM – 12:30PM By appointment only	**Old Station Road, Loughton, Essex, IG10 4PE** **Appointment only** **Book via:** Https://www.swiftqueue.co.uk/bartshealth.php **Telephone number: 020 8539 5522 (Barts Health hospitals main switchboard)** **Please note**: only patients who would usually use **Heronwood and Galleon or / Whipps Cross site** should use the facilities at Forest Medical Centre.
Gants Hill Medical Centre	Monday – Friday 9:30AM -11:30AM Exc. Bank Holidays Appointments available to patients across BHR and registered outside of this practice.	**63-65 Ethelbert Gardens, Ilford, IG2 6UW** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Heronwood and Galleon Unit	Monday - Friday 8AM - 1PM Redbridge patients only By appointment only	**Heronwood and Galleon Unit, Wanstead Hospital, Makepeace Rd, Wanstead, London E11 1UU** **Book via:** Https://www.swiftqueue.co.uk/bartshealth.php **Telephone number: 020 8539 5522 (Barts Health hospitals main switchboard)** Please be aware that a one-way entry and exit system is in operation at this site. Face coverings must be worn at all times whilst on the premises. To comply with social distancing rules, you may be given additional instructions by staff on your arrival.

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Kenwood Medical Centre	9:00 AM – 1:00 PM Wednesdays only Appointments available to patients across BHR and registered outside of this practice.	**737 Cranbrook Rd, Ilford IG2 6RJ** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
King George Hospital	Blood testing services are available for patients under the hospitals' care. This includes oncology (cancer), maternity and haematology patients. If you are one of these patients, you will already have been informed how to have your blood test.	**Barley Lane, Goodmayes, IG3 8YB** **Appointment only**. Ground floor, Outpatients Dept. **Book via:** https://www.swiftqueue.co.uk/bhr.php For those with no internet access, phone King George Hospital: 020 8970 8383
Loxford Polyclinic	Monday - Friday 8AM - 4PM	**Ilford Lane, Ilford, IG1 2SN** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**

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Newbury Group Practice	Monday - Friday 8AM – 4PM Appointments available to patients across BHR and registered outside of this practice.	**Newbury Park Health Centre, 40 Perrymans Farm Rd, Ilford IG2 7LE** **Appointment only** **Book via:** https://10to8.com/book/nelftbookabloodtest/ **Telephone number: 0300 300 1704 / 0300 555 1045 (Lines open 8AM - 4PM)** **Telephone lines can get very busy and it is recommended that patients book online.**
Whipps Cross Hospital	Barts Health patients only Blood test appointments for children between 1-years-old and 9-years-old are available at Whipps Cross Hospital. Please select the children's blood test option when booking your appointment online.	**Leytonstone E11, Area 1 Outpatients** **Please note:** the majority of the appointments at Whipps Cross are for hospital patients attending hospital clinics, if you are a GP patient please select the adult GP option when booking. Book via: https://www.swiftqueue.co.uk/bartshealth.php **Telephone number: 020 8539 5522 (Barts Health hospitals main switchboard)** Blood test appointments for children under 12-months-old: 07546 655 797 (paediatric team on the Medical Day Unit, Acorn ward)

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