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.

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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)

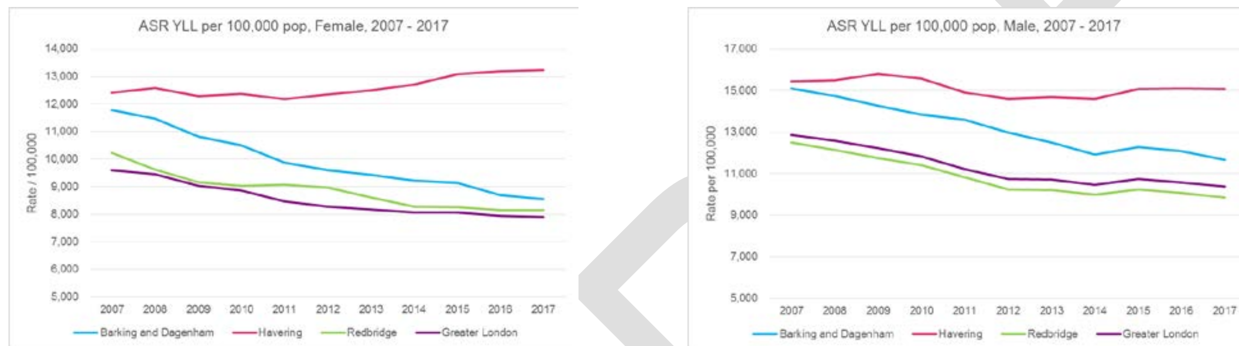
Area	Metric	B&D	H	R	Worst 3 in London (Not in Order)		
Diabetes	Type 1 Receiving All 8 Care Processes				Newham	Enfield	Waltham Forest
	Type 2 Receiving All 8 Care Processes				Waltham Forest	Enfield	Hounslow
	Major Diabetic Limb Amputation				Newham	Tower Hamlets	Redbridge
COPD & Respiratory	Emergency 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.

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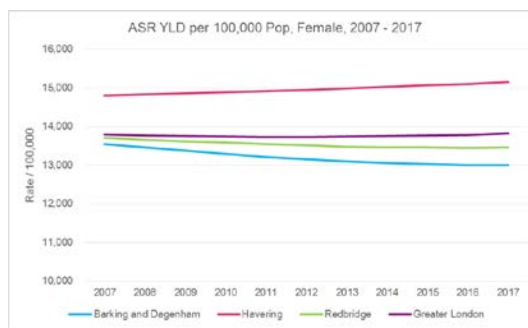
Graph 3 & 4 Showing Years Living with Disability (YLD)



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.**

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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

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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

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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.

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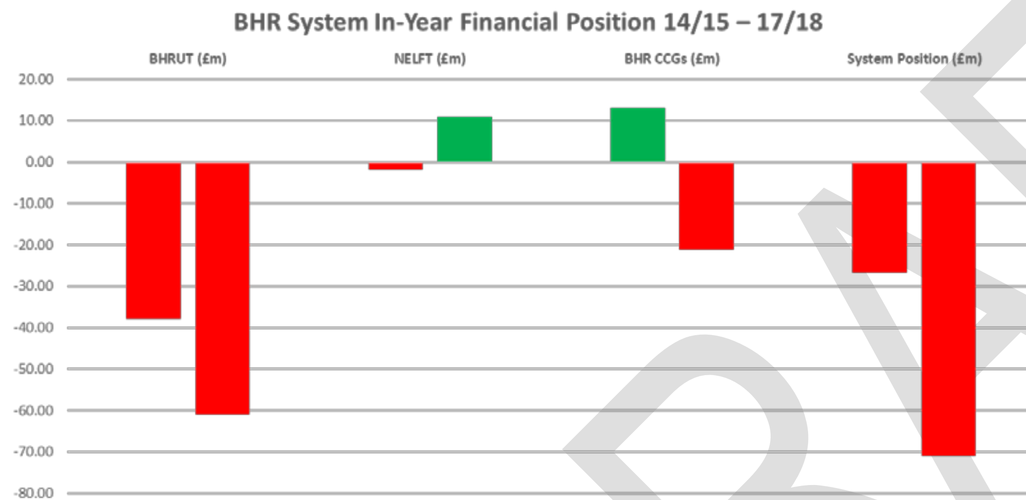
5.0 The Financial Impact on BHR

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.

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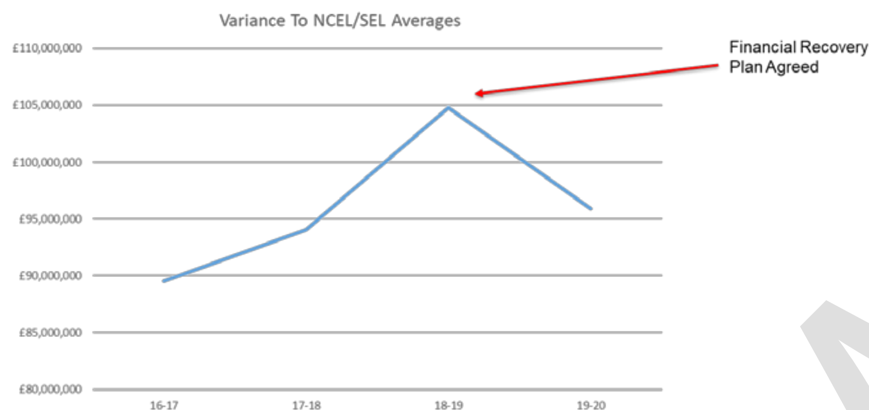
The impact of working together to deliver the aspirations within the FRP is even more clearly seen in Graph 6 below that shows how the excess spend for the BHR System changed over time from 2016/17 to 2019/20.

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).

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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.

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- 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.

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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

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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.

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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%

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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.

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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.

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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.

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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%

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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.

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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.

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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.

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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)

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- 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.

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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.

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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

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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.

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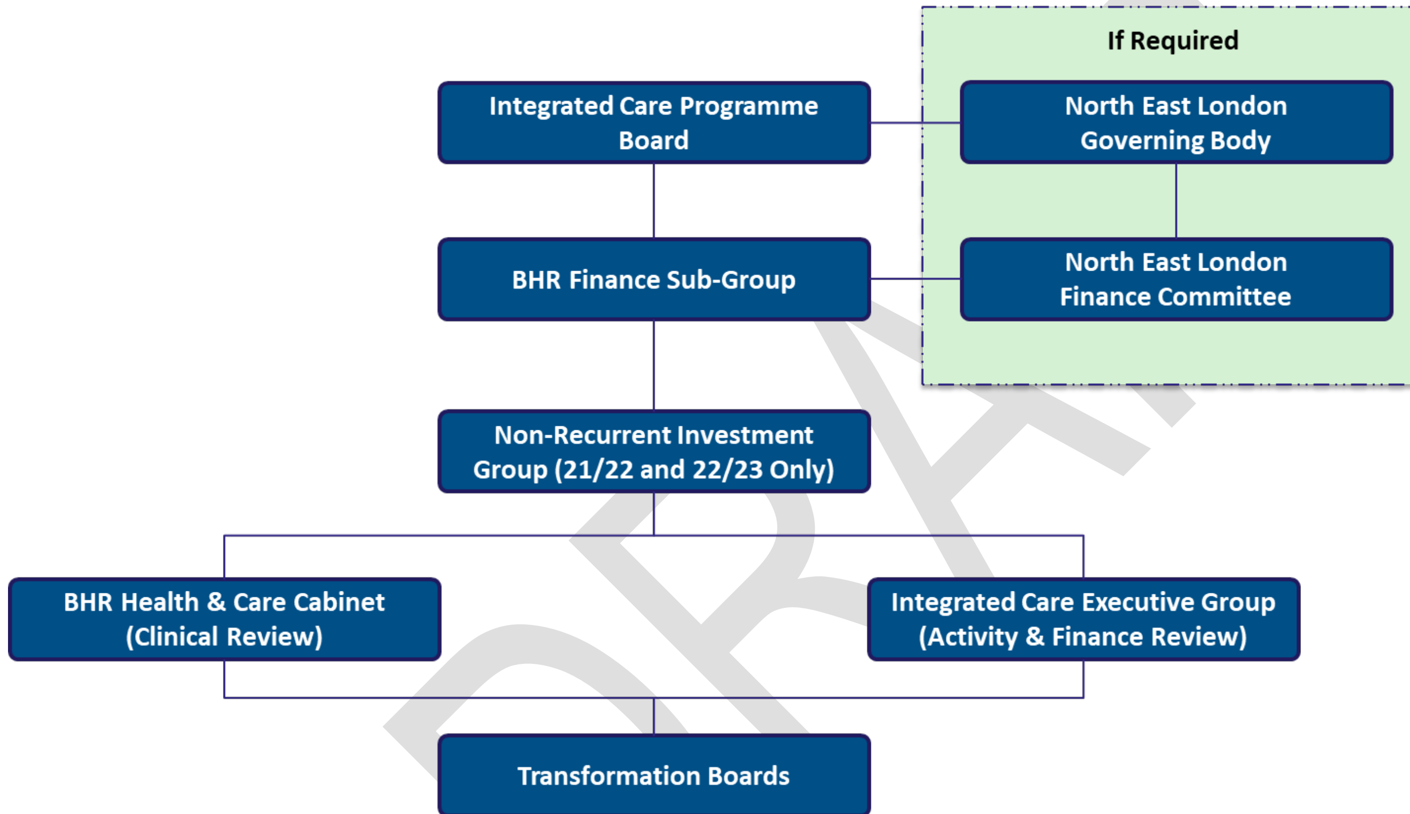
12.0 Governance

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.

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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

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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%

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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).

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- **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.

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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.