APPENDIX 1

Health and Care System Development in Barking and Dagenham, Havering and Redbridge

Summary

Building on the local direction of travel to create more coordinated health and care services, a programme of work is taking forward plans which culminate in a significant change in the way care is planned from April 2021. This is in line with national policy to join up health and care planning and provision to improve outcomes for residents. Our local model builds on previous work and is being co-designed through the leadership and involvement of all system partners.

This paper provides a briefing on how this work is progressing and seeks comments on the direction of travel. Furthermore, detailed proposals will be presented in the autumn which will require approval from partner's key governance bodies.

1. Background

Across Barking and Dagenham, Havering and Redbridge (BHR), all health and care partners want to significantly improve the health and well-being of local people. We recognise that we need to work even more closely together to address significant challenges, keep people healthy, tackle the causes of illness and deal with wider issues that influence health and well-being such as housing and employment.

We want to join up health and social care, physical and mental health services and GPs and hospitals so care is coordinated for local residents. We will work together to improve the standard of services across the area and make sure, wherever people are, they receive a consistent standard of care.

To do this, the **BHR system** is being developed to be up and running by April 2021. It is a new way of working to make sure health and care statutory and voluntary organisations work together to plan and provide services with and for local people. This will mean coordinating services for the population of BHR and sharing resources to best meet people's needs. It is not the creation of a new organisation. It will mean services working together across current organisational boundaries.

2. Progress So Far

Establishing the BHR system will take time to develop. However, we are building on significant recent progress to ensure change in April 2021 and beyond. It is not a new direction of travel. In recent years there has been significant partnership work and relationship building. However, BHR has been a challenged health and care system for many years, trying hard to deal with rapid population growth and deprivation whilst facing

financial pressures, significant workforce challenges, poor estates utilisation and underinvestment in digital technology. BHR partners have done much to respond but delivery remains difficult given the history, culture and the lack of strong system wide accountability.

We do have a foundation on which to build:

- Devolution pilot (2016/7) which, although it did not more forward as intended at the time, provided resource to engage with the public and staff. The outputs of this have informed the initial design work and are just as relevant now. This involved partners from across the system including voluntary and community organisations
- A deep dive into the financial position across the system and we now have a financial recovery plan across the NHS with agreed targets
- The BHR Local Authorities continue to make significant savings to respond to local government financial challenges
- In the NHS, the NELFT and BHRUT Boards have recently approved moving to a Group Model from April 2021 following shadow running, alert to the need to secure strong executive presence at the two Trusts and attract system leadership into the newly formed Group executive roles
- Primary care networks are now in place across all of BHR with a focus on GP practices working together to improve primary care and extend the range of services available to the population
- Transformation Boards have been established to develop new care models for key care groups with strong clinical and professional leadership
- Local authority transformation programmes are in place to develop and delivery new ways of working to improve the lives of local residents
- Partnership governance arrangements are in place including the Integrated Care Partnership Board, the Integrated Care Executive Group, the Health and Care Cabinet and Health and Wellbeing Boards

We are learning from the many examples of integrated care systems nationally and internationally to understand what makes them successful and the obstacles they have faced. We are drawing on these to inform our design in BHR.

By April 2021, we aim to build on the legacy of strong partnerships and shared values across all partners, to establish a system for BHR responsible for planning across health and care, taking responsibility for shared resources and delivering improved outcomes for the population. This will require an acceleration of progress to date.

3. North East London Integrated Care System

The BHR System will operate within a wider North East London Integrated Care System (NEL ICS). The NEL ICS will support decision-making, planning and delivery within local systems and will oversee our arrangements to ensure we are doing a good job and tackle large scale

challenges where we need to work across a bigger area. This is in line with the NHS Long Term Plan which says that 'by April 2021 all of England will be covered by integrated care systems, involving a CCG or CCGs working together with partners to ensure a streamlined and single set of commissioning decisions at system level.' As part of this, a proposal is being developed for there to be one CCG in NEL rather than seven. This will remove barriers to integration through streamlining local governance structures so that key decisions can be made at a local level by local partners. This will support local system development.

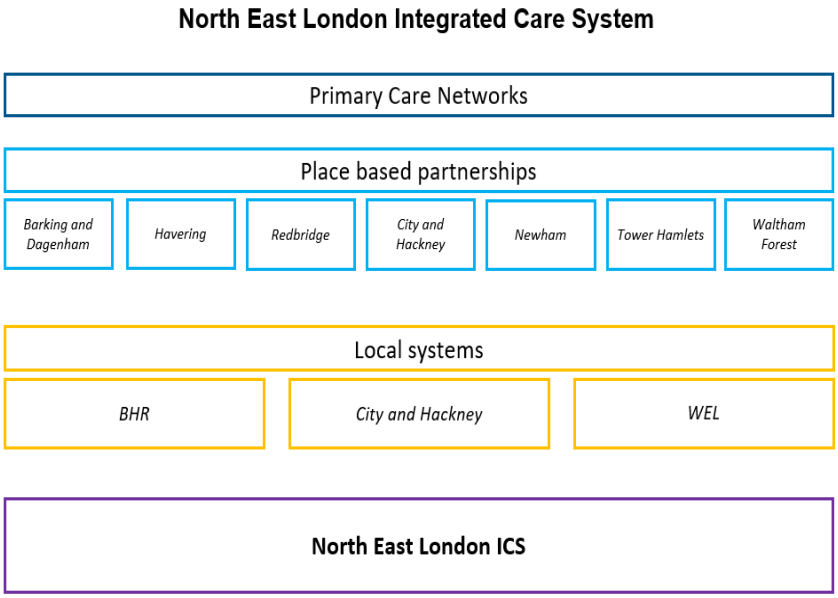
The purpose of the NEL ICS will be based on the functions of strategic leadership, oversight and commissioning. In particular it will:

- Be the place where partners come together to shape the vision for North East London
- Tackle the big health and care challenges and reducing inequalities
- Optimise resource use across the whole system and managing financial risk
- Oversight and assurance for the delivery of health and care across the whole system
- Co-ordinate large scale action to make NEL a great place to work

Some principles have been developed to underpin the development of the NEL ICS:

- Decision-making sits as locally as possible
- Decision-making is at the local level unless it satisfies one of three question tests (Increase our chances to improve population health or reduce inequalities (unwarranted variation), make decision-making smoother and/or quicker, better align accountability for decision-making with accountability for money)
- This is about delegation to primary care networks/localities as well as upwards to NEL when it makes sense
- There are some 'must dos' for a NEL CCG that cannot be delegated e.g. signing contracts
- Some responsibilities will come down from London to NEL e.g. specialist commissioning
- NEL ICS will provide system oversight to check local systems doing what they need to
- Whilst sovereignty and regulation framework remains the same we intend to change the systems and processes, behaviour and culture to improve the way we work
- We will ensure openness and transparency in new ways of working.

The NEL ICS will contain three local systems – BHR, City and Hackney and WEL (Tower Hamlets, Newham and Waltham Forest) which in turn have place based partnerships at a borough level with primary care networks/localities playing a critical role as fundamental building blocks for care delivery.



4. Developing the BHR System

For the past few months, a Design Group reporting to the BHR Integrated Care Partnership Board has been meeting to develop initial proposals for the BHR system.

There are other partners who will be involved in system development and working (e.g. CareCity, Barts Health NHS Trust, Partnership of East London Cooperatives (PELC), broader voluntary sector and community organisations, as well as social care providers) and we are/will be discussing with them how best to do this as our model develops.

5. BHR System Strategy

A BHR system strategy is being developed (initial stage completed early in 2020 and further work to be planned) which provides:

- A case for change
- A vision for the future
- A set of strategic objectives

This draws on a range of existing plans and strategies across partners. These include local health and well-being strategies, the BHR devolution strategic outline case (2017), the draft BHRUT clinical strategy, the NELFT clinical strategy, and the north east London response to the NHS Long Term Plan.

A workshop of the Integrated Care Partnership Board was held in January 2020 to discuss these areas including a vision statement. It was agreed that the vision statement that most clearly captures the involvement of all organisations and residents is:

"Communities working together for better health"

At the workshop, the discussion around system priorities focused on a number of areas:

- It was felt that **prevention cut across a lot of issues** and was a priority that everyone had a part to play in, as well as benefit from
- Given the high birth rate, and length of time spent in BHR by children, **young people and their families, this was felt to be a necessary area of focus**, which should **start with prevention**
- There are real **workforce shortages** faced in the system, particularly by primary care and this needs to be addressed.
- There is a real need to **standardise services across BHR, where appropriate**, to ensure that residents know where to go and staff know where help can be accessed
- Standardisation starts with relationships. There **needs to be trusted relationships** across the system, and this will feed into clinical/professional models, contracting and delivery efforts
- The need to **engage 'as one system' with neighbours**, such as Waltham Forest and Essex was also noted, but this would start with relationships
- **Integrated data** will allow for a focus on wider determinants of health and having a population health management system. This is an unlocking point for the rest of the priorities
- Ensuring that **external communications and engagement** are consistent across the system to make sure that priorities executed consistently
- To understand the scale of reinvestment, and workforce requirement there is a need for a **full demand and capacity assessment.**

Through further discussion, strategic priorities were highlighted for the BHR System to take forward for immediate action:

1. Embrace a population health management approach
    - Create **effective services for children and young people**, as well as their families and **supporting them to age well** through **effective prevention**
    - **Develop trusted relationships** throughout the system, this could include **investing in the development of MDTs** and the review of **contracting and financial management** to provide the environment for MDTs to operate
    - **Data sharing** should be universal within the system and deliver **identification of individual, as well as population needs** and include shared care records and a digital platform

2. Enhance the **retention of local staff** and creating **attractive new job roles**, focusing on future needs to **drive recruitment**
3. A more coherent approach to **communication and engagement**, which delivers **consistent and clear messages** to the public, signposting services clearly, collecting the views of the public and **celebrating the success** of BHR.

These immediate priorities will be scoped to take forward overseen by the Integrated Care Partnership Board.

In order to deliver the strategy and take forward a collective vision, partners have recognised that they need to operate in a new system way of working. This is the design we have been developing.

6. Benefits of the BHR System

In our new model people using health and social services will be equal partners in planning, developing and monitoring care to make sure it meets their needs. For a resident, they will live more independent lives keeping as well and fulfilled for as long as possible. When they need it, they will get earlier intervention and more coordinated, planned care with no join between the organisations that provide it. This will involve all services working together to the same plan, with the same information. More treatment and support will be received at home rather than go to hospital if it is not necessary. If people do need to go to hospital, they will be helped to get home quickly with the right support.

We want to make services less fragmented. In recent years, national policy has encouraged competition as a means to improve quality and choice that can incentivise behaviours and processes that had a detrimental impact on working collaboratively and improving outcomes through coordinated care. This has meant a more fragmented health and care system has emerged. This can mean delays, gaps in care, duplication or missed opportunities to make better use of resources and a system which is difficult for patients and staff to navigate.

By working together the BHR partners aim to:

- Ensure residents are healthier for longer and delay the need for care and support
- Work collaboratively to deliver better outcomes focussing on the wider determinants of health to improve life outcomes for residents (e.g. housing,

education, jobs, environment) and ensuring our children and young people have the best possible start in life
- Make services more coordinated and less fragmented
- Address the quality and performance improvements, including focussing on outcomes, that are needed in local services
- Create services which will attract and retain a skilled workforce, including working to make the best of the ambitious regeneration opportunities across the three boroughs
- Consider the opportunities and benefits of developing the concept of anchor organisations[1] to invest in local infrastructure and job growth/opportunities for local residents.

7. A Focus on Outcomes

By working in a system way we will improve the health and well-being of the residents and patients we serve. In order to focus our work, we will build on previous work to identify those health and care outcomes we will improve and by which we will measure our success. The outcomes framework previously developed identified specific areas and is based on conversations with local people and staff about what is most meaningful to them:

- People to be able to look after themselves and improve their own health and wellbeing and live in good health for longer e.g. reduce the number of years of lost life, reduce childhood obesity, get the community more active.
- The right care delivered at the right time e.g. preventing attendances and admissions to hospital, reducing avoidable time in hospital, reducing the number of people reporting a poor experience of care, increasing the number of people living independently following discharge from hospital.
- Developing improved ways of working in an integrated fashion and using money more effectively e.g. people who work in health and care feel supported to deliver their best, delivery of new care models, reduce demand for more hospital treatment and care.

Outcomes have also been identified as part of the work of the BHR Transformation Boards. These outcomes will be refined in the light of the BHR System Strategy to ensure they are meaningful in targeting those areas that are priorities and where there is unwarranted variation. A final system outcomes framework will be developed by the summer 2020.

8. How the BHR System Will Work

The Design Group developed a set of principles to underpin the new BHR system model:

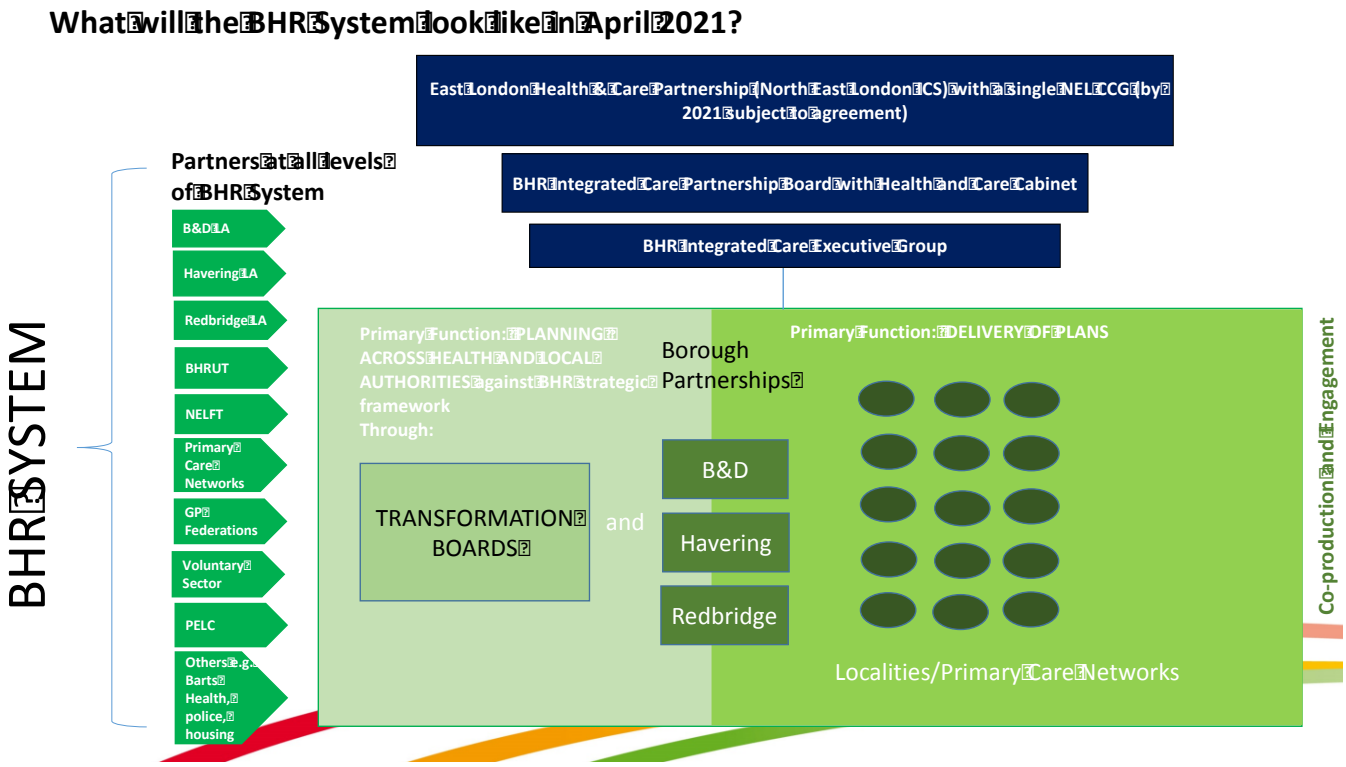
[1] the term anchor institutions refers to large, typically non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to move, given their connection to the local population, and have a significant influence on the health and wellbeing of a local community.

- All the participants of the BHR system will work together as a partnership to improve the health and care of our local residents, including a visible focus on the wider determinants of health
- Together we will devote our capacity and capability to resolve our biggest challenges
- All our collective resource is public money and will be used to best meet the needs of local residents and deal with significant local challenges
- Residents are partners in planning, developing and monitoring care to make sure it meets current and future needs
- We will make decisions as locally as possible working with residents to ensure we focus on the areas that make the biggest difference across the boundaries of health and care
- We will support our workforce to deliver more joined up models of care for individuals and populations
- We will be open and transparent in the ways we work
- We will work together to address risks as they arise across the system
- Whilst the statutory frameworks we all work within may remain, we will change our systems, processes, behaviour and culture to support the way we work collectively.

The BHR system in 2021 will comprise a number of inter-related building blocks as represented in the diagram below. The NEL ICS/single CCG will enable the functions and resources to plan and deliver health care are vested with the BHR system. They will require assurance that BHR system enacts these functions properly. We will develop the existing governance structures (ICPB, Health and Care Cabinet and ICEG – see below) to set the strategic framework, oversee how the BHR system operates and be responsible for the achievement of desired outcomes.

All key partners will be involved in planning and delivery at BHR and borough levels. Primary care networks and localities will be key components of the new BHR system to deliver coordinated care for residents and local populations. Borough partnerships will plan and coordinate service delivery for their respective local populations. Transformation Boards will develop care models for their particular care groups within the overall strategic framework set by the Integrated Care Partnership Board. Through all the system working co-production and engagement will be a key feature.

An outline operating model is attached to this paper as Appendix A.



8.1 Borough Partnerships

Borough partnerships are in various stages of development in BHR. These will involve local partners in planning and delivery. There will need to be a degree of commonality across each borough by April 2021 so local structures deliver the functions set out in the operating model and are responsible for delegated resources, albeit they might operate differently. This will need to be worked through building on the experience of local developing arrangements. In principle, we need to:

- Support collaboration and pooling resources where it makes sense for local areas and communities and explore opportunities to work together within existing and new governance arrangements.
- Be open to pooling resources across partners at a borough level in line with our respective priorities and delivery arrangements.
- Be open to new ways of commissioning and delivering services at a borough level.
- Support the allocation of prevention resources to support joint, strategic commissioning across the partnership.

8.2 Primary Care Networks

There are 15 newly formed primary care networks in BHR. They are fostering a strategic voice for primary care that represents practices individually and collectively, along with GP Federations.

8.3 Localities

These are developing broader locality based partnerships as a focus for local communities to

shape and influence the services that are delivered in their area. They are a mechanism for marshalling the strengths and assets of local communities and ensuring they are at the heart of delivering responsive, preventive services. They can provide a way or organising health and social care for an area. There are examples of locality development in each Borough in BHR, for example the new Thames Locality Board.

8.4 Transformation Boards

There are nine transformation boards leading healthcare planning and transformation across BHR. In the autumn 2019 a report on how to continue their development was completed. This work concluded that progress was being made on transformation and service redesign in an attempt to join up the system for particular care pathways, populations and services to overcome fragmentation. However more work is needed on a more dispersed leadership model to get broader ownership as they have been predominantly CCG-led, as well as a refocus on planning and overseeing delivery. Key next steps agreed were to produce a strategic framework within which all the transformation boards work.

There is borough based transformation programmes in each of the three local authorities. These focus on local planning and delivery to improve the lives and well-being of local residents and improve the health and vibrancy of the boroughs.

8.5 Other

There are also statutory ad other governance arrangements in place which have a responsibility for integrated planning and service delivery such as Health and Well-being Boards (see section 9) and local adult and children safeguarding arrangements. We will build on these and learn lessons for their experience to provide a more joined up approach to health and care.

9. Governance

The Design Group are developing a model of governance for shared decision-making within the current statutory frameworks assuming there will be no change prior to April 2021. This presents some challenges in terms of how partners can work together across boundaries and we will need to work through these. In the first instance the existing three BHR system structures will be developed to be responsible for BHR system and strategy development. These are the Integrated Care Partnership Board (ICPB), the Health and Care Cabinet and the Integrated Care Executive Group (ICEG).

Health and Well-Being Boards will continue to be a critical part of the system infrastructure post 2021. In determining their future contribution in addition to their statutory functions, we can be informed by the Kings Fund Report on HWBBs (2019) which concluded:

- The promised statutory guidance on ICS development should reinforce the positive role of local government, citing examples of where local government is already engaging and the benefits of this engagement
- The current role and functions of HWBs should be reviewed and refreshed, and

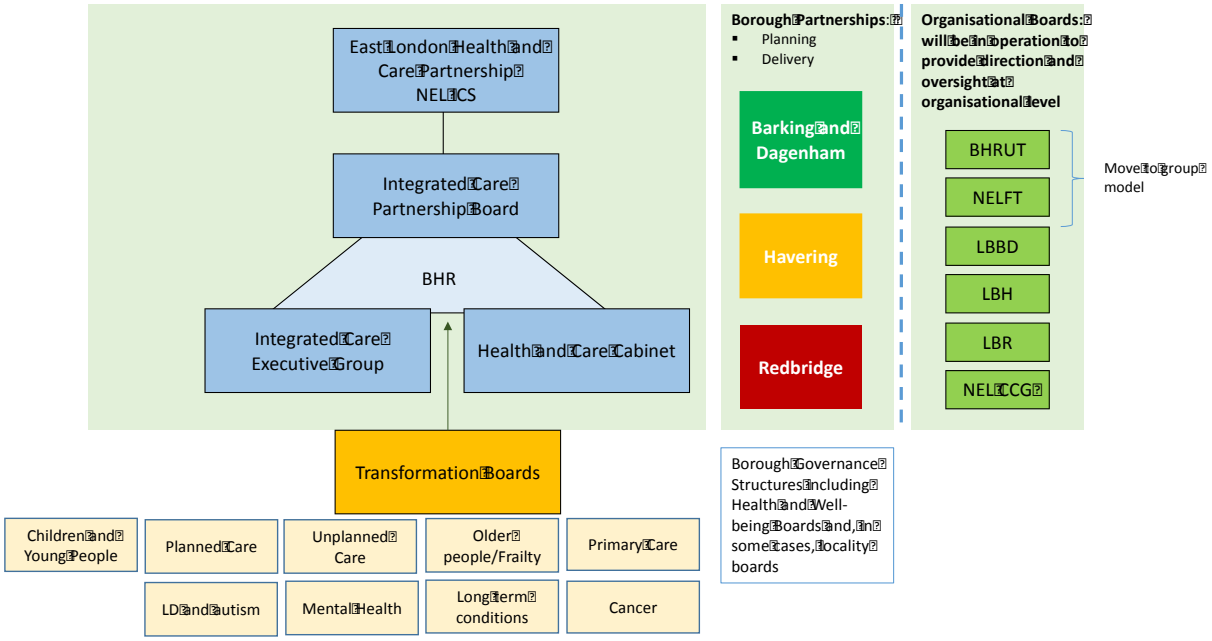
consideration should be given to whether any changes would improve their effectiveness, for example, by strengthening NHS membership and giving boards more powers over budgets and decision-making, subject to local agreement.

- Local authorities can learn from the experience of their colleagues in the first wave of ICSs by making sure they are working together effectively to offer a strong local government contribution to the ICS in their area, based on a clear vision for the health and wellbeing outcomes for their local population.

Within the BHR system, we will work with HWBBs to collectively consider these areas with a view to developing a model for their potential future roles. This could be as the core future governance of borough partnerships incorporating an extended role in decision-making and accountability to residents.

The three BHR governance bodies (ICPB, ICEG and the Health and Care Cabinet) and HWBBs will need revised membership, terms of reference, operating guidelines by 2021. By the autumn 2020 we will have developed the governance arrangements at BHR and borough level in more detail for approval by constituent bodies.

Future Outline Governance Arrangements for Shared Decision Making



10. Maturity Matrix

A national integrated care system maturity matrix (June 2019) was developed to outline the core characteristics of systems as they develop. These were developed from observing and talking to the earliest ICSs, and from the objectives set out in the NHS Long-Term Plan. It is based on similar tools used by the Local Government Association and others, who have experience in supporting system development and change. It provides a consistent framework for all regions and systems across the country.

The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS in the following domains:

- System leadership, partnerships and change capability
- System architecture and strong financial management and planning
- Integrated care models
- Track record of delivery
- Defined and coherent population.

It uses a progression model which shows a journey rather than a series of binary checklists, recognising that systems will not develop all domains at the same pace and will therefore have varying levels of maturity across each domain. By doing this, it seeks to support more nuanced and reflective discussions about system maturity.

The BHR system undertook a self-assessment against the domains in September 2019. The self-assessment identified some gaps we need to address along with some areas that will need particular attention over the next year to make sure BHR is on track. Regular reports will go to the Integrated Care Executive Group to understand progress and risks.

The areas which were identified as needing more work in BHR were:

- Development of primary care networks
- Workforce strategy
- Achievement against NHS constitutional targets
- Population health management.

These areas will be addressed through the BHR system strategy priorities and through current structures.

11.Risks

There are significant risks to the implementation of the BHR system and how it will operate. The Design Group has identified the following initial risks:

RISK TO BHR SYSTEM DEVELOPMENT
If the different accountability structures across health and social care (planning regimes and funding frameworks) are not reconciled to a degree with the new governance structures, system working may be compromised
If there are changes in senior leadership in the BHR system it will have a detrimental impact on the pace of progress and direction of travel (need to re-form relationships, may have different

views/approaches)
If the immediate requirement is to improve performance and financial positions it may mean that solutions are put in place which limit the ability to develop and implement new models of care across the BHR system
If clinical leadership and capacity is lost in the change process due to uncertainty and system changes, strategy development and delivery will be compromised
If the timing of implementation of Group model across BHRUT/NELFT and the development of the BHR system model is not aligned it will lead to uncertainty/confusion for staff and the system, a loss of confidence and delays in implementation
If primary care networks and federations do not reach sufficient stages of maturity, it will impact on the system's ability to improve quality and implement new models
If cultures and behaviours across organisations do not change (e.g. organisational 'protectionism' and competitive behaviours), it will not be possible to work effectively as a system in BHR
If the workforce is not available to deliver new system models of care, as well as keep services going in the meantime, then delivery will be severely compromised now and in the long-term future
If the political environment means a change in the policy environment and national policy changes, it will result in delays to progress and, possibly, a different direction of travel
If digital investment is not forthcoming, the BHR system cannot implement population health models and share information at resident and population levels
If the NEL ICS programme does not deliver in agreed timescales, the BHR system model may be delayed or need to change mid implementation.

These are all significant risk areas. Further work will be undertaken to understand, assess and mitigate these risks to inform a comprehensive approach to risk management.

12. Roadmap

A roadmap up to 2021 is being developed. An outline is attached as Appendix B. 2020/21 will be a preparation year and four work streams are being established to develop more detailed plans in the following areas alongside taking forward the BHR system strategy priorities (section 5) and addressing those gaps against the maturity matrix (Section 10):

- Communications and engagement
- Governance
- Financial framework
- Developing borough partnerships.

13. Recommendations

Members are asked to:

- Comment on any aspect of this report on progress so far on the development of the BHR system
- Continue to support further development of the BHR system
- Note that more detailed operating model will be developed for approval in the autumn 2020

APPENDICES

A BHR System Outline Operating Model
B Initial Roadmap

BHR System – Outline Operating Model

Appendix A

	Role and Activities	Population
Primary Care Networks/localities CO-ORDINATES DELIVERY OF CARE FOR LOCAL RESIDENTS	• Targeted interventions aimed at individuals and families who have increased risk of developing needs, where the provision of services, resources or facilities may restore independence, slow down or reduce any further deterioration or prevent other needs developing • Focused interventions aimed at maximising independence and minimising the effect of disability or deterioration for residents with established or complex health problems • Through multi-disciplinary and multi-agency working, provides the ability to better manage or coordinate the care of individuals • Form partnerships with community groups to support and develop interventions that fill gaps in care • Empower and prepare residents to manage their care • Residents will be at the centre of care and will be equal partners in the design, delivery and monitoring of services • Deliver at scale services which serve populations larger than individual GP practices • Lead on improvement of quality and performance across partners	31-106k
Borough partnerships Delegate LEADS PLANNING AND DELIVERY FOR LOCAL POPULATION	• Shapes and ensures delivery of health and care transformation plans including implementation of new models of care and pathways tailored to local population within framework set by BHR system • Enhanced sharing of data to undertake population care management of demand and early intervention • Removes barriers and shifts resources to produce greater value and better outcomes • Supports the development of PCN/localities and mobilise community resources to meet the needs of residents • Delivers at scale services which serve borough wide population • Focus on wider determinants of health and care including housing, business, leisure and employment • Escalate issues and risks to BHR system for resolution or wider learning	200-300k
BHR Delegate SETS SERVICE AND FINANCIAL STRATEGY	• Overall responsibility for how BHR system works in practice • Overall strategy development supported by Health and Care Cabinet and Transformation Boards • Set outcomes framework, quality and performance standards • Receives full NHS allocation for BHR and develops financial strategy, resource allocation to boroughs, collective risk management approaches within NEL framework • Assures borough partnerships and their delivery of effective, efficient care and support • Custodian of partnership approach – involvement of all partners including wider community, clinical engagement and co-production • Ensures BHR system efficiency through new commissioning and payment models • Cross cutting BHR wide programmes where need to work together e.g. workforce	800k

Outline Roadmap for BHR System Development (in development) Appendix B

	Programme set up and partner commitment		Detailed Development		Approval and Set Up	Pilot and Implement	Go Live
	February 2020	March 2020	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	From 1st April 2021
1. BHR Strategy Implementation	Receive and consider BHR System Strategy including: • Case for change • Vision • Strategic priorities	Agree plan to take forward strategic priorities under leadership of ICPB/ICEG/cabinet including key 2020/21 milestones		Milestones dependent on plans			
2. Setting up the System	Simulation event (26/2) to test design so far with senior leadership and identify further work	Share design proposals with all partners for comment and to endorse direction of travel	Options for borough partnerships developed (scope, governance) based on extending current arrangements where in place	Devise and agree organisational development programme to support system development	Final operating model for approval (Sept/Oct) including revised governance arrangements	Pilot operating model in advance of 1st April covering new governance framework	ICS for NEL and single CCG created (subject to approval) with NHS delegated functions to BHR system
	Programme set up: • Establish work streams (finance, governance, borough partnerships and comms/engage) • PMO approach including risk	Develop communications and engagement plan		Develop single outcomes framework	Establish new 'shadow' governance arrangements for BHR system	Agree operating plan (2021/22) for the BHR system	Ongoing work to ensure BHR system operates effectively
	NEL-led functions work completed – test coherence with local operating model	Transformation Boards refreshed (based on CF recommendations Nov 19) – part. leadership, capacity and focus					
3. Addressing maturity matrix	Understand plans against gaps: PCN development, workforce strategy, achievement against performance	ICEG progress review whole matrix		ICEG progress review whole matrix		ICEG progress review whole matrix	

Ongoing engagement with broader partners and public/patient engagement

Ensure alignment with national policy, NEL ICS development work etc