**Title:** Integrated Care Partnership Board - Update

**Summary:**
This report provides an update on the current position with the work being undertaken through the Barking and Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership Board (ICPB) to transform the local health and social care economy and implement greater integration and improved services to local residents.

**Recommendation(s):**
The Health and Wellbeing Board is recommended to note current progress and proposed next steps, and provide comments to support both Members’ and officers’ engagement with the planning processes in the BHR Integrated Care Partnership.
1. **Background on the BHR Integrated Care Partnership**

1.1 A number of briefings on the establishment and operation of the Barking & Dagenham, Havering and Redbridge (BHR) Integrated Care Partnership have been provided to previous Board meetings, most notably detailing the establishment of these arrangements (14 March 2017; minute 78), and a number of subsequent general updates including the minutes of the ICP Board.

1.2 In the intervening period, the programme has developed specific service improvement proposals, which are grounded in the work that was completed for the Strategic Outline Case for Accountable Care, submitted to NHS England in December 2016. In addition, the Better Care Fund has been approved in the meantime, and this has also influenced future proposals for joint working across Barking & Dagenham, Havering and Redbridge.

2. **Governance Arrangements**

2.1 In addition to regular meetings between the Integrated Care Partnership Board and Joint Commissioning Board, a Children’s Joint Commissioning Board Sub-Group and Provider Alliance group have been established with draft terms of reference (structure chart below).

2.2 The Children’s Joint Commissioning Board Sub-Group has been established to support the design and implementation of an effective joint commissioning model for children’s services within the BHR Integrated Care Partnership.

2.3 None of these groups currently have delegated decision-making responsibilities from the constituent organisations, and do not replace current organisational governance and decision-making arrangements.

2.4 An action was agreed at December’s ICPB to undertake a review of BHR Partnership governance, noting issues around duplication of activities and the burden on organisations to field members to the groups. This will include how the
BHR partnership structure reports to individual agencies. The result of this work will be reported to the first Health & Wellbeing Board meeting of the new municipal year.

3. **Proposed areas for exploring accountable care approaches**

3.1 A key aspect of proposed future health and care system management is move away from directive approaches to commissioning services. Instead of multiple contractual directions being given to providers, broad outcomes will be set, with an associated budget, and providers will be able to shape the approach that they deem most effective for delivering those outcomes. This provides a greater opportunity for influence by managers of frontline services and clinicians.

3.2 Out of the work on the Strategic Outline Case for an Accountable Care System, commissioners extracted proposals for work on three potential areas to test the new ways of working, and these were approved by the Integrated Care Partnership Board. The proposals have been presented to the Provider Alliance, to initiate a dialogue about how providers will shape and respond to the work. These proposals were in relation to the proposed future delivery of “Intermediate Care” and “Diabetes Prevention and Management”. A further proposal around children’s services is still subject to development by the Children’s Joint Commissioning Group.

3.3 Currently, the proposals are subject to discussion, with a view emerging from the Provider Alliance that they may not be the best options to ‘test’ the new approach to delivering care or generate learning about how provider collaboration can transform the system. The Integrated Care Partnership Board has asked commissioners and providers to resolve this, and present a workable set of proposals to a future meeting.

3.4 It is important to note that this debate is about how the work is taken forward, not whether these are priority areas for improvement. In the interim, commissioners continue to lead (in collaboration with providers, clinicians and others) the work to shape an improved response to diabetes management and intermediate care. The latter is part of the Better Care Fund so remains an important commitment by BHR partners.

4. **Procurement under and an ‘accountable care system’**

4.1 Board members may be aware from the national press that a number of procurement issues are emerging as a result of new approaches being taken to break down the commissioner/provider divide. Some of these are subject to legal challenge, including the proposed new accountable care contract developed by NHS England.

4.2 As a result, the Joint Commissioning Board convened a workshop, with external expertise from legal firm Hempsons, to consider potential procurement-related risks, and the limits of collaboration when considering the need to conduct open market procurement exercises. This has yielded some useful points to guide future joint approaches, and has helped all partners across the three local authorities and CCGs to clarify together some of the issues involved. Board members may wish to note that alongside technical and legal considerations, the discussion also emphasised the need to ensure wide involvement of the public, patient and service...
user representatives, and a widened participation of independent and third sector partners (particularly in the social care sector). This is being considered as part of the governance review for the BHR Integrated Care Partnership.

5. **Better Care Fund Update**

5.1 Following the full assurance of the Better Care Fund plan, work continues to deliver upon the outcomes set and to identify how, in year two of the plan (2018/19) closer integration can be further realised, in both strategic governance and in the delivery of a shared work plan, reflecting steers provided by both HWBB and the Joint Commissioning Board.

5.2 Proposals are in final draft for revised arrangements for governance (formerly exercised through groups called Joint Executive Management Committees) across BHR creating a single ‘Committee in Common’ replacing local JEMCs which will improve oversight across the whole system. We also now have a single Section 75 agreement in draft form (inclusive of LB Barking and Dagenham, LB Havering, LB Redbridge and the three CCGs) for the coming financial year, 2018/19. This formal agreement sets out the terms of collaboration, based largely on a standard form of the document provided by NHS England, which has served well for the previous years individually in each borough.

5.3 Currently Barking and Dagenham’s JEMC is the more fully functioning of the three boroughs, being more regularly convened and with the best participation of partners. Steps proposed are also intended to improve focus upon a new shared work plan, driving a better alignment of day-to-day delivery, and spending less time on managing relatively detailed ‘business as usual’. It is key that greater capacity is applied in creating traction on development and innovation, delivering change across and together with system partners. This will reduce some of the duplication currently in the system when it comes to managing, for example, winter pressures and the hospital discharge pathway.

5.4 In support of the changes proposed as part of the ICP, the role of Lead Commissioners is being introduced. This will ensure the clear accountability, and delegated authority, of a single lead across BHR to efficiently commission key services (e.g. Intermediate Care) as part of the new shared governance arrangements and releasing capacity to focus upon system innovation and change. Once again, lead commissioners will be aware of the need to ensure that formal governance arrangements in each borough is respected and properly exercised even when the result is a three-borough arrangement to deliver the services.

5.5 Alongside borough-based pooled funds (as currently exist for each BCF), we will introduce a single pooled fund into which partners can decide to transfer resources to be applied across the system in common, and to support the delivery of the shared workplan from April 2018. This is already the case with the defined contributions made by partners to the Joint Assessment & Discharge Service, for example.

5.6 NHS England have indicated that they view the local steps in this direction as a positive way forward for using the BCF to support our collaborative plans.
6. **Mandatory Implications**

**Joint Strategic Needs Assessment**

6.1 The Joint Strategic Needs Assessment signed off by the Board at its last meeting points to a number of areas where the collaborative arrangements detailed in this report could support delivery. The themes chosen for developing the collaboration (diabetes, intermediate care and a children's health theme) are all amply detailed in, and supported by, the JSNA’s recommendations, as is the general move to integrate services and have them more driven by the frontline rather than complex and sometimes competing commissioning priorities.

**Health and Wellbeing Strategy**

6.2 In considering an imminent refresh of the Health & Wellbeing Strategy, the issues set out in this paper potentially provide useful input as to how the borough may ensure its aims are delivered through improving collaboration across boroughs and between providers and commissioners.

**Integration**

6.3 The matters dealt with in this report are directly supportive of the duty placed on the Board by the Health & Social Care Act 2012. Whilst there is no specific requirement to collaborate or integrate between boroughs, in a system in which hospital and community health partners are working across a wider geography, it is fitting that the borough’s Health & Wellbeing Board ensure that cross-border collaboration is central to its planning on integrated service delivery.

6.4 The Better Care Fund is also a key vehicle for integration of services, recognised in national planning frameworks, and is supported by the direction of travel outlined in this report.

**Financial Implications**

**Financial Implications completed by Katherine Heffernan, Group Finance Manager**

6.5 This report gives an update on the BHR Integrated Care Partnership including Commissioning arrangements, governance etc. There are no direct financial implications arising because of the report.

6.6 The report however mentions introducing a single pooled fund within the Better Care fund (BCF), to support the delivery of the plan. Due to the fact that a two-year plan was agreed, the planned allocations to each of the workstreams for 2018-19 would need to be reviewed by the Joint Executive Management Committee (JEMC) to identify available funding to enable a single pooled fund to be created.

**Legal Implications**

**Legal Implications completed by Dr. Paul Field, Senior Governance Solicitor**

6.7 The Health and Social Care Act 2012, conferred the responsibility for health improvement to local authorities. In addition, as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The Health and Well-Being Board terms of reference establish its
function to ensure that the providers of health and social care services work in their delivery in an integrated manner.

Risk Management

6.8 No financial risk is currently transferred between NHS and local government partners through either the BHR Integrated Care Partnership arrangements or the Better Care Fund proposals. Direct responsibility for other service-driven risks remain with individual organisations as per their current governance arrangements.

6.9 However, sharing of reputational risk, surrounding either service failure or financial difficulty across the system, is implied by the decision to participate in shared management forums for the health and care system. This is currently not identified formally as a risk, but is part of the reason for ensuring that Board members and others within individual agencies are aware of the collaborative work which is underway.

Patient/Service User Impact

6.10 The development of specific proposals for the development or transformation of individual services or care pathways is slow to materialise and, in and of themselves, the matters detailed in this report do not directly change services for residents or patients/service users. Currently the potential changes are being scoped, based largely on consultation done either by organisations themselves, dialogue with clinicians on what could work better for their patients/service users, or in the consultation undertaken for the development of the Strategic Outline Case (ca. 3000 people across the three boroughs).

6.11 Where changes to services are to be made, then engagement with relevant service user groups and residents directly will still be required as per normal procedures.

7. Public Background Papers Used in the Preparation of the Report:

7.1 None.

List of Appendices:

Appendix A: Integrated Care Partnership Board – action notes, 31 January 2018