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

NHS
North East London
Clinical Commissioning Group

BHR Transformation Board 21/22 Update and Developing a Proposal for Ongoing Collaboration

Meeting name: Havering Health and Well Being Board
Presenter: Tracy Rubery, Director of Transformation (BHR ICP)
Date: November 2021

Barking and Dagenham, Havering and Redbridge

Background

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 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.

Due to the Covid Pandemic, the changes in national contracting arrangements, and the positive impacts of accelerated integration of our system Partners, the original FRP has been reviewed and has resulted in the development of the Integrated Sustainability Plan (ISP). The ISP resets the previous FRP and expands the scope to include redressing historic under-investment in Out of Hospital services. The aim of the ISP is to reduce secondary care activity by Transforming Health and Care services and delivering care differently, closer to home, improving outcomes and investing in prevention.

Background

The Transformation Boards are a key part of the system architecture which will deliver the Transformation required to support the assumptions set out in the ISP. Transformation Boards are responsible for the development of care models for their particular care group within the overall strategic framework set by the Integrated Care Partnership Board. They are made up of all partners across health and care in BHR and have strong clinical representation. They will continue to develop plans through co-production with residents, patients and their families. As they develop, Borough partnerships and providers will then be responsible for delivering those models for their local populations.

There are currently eight Transformation Boards in BHR comprising:

- Cancer
- Children and Young People
- LD and Autism (NEL Board)
- Long Term Conditions
- Mental Health (NELFT/NEL System wide Board)
- Planned Care
- Older People/ Frailty
- Unplanned Care

This pack provides an update on the current progress of each of the BHR system Transformation Boards, and a proposal for ongoing collaboration as we move into the Integrated Care System (ICS) arrangements.

BHR 2020/21 Transformation Board Progress

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

OLDER PEOPLE

- The expansion of the **NELFT Community Treatment Team (CTT)** went live in August-21 with 10 of the 11 additional posts recruited. The CTT supports the delivery of the National 2 Hour Community Crisis Response Standard. Based on August 2021 data, the service is forecast to provide a reduction in emergency admissions of 2,112, providing the BHR System with savings of £4m.
- The new **Single Point of Access Discharge** team, hosted by NELFT launched in October 21, , building on the enhanced Hospital Discharge Service (HDS) that was developed during 2020 in response to the covid pandemic. The service supports patients who require health and/or social care support to be discharged into their own home, or an appropriate community setting, as soon as they are medically fit. The service is expected to support c9 patients to be discharged each day, with at least 3,442 reductions in acute bed days per year.
- The **Acute Frailty Service** continues to support c250 patients a month with at least c80% avoiding an admission. Based on April to August data, the services are forecast to deliver 382 less emergency admissions, saving the BHR system £1.8m. The Queens Frailty Unit which was launched in May 2021 and alongside the King Georges Frailty Unit will continue to focus on seeing more elderly frail patients to help increase the speed at which they are discharged from ED and being managed in the community or their own homes and therefore avoiding an admission.

PLANNED CARE

- The **MSK Single Point of Access (SPA)** went fully operational in April-21, following a delay due Covid, with the **MSK Exercise on Referral (EoR)** due to go live in late November-21. Since April, the SPA has reduced 1,106 unnecessary Outpatient appointments and is expected to deliver a reduction of 2,444 unnecessary outpatient attendances in 21/22. With the procurement of the new e-referral system, the reductions are expected increase next year. The EoR will start to receive referrals from the end of November to provide patients with chronic pain an alternative treatment to clinical intervention.
- A **uro-gynae pathway,** to help reduce inappropriate referrals to the Gynaecology department and aid the long term aim of reducing GP referral volumes through targeted education, has been developed and launched in September 2021. The pathway is expected to reduce the number of referrals to BHRUT gynaecology department of 20% by 6 months post-launch.
- The **Community Minor Surgery** service is at the final stages of the approval process with an expected go live date of December-21. The service aims to undertake an over 2,000 additional minor surgery procedures each year in a Primary Care setting, and therefore reducing the burden on the Acute services and support the clearance of the current Elective backlog post covid. The service will also reduce waiting time for patients.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

URGENT AND EMERGENCY CARE

- A **Same Day Emergency Care (SDEC)** unit was successfully launched on Wednesday 28th July 2021. The service has 10 patient spaces and is located in the Majors facility within Queens Hospital. The service is currently seeing 6,720 patients a month, of which, the unit estimates 510 p/m (7.5%) are an avoided admission.
- The **Hospital Ambulance Liaison Officer (HALO)** service, at both the KGH & Queens sites, are in the process of mobilisation and is on track to go-live in November. The service will operate from 10am to 10pm, to help redirect crews to utilise alternative care pathways instead of the acute based services. This will aid with ambulance crews awareness and utilisation of alternatives services, and therefore, contribute to improved patient care by transferring patients to the most appropriate setting and ensuring that more patients are treated at the right place, at the right time, first time.
- A business case for a **Duty Doctor** Pilot is currently being taken through the CCG governance process for approval. The pilot which will run in Havering aims to have a dedicated doctor who will provide a dedicated call-in service which can be accessed by ambulance crews and community health care professionals when they need to seek advice from a GP about a patient's condition. The expectation is that the advice and guidance provided by the service will help prevent the patients from being automatically conveyed or sent to A&E when this could have been avoided. The service is on track to go live in November to support with winter pressures.
- A winter business case covering the following schemes: additional community rehab beds, additional intensive rehab service staff, additional care home rehab beds, increased PELC capacity, a Therapy Assessment at RAFTing pilot, additional 30 bed unit at Queens and a weekend discharge nursing home pilot has been taken through the Urgent & Emergency Care Transformation Board and governance processes. It is expected that all schemes will go live during November and December 2021 to support with winter pressures. All elements support the hospital with discharging patients so that bed capacity is freed up during the winter months, or provide additional capacity at the front door or within the hospital.

CHILDREN AND YOUNG PEOPLE (CYP)

- The **Paediatric Assessment Unit (PAU)** has been successfully implemented at the KGH site following the implementation at the Queens site last year. The service supports children attending ED to be appropriately assessed and monitored with the aim of reducing unnecessary emergency admissions.
- The integrated **Paediatric Hospital at Home** pathway is currently at the final stages of approval, and the expectation is that this will go-live in January-22. The service will support the PAU service through integrating the pathways between secondary care (from PAU), to care in community and home settings. The expectation is that 1,396 admissions will be avoided each year.
- A collaboration between the CYP Transformation Board and BHR Workforce academy has resulted in the successful delivery of a workforce workshop in September-21. The workshop identified short and long term solutions to address the shortage in the workforce affecting children across BHR, enabling further development of initiative’s which was previously constrained by workforce capacity.

BHR TRANSFORMATION BOARDS – 21/22 KEY PROGRESS TO DATE

LONG TERM CONDITIONS

- An **Atrial Fibrillation (AF) Case Finding** pilot in Havering has been approved and is in the final stages of mobilisation. The pilot will go-live by the end of November-21. The pilot utilises a specialised algorithm developed by Pfizer, and approved by the MHRA, to detect patients with high risk of AF related stroke. Patients are then admitted to a Rapid Access pathway for diagnosis and treatment, resulting in a reduced risk of imminent strokes. The pilot is expected to prevent 18 strokes between December-21 and March-22.

- The **Urine Albumin to Creatinine Ratio (ACR) Testing from Home/ACR Diabetes** initiative is a 'post covid catch-up plan' which is expected to be implemented in late November-21. Due to the Covid pandemic, and the reduction in face to face contacts with GPs/Nurses, Diabetic patients were not receiving the full 8 care processes required to detect any risks or issues with their condition that could result in complications associated with Diabetes. This initiative provides the ability to deliver a 'catch-up' plan at scale prior to returning to BAU levels and annual check-ups going forward.

CANCER

- A '**C the Signs'** digital tool was rolled out across BHR in Quarter 1. The tool helps to identify patients at risk of Cancer; which cancer or cancers a patient is at risk of and identifies the most appropriate next steps. There are currently 358 users, helping to improve early detection, referral and diagnosis rates and therefore improving the outcomes for the residents of BHR.

- The **Rapid Diagnostic Centre (RDC)** is now fully live and receiving referrals from B&D. Work is ongoing to roll out the RDC across Havering and Redbridge. The RDC is a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer, but do not "fit" into the Pan-London 2ww tumour specific pathways. The service provides personalised, accurate and rapid diagnosis of patients' symptoms by integrating existing diagnostic provision and utilising networked clinical expertise and information locally. This supports improvements in the Faster Diagnosis Standards (FDS) which is currently at pre-covid levels.

- The **Lung screening project (The SUMMIT study)** delivered by UCLH and GRAIL has to date delivered a service to over 13,000 participants. The aim of the project is to develop & evaluate a new blood test for detecting multiple types of cancer early including lung cancer amongst at-risk residents & contribute to the examination of the feasibility of a large-scale lung screening programme in England. Participants were invited via their GP practice to attend a lung health check, offered a blood test & a low-dose CT scan of lungs. If signs for concern were seen in first scan, these were followed up, either immediately or twice annually depending on severity. The screening project will run until July 2022 but has already impacted patients through early lung cancer detection & patients successfully treated.

BHR Transformation Board 21/22 Scheme Overview (October-21)

Red schemes – denotes progress to next stage of process from previous month

Blue Schemes – New schemes added in current month

Concept Schemes

Ageing Well - OOH - End of life rapid response team
Ageing Well - Hospice End of Life Service (RRT 24hr helpline and Nurse)
Ageing Well - Hospice End of Life Service (Care Home EOL Nurse Specialist)
Ageing Well - Community Falls Care Home Service
Ageing Well - Discharge to assess pilot
EBI Wave 2
ECG LIS
ASD/ADHD
Weekend Nursing Home Discharges
Expansion of Community Falls Service
(ACP) Pharmacist in the Community Treatment Team (CTT)
Community Complex Dementia
LTC Diabetes – out of hospital management
Point of Care Testing (POCT)

Business Case

Hospital Discharge Service
Duty doctor
Winter schemes x8
Community Minor Surgery
Simple Wound Care
Diabetes Assisted Discharge
Tier 3 Weight Mgt
Local NIV Service
Long Covid Extension
Home First Pilot
PINS-Hospital at Home Pathway
ACR Hypertension

Mobilisation

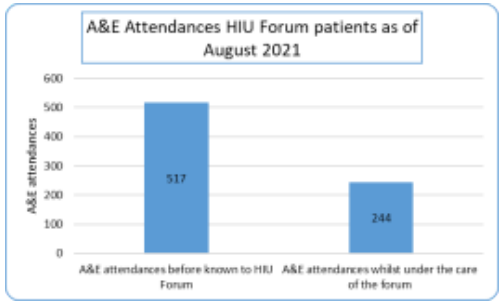
Ageing Well - UCR 2-hour response (CTT Expansion)
AF Case Finding-Havering
Complex Wound care Programme/Dressings and Lymphedema
v Chronic Kidney Disease (CKD) Pilot
Pilot HALO (Hospital Ambulance Liaison Officer)
MSK e-Referral Tool
ACR Testing from Home/ACR Diabetes

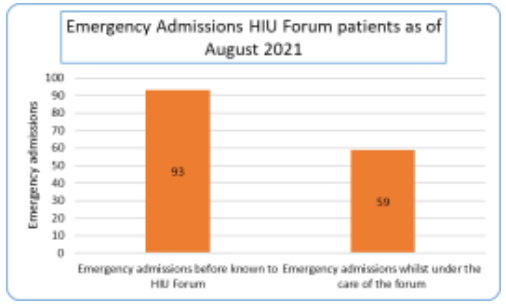
Live Schemes

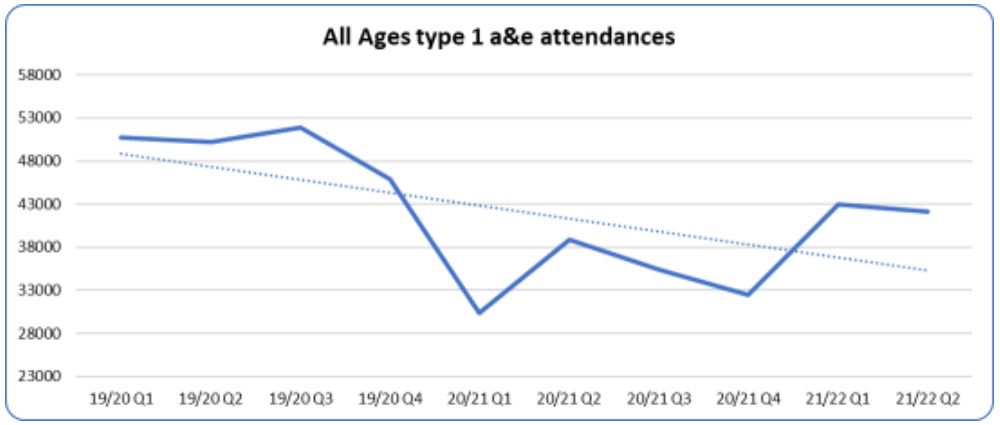
Queens Frailty Hub Service (AFS)
Falls Programme Line - Strength & Balance Service
Local Area Coordination - Havering
Local Area Coordination - Redbridge
Reduce attendances for HIU (ODISH)
Develop SDEC pathways
Advice & Guidance
C2C reduction - Triage/RAS
MSK New Model of Care:
MSK New Model Of Care-EOR
MSK New Model Of Care-Primary Care MSK Team
MSK New Model Of Care-Rheumatology Hub
PIFU (Patient Initiated FU)
Uro-gynae pathway
Children Asthma LISs
LTC LIS - Atrial Fibrillation
LTC LIS - Diabetes Injectables
Respiratory Care - LTC LIS Group 2 (COPD/Asthma)
Diabetes 8CP/3TT

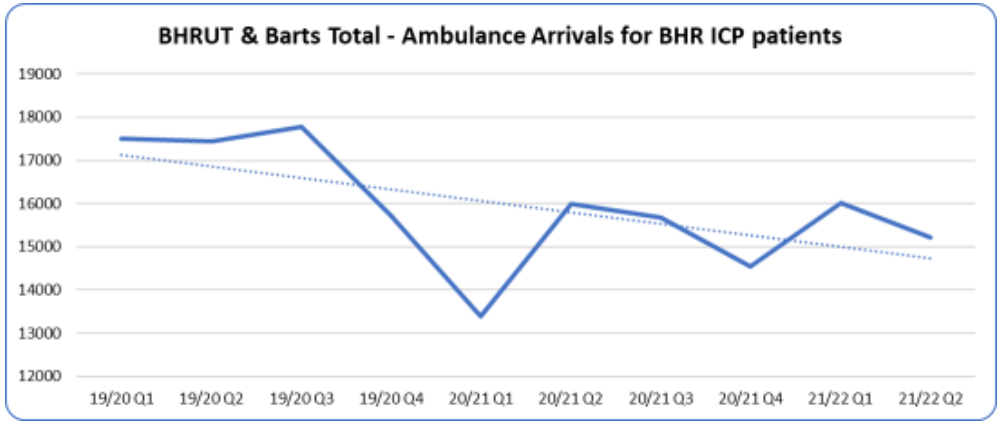
Impact of Transformation

Urgent & Emergency Care Transformation Board Impact Achievements









High Intensity User Forum & Open Dialogue service

The High Intensity User Forum is a multi-disciplinary team, consisting of London Ambulance Service, BHRUT, NELFT, Police, Social Care, patient GPs and others who provide direct care for the patients. They devise care plans and support options for patients who are identified as 'complex high intensity users' to prevent them from utilising urgent and emergency care services when not required, and directing them to more appropriate services to support the needs of the patient.

In 21/22 (as of August 2021), the service has delivered a reduction in emergency admissions of 37% (34 less admissions) and a reduction in A&E attendances by 53% (273 less attendances).

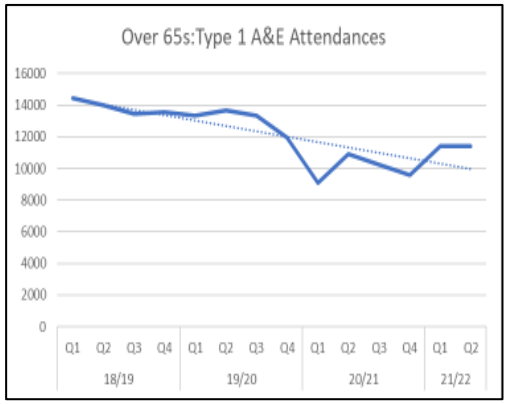
Alternative Care Pathways (ACPs)/Hospital Ambulance Liaison Officer Pilot (HALO)

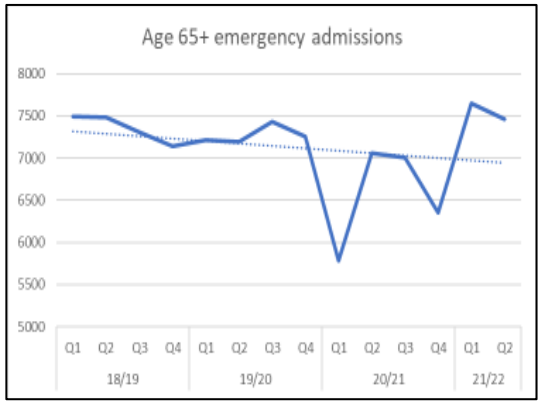
Type 1 A&E Attendances, relating to BHR patients of all ages at BHRUT, continue to show an overall downward trend with a 16% reduction (15,895 less) in A&E attendances in Q1 & Q2 FOT 21/22 when compared to Q1 & Q2 2019/20. Whilst some of the reduction is due to the Covid pandemic, especially in April and May, a significant contributor to this shift has been the successful implementation of 4 UTCs across BHR and the ongoing work to increase utilisation of alternative care pathways so that the emergency department is not the first port of call for patients when clinically safe to utilise alternative services..

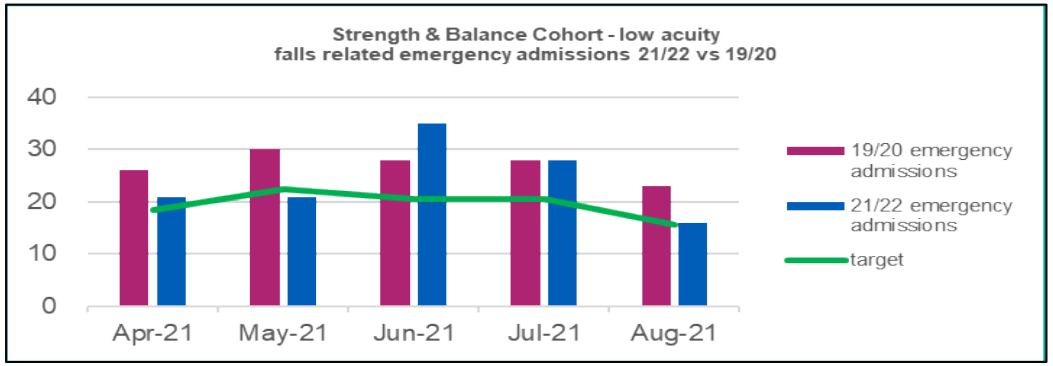
A significant amount of work has been undertaken to ensure alternative care pathways are increasingly available, such as CTT, UTCs, Crisis Centres and Frailty Units. As a result, ambulance crews are now able to take an increasing number of patients to these alternative services. The impact of this can be seen in the reduction of ambulance arrivals, when comparing Q1 & Q2 FOT 2021/22 with Q1 & Q2 2019/20, which shows a 11% reduction (3,699 less conveyances.).

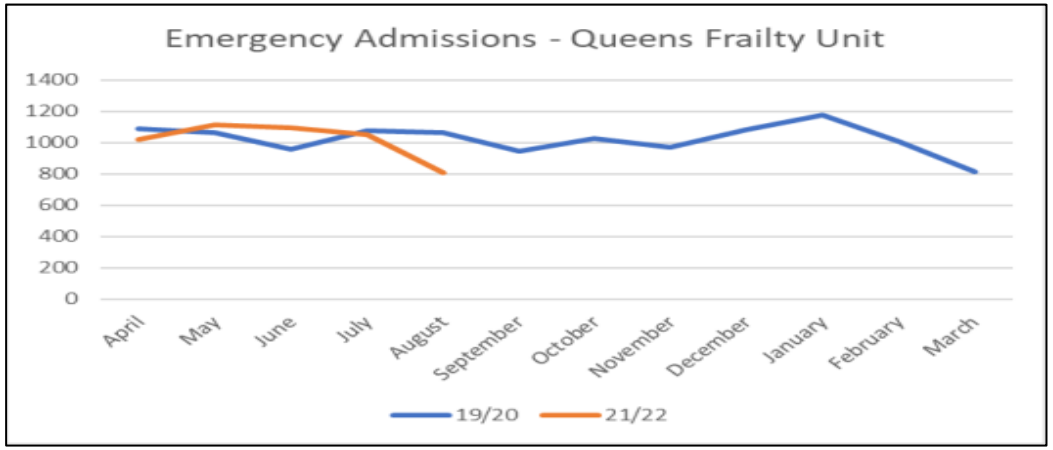
To enhance the usage of ACPs further and to support with winter, LAS has recruited paramedics (HALO) who will review ambulance arrivals, 7 days a week throughout winter and guide/educate their colleagues around the alternatives available. Through doing this, it is forecast to prevent 1,820 A&E attendances throughout winter.

Older People Transformation Board Impact Achievements





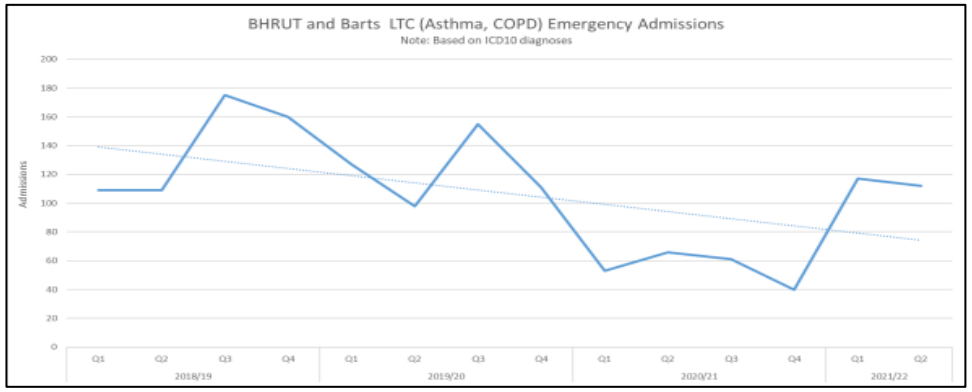


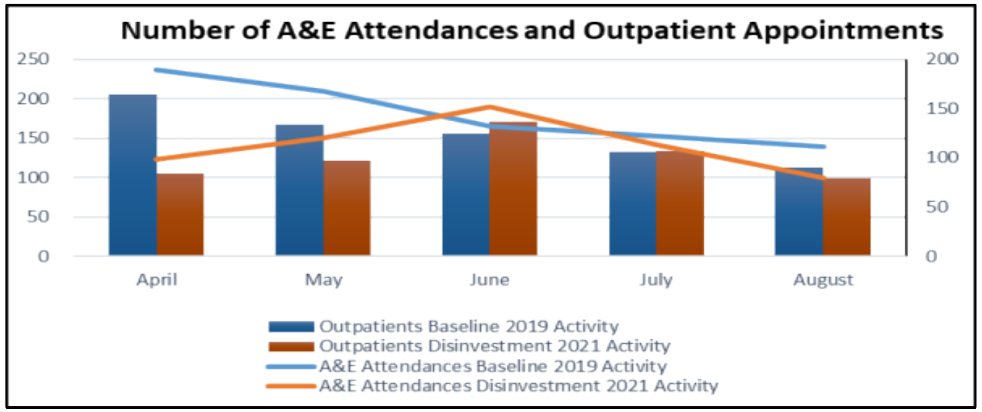


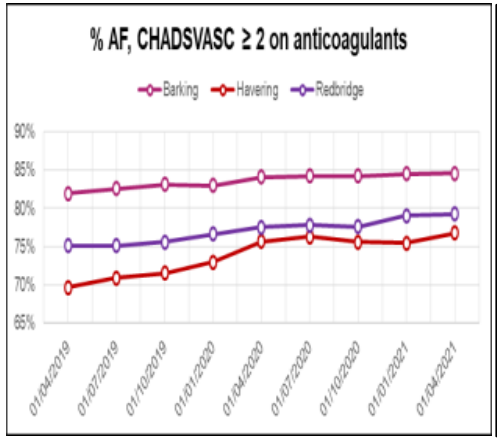
Key Notes

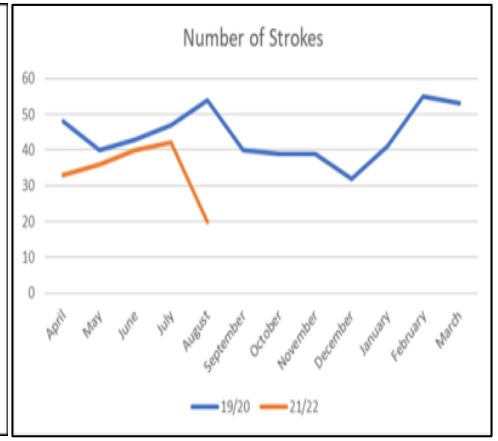
- Due to the impact of covid, the 20/21 position have been skewed and therefore, the 21/22 position have been compared to the 19/20 pre-covid levels.
- The YTD (Q2) level of A&E attendances, for patients aged 65+, is currently 15% (4,167 attendances) lower than the comparable period in 19/20.
- However, the spike in the level of over 65+ admissions in recent months indicates that older patients presenting to Hospital are more complex and with a higher acuity of their condition, in part driven by Covid.
- The Queens Frailty Unit, which was launched in May-21, incorporating the previous ‘ED Front Door’ and ‘Home is Best’ services, is starting to impact on the admission rates through a more dedicated and integrated Frailty service aimed at assessing and supporting patients to be cared for in an appropriate setting where an admission is not required. In August-21, there were 24% (258) less admissions than in August-19.
- The Falls Strength and Balance service was impacted during covid due to social distancing measures and the move to virtual sessions. However, despite a spike in June-21, the 21/22 position shows a 10% reduction in falls equating to 14 less falls by August-21 compared to the same period in 19/20.
- As the Strength and Balance classes resume face to face sessions, it is expected that the number of falls will decrease further in future months.

Long Term Conditions Transformation Board Impact Achievements









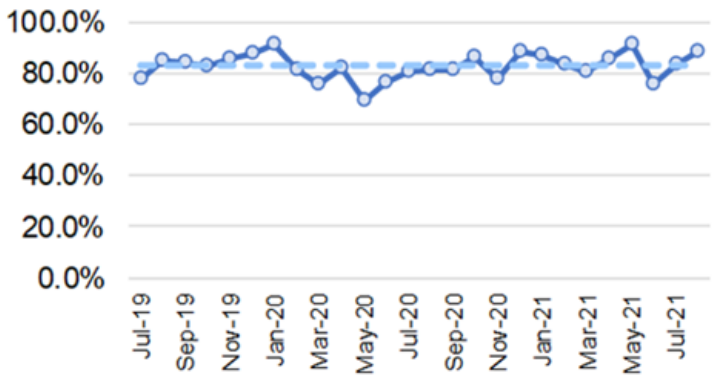
Key Notes

- The LTC Asthma and COPD LIS was implemented prior to Covid, with the purpose of shifting routine spirometry tests, for diagnosis of COPD/asthma, from an Acute setting into Primary Care, and to support patients through the development of care plans to better manage their condition and reduce presentations to Secondary Care.
- Since April 2021, there have been 159 less respiratory related A&E admissions compared to the same period in 19/20.
- COPD and asthma related admissions remain on a downward trajectory, and despite a post-covid surge in admissions in June-21, at Quarter 2, admission remain below the 19/20 position.
- The shift in setting for the delivery of routine Spirometry testing, has resulted in 77% less spirometry activity (reduction of 610 tests between April-21 to August-21) taking place in secondary care. As the Tests are performed in an Outpatient setting, this has resulted in the freeing up of 610 outpatient appointments at BHRUT.
- Since the implementation of the Atrial Fibrillation LIS in 19/20, 93 out of 116 GP practices have had their AF registers reviewed for high-risk patients (CHADVASc >2) who are not on anticoagulation treatment. This review of 769 patients has led to over 200 patients being anticoagulated.
- Due to early detection and intervention, this has contributed to 27% (61) less strokes in 21/22 (to August-21), compared to the same period in 19/20.

Planned Care Transformation Board Impact Achievements

6. Responded within 48Hrs All Specialties (Top 18)

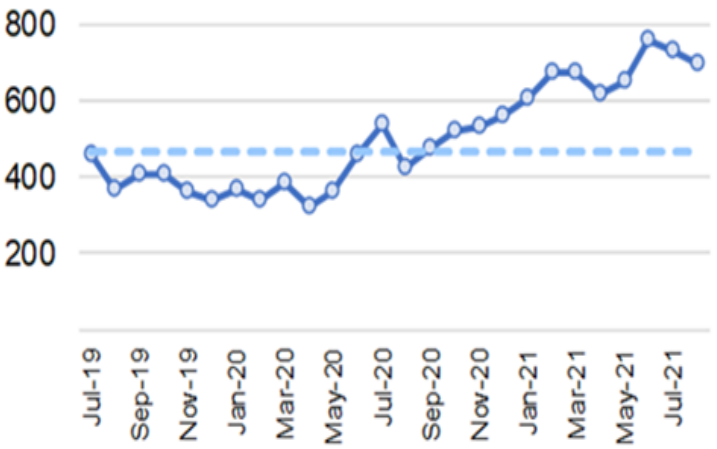
Barking, Havering And Redbridge University Hospitals NHS Trust



Month	Value
Mar-21	80.9%
Apr-21	85.4%
May-21	91.3%
Jun-21	75.6%
Jul-21	83.1%
Aug-21	**88.1%**
Median	82.8%

2. eRS Requests All Specialties (Top 18)

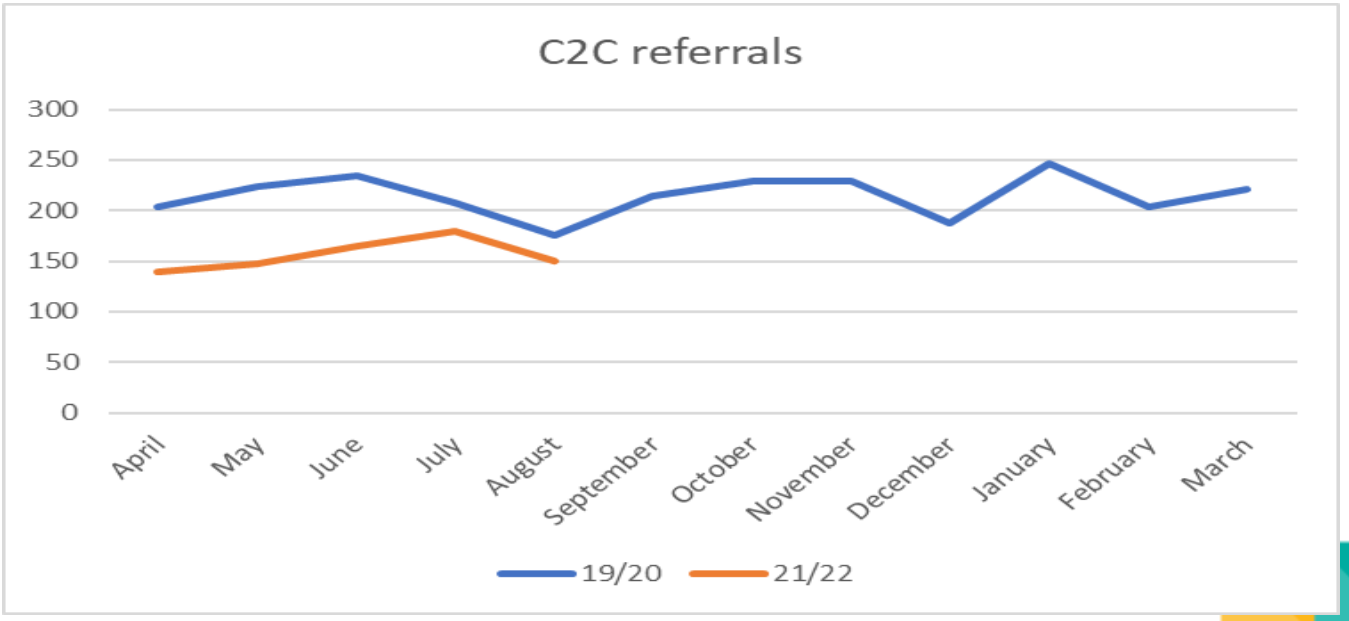
Barking, Havering And Redbridge University Hospitals NHS Trust



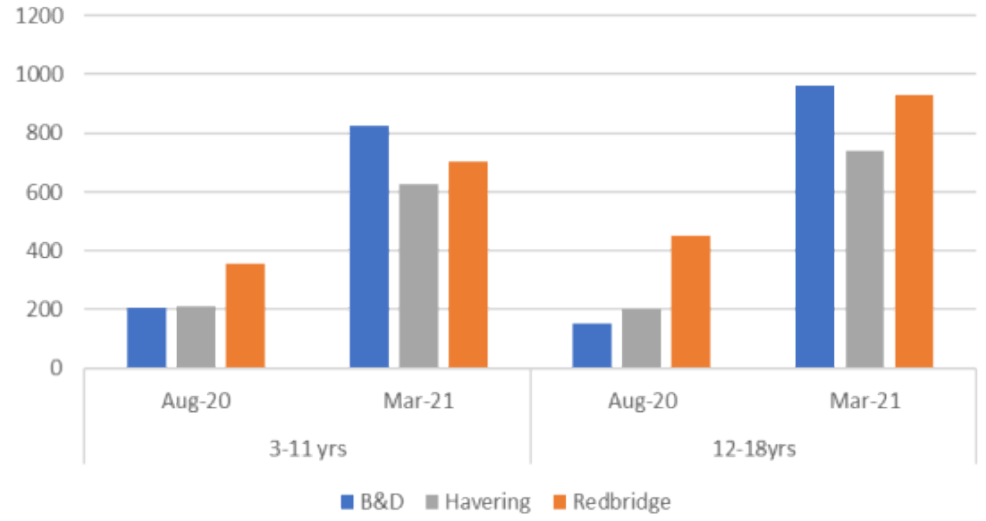
Month	Value
Mar-21	675
Apr-21	618
May-21	652
Jun-21	759
Jul-21	729
Aug-21	**696**
Median	466

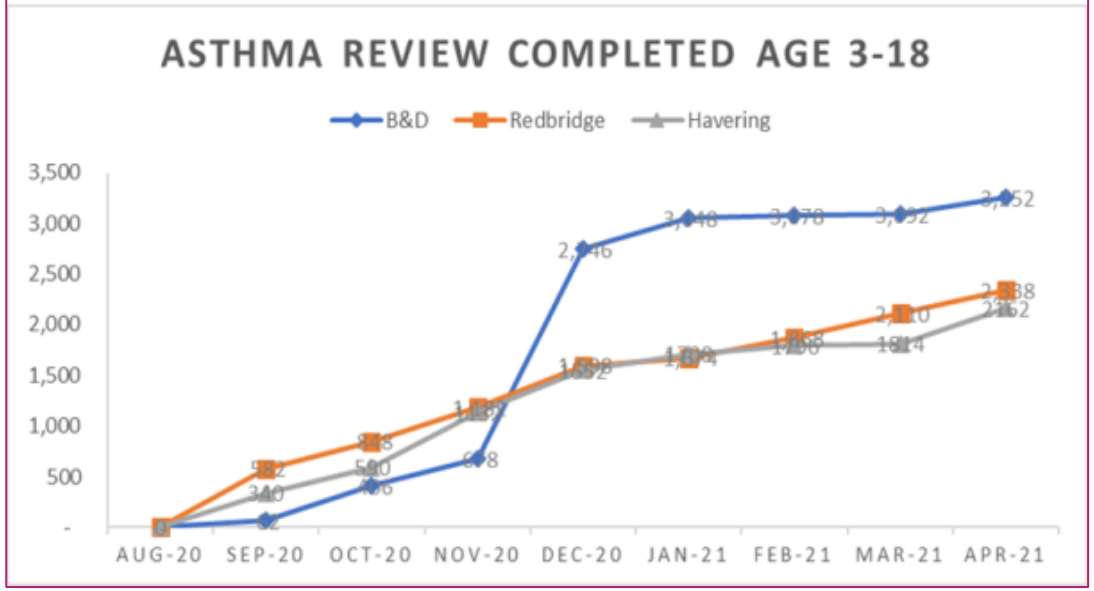
Key notes

- The Advice & Guidance service has continued to improve with an increase in the number of requests for Advice & Guidance on e-RS, whilst maintaining a 83% response rate within 48 hours.
- The improvements in the Trust Directory of Services and combined with the roll out of the Triage/RAS systems, has contributed to a 25% reduction (265 attendances) in the level of Consultant to Consultant (C2C) referrals.
- The C2C policy, following system agreement, is currently suspended and further communication and engagement is ongoing within the Trust to ensure that the legacy processes are reversed to support the reduction in demand on Primary Care.
- The Patient Initiated Follow Up (PIFU) pathways have been piloted in Neurology and the pathway will be rolled out to 4 further Specialties (Trauma & Orthopaedics, ophthalmology, gastroenterology and Prostate Stratified Pathways) in the next few months. The PIFU is aimed at empowering patients, with clinical oversight, to manage their own follow-up pathways based on their condition and requirements. This in turn is expected to reduce the number of unnecessary follow-up attendances going forward.



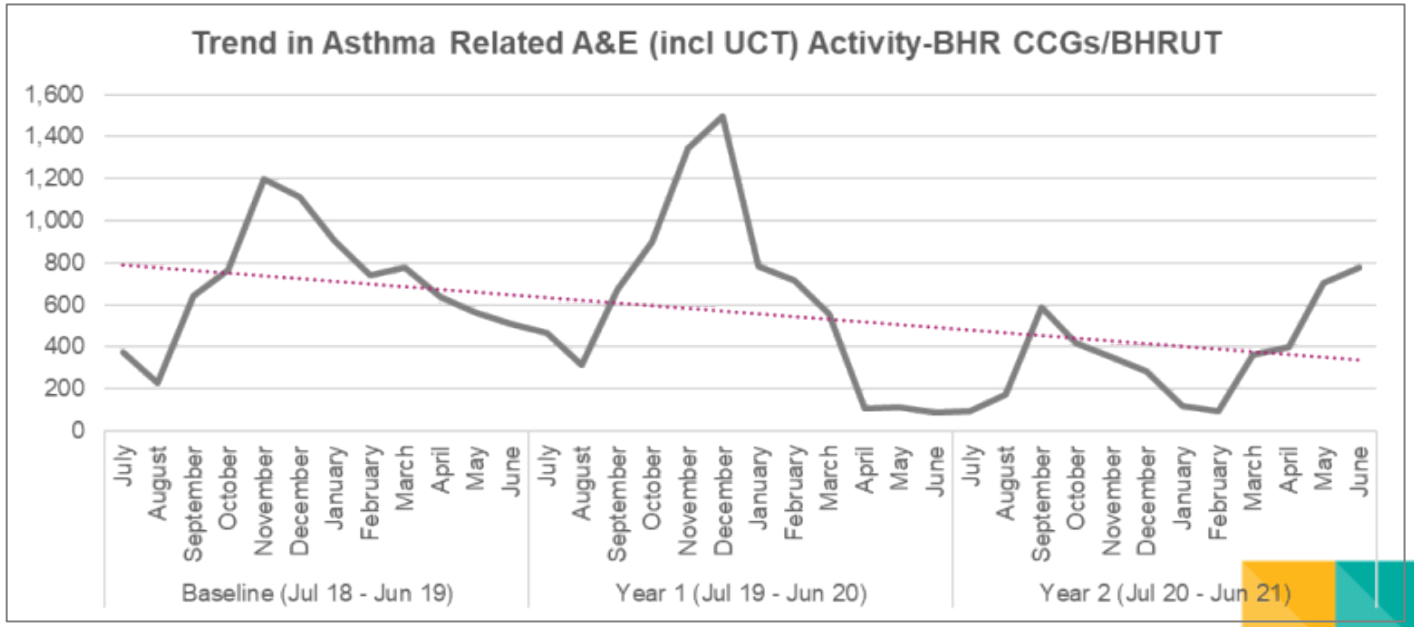
Children and Young People Transformation Board Impact Achievements



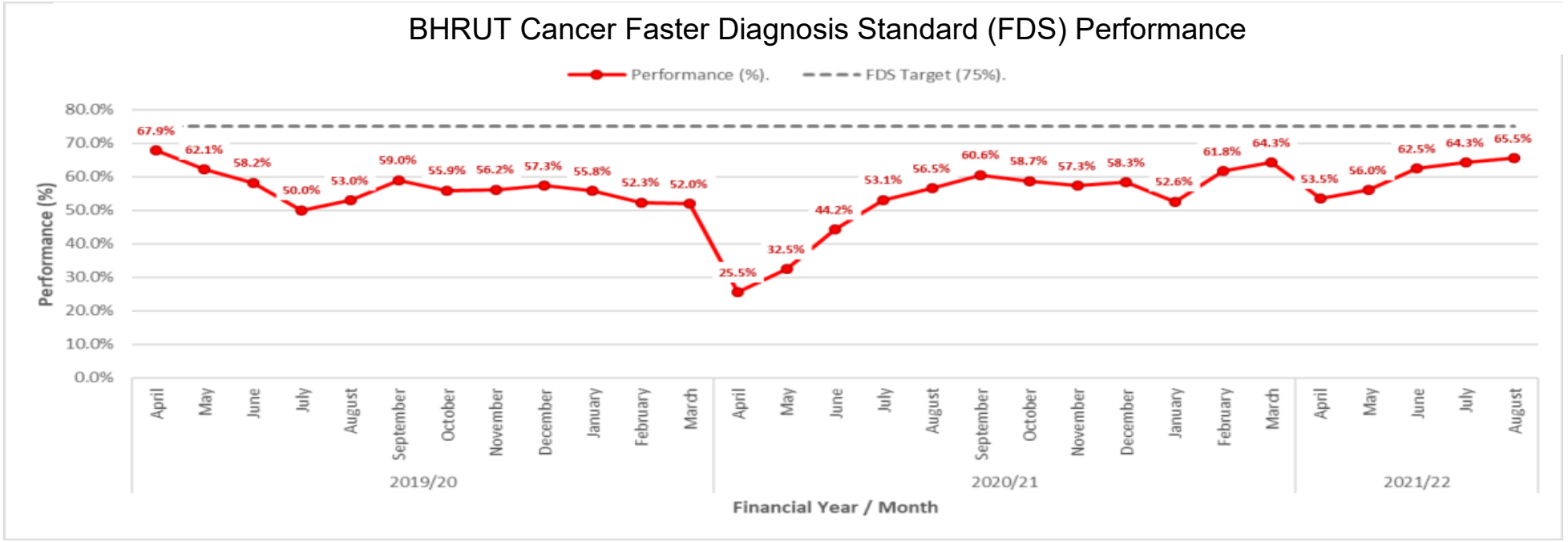


Key notes

- The Sustainable Asthmas LIS, which was implemented in 19/20 in response to the Regulation 28, focuses on providing education and support to children and their families to help manage the Asthma condition through the implementation of Care Plans. The service is an integrated service between Primary Care and Community services.
- The Sustainable Asthmas LIS, has resulted in a 200% increase in the number of care plans issued since its implementation (from 1,574 in August 20 to 4,790 at the end of March 21), with the impact of the care plans seen in the following months and years.
- The implementation of the LIS has contributed to a 48% reduction in Children's Respiratory related A&E/UCC attendances across BHR, (from 8,462 attendances (pre-LIS) to 4,360 over the past year)
- Paediatric Emergency admissions, which are directly attributable to minor Asthma conditions, has also reduced by 48% across BHR, from 405 admissions pre LIS (Baseline Year), to 208 admissions in year 2 of the scheme. Whilst some of the reduction can be attributed to the impact of Covid, admissions have not reached pre-covid levels, in part, driven by the increase community base care provided by the LIS.



Cancer Transformation Board Impact Achievements



Key notes

- Significant work has been undertaken by the Trust to improve the Faster Diagnosis times including:
  - Dedicated clinical review clinics established with consultant time to sign patient off pathway
  - Local process agreed with Primary Care on endoscopy sign off process to support FDS compliance
  - Clinic capacity increased to reduce median waits
  - Clinical triage team booking directly onto Endoscopy list
  - Increased Radiology scanning capacity to support delivery of FDS and resource has been allocated to support Gynae and Urology specifically.

- This work has resulted in the current performance being back at pre-covid levels. The FDS August-21 Published information indicates a performance of 65.50% (+1.30%) from previous month against the 75.0% Target.

- There has also been an improved position for the 28 Day FDS in Gynaecology and Upper GI seen in September 2021.

Impact of Transformation Against the Integrated Sustainability Plan (ISP)

BHR ALL TRANSFORMATION BOARDS ISP IMPACT

SUMMARY ALL TX BOARD	21/22 ISP Target Reduction	YE Forecast Reduction	FOT Variance to ISP
Activity			
OPD Reduction	5,966	18,599	12,633
DC/E Reduction	996	725	-271
NEL Reduction	523	3,290	2,767
A&E Reduction	0	4,644	4,644
TOTAL ACTIVTY REDUCTION	**7,485**	**27,258**	**19,773**
Finance			
Gross Finance Reduction (£'000s)	£3,637	£12,768	£9,131
Finance Investment (£'000s)	-£1,818	-£7,625	-£5,806
TOTLA (Net) FINANCE (£'000s)	**£1,818**	**£5,143**	**£3,324**

The Transformation Targets for 21/22 above are based on the 6% reductions (phased year 1 reductions) identified in the Integrated Sustainability Plan (ISP). The forecast is based on the schemes identified on the previous slide. The reduction in acute based activity is driven by transformational changes including the provision of community based serviced to allow care to be provided closer to home, prevention and early intervention (detailed above).

- Overall, the BHR Transformation Boards are forecasted to exceed the year 1 target reductions in:
  - Outpatient Activity**
  - Emergency (NEL) Admissions
  - Whilst no targets have been set for reducing A&E attendances, through the interventions to reduce emergency admissions, A&E attendances are also reduced as part of transformational services and pathways.

- Whilst the ISP target has not been met for Daycase and Elective activity, transformational initiatives are currently place and/or in progress to ensure that by year 2 (22/23) the cumulative requirements will be achieved. The full year impact of existing schemes will also be reflected in 22/23.

**** To note: Any reductions in Outpatient and Elective/DC activity may be offset by additional activity undertaken as part of the Elective recovery, and therefore any Acute based monitoring or reporting must be undertaken with caution.**

TRANSFORMATION BOARD KEY MILESTONES

- To support the development and delivery of Transformational initiatives, each Transformation Board has developed a set of key milestones which are monitored on a monthly basis to ensure that any slippages are highlighted and appropriate mitigations are put in place. An example of a ‘milestone tracker’.

Project	Milestone	Completion Date	Status
High Intensity User Forum/Open Dialogue Service at Home (ODISH)	Secure ODISH service as part of High Intensity User Forum as a permanent service	Apr-21	
SDEC (Same Day Emergency Care)	Launch SDEC (Same Day Emergency Care) unit	Jul-21	
HALO (Hospital Ambulance Liaison Officer) pilot	Take HALO pilot business case through governance process, starting with assurance on 19th Aug-21 and finishing with ICEG on 21st Oct-21	Oct-21	
HALO (Hospital Ambulance Liaison Officer) pilot	Launch HALO Pilot	Oct-21	
SDEC (Same Day Emergency Care)	Provide 111 with ability to book into SDEC unit	Oct-21	
HALO (Hospital Ambulance Liaison Officer) pilot	Recruit all paramedics for HALO posts	Nov-21	
Duty Doctor	Take Duty Doctor Scheme through governance process, starting with assurance on 2nd Sep-21 and finishing with Finance Committee on 25th Nov-21	Nov-21	
Duty Doctor	Launch Duty Doctor Scheme Pilot	Nov-21	
Intensive Rehab Service	Launch Intensive Rehab Service Scheme	Nov-21	
Increased PELC capacity	Secure additional PELC capacity	Nov-21	
Therapy Assessment in RAFTing	Pilot therapy assessment in RAFTing	Nov-21	
Additional Queens Hospital Beds	Procure additional 30 beds at Queens	Nov-21	
Increased Community Rehab Beds	Secure additional community rehab beds	Dec-21	
End Of Life Care Home Beds Pilot	Launch End Of Life Care Home Beds Pilot	Dec-21	
Weekend Discharge to Nursing Home Pilot	Pilot weekend discharges to nursing homes	Dec-21	

Key	
Achieved/On Track	
Slippage, but can be mitigated	
Achievement at risk	
Not Started	

Developing a proposal for ongoing collaboration

Introduction

The ICS Design Framework Guidance (June 2021), and draft Health and Social Care Bill (first published July 2021) set out in more detail how NHSE/I expect NHS organisations to respond in the next phase of this system development.

Subject to the passage of legislation, the statutory ICS arrangements will comprise:

- **an ICS Partnership**, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- **an ICS NHS body**, bringing the NHS together locally to improve population health and care

Whilst this element of Integrated Care Systems is clear, what the internal governance will look like, what functions will sit at each level of the system, and the form that delegation will take is currently open for Integrated Care Systems to design, creating a system that works best for their local populations. The key principle that will shape how this is designed is that of **subsidiarity**, with key decisions being taken as close as possible to the communities that they will impact. This places a very strong emphasis on the Place Based Partnerships.

In BHR our Place Based Partnerships are in the process of being established, and there is recognition that the form and functions that they take on, initially in shadow form from December 2021, and officially from April 2022, will evolve over time as they become more established.

There is an ask from Place Based Partnerships to the NEL ICS that a framework is developed, making clear what elements and functions will need to be uniform across the seven NEL Place Based Partnerships, and what will be open to local decision.

BHR Partners have undertaken a process to consider and articulate the key areas that we believe we should continue to collaborate on at a BHR level. A second series of discussions will be held following this to scope what we believe should be held at a Place Based Partnership level. It is intended that this will feed into and shape the NEL framework described above.

This process has involved a series of interviews with partner organisations as set out on the following page, alongside discussion with Place Based Partnerships as a group, seeking views on key areas of ongoing collaboration for BHR partners.

This paper summarises the initial outputs from these ongoing discussions, which will be developed into a proposal to be reviewed by Place Based Partnership Boards (BPBs), ICEG and ICPB members in November, noting that any proposal would need to fit within the emerging NEL ICS framework. Once endorsed, the proposal will be shared with NEL colleagues to feed into and shape the framework that is being developed for the NEL Integrated Care System.

Initial emerging themes from the discussions

Key themes from the discussions that have taken place to date are summarised in the following slides. A full record of the discussions with each partner has been recorded separately and can be shared with partners.

- One of the strongest themes to emerge from all of the partnership discussion to date is that BHR in particular has a strong and successful history of partnership working, with innovative and important partnership programmes that partners are keen to continue to collaborate on, such as the BHR Transformation Boards, the associated Integrated Sustainability Plan (ISP) and the BHR Health and Care Academy. There is a strong belief that there is real value in continuing to collaborate at a BHR and wider multi place based level.
- Recognition that BHR level collaboration seems to lend itself well to delivering innovation and transformation in a timely manner. Discussion noted that there will be benefit and economies of scale for working on a wider (e.g. NEL) footprint around some areas, however, need to ensure that this does not mean that innovation is delayed by working at this level / being across too large a footprint.
- The emerging preferred form of delegation from the NHS Board to Place Based Partnerships is a “committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources”, although this may evolve and change over time as the place Based Partnerships and local arrangements become more mature.
- Keen to allow Place Based Partnerships to develop over time and organically, with recognition that we may initially undertake more at a multi borough level from April 2022, with more then moving to the Place Based Partnerships over time as they become more established. Multi-borough working must not undermine development of the Place Based Partnership Boards (PBPBs) as place is still the main focus.
- Mental Health will sit at a NEL level from April 2022 in terms of the Transformation Board, linking with the Provider Collaborative approach. BHR plans relating to local service changes and the BHR Integrated Sustainability Plan will need to be taken into account.
- Recognition that unpicking some budgets and services to be delivered at a place based level may be tricky initially due to historical commissioning of services on a wider footprint within block contracts, however, there is ambition to deliver more at a place based level over time, and agreement that just because it may be difficult to unpick some services to be delivered more locally/innovatively, this shouldn’t be a blocker to attempting to do this.
- Resource will be absolutely key to delivering at each level of the system, and it is imperative that resource is distributed equitably based on the work that will sit at each level of the system, for example, partners need to consider and put into place the resource that is required at a Place Based Partnership level to ensure that these can progress.
- Whatever governance is established to frame each level of the system needs to be agile and flexible to ensure that we don’t get bogged down in bureaucracy.

Initial proposed areas for continued multi borough collaboration from the discussions

Place Based Partnership

- Service delivery and transformation
- Tailoring services to specific local population needs; population health improvement where certain communities have poorer outcomes
- Integrated Care at a place based level
- New models of care – i.e. community hubs
- Primary Care – Local Incentive Schemes, to be at a Borough level where possible
- Primary Care Transformation / development
- Building closer working relationships with Community and voluntary services
- Closer/more integrated working with local pharmacies / optometry / dentists
- Addressing the wider determinants of health at a local level
- Joining up work around the wider determinants of health with health and care interventions e.g. Redbridge overcrowding
- Addressing variation in quality
- Engagement /relationship building with local people so that they can shape local health and care service development

Multi Borough Collaboration

BHR:

- Translation of strategy into delivery, linked to transformation programmes
- Integrated Sustainability Plan
- BHR Transformation Boards
- BHR Health and Care Academy
- Collaboration around key provider footprints, i.e. BHR for BHRUT based pathways
- Lobbying for equity of investment for BHR
- Collaboration around key population health needs, such as obesity
- Partnership response to key challenges, e.g. winter pressures
- Better/ more collaborative use of all estates
- Joint commissioning of some services to achieve economies of scale, e.g. Sexual Health services
- Workforce training programmes
- Promote BHR as a good place to live/work
- BHR JSNA / PNA
- Anchor Organisations work locally
- Supporting provider market/ CVS

Wider Borough Collaboration:

- Mental Health
- Community services
- Acute where there are key population crossovers i.e. Newham for B&D and Whipps Cross for Redbridge

North East London Level

- Strategy setting and translation of national policy and targets
- Oversight and assurance
- Economies of scale for more specialised service commissioning
- NEL wide digital programme
- Sharing of learning and best practice
- Greater commissioning of joint services where there is benefit of doing so, for example, Sexual Health services have worked well at a BHR level. NHS 111 services at a 7 borough level etc.
- Lobbying for equity of investment for NEL
- Estates planning / strategy
- Contract Management
- Commissioning and contracting of primary care services
- Data management / sharing and BI that can be drawn down by BHR / Boroughs
- Oversight of whole population JSNAs to understand key population health challenges
- NEL wide financial strategy (taking into account the BHR ISP)