	ITEM: 5
Health and Wellbeing Board	
Defining the roles, responsibilities and governance of a Thurrock Integrated Care Partnership in the context of the Mid and South Essex Sustainability and Transformation Partnership and local transformation.	
Wards and communities affected: All wards	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health Ian Stidson, Director of Commissioning, NHS Thurrock CCG	
Report Author: Ian Wake, Director of Public Health	

1. RECOMMENDATIONS

- That the Health and Wellbeing Board consider and comment on the report and the themes that it addresses, particularly in terms of the proposals set out in section 5 relating to commissioning and delivery functions at Sustainability and Transformation Partnership, Place and Locality level.

- That the Health and Wellbeing Board agree transformation roles and responsibilities at Sustainability and Transformation Partnership, Place and Locality level and that these form the basis of a Memorandum Of Understanding between the Board and Mid and South Essex Sustainability and Transformation Partnership.

- That Health and Wellbeing Board consider and comment on the proposed new governance arrangements at Thurrock and Locality

level and agree a revised structure that is fit for purpose for the stage of our transformation journey.

2. Introduction

2.1. This paper sets out proposed roles, responsibilities and governance arrangements of the Mid and South Essex Sustainability and Transformation Partnership (STP) in the context of local plans on transformation and health and wellbeing already being delivered in Thurrock through the Joint Thurrock Health and Wellbeing Board.

2.2. Thurrock's Joint Health and Wellbeing Board is a formal committee of Thurrock Council, formed following the NHS and Public Health reforms set out in the Health and Social Care Act (2012). Chaired by the Cabinet Portfolio Holder for Education and Health, it brings together Chief Officer/Director/Executive leads from all key stakeholders organisations involved in delivering health and wellbeing including Thurrock Council. NHS Thurrock Clinical Commissioning Group, Basildon and Thurrock University Hospital, North East London NHS Foundation Trust, Essex NHS Partnership Trust, Thurrock Council for Voluntary Services and Thurrock Healthwatch.

2.3. The Thurrock Joint Health and Wellbeing Board is responsible for ensuring delivery of the Thurrock Joint Health and Wellbeing Strategy 2016-2021, with its 20 Objectives centred around five goals: Opportunity for All; Healthier Environments, Better Emotional Health and Wellbeing; Quality Care Centred Around the Person, and; Healthier for Longer. The Board is also ultimately accountable for overseeing a major programme of both transformation and integration of Health and Care services in Thurrock including the *Better Care Together Thurrock*, *Brighter Futures,* Adult and Children's Mental Health transformation and the construction of four Integrated Medical Centres. Thurrock Health and Wellbeing Board has benefited from geographically co-terminous partnership arrangements with a single unitary authority responsible for all local government services, a single Clinical

Commissioning Group responsible for commissioning of most NHS services, a coterminous Healthwatch and Council for Voluntary Services.

2.4. Sustainability and Transformation Partnerships (STPs) were announced in the NHS Planning Guidance published in December 2015. Their aim was to bring NHS organisations and local authorities in different parts of England together to develop plans for the future of health and care services over a centrally defined geographical footprint, usually based on the geographical location of hospitals. 44 geographical areas were defined by NHS England with an average population size of 1.2 million people. Thurrock falls within the geographical footprint covered by the Mid and South Essex Sustainability and Transformation Partnership.

2.5. Partnership arrangements within the Mid and South Essex Sustainability and Transformation Partnership are complex. The geographical footprint encompasses two unitary authorities responsible for all local authority services including public health, adult social care and education (Thurrock and Southend), part of the geography covered by one top tier (Essex County Council) responsible for public health, adult social care and education and seven second tier district and borough councils. It also includes five CCGs, three hospitals, three different Healthwatch organisations, two major NHS community providers, one secondary mental healthcare provider and a number of mental health community providers.

2.6. The NHS Long Term Plan published in January 2019 set out proposals to create “Integrated Care Systems” (ICSs) to become the principal planning mechanism through which NHS commissioners and providers and local authorities will make shared decisions about financial planning and prioritisation. The plan stated that beyond 2019/20 Government will introduce further financial reforms that will support ICSs to deliver integrated care. Through a process of earned financial autonomy NHS England will give local health systems greater control over resources on the

basis of a track record of strong financial and performance delivery, assessed in part through the new Integrated Care Systems accountability and performance framework.

2.7. Whilst the NHS Long Term Plan stopped short of defining the geographical footprint on which Integrated Care Systems will operate, it has been clear that NHS England intends to use Sustainability and Transformation Partnership Footprints to deliver the Integrated Care Systems proposals. The plan requires the NHS to deliver £290 million of savings from commissioning and Clinical Commissioning Group running cost budgets have been reduced by 20%. In Mid and South Essex, NHS England have directed Clinical Commissioning Groups to form a single 'Joint Committee' at Sustainability and Transformation Partnership level to lead hospital and mental health commissioning, and are in the process of appointing a single Accountable Officer to oversee the work of the five existing Clinical Commissioning Groups.

2.8. The NHS Long Term Plan also proposed the creation of Primary and Community Care Networks (PCNs) in recognition of the increasing numbers of the population living with multiple comorbities and the need to integrated Primary Care, Community Healthcare and community mental health provision. The plan proposes that general practices will join together to form primary care networks – groups of neighbouring practices typically covering 30–50,000 people. Practices will enter network contracts, alongside their existing contracts, which will include a single fund through which network resources will flow. Primary care networks will be expected to take a proactive approach to managing population health and from 2020/21, will assess the needs of their local population to identify people who would benefit from targeted, proactive support.

2.9. Alongside primary care networks, the plan commits to developing 'fully integrated community-based health care', ending the current fragmentation of primary and community health care. This will involve developing multidisciplinary teams, including GPs,

pharmacists, district nurses, community psychiatric nurses, reablement teams, community geriatricians, adult social care staff, allied health professionals and staff from the third sector working across primary care and hospital sites

2.10. Whilst there is much to be welcomed in the NHS Long Term Plan in terms of additional resources for the NHS, a focus on prevention and early intervention, and the creation of a more integrated primary care, community and mental health offer at locality level through Primary and Community Care Networks, proposals to move NHS commissioning and system leadership responsibilities from the Thurrock footprint to an Integrated Care Systems that covers Mid and South Essex is potentially problematic, moving decisions about transformation in Thurrock from a local system with a high degree co-terminosity and trust between partners, to a system with highly complex partnership arrangements set over a geographical footprint that makes little sense to our residents. The reduction and centralisation of NHS system leadership capacity over a wider geographical footprint also risks disengagement of key NHS system leaders in local transformation plans. However, this paper also recognised that there are some system-wide activity that it makes sense to undertake once over a wider geographical footprint. As such, there is an urgent need to define and agree across the Sustainability and Transformation Partnership and among all partners what activity, roles and responsibilities sit best at Sustainability and Transformation Partnership versus Health and Wellbeing Board and Primary and Community Care Networks/locality level. As such, it seeks to set out some principles to start a discussion about what best sits where.

3. Background – Thurrock's Transformation Journey to date

3.1. This section provides a brief history of Thurrock's Health and Care Transformation journey to date including all major achievements.

3.2. **Building Positive Futures:** Launched in 2012, Building Positive Futures (BPF) developed its programme of work under three clear building blocks:

- **Stronger Communities** comprising of a range of different initiatives including Asset Based Community Development, Local Area Coordination, Time Banking, Community Hubs, Small Sparks, Micro Enterprises and Shared Lives
- **The Built Environment:** including the establishment of a Housing Planning and Advisory Group as a forum through which Adult Social Care could influence planning decisions to capitalise on opportunities to deliver wellbeing through the built environment, and adoption of Housing Our Aging Population Panel (HAPPI Housing) principles.
- **The Integration of Health and Social Care** including appointment of an Integrated Care Director between the Council and NELFT; creation of a *Thurrock First* – a single point of telephone access and multi-agency team to accept adult social care and mental and community health referrals; creation of a Rapid Response and Assessment (RRAS) team to provide immediate care to residents and support to their carers to prevent avoidable hospital and residential care admissions; and the creation of a Better Care Fund that pooled CCG and Council Budgets around a shared vision for integrated community health and adult social care.

3.3. **Integrated Medical Centres:** In 2015 the Care Quality Commission highlighted a major crisis in Primary Care, rating 80% of our GP surgeries as 'Requiring Improvement' or 'Inadequate'. Thurrock was highlighted as the fourth most under-doctored area in England with ratios of Full Time Equivalent GPs: Patients reaching 1:13,000 in some surgeries. After undertaking locality needs assessments, Public Health recommended the creation of four Integrated Healthy Living Centres (since renamed Integrated Medical Centres) as one solution to both improve primary care capacity and create attractive working environments that would attract new GPs to the Borough. The recommended blue print for

each Integrated Medical Centres encompassed a wide range of health, wellbeing and care services in a single building with integrated teams including a new and expanded Primary Care Offer, diagnostic facilities, secondary care outpatient clinics for the most common specialties, health improvement and lifestyle modification programmes, community and mental health treatment and services that addressed the wider determinants of health including community and voluntary groups, libraries and community hubs, housing advice and Local Area Coordination. Work is currently underway to deliver this programme with the first Integrated Medical Centre in Tilbury due to open in 2022.

3.4. **The Case for Change: A New Model of Integrated Care:** In 2016, Thurrock's Director of Public Health published an Annual Public Health Report that focused on actions to make the adult health and care system sustainable in financial and operational terms. As a result of this report, and in conjunction with Adult Social Care, health and third sector partners, the Director for Public Health developed and published 'The Case for Change: a New Model of Care'. Initially piloted in Tilbury and Chadwell, the New Model of Care has three major work streams addressing Primary Care Capacity and Capability including a new mixed skill clinical workforce, a comprehensive programme of Long Term Condition case finding and improvement in clinical management, and a new model of Integrated Community Health and Domiciliary Care through creation of self-directed 'Wellbeing Teams/Worker'.

3.5. **Better Care Together Thurrock**: **Implementing the New Model of Integrated Care.** Better Care Together Thurrock (BCTT) was formed of senior-level partners from Adult Social Care, the Voluntary and Community Sector, Community Health, Mental Health, the Acute Trust, the CCG, and Primary Care to manage implantation of *The Case for Change*. A key first step was for partners to agree on a vision for the future. The Vision was agreed at a Theory of Change workshop hosted by Thurrock Community and Voluntary Sector and Thurrock Coalition with all key health and local authority stakeholders.

3.6. Better Care Together Thurrock also saw the establishment of a governance structure to manage the implementation of the New Model of Care including a Steering Group and sub groups responsible for delivery of the three work streams. The mixed skill primary care clinical workforce and two wellbeing teams for Tilbury and Chadwell went live in 2019. A Population Health Management Programme consisting of 13 separate programmes relating to primary prevention, long term conditions case finding and improving the management of different long term conditions is also live and early evaluation is already demonstrating a positive impact on demand reduction in secondary care.

3.7. **Community Led Support (CLS):** Community Led Support is a new strengths based model of social work practice embedded into the community. The first team has been based within the Tilbury and Chadwell Community hub and undertake outreach in other community settings. It aims to trust professional staff to work using the same 'strength based' approach used by Local Area Coordinators, starting with 'what's strong?' rather than 'what's wrong?' and moving away from the traditional assessment of needs approach.

3.8. **Thurrock Integrated Care Alliance: integrating commissioning and the move towards a single system wide contract**. The Thurrock Integrated Care Alliance was established in 2018 to provide strategic direction to the local health and care system including the third sector, set shared objectives and outcomes for the system and lead the integration of commissioning. Following discussion at Thurrock Integrated Care Alliance, commissioners have awarded longer term contracts with providers. All stakeholders represented at Thurrock Integrated Care Alliance have developed and signed a Memorandum of Understanding that describes a framework within which partners will work to build a Population Health System which aims to reduce the number of unplanned hospital and residential care admissions; reduce avoidable A&E attendances; reduce the number of delayed

transfers of care; keep people as independent as possible for as long as possible, and; move more services out of hospital and into the community. The next stage of the work programme is to agree a single Integrated Alliance Contract across all providers with high level health outcome priorities and mechanisms for financial risk and reward sharing.

3.9. **Adult Mental Health Service Transformation:** A 2018 JSNA Product on Adult Mental Health Services together with an LGA Peer Review highlighted a series of issues with the way adult mental health services were commissioned and delivered in Thurrock including long waiting times, fragmentation of both commissioning and delivery, and services that had a narrow clinical focus and failed to adequately address wider determinants of health and physical health needs of clients. Further research by Thurrock Healthwatch highlighted significant levels of dissatisfaction amongst service users. To address these concerns a new programme of Mental Health Transformation including proposals to create new models of more holistic and integrated care for Common Mental Health Disorders and Serious Mental Ill Health and a new commissioning outcomes framework. A multi-agency team from EPUT and MIND are currently being trained in the *Open Dialogue* family therapy solutions based approach to managing residents in mental health crisis, and it is envisaged that this will form the basis of a new model of crisis care from 2020/21. A Thurrock Mental Health Transformation Board has been established to manage the programme.

3.10. **The Brighter Futures Programme** integrated services for children and young people (aged 0-19) historically commissioned and delivered separately by the council's Children's Services Directorate, Public Health and Thurrock Clinical Commissioning Group. It comprises of three key work programmes;

- *Children's Centres* that focus on improving outcomes in child development and school readiness, parenting and health and wellbeing;

- *Healthy Families* including the Health Visiting Programme that gives advice and guidance to all new parents, and the School Nursing programme that works to keep children healthy in schools; and
- *The Prevention and Support Service* which provides targeted help to families that have specific needs encompassing issues such as parenting support, domestic abuse, and sexual violence and to Troubled Families with programmes focussing on access to education, worklessness, and parental physical and mental health.

Emerging Learning and Features of 'Vanguard' ICS sites

3.11. The Kings Fund in their report 'A year of integrated care systems' undertook a qualitative evaluation of 'vanguard' Integrated Care Systems sites in England. The purpose of their study was to understand how the early adopter Integrated Care Systems are being developed and identify lessons learned. Eight of the 10 early adopter sites were studied: Bedford, Luton and Milton Keynes; Berkshire West; Buckinghamshire; Dorset; Frimley; Lancashire and South Cumbria; Nottingham and Nottinghamshire and South Yorkshire and Bassetlaw. Two Integrated Care Systems sites (Surrey Heartlands and Greater Manchester) were excluded because of the distinctive characteristics in place in these areas under their devolution deals.

3.12. There is no 'blueprint' for developing an Integrated Care Systems; the changes being proposed by central government create significant latitude for local systems to shape their own understanding of what an Integrated Care Systems could and should look like.

3.13. Across the study, the Kings Fund identified integration activity at three different levels: Neighbourhood, Place and System. There was a broad consensus around the types of activities occurring at each level:

- **Neighbourhoods** tended to cover populations of between 30,000 and 50,000. They were typically based around GP catchment areas, with practices working together in networks or federations. This was usually the level at which multidisciplinary community teams operated, recognising that they need to respond to the characteristics and needs of local populations.

- The **place** level was where most service change and integration was taking place. The 'place' was typically defined by a local authority, clinical commissioning group or acute trust footprint, or

determined by the natural geography of a town. Local authority involvement was often strongest at this level.

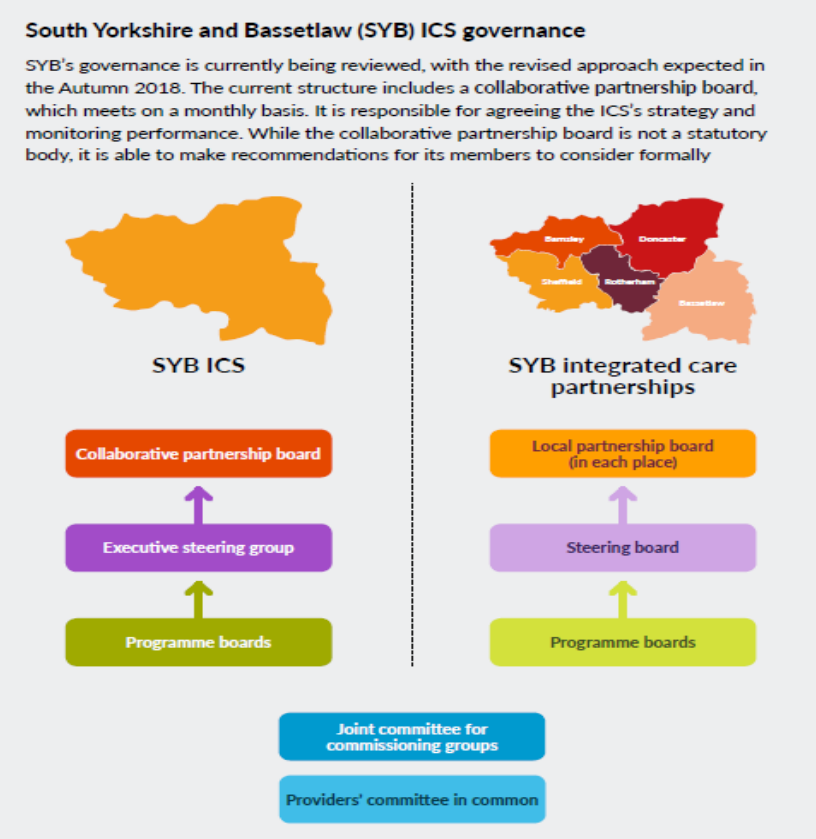
- The **system** level was seen as the basis for activities and functions that need to happen 'at scale'. This included specialised commissioning, acute service reconfigurations, workforce planning, and the development of digital and estates strategies. Its geographical footprint matched that of the entirety of the Integrated Care Systems.

3.14. The Kings Fund Research found broad consensus on the need to cultivate activity at each level to make progress on integration. **They concluded that between 70-90% of the focus of activity/integration should be at the place and neighbourhood levels with the remaining 10-30% occurring at system level.**

"Places within the ICS are more around what people see as 'place'. I think local government boundaries and CCG Boundaries are all part of that, because you can't make it real for clinicians, patients and residents unless you operate at that smaller scale" **Local Authority, Frimley ICS.**

3.15. Governance arrangements within the vanguard Integrated Care Systems sites often reflected the divisions between system, place and neighbourhood. Many ICSs have created an overall Programme Board at system level, and then 'Integrated Care Partnership' boards operating at place level to reflect and manage the majority and variation of integration activity happening at place as opposed to system level. For example, the South Yorkshire and Bassetlaw Integrated Care System has a Collaborative Partnership Board for system level activity, and then five 'Integrated Care Partnerships', each with its own Board and governance structure, covering the four unitary authority areas of Barnsley; Doncaster; Sheffield and; Rotherham, together with the second tier district of Bassetlaw (part of the geography covered by Nottinghamshire County Council).

Figure 1: Governance Arrangements between South Yorkshire and Bassetlaw ICS and its five Local Authority areas.



3.16. The impact of changes to NHS commissioning arrangements were also highlighted in the research. Some Integrated Care Systems had included mergers of constituent Clinical Commissioning Group commissioning functions with shared Accountable Officers, others had left them unchanged. The report highlighted a lack of agreement about the benefits and risks of merging Clinical Commissioning Groups but did highlight resistance in some areas around weakened links with local authorities where coterminous boundaries had previously existed. The research also highlighted the desirability of different commissioning arrangements at different parts of the system, drawing the distinction between 'strategic commissioning' of system wide priorities and 'tactical commissioning' at neighbourhood and place level. The research also concluded that the line between commissioners and providers is becoming blurred as local integrated care partnerships take on

the commissioning functions at place level and the fact that commissioners are increasingly making use of long-term outcomes-based contracts in future rather than the historical 'transactional' commissioning approach used by the NHS.

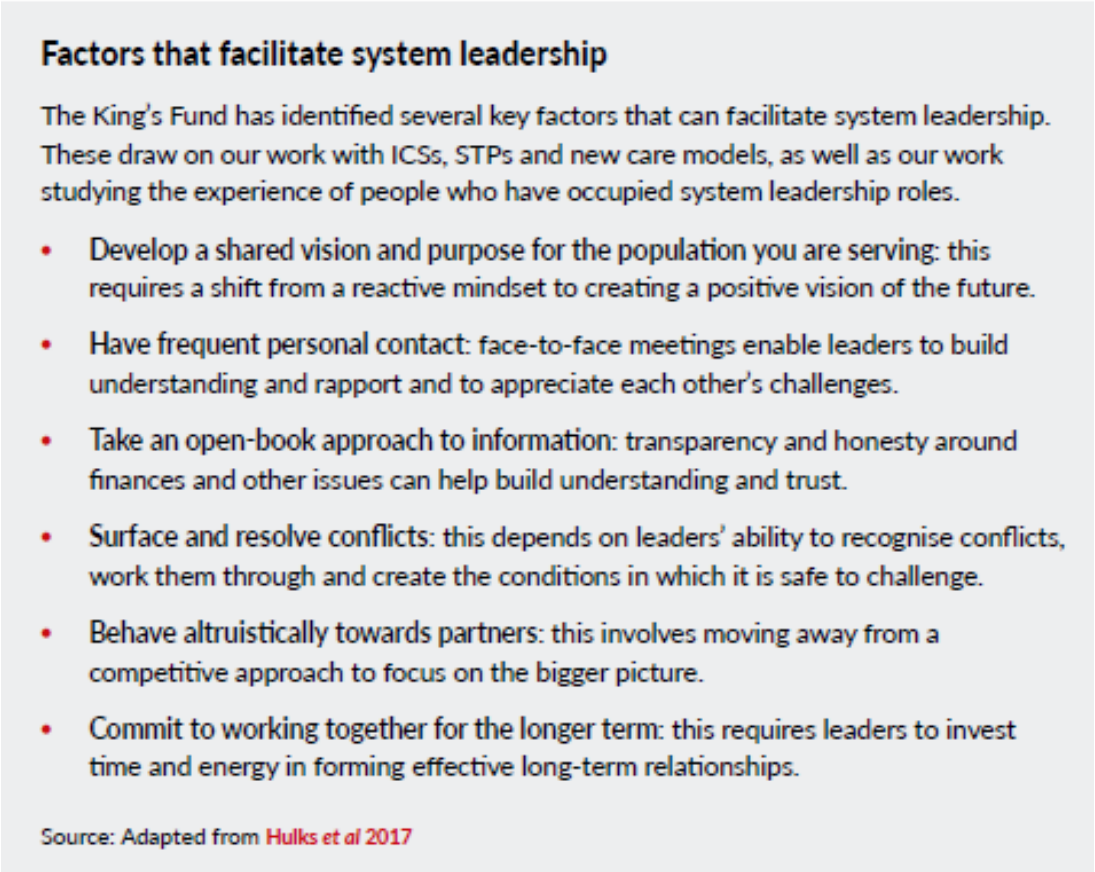
3.17. Many of the 'vanguard' Integrated Care System sites were working to improve information-sharing, particularly in terms of the ability of individual clinicians in different organisations to share information on individual patients for the purpose of improving clinical care, safety and patient experience. Several Integrated Care Systems had developed shared care records at patient level.

3.18. Some Integrated Care Systems had also developed infrastructure for data-analytics for commissioning purposes and to identify needs and determine service priorities, particularly in relation to population health management.

3.19. Prevention and population health were often described as an area where both the place and system levels needed to play a key role. Interviewees emphasised the need to focus not only on healthcare and social care, but also the wider determinants of health such as housing and employment.

3.20. Systems Leadership was identified as one of the critical factors that determined success on integration. Because there is no legislative or statutory framework for Integrated Care Systems, the level of trust and the quality of personal relationships between system leaders from different organisations was critical to the speed at which progress was made. Figure 2 (overleaf) highlights key factors identified by the Kings Fund research that facilitated systems leadership.

Figure 2: Factors that facilitate systems leadership



Factors that facilitate system leadership

The King's Fund has identified several key factors that can facilitate system leadership. These draw on our work with ICSs, STPs and new care models, as well as our work studying the experience of people who have occupied system leadership roles.

- Develop a shared vision and purpose for the population you are serving: this requires a shift from a reactive mindset to creating a positive vision of the future.
- Have frequent personal contact: face-to-face meetings enable leaders to build understanding and rapport and to appreciate each other's challenges.
- Take an open-book approach to information: transparency and honesty around finances and other issues can help build understanding and trust.
- Surface and resolve conflicts: this depends on leaders' ability to recognise conflicts, work them through and create the conditions in which it is safe to challenge.
- Behave altruistically towards partners: this involves moving away from a competitive approach to focus on the bigger picture.
- Commit to working together for the longer term: this requires leaders to invest time and energy in forming effective long-term relationships.

Source: Adapted from Hulks *et al* 2017

4. Discussion: What does this mean for Thurrock and Mid and South Essex Sustainability and Transformation Partnership /Integrated Care Systems?

4.1. The Kings Fund research clearly highlights the variation in form, function and governance arrangements between different Integrated Care Systems vanguards, and the need to develop local arrangements that are meaningful to local partners and transformation activity. There is no 'single blue-print' nor 'one size that fits all' when it comes to the development of Integrated Care Systems. It does however also conclude that most integration activity happens at 'place' and 'neighbourhood' level as opposed to system level.

4.2. As set out in section 3, Thurrock has a strong story to tell at 'place level' in terms of local transformation with a very high degree of trust and strong relationships between stakeholders, a strong

Health and Wellbeing Board integrating wider determinants of health in terms of regeneration, planning, education, employment and housing through our Joint Health and Wellbeing Strategy and associated action planning on the 20 Objectives that sit under it. The Clinical Commissioning Group has also forged a very clear locality focus with General Practice through the establishment of hubs and a stronger working relationship between practices. It is important that any new arrangements with the Sustainability and Transformation Partnership/ Integrated Care Systems preserve and augment these programmes rather than undermine them, whilst also recognising the merit of undertaking some tasks 'system wide' at scale where this makes sense.

4.3. Work on Asset Based Community Development, Better Care Together Thurrock, Primary Care Hubs and four Integrated Medical Centres is increasingly shifting focus to integration at 'neighbourhood/locality' level within the four defined localities of Purfleet and South Ockendon; Grays; Tilbury and Chadwell; and Stanford and Corringham. The mixed skill Primary Care clinical workforce is now live in Tilbury and Chadwell and partly in place in the Grays locality with plans also in place to roll out the programme to all four localities in the next two years. Community Led Solutions Team is live in Tilbury and Chadwell and is already integrating well with other locality council services including the locality housing office and Tilbury Community Hub, and with other third sector assets within the locality. Two Wellbeing Teams is now live in the Tilbury and Chadwell localities and there is an aspiration to create further wellbeing teams in the other three localities.

4.4. The commitments to develop Primary Care Networks at locality level set out in the NHS Long Term Plan create an opportunity to build on this work and develop a comprehensive primary, community and mental health service offer at locality level linked to asset based approaches and third sector capacity, building and further integrating the existing Primary Care Mixed Skill Workforce, Community Hubs, Integrated Medical Centres, Community Led

Solutions and new model of care for Common Mental Health Disorders.

4.5. There are also plans to develop single locality public health contracts encompassing healthy lifestyle services like stop smoking, self-care programmes, NHS Health Checks and weight management, together with Long Term Conditions Case Finding and clinical management improvement including hypertension and Stretched Quality Outcomes Framework. Other NHS and Adult Social Care commissioned enhanced services could in time be added to these to create 'single locality budgets' with the opportunity to devolve part of the Adult Social Care and Clinical Commissioning Group commissioning functions from Thurrock wide to locality level. The Better Care Fund could be revised to act as the financial delivery mechanism to achieve this.

4.6. Thurrock Council and the Better Care Together Thurrock programme also has an aspiration to deliver Community-Led Commissioning/Resource prioritisation. We wish to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process. This may involve communities actually commissioning directly, being involved in commissioning, or influencing through providing a list of key priorities.

4.7. Thurrock's transformation programme has also been based on the concept of 'distributed leadership' and devolution of decision making down to the front line. Our *Stronger Together* or *Better Care Together Thurrock* programmes have focussed on engaging front line professionals, the third sector and the community in designing and implementing service transformation, basing staff within the community, removing centralised bureaucratic control and empowering them to make decisions. These values are common to many of our programmes including the mixed skill Primary Care clinical workforce, Local Area Coordination, Community Led Solutions and Well-Being Teams. As such, in

deciding where decision making at each level of the system sits, this paper proposes the concept of 'subsidiarity'

4.8. Thurrock Clinical Commissioning Group is seeking to drive forward a programme of primary care transformation that will results in a much wider range of services being delivered from a primary care environment and reducing significantly the number of Thurrock residents needed to attend acute services. Primary care will also evolve within localities to share workload and expertise within each of the four netwoks.

4.9. Given the above, this paper proposes that the principle of '*subsidiarity';* the principle that the starting point for planning, transforming and delivering services should be at as local level as possible, and that any more central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level. The following is therefore proposed as a blue-print for what should be delivered at each level:

4.10. **Locality Level:** Devolution of the maximum number of programmes to create four locality based integrated health, wellbeing and care offers, moving services closer to communities, empowering front line staff to design and deliver a service offer that responds to local need, and engaging communities and the third sector in the wellbeing agenda. New models of integrated locality care would be supported by locality based integrated commissioning arrangements between the Clinical Commissioning Group and local authority with some budgets and integrated through the Better Care Fund to create single locality budgets and commissioning plans.

4.11. Future services that could be delivered at locality level include (but are not necessarily limited to):

- Locality based healthy lifestyle services including self-care/patient education, smoking cessation, sexual health (spoke services), cervical screening, weight management

- Skill Clinical Workforce and integration of community healthcare and Allied Health Professionals
- Wider range of minor operations co-ordinated across GP practices (e.g lumps and bumps, vasectomy services)
- Phlebotomy services
- Long Term Conditions case-finding programmes including hypertension, AF and depression screening.
- Support for Carers
- End of Life care
- Delivery of dental care and improved oral health programmes
- Delivery of MSK services
- Wound Care
- Single, integrated ‘one stop shop’ clinics for the management of diabetes, cardio-vascular disease and respiratory long-term conditions with input from secondary care consultants.
- New model of care for Common Mental Health Disorders and some mental health services for patients with SMI including IAPT, Dementia and Psychiatric Nursing
- Primary community care integration and delivery including development of PCNs, the new Primary Care Mixed Skill Workforce, District Nursing, other Allied Health Professionals and Social Workers as set out in the NHS Long Term Plan.
- Individual IMC clinical models including diagnostics (e.g. 24 hour blood pressure monitoring) and some secondary care outpatient clinic provision
- Consultant led integrated primary/secondary care specialist clinical provision (gerontology, community paediatrics, diabetes, neurology/epilepsy, community cardiology have been suggested by local GPs)
- Proactive clinical outreach to residential care homes
- Community Led Solutions Teams
- Social Prescribing
- Wellbeing Teams (delivery at neighbourhood level)
- Asset Based Community Development approaches (delivery at neighbourhood level) including community assets and community resilience building

- Local Area Coordination
- Locality Housing and employment support
- The Schools Wellbeing Service (defining a school as a community)
- Children's Centres – a wide range of services and support for families with young children.
- The Edge of Care Service (supporting families on the verge of having children taken into care).

Commissioning arrangements at locality level could encompass:

- Locality Based contracts for long term conditions case-finding and clinical management including hypertension case finding depression screening,
- Public Health services currently delivered contracted through individual GP practices healthy lifestyles services including smoking cessation, NHS Healthchecks, sexual health spoke services, cervical screening, weight management
- Current Local Enhanced services with GP surgeries
- Delivery of Local Dental Contracts devolved from NHSE
- Primary and Community Care Networks contracts
- Voluntary Sector contracts were provision is locality focussed
- The provision of some community services delivered through NELFT contract
- The provision of some mental health services delivered through EPUT contract
- The provision of some services delivered by the the hospital that can be delivered in the community through the contract with Basildon hospital
- Some market development for example Micro-enterprises and grass-roots organisations.

4.12. **Place/Alliance (Thurrock Health and Wellbeing Board) level:** Activity that links to key strategic functions of Thurrock Council/Clinical Commissioning Group, where there is a need for borough wide oversight or where there is insufficient universal

demand to plan at locality level. This would include but may not be limited to:

- Strategic management/oversight of:
    - Thurrock Joint Health and Wellbeing Strategy and Outcomes Framework
    - Integrated Medical Centre programme for Thurrock
    - Better Care Together Thurrock
    - Population Health Management Programme
    - Brighter Futures Programme
    - School Based Mental Health Wellbeing Teams Programme
    - Mental Health Transformation Programme
    - Better Care Fund
    - Section 75 Agreement between EPUT and Thurrock Council
    - Community development/empowerment – Stronger Together
    - Market development/delivery

- Thurrock Integrated Care Alliance and shared outcomes focused health and care Alliance Contract
- Thurrock First
- Thurrock Rapid Response and Assessment Service
- Planning and Regeneration Strategic Programmes that impact positively on wellbeing and wider-determinants of health including Older People's Housing Strategy, Housing Planning and Advice Group, Health Impact Assessment
- Commissioning of borough wide specialist Public Health Services including Drug and Alcohol Treatment, Sexual and Reproductive Health (hub), NHS Health Checks, (strategic oversight and social marketing research implementation), Thurrock Healthy Lifestyle Solutions (hub), Brighter Futures Healthy Families (School Nursing and Health Visitors)
- New Model of Care for Serious Mental Ill Health Disorders and proposed new Open Dialogue approach
- Thurrock Joint Strategic Needs Assessment Programme
- Adult Social Care Commissioning where provision is borough wide

- Discharge Planning from secondary to adult social care including Delayed Transfers Of Care
- Whole Systems Obesity Strategic Planning
- Planned care activity Continuing Care
- Minor Injuries
- Primary Care Strategy

4.13. **South West Partnership**

There will also remain a need to commission services across a South West footprint as health commissioners share specific pathways and providers. Examples of existing work are:

- Respiratory pathways (specialist care)
- Diabetes pathways (specialist care)
- Gynaecological, Urology and Neurological care

4.14. **Sustainability and Transformation Partnership (ICS Level):** System level activity that is best done once at scale. The following activities as best delivered at Integrated Care System/ Sustainability and Transformation Partnership level:

- **Planning for the future**: Developing system wide plans for improving health and wellbeing
- **Aligning commissioning**: Rather than taking on all current commissioning functions, the Integrated Care Systems should focus on the 'strategic aspects' where it is sensible to do once at scale, or where the function has already been aligned to the Clinical Commissioning Group Joint Committee: These include:
    - Secondary healthcare where it involves more than one hospital site
    - Specialist NHS commissioning
    - Mental Health secondary care commissioning functions including the new crisis care pathway
    - Specialist Learning Disability and other specialist support
- **Integrating regulation**: Over time, it is expected that some regulatory functions that currently sit within NHS England and NHS

Improvement regional teams will be brought within Integrated Care Systems.

- **Maternity Services**: The local maternity system is a mechanism through which Sustainability and Transformation Partnerships can transform maternity services collaboratively with a focus on delivering high quality, safe and sustainable maternity services with improved outcomes for women and their families. They have been established across England to develop and implement a local vision for transforming maternity services by 2020/21.
- **Performance Management**: Responsibility for overseeing performance across the system including setting local standards and monitoring towards achieving shared goals
- **Owning and resolving system challenges**: Complex system wide pathways, for example the poor local performance on cancer 62 day or A&E waits are best addressed at system level
- **Workforce Health and Planning** including plans to support staff retention, wellbeing, capacity and skills gap mapping and action to address this
- **Data Integration:** Activity to develop a single shared care record between health and care providers is best developed once at system level
- **Health Intelligence:** There is merit in looking to create a single Public Health intelligence function that can analyse system wide data-sets once, develop system wide predictive models, highlight variation in healthcare outcome etc.
- **System Wide Population Health Management and Prevention Activity:** There is merit in undertaking some prevention activity once at system level, particularly where it involves system wide providers e.g. MSB/EPUT. Examples could include embedding prevention activity such as the 'Ottowa' Stop Smoking model within hospitals, Atrial Fibrillation Screening of medical admissions, Hospital Based Alcohol Nurse Liaison Services

It must be recognised that there will be movement between Localities, Place , South West commissioned services and Sustainability and Transformation Partnership commissioned

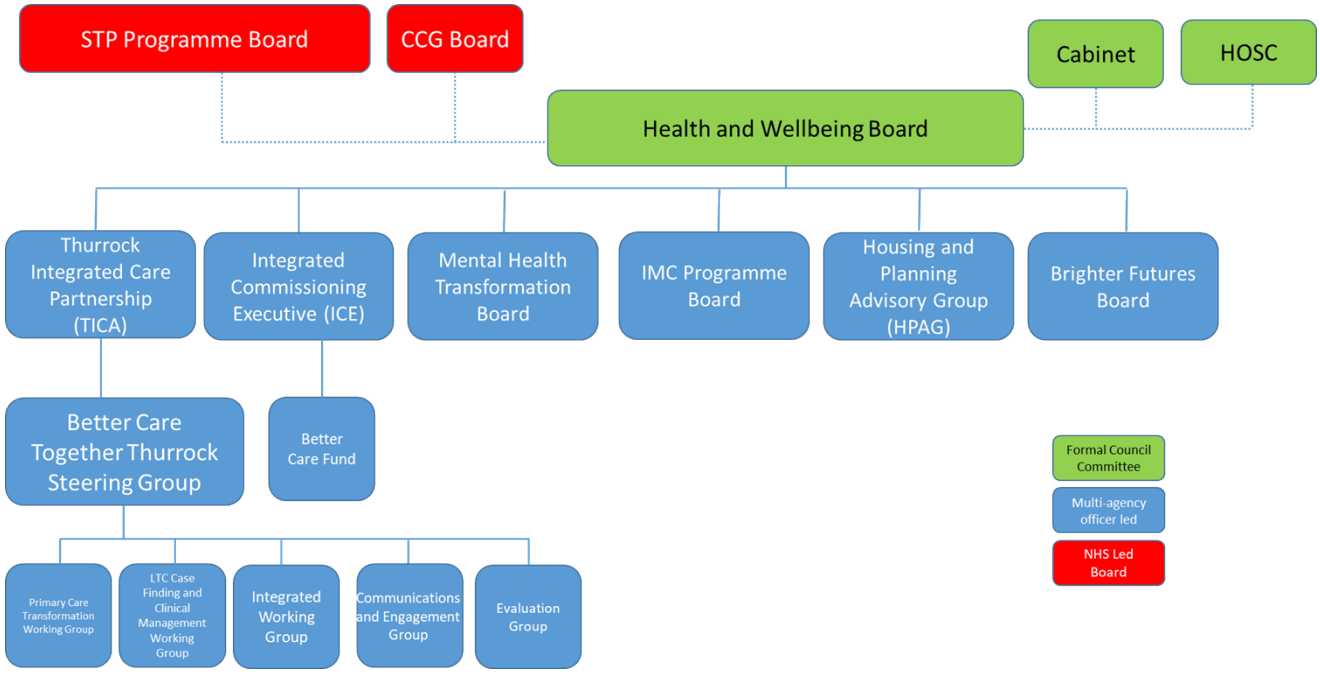
services as our system matures and drives a stronger `place based' service

4.15. Services for Children and Young People (aged 0-19) and their parents described in 3.12 through the Brighter Futures Programme are currently delivered through the Brighter Futures Programme Board. The model also operates partly on a locality level but with three rather than four localities which are not co-terminous with those used for adult health and wellbeing. There may be opportunities over time for integration of these with locality and neighbourhood services described in 5.10, although further discussion with key stakeholders is required.

4.16. Governance arrangements for the health and care transformation programme at Thurrock level have developed over time. There is recognition across all stakeholders that these need review to ensure they remain fit for purpose. This is perhaps particularly important given an increasing focus on integration at locality as well as place level.

4.17. Figure 3 shows at high level, the working groups, programme boards and committees responsible for our health and care transformation programmes.

Figure 3: Current Governance Arrangements – Thurrock Health and Care Transformation



4.18. There are a number of issues with the current arrangements. The Integrated Commissioning Executive and Better Care Fund management sit in parallel silos to the Integrated Commissioning Care Partnership (TICA) and Better Care Together Steering Group. Moving forward, the Better Care Fund needs to act as the strategic financial delivery mechanism for integrated commissioning and locality budgets, and current arrangements do not adequately support this. Integrated Commissioning Executive generally concentrates on the operational management and performance of the Better Care Fund and doesn't adequately link finance to the strategic direction set through (for example any future Alliance Contract).

4.19. Similarly Mental Health Transformation and the IMC Programme, whilst discussed at Thurrock Integrated Care Partnership, also sit in parallel silos despite being key dependencies of successful integrated care.

4.20. There is arguably some duplication between what is discussed at Thurrock Integrated Care Partnership and the Better Care Together Steering Group; both boards receive updates from the three working groups that sit under the Better Care Together Steering Group

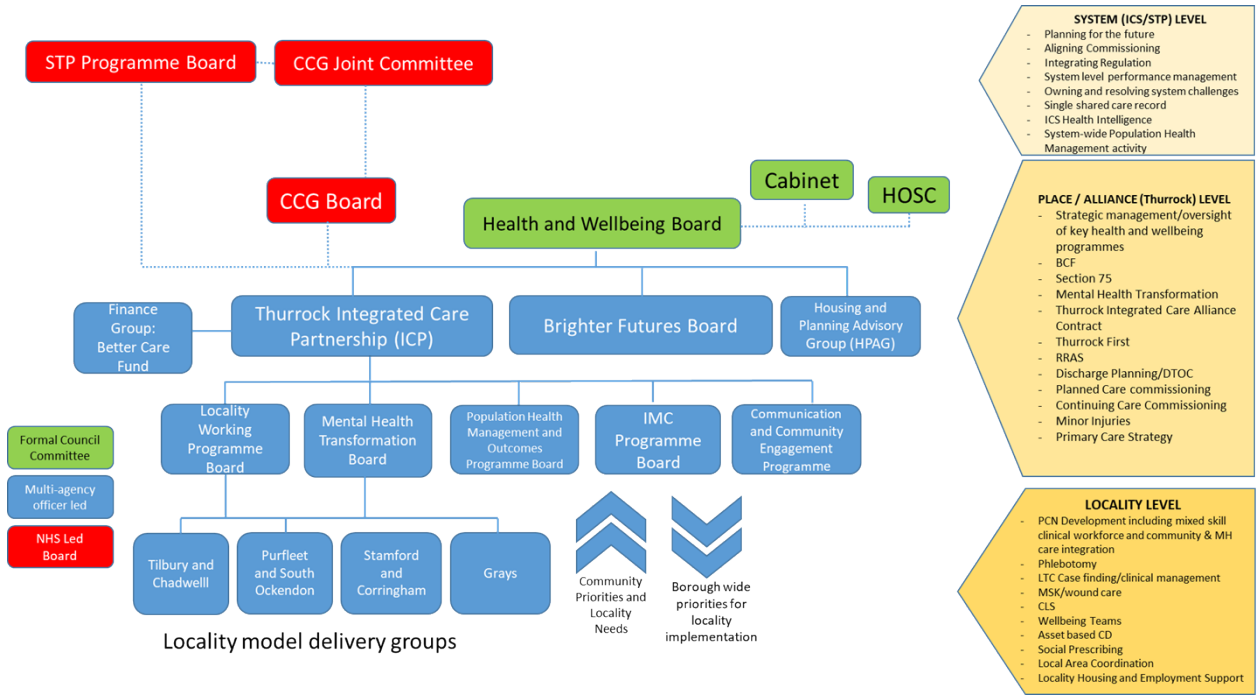
4.21. Multiple strategic groups report into the Health and Wellbeing Board, however the relevant infrequency of the meetings and the fact that as a formal council committee and public meeting limit the scope for open and honest conversations about system transformation issues. The Health and Wellbeing Board also has a much broader agenda encompassing wider determinants of health, children and young people's health and the place based health and wellbeing agenda.

4.22. Evaluation and Communications and Community Engagement sit low down in the structure and are concerned with the narrower focus of Better Care Together as opposed to the wider strategic transformation programme. Neither have met for some time and there is a need to strengthen and integrate their functions such that they are embedded into the entire programme.

4.23. It could also be argued that there is insufficient focus within the governance structure on integration at locality level, and where focus occurs it is split between different working groups. The Primary Care Transformation Working Group has been responsible for overseeing implementation of the Mixed Skill Clinical Workforce at locality level. Conversely the Integrated Care Working group has been responsible for overseeing the implementation of Wellbeing Teams and Community Led Solutions. As such development of a new health and care offer at locality level is split between two groups and we have not potentially maximised opportunities for creating a single integrated offer. There is some evidence of the impact of this, with the new Community Led Solutions Team reporting that they feel strongly integrated with the locality housing office and Tilbury Community hub and third sector assets, but insufficiently linked in the new mixed skill clinical workforce attached to the network of GP surgeries. The Mental Health Transformation Strategy also contains actions to develop an integrated Common Mental Health Disorder offer at locality level, but governance arrangements for this sit in parallel to both Primary Care Transformation and Integrated Working work streams.

4.24. To address the above issues, this paper proposes reforming governance at Thurrock level in line with the structure set on in Figure 4 and invites comment from stakeholders.

Figure 4: Proposed Revised Governance Structure at Thurrock Level



4.25. The strategic commissioning functions of the Integrated Commissioning Executive (ICE), The Better Care Together Thurrock Steering Group and Thurrock Integrated Care Alliance are combined into a single Thurrock Integrated Care Partnership Board (ICP) that would have over-all strategic oversight of the health and care transformation agenda. Whilst the work programme of this board would be considerable, this reform has the advantages of both integrating the Better Care Fund under the strategic commissioning agenda and development of an Alliance Contract, and the Better Care Together Thurrock agenda, allowing it to act more effectively as the financial delivery mechanism for health and care integration. It also removes the duplication of discussion about the Better Care Together Thurrock work streams that currently occurs at both TICA and the Better Care Together Thurrock Board. A finance group would report to the Thurrock Integrated Care Partnership and would

have responsibility for financial monitoring and oversight of the BCF, integration of health and care budgets and for actuarial work in identifying system level savings from integration and more proactive care which could inform issues like ‘risk and reward’ in an Alliance contract.

4.26. The Integrated Medical Centre Programme Board and Mental Health Transformation Board also report into the new Integrated Partnership Board, meaning a single strategic Board has oversight of all major health and care transformation work relating to adults and older people.

4.27. To support integrated working at locality level, the Primary Care Transformation and Integrated Workforce Groups are combined into a single Locality Working Programme Board to oversee a combined strategic programme of integrated health and care at locality level. This would encompass roll out of the primary care mixed skill workforce in Stanford and Corringham and Purfleet, roll out of Well-being Teams and Community Led Solutions (subject to evaluation) in other localities and the expansion of an integrated locality offer encompassing community NHS staff as set out in the NHS Long Term Plan. This new arrangement removes the separation of oversight of the Primary Care mixed skill workforce and other community initiatives including Community Led Solutions and Wellbeing Teams.

4.28. To enhance capacity at locality level and in anticipation of the further development of Primary Care Networks, four Locality Delivery Groups have been created where clinicians, Adult Social Care professionals and other front line staff can refine individual locality integrated models. Locality groups would have a key function in driving the priorities of the Integrated Care Partnership by identifying and communicating upwards key locality priorities. Comment on the exact function of the locality groups but their remit could also include:

- Co-commissioning of services with the third sector and communities that respond to community needs.

- Integration of health, care and third sector commissioning at locality level including a single locality budget.

- Developing and managing locality based commissioning functions and outcomes based contracts to include the PH LESs, H/T and other case finding, Stretched Quality Outcomes Framework, the Clinical Commissioning Group AQP contracts, Long Term Condition management etc. There is a real opportunity to foster collaboration between networks of practices with a stronger focus on prevention based on single locality contracts.

- Development of the operating models of the Primary and Community Care Networks for example a single triage, sharing of back office functions, developing clinical services that could be delivered once for all practice.

- Development and management of single locality delivery models, joining the dots between the Primary Care mixed skill workforce, secondary care consultants, additional community staff aka proposals in the NHS Long Term Plan, CLS, Wellbeing Teams, wider determinants of health e.g. housing locality offices.

- A forum for further development of the integrated clinical models in each of the four Integrated Medical Centres

4.29. The Long Term Conditions Case Finding and Clinical Management Working Group is rebranded as the 'Population Health Management Programme Board' reflecting its expanding role in also managing primary prevention programmes such as smoking cessation and weight management, and its oversight of data integration through MedeAnalytics and the predictive analysis and risk stratification tools that are being developed. It would also take on new responsibilities for measuring and quantifying population health outcomes and impact of the programme and for programme evaluation, giving a higher profile to these key tasks.

4.30. A new Communication and Community Engagement Programme Board replaces the Communications and engagement group that sat under the Better Care Fund. It would have a broader remit for the entire transformation programme as opposed to simply the Better Care Fund workgroups. It would also give a renewed focus to a stronger programme of community engagement and design of a community co-commissioning function which could be implemented at locality group level.

4.31. The Health and Wellbeing Board, as the highest level strategic board remains responsible for delivery of the Health and Wellbeing Strategy including place and wider determinants of health.

4.32. The Brighter Futures Board remains parallel to the Thurrock Integrated Care Partnership which has a focus limited to Adults and Older People. Stakeholder may wish to consider whether this is ultimately the optimum arrangements. It could be cogently argued that the Brighter Futures Board should also report into the Thurrock Integrated Care Partnership to create a single 'all age' transformation programme. Conversely, given that Brighter Futures works over three non-coterminous localities, and because the new Integrated Care Partnership would already be managing a programme historically covered by three other Boards, the proposed arrangements may be more workable in the shorter term, with the Health and Wellbeing Board retaining overall strategic responsibility for an 'all age' people and place agenda.

6. Conclusions

6.1 The evaluation work from the Kings Fund described in section 4 clearly recognises that most integration happens at place and neighbourhood as opposed to system level. There is a need to reach a formal agreement between Thurrock Health and Wellbeing Board and the Sustainability and Transformation Partnership/any future Mid and South Essex Integrated Care Systems setting out roles and responsibilities set out in 5.11 and 5.12. This could take the form of a Memorandum of

Understanding between the Sustainability and Transformation Partnership and Thurrock Health and Wellbeing Board.

6.2 The model opted by South Yorkshire and Bassetlaw and many other of the Vanguard Integrated Care Systems areas, with an over-arching ICS and then distinct Integrated Care Partnerships (ICPs) at unitary authority would achieve this. The Thurrock Integrated Care Alliance or Thurrock Health and Wellbeing Board could be used as the future Integrated Care Partnership Board. The proposed single population based locality contract to be developed between all key stakeholders as part of the Thurrock Integrated Care Alliance could act has the strategic delivery vehicle.

6.3 There has been an increasing move to devolve focus from borough to locality level in many of our transformation programmes, and the advent of the new Primary Care Networks provides an opportunity to cement and build on this work to create comprehensive and holistic models of integrated service delivery between the NHS, council and third sector.

6.4 There is further opportunity to support locality models of deliver through creation of locality based commissioning contracts with single integrated locality budgets with a potential opportunities for an element of co-commissioning with the community. These could be developed over time by combining existing public health, CCG and Adult Social Care budget lines in a single pot with a single outcome based contract available to practices and other providers dependent on delivery of agreed locality population health outcomes. There are plans to start this process by creating a Public Health contract covering Stretched QOF, hypertension case finding, smoking cessation and NHS Health Checks at locality level in 2020/21. In the medium term, the Better Care Fund is one mechanism through which a broader and more comprehensive locality based contract could be delivered, although further detailed financial analysis and planning.

6.5 There are a number of opportunities within the proposed governance arrangements for greater integration with the children's agenda. It is proposed that a link is developed between the LMS Board and the Health and Wellbeing Board; additionally that the proposed Communications and Engagement Board takes a life-course approach.

6.6 In order to maximise the impact of the Health and Wellbeing board, consideration should be given to having a board of "two halves" defined as follows. A preliminary board discussion referred to as a system leaders meeting, followed by a public meeting. There is also opportunity for board meetings to be themed on either a quarterly or annual basis.

6.7 It is hoped that the proposed changes on governance arrangements at Thurrock Place and locality level provide a useful starting point for further discussion. The proposals seek to integrate the current number of Boards that have developed over time into a more coherent structure under an Integrated Care Partnership, whilst providing further focus on integrated locality models.

7 Implications

7.1 Financial

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

This report discusses possible high level future proposals for further integration of commissioning functions between the council and CCG, and for the devolution of some commissioning responsibilities from Thurrock to locality level to create locality budgets. Further detailed financial planning and agreement between the local authority and CCG will need to take place to make these a reality. Use of the Better Care Fund is one potential financial delivery vehicle.

7.2 **Legal**

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

The report seeks to act as a discussion paper for key stakeholders. There are no immediate legal implementations arising from this report.

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7.3 **Diversity and Equality**

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

The report sets out proposals to further integrate existing clinical, public health, adult social care and third sector services and locality level. Moving services closer to where people live, and by shifting focus their focus to more holistic and preventative models should result in improved access, better care coordination and enhanced opportunities for early intervention and prevention. This will assist key stakeholders to improve the health and wellbeing of our population and reduce health inequalities.

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