**A Review of Organisational Arrangements
of NELFT and BHRUT
to enable the delivery of improved and sustainable
health and wellbeing outcomes
for the people of Barking, Havering and Redbridge**

Contents

A

Executive Summary

There is no doubt that the the health and care statutory organisations in the Barking, Havering and Redbridge (BHR) system are determined to improve the health and wellbeing of their populations. After a number of reviews which, in some areas, identified the scale of improvement required, the two Trusts: Barking, Havering, and Redbridge University Hospitals NHS Trust (BHRUT) and the North East London Foundation Trust (NELFT) are committed to work in ever closer union to deliver those improvements.

This review has identified the current set of challenges and placed those in the context of the NHS Long Term Plan's described strategic direction. Having interviewed senior leaders of both Trusts, the three Local Authorities, primary care federations, commissioning organisations and NHSE&I there is a clear consensus to develop an integrated system of delivery which places the individual person at the centre of care. Likewise there is agreement to strengthen primary, community, social and mental health care within each neighbourhood in each Borough.

This desire will not happen without determined and deliberate action. The 'will' to deliver strategic change must be coupled with the 'means' to make it happen. Trusted relationships with partners across the three boroughs are essential prerequisites. But the architecture and apparatus must also be developed to bring a strategic intent into reality.

The old adage "if you keep what you've got – then you'll always get what you've had" is really relevant. This review identifies governance and organisational archetypes and concludes that different arrangements are necessary. Three different models are considered, benefits and risks are identified, and a preferred model is recommended:

A new integrated system:

> With 3 organisations, based on borough boundaries, with new responsibilities which progressively will include all health and care services;

> Each Borough-based, local care organisation will have its own leadership team which will operate within an accountability framework;

> The accountability framework will be created by the two Trust Boards delegating their responsibilities jointly to a Committees in Common to operate as a Group HQ function;

> The Committees in Common will consist of joint, common non-executive directors and joint, common executive directors. Recruitment to a single, common Chief Executive is recommended at the earliest opportunity;

The report identifies that the development of these arrangements will take time and will need to be supported with an investment plan for transformation.

Huge importance is attached to developing the conditions which enable co-creation, by system partners and their leaders, of the arrangements to enable progressive convergence of services and associated resources. At this point in time, the precise nature of these arrangements do not need to be described. Indeed, it would be counter productive to do so. However what is required from system partners is a commitment to:

- The desired goal of creating integrated services across each of the three boroughs;

- The development of the 'road map' which outlines the key sequences of the organisational design and development change programme, in particular:

  o Approval of the 'first base' to deliver 'model 2' as outlined in this report – the union of the two Trusts through a committee in common arrangement and the strengthening of local management to engage with staff to continue improvement to standards of service;

  o Using the Foundation Trust, NELFT, as the 'anchor organisation' to support the creation of the Committees in Common and partner with BHRUT to create common governance arrangements and which support the creation of the 3 Borough-based, care organisations.

  o Approval in principle to the ambition to build the 'model 3' arrangements (ie, the inclusion of primary and social care) using the local care organisations, created by 'model 2', to enable this;

- An investment plan adequate to meet the costs of change and transformation and which describes the return and benefits of the investment.

It has been a pleasure to meet with and work with all of the leaders in the BHR and North East London systems and through our conversations there has been clear theme that *now* is the time to take the big, bold step on this exciting journey of transformative change.

Whilst it is recognised that organisational change is not, by itself, a panacea to the improvement that should be expected, it is a necessary first step to create a better arrangement for the two Trusts and their partners to provide integrated care. Moreover the emergent consensus is a reflection that the leaders of BHR are ready and wanting to take the opportunity to be pioneering and support staff to improve services to their local populations.

Sir David Dalton
8th August 2019

B

Introduction

BHR system leaders have a strong recent history of exploring and reaching agreement of '*what*' they want to achieve ie, to develop a new model of care to improve health and care to their populations and have expressed clear intentions to deliver integrated services.

What is lacking is a route map of '*how*' individual organisations make the necessary changes to enable sustainable improvement to take place to deliver:
(a) the strategic requirements for integrated care, and
(b) arrangements for collective decision-making, so that decisions 'stick' across the boundaries of care sectors (eg hospital, community, primary and social care) and also the boundaries of the 3 Borough geographies.

Immediate issues must be addressed, namely, the impending departure of a long serving CEO, the departure of an interim CEO, coupled with current reliance on interim senior directors. Action on future organisational and leadership arrangements must be taken without delay. Three options have been identified with a recommended preferred model.

Background

Recent history shows a range of reported difficulties with patient outcomes, financial performance, reliable delivery of services to a standard, effective governance, internal relationships, and staff satisfaction with their employer. It is acknowledged that significant improvements have been made over the last year or so. It should be noted that BHRUT still has significant difficulty in achieving constitutional standards and financial stability. Some organisations in the wider system may say that these problems do not include them. This may be true in a narrow sense but reliable improvements and the delivery of the desired model of care will only be possible if 'your neighbour's problem' becomes a BHR *shared* problem to resolve.

There are now many encouraging signs that joint delivery arrangements can result in improvement and success. And yet – the degree of organisational separation still impedes the ability to deliver strong integrated systems of working - where the wider population of BHR is placed above those of individual organisations. Current arrangements also impede being able to take the very best of one organisation's systems and processes to rapidly
implement into another.

Whilst good progress is being made to address the 'success factors' identified in the PWC report, July 2017, the Grant Thornton report and the Deloitte Reports of 2018, - there is still a significant amount to do. Without addressing these issues, the ambition of providing better and reliable services, to individuals and communities, will remain elusive.

There can be no doubt that 'trust' has to be at the heart of any major transformative change: trust across organisations and internally, between leaders and workforce. New arrangements in BHR have begun to design locally integrated services, which

are focused on 'place'. Considerable and impressive work has been taken forward since the case for an Accountable Care Organisation was made in 2017. Of great note are the contributions now being made by the NEL Commissioning Alliance and the joint BHR CCGs, this is manifest in the improved relationships which have developed between Commissioners and Providers in BHR.

And yet, the necessary mechanisms remain lacking - which need to provide stable leadership, with strong governance, enabling effective decision making. All leaders within the system accept that change is necessary.

Setting BHR within a National Context

Problem Statement
There are several problems which must be addressed to enable health and care providers in BHR to deliver more consistently and reliably, high quality services and to function as part of a maturing integrated care system, capable of delivering the Long Term Plan's vision of a new service model for the 21st century. The following problems need to be addressed:

- There is too much unwarranted variation across NE London, in clinical outcomes, service quality and productivity;
- Care is fragmented across 3 BHR geographies and across multiple care sectors and as a consequence the patient/person/carers' experience is less than it could be;
- Service change and improvement takes too long with providers able to delay change due to the absence of collective decision making;
- Best practice and improvement methodologies exist but there are inadequate arrangements in local systems to assure their replication and reliable implementation;
- The high turnover of Chief Executives and Directors has been disruptive causing difficulties with succession planning; and
- Operational leadership needs to be more highly valued in its own right.

Please Note: NELFT not only provides services within the 3 boroughs of BHR but also has additional, significant extra-territorial responsibilities in Kent, Essex, Waltham Forest and Barnet. Whilst the outcome of this review may have implications to the organisation of these services – it is not intended to alter current responsibilities which should be enabled to continue to provide good value to commissioners.

What is the opportunity we are looking to create?
The opportunity must be taken for the local BHR health and care system to use resource more efficiently and effectively. For the goals of the Long Term Plan and the ICS strategy to be delivered, then changes will be required to the way providers operate within an integrated care system, namely:

- Develop new models of integrated care which are focussed on neighbourhoods within a locality, and which are consistent across the 3 Boroughs;

- Develop new models of shared hospital and community services which can assure delivery of services to meet clinical standards reliably across seven days of the week;
- Develop standardised care pathways and systems which reduce variation in clinical practice and make best use of the workforce currently employed within differently governed care sectors (eg acute, community, primary and social care);
- Promote innovation and ensure more rapid spread and reliable implementation of best practices, services and technologies;
- Create better approaches to developing the workforce and managing NHS leadership talent, thereby reducing the reliance on short term consultancy and agency support;
- Deliver standardised and more efficient corporate and clinical support services at scale;
- Create a stronger focus on delivering operational excellence by strengthening locality and site management.

How can the BHR system realise these opportunities?
The BHR provider (statutory) system mirrors the BHR commissioning system and consists
of 2 Trusts, 3 primary care federations,15 primary care networks and 3 social care departments. The current fragmentation slows the speed of decision-making and impedes the realisation of opportunities. Much greater collaboration is therefore necessary to enable both the provision of reliable, high quality services, to an agreed standard and the implementation of new 21st century service models. New forms of shared decision making and governance should be developed such as Committees in Common approach and/or by Group governance arrangements. It should be for BHR system leaders to determine the arrangements that suit their specific circumstances. They must be supported to find these solutions as quickly as possible.

At the heart of of these arrangements are two goals:

1. Delivering change and improvement at pace – and implementing this reliably. BHR health & care providers, and system partners, must make the best decisions for the greater good of a population rather than pursue individual organisational interests;

2. Implementing best practices and methodologies. BHR providers should develop their own standard operating model (SOM), enabling services to be provided to a standard – reliably. Collaboration must support integrated service models in localities and shared services across wider geographies. It is expected that best practices found within one BHR organisation is made available to all.

Governance and Organisational Archetypes – The Group Concept
Whilst there are a range of governance arrangements and organisational archetypes that can support collaboration, Groups are recognised in the Long Term Plan has having increased importance. It is of great interest that the BHR system has already begun to express an interest in a group model for its health and care system.

A 'group' operates at scale, with a small headquarters which provides strategic direction and investment to its operational delivery units. It determines the best methodologies for continuous improvement, standardisation of clinical and non-clinical processes and talent management. Senior local management teams within operational delivery units have devolved autonomy to manage services within parameters agreed with the Group HQ.

A 'group' may comprise one legal entity or it may be a form of joint enterprise between a number of distinct organisations. Groups are designed to have standard operating models, including:

- standardised practice to reduce unwarranted variation through cross-cutting networks;
- standardised provision of corporate and clinical support services which may also extend to other providers outside of the group (enabling aggregation and consolidation of functions);
- Standardised improvement methodology enabling deep staff engagement;
- a group-wide talent management and leadership development programme;
- a single capital account enabling best VFM through investment; and
- an accountability framework which supports the group headquarters to hold the operating units to account for delivery.

Groups are not simply large multi-site NHS providers: they involve fundamentally different ways of managing the relationship between a strategic headquarters and a number of operating units.

Nor must they be seen as a model for managing acute health services – they can and should encompass providers of community health services, mental health services, primary care and social care – to become a truly integrated care provider.

The development of groups must be designed to allow for single, shared services covering a wider population base across a number of hospitals or community or mental health or social care providers (the horizontal level); and to support the development of integrated care (across primary care, community services, hospital services etc) for individual borough localities (the vertical level). This means that Groups can consist of operating units which provide integrated care within a locality, providing scale and risk share benefits.

Of greatest importance is that potentially a Group HQ for BHR with 3 Borough-based Local Care Organisations can design and deliver services which meet the complex social and health care needs of individuals and families. It is vital that any new arrangements balance the social and clinical needs of individuals and families. Neither a medical nor a social model of care must become the predominant model – an equilibrium must be achieved which enables holistic, person-centred care to be provided. More consideration is given to this in the Appendix on Local Care Organisations.

C

The Benefits Case – Improving Care and Standards

The populations of BHR, served by the Trusts, are not receiving the standards of service, reliably, to which they are entitled. Both NHS Trusts must continue to demonstrate improvement and reliability to meet the constitutional standards and to achieve financial resilience. This must be a shared aim and will not be achieved if either one organisation gains as the other loses, or if the the separate components of health and care are not more closely associated.

The NHS Long Term Plan makes a renewed commitment to the importance of collaboration across providers of health and care so that an individual and their carers are placed at the heart of an integrated system of delivery. Acute hospitals, although always an essential and important component of a health and care system, have in the past asserted a disproportionate level of influence over the arrangements of services and associated resources. An opportunity is now provided to distribute services and resources into neighbourhoods and communities to create a new equilibrium. Primary care, social care and mental health services are an important foundation for meeting the overall needs of local populations. We know that mental health inequalities are linked with a wider cultural and societal system of disadvantage that impact on a person's wellbeing. The further enhancement of integrated, population level health systems will support more localised and personalised responses to health inequalities.

The key to sustained and reliable improvement across the three boroughs of BHR will be found in creating shared values and single systems. This high degree of standardisation of policies, procedures and pathways is the means to achieve shared goals and objectives, as illustrated over these themes:

Quality Benefits:
- Standardisation will remove the variation of multiple agencies operating multiple systems which impede effective patient care. For example:
    if a Redbridge patient with frailty is admitted to Queens Hospital and is then ready for transfer/discharge, it is not currently possible for an on-site Havering Social Worker to undertake an assessment on behalf of Redbridge Council. Delays ensue in organising separate and different social care, community services and care home assessments and packages of care. The lack of standard systems is getting in the way of providing best care, it provides for a poor patient experience and results in higher levels of 'stranded patients' whose bed days could otherwise be used for other patients;
- Better co-ordinated care across agencies, especially for frailty assessment and long term condition management should reduce the need for higher than national average attendance and admission into hospital; for example, in the future:
    a frail 67 year old Barking man (Ibrahim) living in squalid conditions had been refusing services and would not come into clinic to be seen. He received a home visit by Social Workers, as part of the new enhanced care team who assessed his home environment. The social worker

observed his squalid and cluttered conditions and noticed leg ulcers. A trusted assessment and referral was made by the social worker so that the District Nurse came to review his leg and started to treat the leg ulcers. Staff built up trust with Ibrahim, and were able to return to his home to undertake a fire risk assessment and recommend a home care package which Ibrahim accepted and meant that he could continue to stay at home receiving support.

- Too much money and too many patients unnecessarily attending the most expensive parts of the system - the hospital.
  In Thurrock a NELFT project determined that there were 453 potentially avoidable emergency hospital admissions for ambulatory care-sensitive conditions and 1,844 delayed days for delayed transfers of care could have been avoided if improved primary and community care services been available. Furthermore 77% of A&E attendances were for issues that needed "advice only and no or minor treatment", and could have been treated in by primary care/community based staff.
- Alternative arrangements to the current 2,000 outpatients per day at Queens and Kings hospitals could be found across the 3 boroughs. This would require digital solutions and a level of interoperability across the digital platforms. It is unlikely that the separate systems operated by the separate organisations will achieve this. A common shared care record must be developed.

Performance:
- Tackling the current patient flow impediments found across the BHR system where demand to access services outstrips supply of capacity. Opportunities must be taken to address shortcomings in the primary care workforce and system to build multi-disciplinary team capacity within neighborhoods and thereby reduce the dependency on secondary care services;
- Strengthening local site management enables better relationships between leadership and workforce so that the former is accessible and has a granular detail of understanding of site-specific problems relating to performance;
- System improvement in ED 4 hour performance is dependent more on the use of common care pathways across care sectors, than on the operating model within ED;
- Inappropriate use of acute beds forces c£200m of work to be commissioned outside BHRUT, with a large portion accommodated in the private sector, at a considerable and unsustainable cost.

Workforce:
- New solutions must be found to address current high vacancy rates, gaps in rotas and lower retention. In part, a single employer would enable the sharing of best employment practices, a more rapid pursuit of shared roles and blending/changing skill mix;
- The opportunity must be taken to address the lower than average expressed satisfaction by staff in employment at BHRUT and to improve levels of engagement and inclusion of the workforce, particularly in improvement against racial equality standards.

Finance:

- The need to invest in primary care and neighbourhood care is paramount and yet the shift of resources from the acute sector to these other parts of the system is impeded due to the sense of loss that the acute Trust experiences in any proposed disinvestment. Creating a single provider system changes the mindset so that leaders can see that this is not dis-investment but is re-investment from one part of the system that they are responsible for to another part, ie they are not losing £ but re-purposing £ within their system.
- Back office savings in corporate management costs could be realised rapidly. This should include a simplification and rationalisation of processes, systems and methodologies so that these are standardised across organisations.
- The opportunity to access value from the Goodmayes site, for the greater good, must be pursued to provide much needed regeneration of the area, including affordable housing for key health workers.

There is a growing body of evidence nationally and globally that an integrated system of care delivery provides for better care, better experience and a better use of resources. An evaluation of one of the country's 'Vanguards' for new models of care – Salford - is able to show evidence of improvement that has resulted from their collaborative approach to building a better integrated system across all health and care partners.

SALFORD TOGETHER HEALTH & SOCIAL CARE WORKING WITH YOU AND YOUR COMMUNITY

Salford is recognised as one of the country's most developed integrated care systems. Since 2015/16 new models of care have been progressively introduced with the following impact:

❖ 1% reduction in ED attendances and 7% reduction in NEL admissions.

❖ New urgent care multi-disciplinary team responds to referrals within 2 hours and manages a person for 72 hours at home. The team has accepted 1740 referrals and reduced ambulance conveyance to hospital by 10.1% (-2294) releasing 1,400 hours back to the ambulance service.

❖ 262 people last year received support from the enhanced care team which identifies and focuses on high-risk elderly patients with frailty. The team use a common shared digital record to ensure all information relating to the person is available at all time. There has been a 12% reduction in falls-related admissions (3289 to 2898).

❖ Salford's new integrated discharge team, including a housing officer, provide a 'trusted assessor' system enabling patient assessment by any member of the team, regardless of district of residence. Delayed transfers of care (DTOC) have been reduced by 75% so that Salford now has the 9th lowest DTOC rate in the country and a 15% reduction in the rate of permanent admissions into care homes.

❖ The cost of the introduction of new models of care = £8.4m gross, which enabled a reduction to the net cost of service by 1.4% to 5.8% reduction to costs (variable to project).

The evidence is compelling: that the populations of Barking & Dagenham, Havering and
Redbridge would benefit from developing a different set of arrangements for delivering integrated services. It is appropriate to consider whether different governance and
organisational arrangements would enable and accelerate the changes that are necessary.

Structural Change and Reorganisation

So much is said about the risks and pitfalls of reorganisation - but it is helpful to remind the reader that (1) any structural organisational change should be purposeful to ensure that 'form follows function' and (2) most commentators would add that structural change rarely provides all of the benefits that are expected of it, noting that (3) change can be a distraction which has an opportunity cost in consuming time and attention and (4) it can unhelpfully elevate anxieties within an organisation, with consequent unwelcome behaviours.

The leadership of organisations must then believe that the benefits which can accrue will outweigh these risks or costs.

Pace and Timing
In the ideal world you would create an organisational and governance arrangement designed to meet the known requirements of an agreed health and care strategy. BHR organisations do not have this luxury - they must decide how to respond to the impending loss of CEOs and interim appointments. They must act now.

It is fortunate that a current review of the acute strategy (Carnell Farrar) is taking place enabling this to be reconciled with the emergent strategy for organisational design and development. The clear imperative must be to design new organisational arrangements with the best available knowledge and the need to meet the known requirements for integrated care expressed in the NHS Long Term Plan.

The response to this issue has been to signal the need for *'progressive convergence'* - a phrase which the common Chair of the two Trusts uses to helpfully communicate the need to work incrementally towards a solution where tactical change can be implemented, consistent with an emergent strategic direction of travel. A gradual approach to *ever closer union* between the two health care Trusts in BHR appears sensible. This is supported by a number of joint/shared appointments of the Chair, a NED, & Director of IT.

It is my strong view that tactical organic change will now be insufficient. It is essential that the organisations move up the gears and accelerate the delivery of new organisational arrangements as part of a new strategic direction and which build on the helpful positioning of 'progressive convergence' for the two NHS organisations.
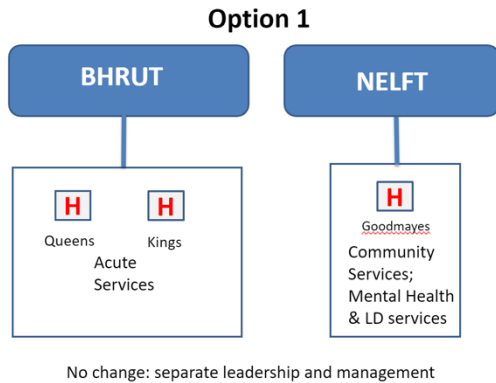
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The Options for Organisational Design

If structural and system re-design are to be pursued to support local integrated working, and allow progressive development towards longer term strategic goals then there are a number of key organisational design issues to address:

- how does structural design support the ambition of local integrated working?
- how does the design reflect the prominence of the plan to develop integrated delivery systems for each locality?
- How do you vest services, currently provided by each Trust, in a placed-based service, eg urgent/acute care, community services (physical and mental health), etc?

Three principal choices for organisational models have emerged from discussion with
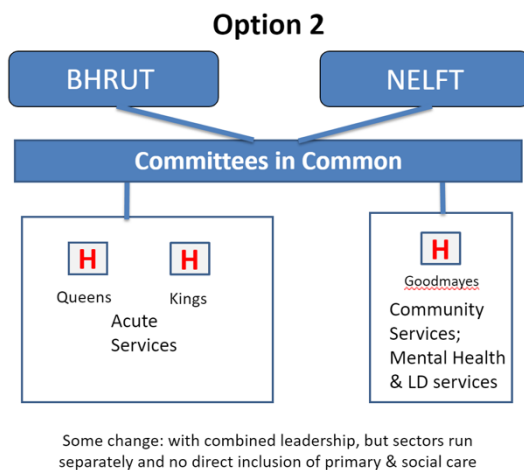multiple stakeholders:

1. **Do Nothing -** Continue with status quo arrangements and appoint 2 CEOs for the two Trusts, retaining existing organisational, leasdership and management arrangements;

2. **Do Something -** Appoint one CEO for the two Trusts and develop a Committee in Common approach to the shared governance of both Trusts, but continue with the separate management of (1) acute services and (2) community & mental health services;

3. **Do the Best Thing -** Develop new integrated service arrangements across BHR with 3 Borough-based integrated health and care organisations, supported by a single group HQ (committee in common) governance arrangement – requiring a single Group CEO and 3 Chief Officers for each Local Care Organisation.

Three Organisational Models are illustrated as follows:

Option 1

BHRUT

NELFT

H	H
Queens	Kings

Acute Services

H
Goodmayes

Community Services; Mental Health & LD services

No change: separate leadership and management

Option 1
- Maintains separate Trusts
- Recruit to 2 CEOs
- Maintains current service delivery portfolios
- Inconsistent with integrated care strategy

Option 2

BHRUT

NELFT

Committees in Common

H	H
Queens	Kings

Acute Services

H
Goodmayes

Community Services; Mental Health & LD services

Some change: with combined leadership, but sectors run separately and no direct inclusion of primary & social care

Option 2
- Trusts remain but delegate powers and functions to a Committees in Common
- Single CEO recruited
- Maintains current service delivery portfolio
- Opportunities created for synergies of back office functions and partial integration
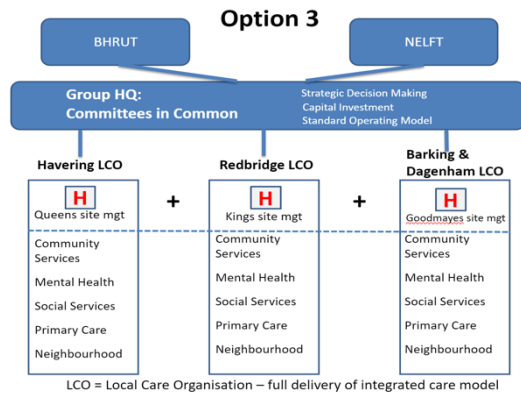
Option 3

Option 3

- Trusts remain but delegate full powers and functions to Committees in Common
- Single CEO recruited + new leadership teams for each of the 3 LCOs
- Creates new fully integrated Care Organisations consistent with Borough boundaries and inclusive of all health and care services
- Significant opportunities for synergies and standardisation

An assessment of benefits and risks is outlined below. The following enabling factors
have been used:

- improving quality and patient/person experience
- integration
- efficiency and financial benefits
- workforce recruitment & retention

	Quality & Pt Exp	Integration	Efficiency & £	Workforce
Option 1 *Do Nothing*	Existing programmes continue	No benefits accrue other than by consent of multiple parties	No benefits accrue other that by consent of multiple parties	Existing workforce engagement programmes continue
Option 2 *Do Something*	Improved patient flow possible. Elementary improvements across the boundaries of hospital and community care	Partly consistent with ICS intentions. Improved arrangements x-acute/community/ MH can be enabled. Does not include primary or social care other than by consensual arrangement	Back office savings can be achieved. Some opportunity for standardisation and VFM.	Best practice elements of NELFT engagement and inclusion + BRHUT pride approach can be melded and used.
Option 3 *Do the Best*	New person centred care model can be developed. Strengthened locality and site management.	Most consistency with ICS intentions. New 'placed based' arrangements allow synchronisaton with Local Authority priorities and connect to political democracy. Fully integrated model of care focused on neighbourhoods. Enables greatest support for primary care.	Maximum efficiency opportunities across all organisations thro' control of all systems & pathways. Greatest opportunity for standardisation and VFM Provides greatest value from the BHR £ - through financial pooling and risk sharing.	Opportunities for greater workforce agility in roles. More responsive locality and site leadership. Brand BHR as the place in London for innovative and pioneering design of care models.

The three options have been discussed in short engagement sessions with principal system leadership actors. There is a clear consensus amongst BHR leaders for Option 3 – which is seen to offer the most opportunities, over the long-term, for providing resilient, person-centred care. The pursuit of Option 3 is not without risk, as shown by this risk assessment:

	Risk	Mitigation
Timeline and Change Fatigue	The BHR statutory organisations have experienced numerous reports recommending change, including the 2017 recommendation to create an ACO. To begin a major change programme requires full support and commitment from all parties. It is not for the 'faint hearted' and will require constancy of purpose. If the timeline is too ambitious, then risks of failure increase. If it is too long, then either a lack of a sense of urgency or change fatigue can set in and make improvement difficult.	A clear programme of change must be understood and communicated. At the outset a programme of 2-3 years is expected. It is vital that the sequencing of key programme developments and changes is developed with co-dependencies understood. Each milestone should be celebrated. NHSE&I must commit to the programme and provide necessary support.
Resources	A transformation programme of this magnitude must be adequately resourced. There will be significant costs associated with change and double running costs.	A business case should be developed which describes the investment required and the return which will be provided. It is anticipated that the cost to develop this innovative programme will be in the region of c.£40m/3 years ie, £10-15m/LCO/3 years (based on Greater Manchester costs)
Search for CEO and leadership team	This is a significant recruitment. The detail of the person specification will be produced by the employing organisation but it is important to attract a seasoned/experienced CEO (the role is not considered appropriate for an inexperienced CEO); Leadership teams will be required for each LCO including the appointment of a Chief Officer for a LCO who will provide strong locality and site operational management	Longevity of tenure must be sought, ie, an appointment of 5+ years (a novel, supportive remuneration package is required to achieve this aim); The post holder must demonstrate 3 qualities: - Strategic creativity; - Strong belief in collaborative working; - Track record of performance exercised through accountability; - Resilience and tenacity. LCO Chief Officer must demonstrate a strong focus on operational management and performance, with good team leadership skills.

Recommendation

Option 3 has the greatest support from all BHR system leaders and if the mitigations are in place then it should be pursued, as it has the greatest opportunity to transform health and care services for the BHR population.

However, if adequate mitigations are unable to be secured then Option 2 would be the safest option to pursue and would allow development at another later opportunity.

I strongly recommend that partners pursue Option 3 and develop Local Care Organisations (LCO) for each Borough with responsibility for all elements of health

and care. The two NHS Boards and other entities should vest services within the LCO. Local Authorities would vest their responsibilities for social care into these borough based LCOs. Primary Care Federations and Networks should be part of this single system of governance.

The two Trust Boards should create the organisational vehicle to enable the change to happen – this is the Committees in Common (CiC). (See below for further details)

The new Group HQ would be created through the establishment of the CiC, and it would set an accountability framework enabling LCOs to operate and account for delivery against plan. The 'single system of governance' for the LCO would require all sovereign bodies and partners to delegate responsibility for decision making (in whole or in part) to the LCO.

Operational management must be strengthened within each locality together with clear accountabilities for principal sites. It is proposed that each LCO Chief Officer takes responsibility for a principal site:
- Havering LCO for Queens
- Redbridge LCO for Kings, and
- Barking & Dagenham LCO for Goodmayes

This distribution of responsibility across LCOs will provide equivalence of responsibility for each LCO and their leadership teams. It is likely that some services will be 'hosted' by one LCO on behalf of others where this made operational sense.
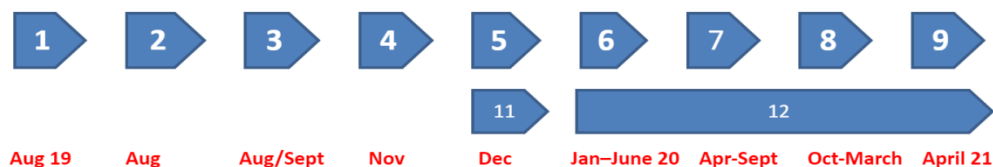
Getting to First Base
Immediate action must be taken - to get to the 'first base', enabling thereafter a longer and deeper strategic change for BHR health and care service provision.

Base camp is the crucial stage in the journey – the new CEO, with system leadership partners, should describe a picture of the future destination which is compelling and attractive so that the direction of travel from base camp towards to the ultimate strategic goals are understood by all.

This requires a 'road map' which outlines the key sequences of the organisational design and development change programme.

Road Map

Indicative Road Map

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

| | | | | 11 | 12 |

| Aug 19 | Aug | Aug/Sept | Nov | Dec | Jan–June 20 | Apr-Sept | Oct-March | April 21 |

1. Agree common strategic intent (Model 3) between NELFT & BHRUT + local authority and primary care system partners
2. Agree with NHE&I high level benefits realisation and resource plan for Group and each LCO
3. Recruit to single Group CEO
4. Produce investment business case for London region/NEL ICS
5. Agree principles of investment case = Model 3 now LIVE
6. CEO starts, begin formation of CiC and establishment of Group HQ with Group Director positions; agree detail of investment case
7. CiC formed - establish LCOs in shadow form and appoint Chief Officers and leadership teams
8. Agree LCO Provider Alliance with all system providers and with CiC (NELFT) as the 'Lead Provider'
9. Begin delivery of LCO plans

11. Failure to agree investment case = pursue Model 2 organisational form -
12. Create plan to maximise benefits of limited integration

It is important to understand that the scale of change recommended is considerable and will require strong leadership and trusted relationships with partners. Sequencing of key events is essential to understand and the above 'road map' indicates what these are likely to be.

At point 5 / point 11 on the diagram is a key milestone which is the point when either a settlement is or is not reached with the Regional Office/NEL ICS for the financial and other support required to deliver the preferred option 3. If a settlement is not reached then it is understood that the Boards are likely to consider that the safe route for development if to pursue option 2 which can provide more limited benefits and opportunities for some synergies.

Whichever route is taken both options allow the recommended immediate recruitment of a single, common Group CEO and the establishment of a Committees in Common.

Issues and Consequences for Longer Term Consideration

Some people in NELFT raised with me the long-term future of the extra-territorial responsibilities for community services that NELFT had secured over recent years eg, in Essex, Kent, Waltham Forest and Barnet. It is entirely understood that the operating conditions for Trusts encouraged growth and expansion enabling additional revenues to provide a greater contribution to overheads. It is my opinion that these conditions in the NHS are now changing and will provide a challenge and a risk to these contracts and their income. It is likely that each local system will consider how they might create a local place-based provider for integrated care, with comprehensive service responsibility (rather than reliant on an extra-territorial provider). It is entirely possible that NELFT will be able to continue to demonstrate good value – providing high quality at an affordable cost. If so, managerial arrangements for these 'non-core' contracts can continue or be established. The point being that the recommendations of this review signal two changes: firstly, that other localities will be questioning whether their current service delivery arrangements will suit future strategic directions; and secondly, that NELFT needs to shift its mindset to become the lead provider of comprehensive, integrated health and care services for BHR.

Another issue has been raised and that relates to the future of higher tier (inpatient) mental health services. With the inclusion of lower tier (community based) mental health services within the newly formed 3 BHR LCOs, the residual higher tier services can either be allocated to a LCO to manage eg Barking and Dagenham LCO, or consideration might be given to service, workforce and economic benefits of having a single mental health provider for North East London. These are considerations for another time, but I have felt it important to raise it as a potential consequence of this review and the changes that are expected to take place in parallel across London.

It should be noted that the *Dalton Review* (2014) concluded that the best performing healthcare groups served a population size of 1-2 million and comprised 5-8 delivery units. I have considered this in the light of the recommendations of this Review and have noted that BHR population growth is expected soon to exceed 1million and will fall in the lower end of the parameters. As such, I should note that greater economies of scale might be possible with further consolidation, which could be considered in the longer term.

Finally, there are concerning issues regarding workforce recruitment of senior clinical staff in multiple services of both Trusts and primary care. These shortages are significant in urgent/acute care, care of the elderly, CAHMS services and in primary care. It is considered that even if there could be greater confidence exhibited by a stronger integrated BHR group - with an ability to portray itself as a great place to work - this would not resolve chronic staffing difficulties.

It is my opinion that over the next 5 years it would be sensible to begin consideration of aligning a BHR Group (with its 3 local care organisations) with the other entities of North East London (Barts Group, Homerton FT and East London FT). It is likely that this would provide opportunities for workforce recruitment and resilience which BHR may be unable to achieve on its own. The expected development of shared clinical

services for Neuroscience services and Vascular Surgery would offer a helpful 'bridge' for this consideration.