Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	27th July 2022
Title of paper	Place Based Partnerships: Reviewing Their Future Configuration
Presented by	Jane Scattergood, Director of Nursing and Quality
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Agenda item	9
Confidential	No

Purpose of the paper

Share the outcomes of the review of the five current Lancashire and South Cumbria Placed Based Partnerships (PBP) and propose to reconfigure and align boundaries with local government footprints to allow for deeper integration and joining up of care for our citizens.

Executive summary

National Policy sets out a clear intention of a more joined-up approach to health and care built on collaborative relationships; using the collective resources of the local system, NHS, local authorities, the voluntary sector, and others to improve the health of local areas.

In Lancashire and South Cumbria, Place Partnerships have been formed around 5 footprints across the 8 legacy CCGs and aligned to the acute provider trust footprints across LSC.

There are currently two upper tier and two unitary Local Authorities within the footprint:

- Blackpool
- Cumbria
- Lancashire
- Blackburn with Darwen

None of the existing place partnerships are coterminous with the LA footprints.

This review has sought engagement on the option of aligning the place partnerships to the four local authority boundaries to promote deeper integration and collaboration with health and social care.

Recommendations

Recommendation

The Board are asked to:

- Approve the proposal to align our Place Based Partnerships with our local authority footprints.

• Should the Board approve the proposal to align our Place Based Partnerships with local authority footprints the paper sets out further recommendations for implementation that should be considered.

Governance and reporting (list other forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Implications				
If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed				
Equality impact assessment completed				
Privacy impact assessment completed				
Financial impact assessment completed				
Associated risks				
Are associated risks detailed on the ICB Risk Register?				

Report authorised by:	

Integrated Care Board – 27th July 2022

Place Based Partnerships: Reviewing Their Future Configuration

1. National Context

1.1 The Health and Care Act 2022 sets out a more joined-up approach built on collaborative relationships; using the collective resources of the local system, NHS, local authorities, the voluntary sector, and others to improve the health of local areas.

1.2 *"The case couldn't be clearer for joining up and integrating care around people rather than around institutional silos – care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, prevention and helping people live more independent lives for longer. We need the different parts of our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives."* *Integration and innovation: working together to improve health and social care for all*

1.3 Instead of working independently every part of the NHS, public health and social care system are charged with continuing to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met.

1.4 *Thriving places: Guidance on the development of place-based partnerships* sets out that as far as possible, the footprint of place should be based on what is meaningful to local people, has a coherent identity and is where they live their lives – such as a town, city, borough, or county.

1.5 The essence of integration and support for healthier lives across the life course will be enacted in neighbourhoods, scaled up to a Place footprint where it makes sense to do so. Within our current footprints there are vibrant integrated neighbourhood teams whose boundaries would be largely unchanged by alignment with local authority footprints but whose relationships will be altered both by the legislative changes that brought about the closure of CCGs, the creation of a single ICB organisational footprint and by an opportunity to integrate more deeply with social care services, VCFSE and District / Unitary councils.

1.6 The white paper Health and social care integration: joining up care for people, places and populations published in February 2022 sets out proposals that aim to provide better, more joined-up health and care services at 'place' level. There is intent for NHS and local government organisations to do more to align and pool budgets and ICSs will be required to support joint health and care workforce planning at place level. Progressing deeper integration would be unduly hampered if alignment was not enabled.

2. Local Context and Basis for Review

2.1 National Policy sets out a clear intention of a more joined-up approach to health and care built on collaborative relationships; using the collective resources of the local

system, NHS, local authorities, the voluntary sector, and others to improve the health of local areas.

2.2 In Lancashire and South Cumbria (LSC), Place Partnerships have been formed around 5 footprints across the 8 legacy CCGs and aligned to the acute provider trust footprints across LSC.

2.3 There are currently two upper tier and two unitary Local Authorities within the footprint:

- Blackpool
- Cumbria
- Lancashire
- Blackburn with Darwen

2.4 None of the existing place partnerships are coterminous with the LA footprints.

2.5 This review has sought engagement on the option of aligning the place partnerships to the four local authority boundaries to promote deeper integration and collaboration with health and social care.

2.6 The current five Place Based Partnerships are reflective of our previous CCG footprints, being two single CCGs and 6 CCGs working closely as three partnerships, and reflective of the acute provider trust footprints across LSC. The current configuration of the place-based partnerships has supported a philosophical shift to meeting a locality's health needs, but many of the achievements have actually been transacted by the relationships between CCGs, Providers and Partners. Now that locality-based commissioning such as this is replaced, as described in the legislation, by system delivery partnerships the transactions that supported the partnerships to deliver will be reframed.

2.7 When considering the feedback from the engagement exercise, untangling the positives of the current places' geographies from the achievements of current Places as pairs of or single CCGs with the freedom to act and commit resource has been difficult.

2.8 The current Place Based Partnerships have strived to develop and promote relationships, but these are often built on commissioning arrangements with the majority of activity taking place between parties rather than being driven by the current place footprints.

2.9 Many of our current Places, whilst joined up, still have legacy differences in contractual arrangements with various service providers, leading to unwarranted variation.

2.10 The current construct would impact on the successful delivery of the national policy and our local strategy and ambition for deeper integration and collaboration, joined up use of resources and addressing unwarranted variation at 'place'

2.11 The basis of the review was to consider the potential benefits of aligning our Places with local authority footprints to enable delivery of the integration agenda and make

real tangible progress on supporting our citizens to live healthy lives across the life course. Consideration included any existing arrangements that are valuable and should be accommodated should a decision to align with local authority geographies be made.

2.12 The engagement exercise took place mid-May to mid-June 2022 and included an online survey generating 243 responses and conversations with over 170 individuals and groups. The review explored how re-aligning the boundaries of the places in LSC to the four upper tier or unitary local authority footprints might enable the partners within each of the places to best work together to achieve the required level of deep integration. The review considered what works well in the current footprints, any architecture which should be preserved, and what opportunities and risks are presented if the proposal to align our Place Based Partnerships (PBPs) to local authority footprints is taken forward.

2.13 Comprehensive feedback was presented to the designate Board 21 June 2022 and the feedback was shared widely with colleagues and stakeholders.

2.14 The ICB executive has reflected on the feedback and have given high level indications of their intent for the ICB target operating model, which impacts on all aspects of remit, scope, and governance at system and at place.

3. Outcome of Review

3.1 The proposal to align with local government footprints was broadly welcomed by PBP Chairs, Local Authority Chief Executive Officers (Unitary, Upper Tier and District), NHS Provider Trust Chief Executive Officers, NHS Provider Trust Chairs, partners in the Voluntary, Community, Faith and Social Enterprise sector (VCFSE), Directors of Public Health, NHS England, Regional Director of Public Health NHSEI / OHID, Directors of Adult Social Care, Directors of Children's Services, North West Ambulance Service (NWAS), Lancashire Fire & Rescue Service, Cumbria Fire & Rescue Service, Lancashire Constabulary, Cumbria Constabulary, the Designate ICB Executive, and Healthwatch.

3.2 Concerns were expressed by our colleagues in Primary Care (General Practice), LMC colleagues, CCG Leadership, CCG Clinical Leadership, and elements of existing PBP teams.

3.3 Some concern was expressed by colleagues in community health services, population health teams, some PCN clinical leadership, Hospices and Primary Care (Dental, Pharmacy and Eye Health).

3.4 The proposal was recognised as an opportunity by the Dental, Pharmacy and Eye Health Local Professional Network Chairs and NHS England Primary Care Commissioners.

3.5 Concerns were broadly related to:

- Place's ability to commit resource / commission on what was seen as a natural health community in a hospital hinterland

- a deep understanding of clinical leadership in CCGs and lack of clarity on the future of clinical leadership within the ICB and at Place
- the dialogue between primary and secondary care and how that is critical for developing care pathways and raising the threshold for admission to hospital.
- the operating geographies of valued groups, being mapped to the existing five Places, in particular GP alliances and GP leadership groups

3.6 Feedback on the proposal to align with local authority footprints revealed a need for clarity on the remit and scope of Place over the next 1 to 7 years. Colleagues expected that Place Based Partnerships would have a commissioning function, with a delegated budget to fund services and commit resource.

4. ICB High-level Plans for a Target Operating Model

4.1 The following paragraphs describe the ICB's high level plans for a target operating model, which impacts on all aspects of remit, scope, and governance at system and at Place.

4.2 The ICB, now established, has taken on the NHS commissioning responsibilities of Clinical Commissioning Groups (CCGs) as well as some of NHS England's commissioning functions, including delegated responsibility for commissioning the four elements of primary care (Dental and Eye Health from April 2023) and some specialised services.

4.3 The previous commissioning boundaries of the eight CCGs have already changed to the single ICB footprint. Our Places, current or proposed, will not be the foci of commissioning activity.

4.4 NHS Provider Trusts will be key delivery partners, having a much more collaborative provider / commissioner relationship with the ICB, and supporting the achievement of the strategic intent. As the ICB target operating model is developed the relationship with system constituent members (the Trusts as singular organisations, other key providers such as care providers and hospices, and the Provider Collaboratives) will be crystalised and clarified.

4.5 In the pursuit of quality and efficiency improvements our secondary care services may be increasingly networked or shared. This is particularly true of fragile, small volume services and services that do not offer a time critical intervention. This will dilute the relationship between the resident and the hospital closest to their home, for some services.

4.6 Legislation has determined that we will move away from a contract culture and develop longer term partnership relationships with delivery partners. Partners will include NHS organisations, care providers, hospices, and voluntary, community, faith, and social enterprise (VCFSE) organisations. The ICB is enabled by new powers to enter into delivery partnerships without a competitive process, this will allow funding to flow to public service and VCFSE organisations without a burdensome tender and contract process and enables increased flexibility and secures efficiencies which can be re-directed to invest in front-line service.

4.7 Management of the financial relationships with delivery partners will be centralised in the first instance. 2022/23 is viewed by NHS England as a transition year. Delegation of resource to commit at place is not supported in 2022/23 and unlikely in 2023/24. This provides an 18-month window in which to set the foundations of the remit, scope, and opportunity of Place Based Partnerships, followed by a programme of no less than three years to progress deep integration.

4.8 The principle of subsidiarity will be supported by the development of increased autonomy, funding and responsibility through creditable performance earned over time. Funds for transformation and to support development will be available to Place Based Partnerships. The ICB will agree priorities for action in a new improvement hub / transformation programme, these areas may attract funding for action at Place.

4.9 The ICB Executive is developing a road map for system development:

4.9.1 Year 1 – Stabilise

To include: Agreement with partners of five performance indicators for improved population health, collaboration on shared services and an improved out of hospital system, implementation of new target operating model for the ICB, including its connections with the Provider Collaborative Board (PCB) and Integrated Care Partnership (ICP), development of new financial framework for the system and delivery of a balanced plan, to stabilise fragile clinical services and a new multi-disciplinary clinical leadership model.

4.9.2 Years 2 to 3 – Recover

To include: Out of Hospital transformation, deliver a new financial framework, standardised commissioning model developed and delivered, a major investment programme developed for health improvement/population health, and transformation programmes driving innovation and shaping the future health and care landscape.

4.9.3 Years 4 to 7 – Transform and Excel

To include: Deliver a model for “hospitals of the future”, meaningful impact achieved on population health metrics, full integration delivered, continuous improvement in system oversight framework ratings for ICB and NHS Trusts, positive indicators of a sustainable positive shift in health inequalities and complete implementation of the Fuller stocktake recommendations.

4.10 Feedback on the proposal to align with local authority footprints revealed a need for clarity on clinical leadership. Clinical and care professional colleagues need clarity on their opportunity to lead at neighbourhood, place, and system and how their professional views may be instrumental in all decision making.

4.11 After significant engagement the system has an agreed set of principles and continuum for a Clinical and Care Professional Leadership Framework, the model will be developed and will be ready to implement from 1 January 2023.

5. Challenges and Opportunities from the Findings of the Review

5.1 Geography and scale

5.1.1 The review revealed broad recognition of the opportunities for deeper integration and collaborative work on health inequalities and the wider determinants of health in the smaller, contained footprints of the unitary councils Blackpool and Blackburn-with-Darwen.

5.1.2 The value of the District councils and their connectedness to citizens' lives and wider determinants is well understood and regarded. A single Lancashire place needs to embrace the contribution of the Districts and enable integration on District / town and neighbourhood footprints.

5.1.3 The review considered delivery units within a single Lancashire place on District footprints to be responsive to population needs, but the resource and capacity of teams would be too diluted if spread across 12 Districts.

5.1.4 The review considered perhaps 3 delivery units within a single Lancashire Place, and whilst thinking about population differences and similarities and the way citizens live their lives, proposed an East Lancashire delivery unit, a Central Lancashire delivery unit that would include West Lancashire and a North Lancashire / coastal delivery unit. Adult Social care in LCC upper tier is divided into these sectors which supports integration. The 3 sectors do not cut across District boundaries.

5.1.5 Unanswered questions remain in relation to the footprint of South Cumbria and the new Westmorland and Furness Local Authority which is not aligned to our current South Cumbria. A decision on boundaries of the ICSs should be pursued with all relevant local authorities, both ICSs, NHS England, providers at place, and partners.

5.1.6 If the proposal were to be accepted and taken forward, the Place boundaries would need to be permeable to enable and protect the groups, meetings, dialogues, interactions where value is added and of benefit to our citizens.

5.1.7 For future delegated funding of place: the review revealed worries about masking of deprivation / need, particularly in a place the size of Lancashire. Concern that funds will not flow to those most in need is keenly felt, in particular in areas where pockets of need exist in proximity to affluence e.g., Fleetwood, Skelmersdale, Morecambe, and Barrow-in-Furness.

5.1.8 PBP teams in small unitary footprints may need to be positively weighted beyond fair shares funding to protect against critical mass fragility.

5.2 Primary Care

5.2.1 NHSE had delegated to the ICB delegated responsibility for commissioning the four elements of primary care – General Practice, Community Pharmacy, Dental and Eye Health (the latter two from April 2023). The current place based, 'primary care commissioning teams' will need to:

- develop to take account of new responsibilities for all four disciplines and progress quality assurance and improvement oversight.
- operate within a small enough geography as to be meaningful and support their functions.
- be supported by an appropriate architecture which enables dialogue with valued groups – the alliances, the Local Medical Committee (LMC), the Local Dental Committee (LDC), Local Pharmaceutical Committee (LPC), Local Optical Committee (LOC), and professional networks.
- develop to support implementation of the Fuller recommendations

5.2.2 It is important that ICB executive clinical leadership, inclusive of GP clinical directors lead and inform this critical work.

5.2.3 Primary care services maintain an important dialogue with secondary care, developing care pathways, improving outcomes, and delivering more care close to or at home. The legislative changes to the 'commissioning' footprint and the move to delivery partners will change the way that dialogue takes place.

5.2.4. Robust architecture will be required to enable and promote the dialogue between primary and secondary care at system level, across the ICB footprint and at hospital hinterland footprint. Local innovation should be fostered and tested, a maintained dialogue enables that, but once tested, improvements should be shared across the ICB to drive up quality and reduce unwarranted variation.

5.4.5 The architecture should embrace all stakeholders and enable dialogue across the system. For example, the Provider Collaborative Clinical Integration Group has identified nine priority workstreams. Primary care dental providers will want to further influence and contribute to the improvements in the Head & Neck / Oral & Maxillofacial workstream.

5.4.6 This dialogue delivers real benefits, for example, in Morecambe Bay and East Lancashire, following cataract surgery the post-operative assessment is conducted in primary care optical practices. Clinical data flows efficiently between acute Trusts and optical sites to facilitate the patient journey and enable reporting and governance. In some locations the initial cataract referral is refined by optical practices to reduce secondary care overheads during initial assessment and ensure only those who want and need treatment arrive at a surgical centre.

5.4.7 The ICB and the primary care professions may wish to consider developing a primary care collaborative.

5.5 OD

5.5.1 The ICB executive have determined that our Places will be the engine room and focus of the integration and health creation ambition. Progressing integration and tackling health inequalities in the places our citizens live will, as a principle of the target operating model, be prioritised for investment funding.

5.5.2 Population Health Teams have been established based on our current five places. Linking them more readily with local authority footprints where action on health and

wellbeing across the life course can be shared and progressed together makes good sense. The population health teams will need support to re-focus on a new footprint.

5.5.3 All colleagues and partners recognised the importance of all contributors / agencies in influencing well-being. In particular partners valued the contribution of the District or unitary authorities in this regard, they are seen as being connected to their citizens, agile, and responsive. Unitary and district, or lower tier, local authorities have responsibility for public services that impact on the way citizens live their lives across the life course. Planning, waste management, green spaces, housing, and leisure all have an impact on our wellbeing.

5.5.4 Partners valued the contribution of VCFSE partners but wanted more dialogue to be supported to collaboratively anticipate and respond to community needs. Partners in VCFSE and in existing PBPs are seeking clarity on how to engage with each other meaningfully.

5.5.5 In the first instance our Places will be the foci for deeper integration, functions that Places will lead on will include integration of health and care, Continuing Health Care, Safeguarding, Special Educational Needs and Disabilities, improving care home quality, and enhancing community and mental health provision.

6. Examples of What's Working Well

6.1 There is a need to protect the structures that work well and deliver for the population beyond the borders of the Local authority for example:

- Discharge team arrangements at Blackpool Teaching Hospital, interfacing with social care from both LCC and Blackpool Council
- ELHT interface with the community, both where directly responsible for provision and in collaboration with LSCFT, and adult social care, enabling enhanced patient flow and reducing patients not meeting criteria to reside
- Children under the care of UHMB Ophthalmology in Morecambe Bay who need a specific type of eye examination (cycloplegic refraction) are now examined in primary care where the children usually need to go to get their glasses anyway. Information flows between sites using a secure web platform, linking the clinicians at each end. This has strengthened professional relationships in paediatric practice to the ultimate benefit of patients.

6.2 The proposals within this paper would look to maintain and build on current delivery structures that work well regardless of place boundaries.

7. In Summary

7.1 The opportunities presented by alignment of our Places with Local Authority footprints are significant when applied to integration of health and care, and to population health creation across the life course.

7.2 As the Health and Care Act 2022 has created a new operating model, driving a collaboration and integration ethos on new ICS footprints much of what was

perceived as precious in our current footprints will be disrupted by the cessation of CCGs in any case.

7.3 To do nothing would impact on the successful delivery of the national policy and our local strategy and ambition for deeper integration and collaboration, joined up use of resources and addressing unwarranted variation at 'place'

8. Recommendation

8.1 The Board are asked to:

Approve the proposal to align our Place Based Partnerships with our local authority footprints.

8.2 Should the Board approve the proposal to align our Place Based Partnerships with local authority footprints the following recommendations for implementation should be considered:

- Develop a shared vison and memorandum of understanding with Local Authority partners to describe shared commitment to action. The system should develop an agreed way of holding each other to account.
- Develop clear OD plans that support teams to move to a new way of working, to harness system thinking and an 'improvement and integration first' way of working that does not rely on a commissioning relationship, delegation of funding or contractual levers.
- An agreed timeline for the establishment and development of Place over the next 3 to 5 years, with a clear statement of remit, delegations, and desired outcomes. This will help all partners understand what is within and outside of the scope of PBPs. Understanding the framework within which place operates will help partners at place build or maintain trust relationships and develop a common purpose.
- Production of a detailed Clinical and Care Professional Leadership Framework in the autumn of 2022 for implementation January 2023.
- A specific piece of work is indicated when considering the scale of Lancashire County Council upper tier and the interface with a single proposed Place Based Partnership. The need to link more actively with the District Councils and consideration of size and scale of delivery units or sectors within Lancashire for both operational manageability and responsiveness to disparate population needs is well recognised.
- Develop a delivery model to take account of new responsibilities for all four primary care disciplines and progress quality assurance and improvement oversight.
- Develop to support implementation of the Fuller recommendations
- The ICB and the primary care professions may wish to consider developing a primary care collaborative
- Consideration of future governance arrangements
- Recognition of smaller but critical partners, such as Hospices and VCFSE partners