Health and Care in and across the Humber and Place Partnerships

Condensed version for Primary Care Collaborative v27.05.21

Further detail to be added through design phase May-July 2021

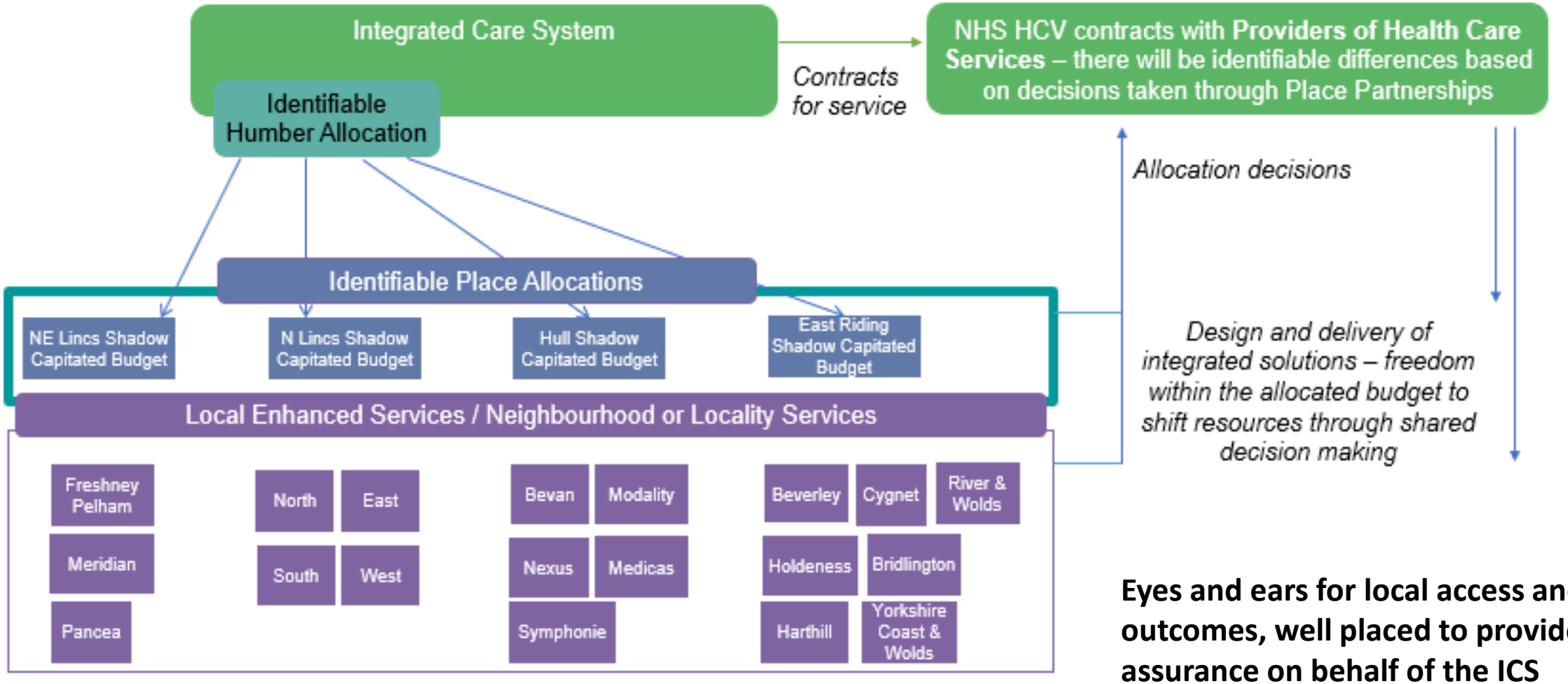
Operating Principles

- Statutory functions will transfer into a new NHS body - NHS Humber Coast and Vale - from April 2022. Any Local Authority / Adult Social Care functions held by CCGs will transfer back to Local Authorities.
- Subject to legislation, HCV will be the employer and receiving organisation for the NHS functions and accountabilities of the six current CCGs. Where partnership arrangements exist any Local Authority functions and accountabilities will transfer back to the local authority. The employment commitment excludes Board level leaders so it's important to ensure that all colleagues are receiving support during the change.
- HCV will discharge its responsibilities through Place-based and Sector-based units of operation (Place Partnerships and Provider Collaboratives). These will deliver integrated solutions for the services operating in Place or system-wide across a Sector. The pyramid in Appendix 1 describes this in more detail.
- The NHS resource allocation will flow to Place via a Humber allocation into the ICS. The Humber Partnership Director (Emma Latimer's role) is the designated officer responsible for allocations to Place.
- Humber will work through the four Place Partnership joint committees to facilitate allocation decisions about local services which drive integration, improve health outcomes and reduce health inequalities.
- Place Partnerships will be hosted by each of the four Local Authorities, with a Place NHS Director and very senior clinical leadership supported by other professional support functions.

Place Partnership – Place Shaper

- Commissioning evolves into two broad activities:
  - *system integration* (design, delivery, development – more operational and working with providers)
  - *strategic planning* (populations, partnerships, shared priorities, shared truth)
- Place Partnerships will be responsible for strategic leadership and integrated delivery for the health-improving / enabling activities it can most influence, e.g. those identified in the pyramid in Appendix 2.
- Place Partnerships are led by an Executive Place Director / hosted by LA and accountability through HWB
- Strategic leadership and integrated delivery team led by an NHS Director (COO), accountable to Humber Partnership Director (Emma Latimer's role) with a 'dotted line' to an Executive Place Director (such as a Council Chief Executive).
- Directly accountable to an NHS Place Director
  - Primary Care Integrated Delivery – working directly with Primary Care including dental, pharmacy and optometry, council wards and localities
  - Strategic Planning NHS and LA across the whole Place system
  - Provider Collaboration – multi-agency leadership and integrated delivery
  - Appendix 3 gives an idea of what teams will do (it might look different in each place in order to reflect differences in populations, communities and the multi-agency landscape)

Custodians of the Place Pound



Eyes and ears for local access and outcomes, well placed to provide assurance on behalf of the ICS

Humber Partnership – Adding Value to Place

- The Humber is a small core team and budget to commission bespoke / external expertise.
  - Strategic development – embedding system operating, creating the conditions to enable all partners to participate, aligning health with socio-economic objectives e.g. anchor institutions, research, innovation, enterprise, education, workforce.
  - System planning and assurance – coordinating priorities at neighbourhood, place and Humber to deliver improvements in health, inequalities, integration, unwarranted variation, and efficiency in how resources are allocated. Resolving disputes and responding to new/unexpected priorities.
  - Population Health – facilitating efficient, effective, and objective decisions by drawing together public health and population intelligence, health economics and behavioural insights.
- The Humber will have a named very senior finance lead, and input from nursing and quality, business intelligence and communications.
- Executive, clinical and lay leadership will be drawn together through existing distributive leadership discharged through the Humber Partnership Board and its sub-structures - see Appendix 2.

Provider Collaboratives

- The role of Provider Collaboratives is standardising care, optimising resources (sites, staff, scale) and shared approaches. The Provider Collaboratives are developing governance to share costs, benefits, risks, and interface with Local Authorities Place and Primary Care collaboratives. They align with the activities described in the 'ICS' section of the pyramid in Appendix 1.
- Sector-based Provider Collaboratives have an important role to play in Place Partnerships. For example, solutions to addressing access to A&E and outpatient services may be more readily addressed through investing or reallocating resource into other local services and sharing risks across the Place Partnership
- Membership reflects HCV geography e.g. Provider Collaboratives in North East Lincolnshire will be represented by North Lincolnshire and Goole NHS FT, Care Plus Group and Navigo.
- Provider Collaborative and Place Partnership arrangements will both need accountability and assurance arrangements for the things they are responsible for – these will need to be consistent especially around local access and interface services.

Timeline

Place arrangements will be developed in distinct phases:

- DEVELOP April – September 2021
- AMALGAMATE with CCG arrangements September 2021
- TEST October – March 2022
- OPERATE April 2022 – October 2023
- MATURE October 2023 – March 2024

When it is established, NHS HCV is expected to adopt the NEY Regional Development Frameworks* to provide a consistent framework for peer review / self- assessment of Place Partnerships and Provider Collaboratives.

*Appendix 4 Place Partnership Development Framework

*Appendix 5 Provider Collaborative Development Framework

Transition for our CCG teams

- The **majority of services will be designed, delivered and overseen at Place**
- **Not all services will operate within a Place footprint – some will operate at ICS level – for us this is NHS HCV** (e.g. some acute and MH services currently commissioned by NHSE and CCGs) **and supra ICS footprint – for us this is the North East and Yorkshire region** (e.g. the majority of NHS E Specialised Commissioning services, screening and immunisation services)
- Some roles will operate and be described differently reflecting an increased focus on
  - population health, health inequalities
  - system as opposed to organisational planning – no more commissioner-provider split
  - participatory clinical and citizen leadership
- Legislation and guidance will not come up with the answers for how our teams will operate or be structured – *Humber CCG System Development Group established*

Accountability proposal - CCG functions

Enabling teams/roles accountable to an ICS (HCV) Executive Lead but with Place Presence

- Nursing and quality
- Governance, assurance, risk and administration
- Finance, contracting, procurement
- Business Intelligence and performance
- People, culture and OD
- Communications and Engagement

Place teams/roles accountable to a Place NHS Director (COO)

Integrated Delivery and Development working with defined population health budgets and outcomes

Place: Health, social care, primary-secondary care interface. Provider Collaboration/Planning.

Neighbourhood: Primary Care enhanced services, Medicines Management, Social Prescribing, Wider Determinants. Primary Care Development.

Place NHS Director (COO) accountable to Humber Partnership Director and 'dotted line' to an Executive Place Director

- NHS Chief Operating Officer (Place NHS Director)
- Clinical leadership (medical, nursing)
- Lay leadership

ICS (HCV or Humber) teams/roles accountable to Humber Partnership Director of other ICS Executive Lead

Integrated Delivery and Development

Acute, MH, W&C

Integrated Delivery and Development Programmes e.g. Elective, Cancer, TCP, HASR, Digital

Strategic Planning (Population Health, System Plan, Partnership Development)

Commissioning, planning, PMO re-named Integrated Delivery and Development
Lay leadership – some ICS roles (ICS Health and Care Partnership), some Place roles – tbc by national guidance / Place work led by COOs
Strategic planning – Small core team-Humber, accountable to Humber Partnership Director

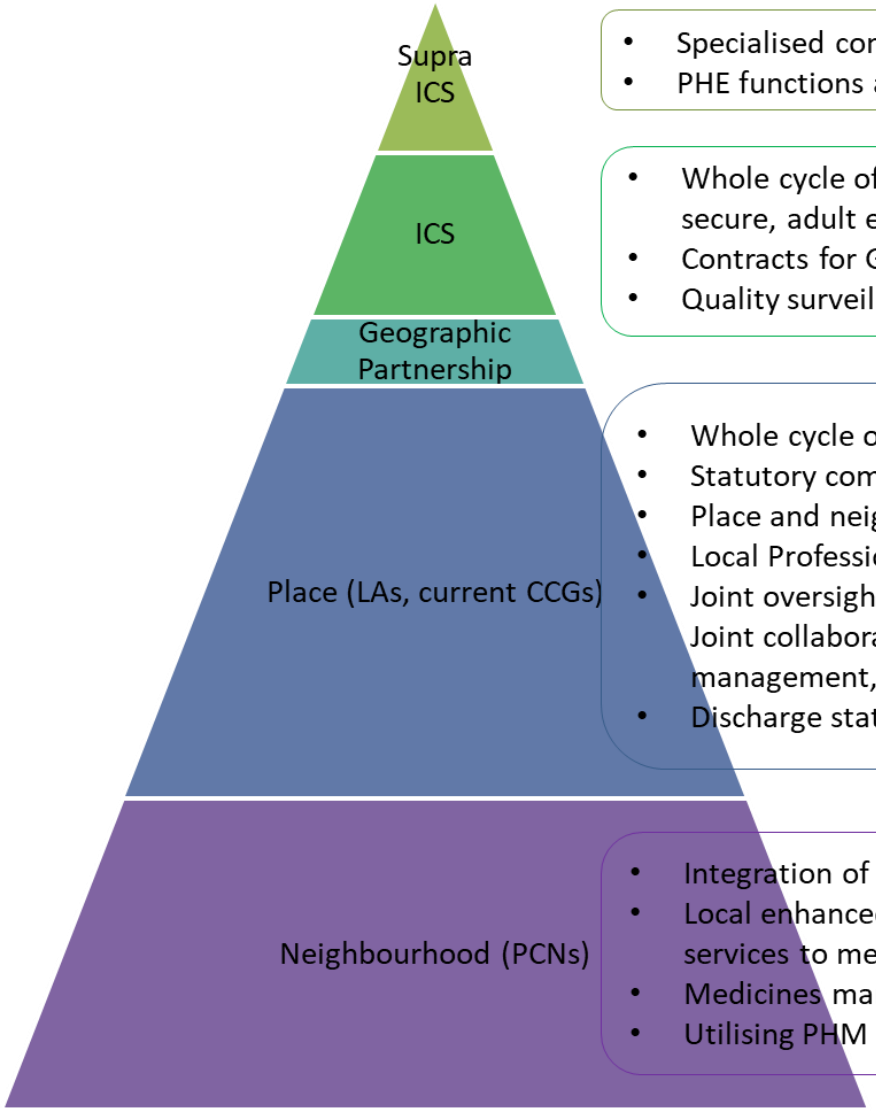
Place Models

- Place arrangements will define integrated care arrangements for health and care in each Place - Hull, East Riding, North Lincolnshire and North East Lincolnshire (NEL shared mid May)
- Development is being led by Local Authority Chief Executives and CCG Chief Operating Officers and is involving local providers.
- Place arrangements will reflect local vision/priorities recognising health inequalities and local set up
- Place responsibilities/high level teams at various stages of development – to be confirmed by the beginning of July to enable engagement/approvals through governance to prepare shadow operating from Sep/October.

APPENDIX 1 What will be done where (HCV work for Region)

Fig 1. Building from the neighbourhood up – aligning CCG and NHSE commissioning

What will be done *at neighbourhood, unless it's better done at place/ICS, or at place unless it's better done at ICS level.*



- Specialised commissioning for c.49 services (c.80 national) . Primary care performer list . Ambulance
- PHE functions aligned to NHS E services . Screening and Immunisation

- Whole cycle of speciality care including (a.) 18 Specialised services (see Product 3 Appendix B) (b.) adult secure, adult eating disorder and CAMHS Tier 4 . Non-custodial community facing health and justice
- Contracts for General Practice (Core), Optometry (Core), Dental (Contract), Pharmacy (Contract)
- Quality surveillance . Oversight and Assurance (Service Quality and Population Health)

- Whole cycle of urgent and emergency H&SC. Potentially A&E, general inpatient care, ambulance
- Statutory committees responsible for Place Pound, partnership development of place and PCNs
- Place and neighbourhood reporting through to the ICS – one version of the truth
- Local Professional Networks and GP Leadership
- Joint oversight, QI, allocation of place pound to care homes, community beds, home care, hospices, Joint collaboration with other health determinants e.g. education, employment, communities, weight management, screening
- Discharge statutory responsibilities on behalf of ICS - SEND, child death reviews, safeguarding

- Integration of primary care and the wider neighbourhood offer
- Local enhanced services (GP, Optometry), flexing of Dental and Pharmacy contracts to deliver enhanced services to meet local needs, social prescribing and VCS
- Medicines management and prescribing
- Utilising PHM in real time to plan proactive care responses

APPENDIX 2 Humber High Level (subject to legislation)

NHSE, CCG and new statutory functions and duties are the responsibility of the ICS under the new NHS Act

Delegations

The ICS determines which of its duties it retains and which it delegates / how they are delivered

Integrated Care System

Two statutory bodies: An **NHS Body** and a **Health and Care Partnership**

Geographic Partnerships

Humber Partnership Director

Informal arrangements supporting integration across 15 statutory organisations and 19 PCNs

Humber Partnership Board

- Advisory Board (Lay and Elected members)
- Oversight Management Board
- Clinical and Professional Leaders Board

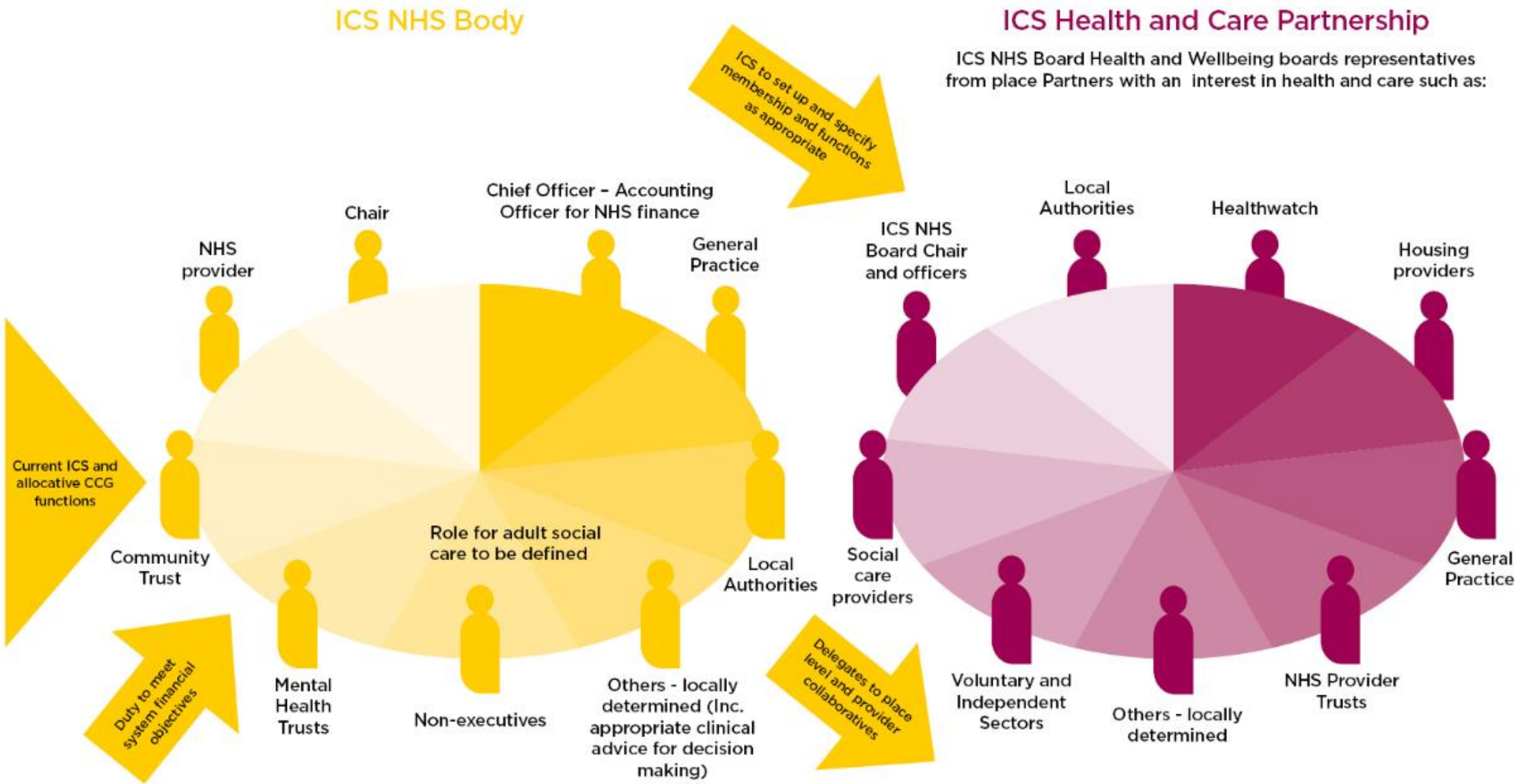
Places

- NE Lincs
- N Lincs
- Hull
- East Riding

Formalised arrangements through which the 4 Humber Places can collaborate e.g. through regular meetings of Place leaderships and the Humber Partnership Director

Local neighbourhood teams and professional networks organised around PCNs

- Freshney Pelham
- Meridian
- Pancea
- North
- East
- South
- West
- Bevan
- Modality
- Nexus
- Medicas
- Symphonie
- Beverley
- Cygnet
- River & Wolds
- Holdeness
- Bridlington
- Harthill
- Yorkshire Coast & Wolds


ICS NHS Body
ICS Health and Care Partnership
ICS NHS Board Health and Wellbeing boards representatives from place Partners with an interest in health and care such as:
ICS to set up and specify membership and functions as appropriate
Current ICS and allocative CCG functions
Duty to meet system financial objectives
Delegates to place level and provider collaboratives
NHS provider
Chair
Chief Officer – Accounting Officer for NHS finance
General Practice
Community Trust
Mental Health Trusts
Non-executives
Others - locally determined (Inc. appropriate clinical advice for decision making)
Local Authorities
Role for adult social care to be defined
ICS NHS Board Chair and officers
Local Authorities
Healthwatch
Housing providers
Social care providers
General Practice
Voluntary and Independent Sectors
Others - locally determined
NHS Provider Trusts

APPENDIX 3 An idea of Integrated Delivery and Development Teams at Place

Primary Care Integrated Delivery	Strategic Planning NHS and LA	Provider Collaboration support and facilitation	Quality and performance
Strategic leadership to PCN's. Integrated Delivery Population health management Management support to clinical leadership for pathway design Risk stratification BI and intelligence, Interpretation and Information Embed the working of PCN's in place and wider system with clear alignment of plans. Quality outputs & outcomes	Strategic Leadership Adults , Children (SEND/ Safeguarding) & Vulnerable People (MH, Homeless , LD) Integrated Delivery Commissioning & Contracting support to VCS, Carers, PH services. Wider determinants, public sector partnership health inequalities Early intervention & prevention Manage neighbourhood/community based arrangements	Strategic leadership to multi agency working at place , Humber & ICS Integrated delivery through collaboration with providers Manage delivery , monitoring and evaluation of collectively agreed operating model to deliver whole-population integrated care.	Delivery of statutory duties at place and outcomes based on effective patient/public involvement Mutual accountability arrangements across place partnership to deliver and oversee improvement Accountability back to the HWBB and ICS against quality, finance and performance indicators Learning and improvement cycle back to other core functions
Health Inequalities – data collation and interpretation, working to a common framework Patient and Public (engagement, experience and consultation) Providing expertise in Acute care, Urgent care, MH & LD, Primary Care, Children & YP			

The Place models for Hull, East Riding, North Lincolnshire and North East Lincolnshire (and York and North Yorkshire) will reflect differences in populations, communities and the multi-agency landscape.

APPENDIX 4 Supporting Places in their Development (based on WY&H)

Is the Place **Emerging**, **Developing**, **Maturing**, or **Thriving**, according to these areas of development?

Ambition and Vision

- Is there a clearly defined place contribution to the **ICS big ambitions**.
- Is the Place working to a **single source of data**?
- Does the Place have **a clear strategy** setting out the vision?
- Is there **clear ownership** of the strategy across all partners in place?
- Have all organisations signed off the **joint plan** through their own governance?
- Has **clinical leadership and citizen voice** been embedded in the design and development of the joint plan?

Design and Delivery

- Does the Place have a structure in place which clearly articulates its **role and responsibilities** at place?
- Does the Place have clear **management and leaderships** arrangements in place?
- Are there **effective processes** and systems in place to make it work?
- Is there clear governance in place to establish a **Joint Committee** which can act as a sub-committee to discharge finance, quality and performance to?
- Is there an **effective decision making** framework in place?
- Are there processes in place for partners to hold each other accountable for performance, as part of a **mutual accountability framework**?

Improvement Ethos

- Performance **development and improvement** rather than traditional performance management
- **Data driven, evidence based** and rigorous approach to design and delivery, including real time data to track continuous improvement
- Focus on improvement, **supporting spread and adoption of innovation** and best practice between partners
- **Staff, service user and patient driven, requiring skills in change and improvement**
- Harness and leverage partners capacity and expertise in improvement
- **Peer review** a core component of improvement methodology
- **System oversight and assurance will prioritise deployment of improvement support with input from places**

System Leadership for effective partnership working

- Does the Place have **an OD culture of shared learning**?
- Do the system leaders consistently **demonstrate the agreed Place values and behaviours**?
- Has the **workforce moved from 'payslip to place'?**
- Is the **Place clear on what behaviours would enable true trust and therefore collaboration**?

WY&H has commissioned an external provider to develop a tool which Place Partnerships will use to self-assess behavioural competence to enable change through influence and personal / team change readiness.

APPENDIX 5 Provider Collaborative Development Framework (NE & Cumbria)

A **thriving** Provider Collaborative seeks to go beyond the minimum and has an ambition to excel for its population

Ambition and Vision

- Vision based on evidence informed by challenges faced by **population**, services, organisations
- Compromise
- **Clear, measureable outcomes**
- Strategy to deliver triple aim
- **Membership from all NHS provider trusts**
- Shares best practice
- Links with other PCs
- **Co-produce with patients**
- **Early intervention and prevention programme**

System Leadership

- Collaborative, **inclusive governance**
- Transparent and robust governance, holding each other to account
- Culture of shared learning to support shared decision making, **development of future leaders**
- **Clear plan re. end state 18m-2 yrs**
- Agreed values and behaviours, embedding within their own organisations
- **Staff feel they work for their PC or system as well as their organisation and are able to move flexibly**
- Effective delivery of **improvement plan**
- PC work and plans **seamlessly dovetail with Place**

Infrastructure and Systems

- Agreed operating model to deliver triple aim considering **whole population joined up care**
- Clear lines of accountability and governance, TOR co-owned and clear alignment to constituent trusts
- **Mutual accountability** arrangements
- Track record of success in **improving health outcomes, service quality and access**
- Hold **population/pathway based contracts that span multiple care settings and multi year time horizons**
- **Share risks and gains** across providers, transparency around resource availability, allocation and capital prioritisation
- Joint **finance plan and impact on outcomes**
- **Shared infrastructure including clinical leadership, data, waiting lists to ensure equity of access, equitable Covid recovery, prioritisation of resources and further investment in prevention**
- Track record of mutual aid, reconfiguration