Report to:	Cabinet	**Date of Meeting:**	1 April 2021
Subject:	Strategic Integrated Care Partnership and Governance		
Report of:	Chief Executive	**Wards Affected:**	(All Wards);
Portfolio:	Cabinet Member Adult Social Care Cabinet Member Health and Wellbeing Cabinet Member Children, Schools and Safeguarding		
Is this a Key Decision:	Yes	**Included in Forward Plan:**	Yes
Exempt / Confidential Report:	No		

Summary:

1.1 This paper provides an update on the proposed arrangements for the next phase of development of the place-based approach to Integrated Health and Care in Sefton, referred to as Integrated Care Partnership (ICP)

1.2 The ICP will be underpinned by a revised governance structure and a range of task and finish groups to ensure we develop our own transformational programme.

1.3 The report has been tabled and supported at the Health and Well Being Board prior to submission to Cabinet.

Recommendation(s):

1) Note the progress made to date by the Council and its Partners in establishing the Integrated Care Partnership;

2) Cabinet Members are asked to consider and approve the recommendations contained within the report.

3) Agree the leadership and support systems to deliver the changes. It is therefore recommended that the Executive Director of Adult Social Care and Health be designated as Place Lead.

4) Agree that regular progress reports would be presented to the Health and Well Being Board and Cabinet with any Key Decisions escalated as required.

Reasons for the Recommendation(s):

Proposed legislative changes once enacted will require new arrangements to be put in place. The report sets out the infrastructure needed to achieve this.

Alternative Options Considered and Rejected: (including any Risk Implications)

Proposed legislative changes once enacted will require new arrangements to be put in place and so doing nothing is not an option.

What will it cost and how will it be financed?

(A) Revenue Costs

There are no revenue costs associated with this report at this stage

(B) Capital Costs

There are no capital costs associated with this report at this stage

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): There are no resource implications arising from this report at this stage
Legal Implications: There may be legal and policy implications for the Council contained within the proposed legislative changes that will be enacted in April 2022 and will be presented for decision as required.
Equality Implications: There are no equality implications at this stage, however any policy change will be subject to an equality impact assessment.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Proposals allow a Sefton Health and Care system focus on health inequalities and wider determinants of health
Facilitate confident and resilient communities: Proposals allow greater localised control and focus on the needs of the borough of Sefton in the design, delivery and review of Health and Care Services
Commission, broker and provide core services: Proposals strength the role of Strategic Commission at a Sefton borough level and encourage greater collaboration for better outcomes.
Place – leadership and influencer: proposals set out the road map for greater local control driven by the Health and Wellbeing Board.
Drivers of change and reform: Proposals allow a Sefton Health and Care system

focus on health inequalities and wider determinants of health
Facilitate sustainable economic prosperity: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Greater income for social investment: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Cleaner Greener; Proposals will allow a greater focus on wider determinants of Health

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD6338/21) and the Chief Legal and Democratic Officer (LD 4439/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Proposals build on the NHS England led national consultation Integrating care: Next steps to building strong and effective integrated care systems across England (which closed on the 8th January).

Implementation Date for the Decision

Following the expiry of the "call-in" period for the Minutes of the Cabinet Meeting

Contact Officer:	Eleanor Moulton
Telephone Number:	07779162882
Email Address:	eleanor.moulton@sefton.gov.uk

Appendices:

The following appendices are attached to this report:

1) Strategic Report

Background Papers:

NHS England Consultation:

https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

Health and Social Care White Paper:

Working together to improve health and social care for all - GOV.UK (www.gov.uk)

1. Context and proposals

1.1 The development of an ICP (Integrated Care Partnership) in Sefton is in line with national policy set by NHS England/Improvement in respect of developing Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP) by April 2022. This development also reflects the approach being taken at a Cheshire & Merseyside Health & Care Partnership level in terms of its own development as an ICS comprising a number of Integrated Care Partnerships (of which Sefton is one).

1.2 Organisations in Sefton have been developing stronger and more effective ways of working together to address health and wellbeing inequalities and the response to the pandemic has further strengthened these partnerships. This approach was initially developed through a Provider Alliance model, however with proposed changes around legislation contained within the White Paper there will be a requirement that system partners should now begin to formalise arrangements for an Integrated Care Partnership at Place or Borough level with "place" being the terminology used in NHS policy. Attached at Appendix 1 is a detailed strategic position which sets out the proposed approach for Sefton and reflects the current thinking around the White Paper for Health and Social Care published on the 11th February 2021.

1.3 The Sefton Integrated Care Partnership will bring together key partners from across the Sefton, recognising both the vital role of wider cross-sector partners and the central role that Primary Care Networks will play in adopting a population health management approach in Sefton. The Integrated Care Partnership will work together to deliver improved health and care outcomes for Sefton's population. The Health and Wellbeing Board and system partners have already agreed several key priority areas embodied within the Health and Wellbeing strategy which can be viewed here: https://www.sefton.gov.uk/media/1648266/sefton-health-and-wellbeing-strategy-2020-2025.pdf

1.4 As previously stated, Appendix 1 sets out the partnerships strategic position and in order to develop the position into our Integrated Care Partnership it is proposed that a review of the terms of reference of the Health and Well Being Board is undertaken. In addition, a range of task and finish groups will need to be introduced and these are set out in section 13 within Appendix 1. This phase of development will take place over the next 12 months to 31 March 2022 and the governance structure will be refreshed as part of the development of the Integrated Care Partnership.

1.5 The White Paper makes specific reference to "collaborative commissioning" and the requirement for provider organisations and commissioners to work closer in order to improve Health and Wellbeing outcomes for their Place or Borough. In Sefton we continue to make progress in this area and there continues to be ongoing focus on the integration of 'commissioning' which will support the successful delivery of the Integrated Care Partnership. The 'Place' will be led by the Executive Director of Adult Social Care and Health who will work together with all partners to deliver the strategy with governance and oversight from the HWBB.

1.6 The Accountable Officer for the CCG's has discussed the paper with the Governing Body of NHS South Sefton CCG and NHS Southport and Formby CCG who are both supportive of the approach. The report has been shared with the Cheshire and Merseyside Health Partnership and other key partners. The role and function of the Governing Body of the CCG's will be affected by the proposed legislative changes brought about by the White Paper and introduction of the ICS and so the Accountable Officer from the CCGs and the team will provide a strong steer through this period of transition. It is proposed that the Accountable Officer provides Executive Sponsorship to the Transformation and Integration programme to support the Executive Director for Adult Social Care and Health, in this interim period and supports the development of the Primary Care Networks in the Borough.

2. Conclusions

2.1 This report and the detail contained within Appendix 1 outlines the proposals to develop the Strategic Integrated Care Partnership (ICP) as the 'place' arrangements and as the next steps in our ambition for integrated Health and Care arrangements in Sefton. This is in direct response to the national proposals from NHSE/I to develop a Cheshire and Merseyside Integrated Care System (ICS) by 2022 and the requirement for 'place based' arrangements as part of this transformation agenda.

Appendix One:

Sefton Council

Integrating Place Making Care systems for Sefton Local Authority Area

The Sefton Integrated Care Partnership (SICP)

Integrating Place Making Care Systems for Sefton Local Authority

The Sefton Integrated Care Partnership (SICP)

1. Purpose of the report

The following is a Sefton Borough Council position statement regarding the new arrangements for NHS Integrating Care in terms of 'place'. The report sets out what is expected and what can be defined locally in relation to place making. The report also outlines the steps we need to consider and the time scales for implementation.

2. Background

It has been recognised that the NHS has been largely organized to provide episodic treatment for acute illness to date and the fact is now, more than ever, needs to deliver joined up support for increasing numbers of older people and those living with chronic conditions. Nationally there continues to be an unacceptable inequality in the health of our population and life expectancy is stalling with the wider determinants of health being now well known but often tackled in silos. The Health Foundation (2017) suggests that as little as 10% of a populations health and wellbeing is linked to access to health care. Sefton welcomes the opportunities to work with the NHS and partners in addressing unacceptable health inequalities which sadly persist at national, Cheshire and Mersey and borough level.

The integration of health and care has the potential to drive improvements in population health by reaching beyond the NHS to involve local authorities and other agencies to tackle the wider determinants of health that drive longer term health outcomes and inequalities. Together we are better placed to promote positive health related behaviour, ensure equitable access to quality clinical and social care services. But we can also tackle those issues which influence opportunities and behaviours. These relate to our built environment and socio-economic situation.

Our Place should be bold and ambitious in tackling the wider determinants such as employment, physical environment, personal income, housing, food security, transport, education and skills as well as creating safe and nurturing communities that can flourish.

The Cheshire and Merseyside Sustainability and Transformation Partnership (STP) was established in 2016 as a fore runner of the Health Care Partnership and today includes 9 CCG's, 9 LAs and 19 NHS Provider Trusts.

Key background papers on integration include the LGA Paper "Integrated Commissioning for better outcomes" published in April 2018 (Integrated Commissioning for Better Outcomes: a commissioning framework | Local Government Association)

clearly stated getting integration right is now more important than ever for the populations and people who use Health and Care services, and for the families that support them. This also outlines the critical role of Health and Wellbeing Boards in driving this process forward. Reiterated by the Kings Fund in November 2019 in its paper on Health and Wellbeing Boards and Integration which can be found here:

www.kingsfund.org.uk/publications/articles/health-wellbeing-boards-integrated-care-systems

Covid has demonstrated the importance of addressing equity and inequalities within our communities and we need to improve the lives of our poorest communities through transformation and integration of care and systems, but we need to draw in our wider partners to assist us with this change.

On 11 February 2021, the government published a White Paper Integration and innovation: working together to improve health and social care (DHSC, 2021), setting out a raft of proposed reforms to health and care. This was accompanied by an NHS England (NHSE, 2021) publication- Legislating for Integrated Care systems, which set out the five recommendations NHSE made to government to inform the white paper. These recommendations were set alongside some principles to guide how the Government progresses this work.

The recommendations are:

i. The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

ii. ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

iii. The NHS ICS statutory body should be supported by a wider statutory health and care stakeholder partnership. Explicit provision should also be made for requirements about transparency.

iv. There should be maximum local flexibility as to how the ICS health and care stakeholder partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where this work well. The composition of the board of the NHS ICS statutory body itself must however be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance.

v. Provisions should enable the transfer of responsibility for primary medical, dental, ophthalmic and community pharmacy services by NHS England to the NHS ICS statutory

body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

3. Context

The main vision and principles are embodied within the Health and Well Being Strategy 2020-2025 (a set of shared priorities that stretch across organisations is key requirement of the emerging models) and focus upon:

- Improving health and wellbeing outcomes for and with people and reduce inequalities.
- Creating conditions for partners to focus on single set of outcomes
- Transforming the current crisis response, demand led acute approach to prevention, to enablement and supporting people to stay well and independent in their own communities.
- Providing a single and consistent commissioning voice to providers, voluntary sector, and independent sector communities.
- Providing a place-based approach based on neighbourhoods and needs led with a focus on joint strategic needs assessment based on a focused single set of data and intelligence
- Enabling commissioning staff to work together to commission joined up services which are cost effective.
- Improving the quality and experience of all health and care services.
- Working with the Council to develop primary care networks to further develop integrated care for communities.
- Creating capacity by utilising and maximising workforce assets and skills, reducing administration to facilitate local system leadership.
- Working together on addressing the financial pressures within the system
- Creating capacity to accept delegated authority for the commissioning of other NHS England commissioned services.
- Enabling the organisation to join up areas of best practice into a single strategic overarching pathway of prevention, care and support.

Based on the most recent 2019 Index of Multiple Deprivation (IMD) Sefton is ranked 89th out of 317 local authorities. The burden of deprivation does not fall equally across the borough. Thirty-eight of Sefton's 189 Lower Super Output Areas (LSOAs) are in the most deprived 10% nationally. This equates to approximately 58,000 residents (21% of the population). Conversely only seven Sefton LSOAs fall in the least deprived 10% nationally (4% of the population and 10,000 residents).

Sefton's ranking in 2015 was 100th, indicating that Sefton has become relatively more deprived. Sefton's 2015 IMD ranking was 100 (higher is more deprived). This suggests that Sefton has become relatively more deprived, compared to other parts of the country since 2015. Sefton's 2019 rank places it in the second most deprived quintile (or fifth) of

local authorities. Despite this, *on average,* Sefton was the least deprived local authority in the Liverpool City Region according in 2019. This decline reinforces how important it is for the Borough to focus explicitly on its locality commissioning programme with an emphasis on early intervention and prevention.

The Due North report (2014) highlighted differences in health across England – people in the north had worse health when compared to people living in the south. It recommended:

- Tackling poverty and economic inequality within the North and between the North and the rest of England.
- Promoting healthy development in early childhood.
- Sharing power over resources and increase the influence that the public has on how resources are used to improve the determinants of health.
- Strengthening the role of the health sector in promoting health equity.

It also recommended tackling health inequalities by building on the strengths of a community, for example the expertise of people in the area. The report stated that the public must have a say in how resources are used to improve health and reduce health inequalities. These findings were used by Public Health England to establish a Well North programme to pilot this approach across a number of areas in the North of England. Sefton was one of the first areas selected to take part in the programme.

Health inequalities are created over time, sometimes over decades, and can take just as long to be addressed. As stated in 'Health Equity in England: The Marmot Review 10 Years On' (2020) [IV] (and he repeats this in the December review on the impact of Covid – Build Back Fairer) more work is needed to reduce the widening health inequalities gap.

The recently published Sefton Public Health report highlighted what action can be taken at a local level to address the wider determinants of health in order to reduce many of the avoidable health inequalities we have in Sefton. In line with the approach recommended by the Due North Report (2004), Well Sefton has worked hard to address inequalities by focusing on a community-led approach, building on local assets and developing community capacity. Coincidentally, the Public Health approach underpinning Well Sefton aligns closely with the recent recommendations published in the Marmot Review 10 years on. The Sefton Public Health report recommends the use of a local social value approach, investment in social, cultural and economic resources in deprived communities, a focus on early intervention and prevention, recognition of the value of engagement with local communities and a vision of community led partnerships. The Sefton Health and Wellbeing Board in its March 2020 meeting approved a report on the proposed engagement in the work to see Cheshire and Merseyside become a Marmot region and recognised its significance in delivering the Sefton Health and Wellbeing Strategy (which can be viewed here, https://www.sefton.gov.uk/media/1648266/sefton-health-and-wellbeing-strategy-2020-2025.pdf).

In 2019 Sefton's Clinical Commissioning Groups (CCGs) published the five-year strategy Sefton2gether-Shaping Sefton II, in line with the NHSE requirement following publication of the long term plan. The CCGs worked closely with the local authority that was simultaneously refreshing the Health & Wellbeing Board strategy. This document built of the earlier work of the CCGs strategic plan Shaping Sefton I and affirmed the role of the local NHS alongside the council as anchor institutions with the ability to provide much needed employment to the community adding social value. The plan strengthens the focus on tackling the wider determinants of health.

The Cheshire and Merseyside Health Care Partnership formally wrote to NHS England on the 28th January 2021 to seek approval to become recognised as an Integrated Care System citing its potential to drive improvements in population health by reaching beyond health and care to tackle wider determinants through:

- System stewardship
- Inclusive arrangements
- Engagement with Public Staff and other key Stakeholders
- Planning and establishing an approach to Finance and Performing
- Enhancing Integrated Commissioning at place/borough level
- Provider collaborative
- Responding to and embedding NHS Constitution
- Academic partnership to underpin programme evidence and evaluation.

The ICS (Integrated Care System) application from the Cheshire and Merseyside Health Care Partnership references the Local Authority as being able to provide focus through the Health and Wellbeing Board. With the fundamentals of an ICS integration being focused on an improved population health and healthcare, tackling unequal outcomes and access to services, enhancing productivity and Value for Money and Helping the NHS to support broader Social and economic development. Reflecting the priorities defined by the Sefton Health and Wellbeing Strategy. The application also highlights the need to increase networks into areas of influencing and affecting wider determinants recognised as key council focuses of deprivation, environmental degradation and the build environment including housing, as well as linking Education, employment, and service delivery at place.

4. Definitions

Within the guidance issued by the Department of Health, the role of 'Places', are defined as meaning "long-established Local Authority boundaries", at which joint strategic needs assessments, health and wellbeing strategies and commissioning approaches are developed in partnership, to deliver the following:

- Closer working with LA and VCS partners on prevention and health inequalities
- Joining up Council/ hospital/ community services
- Clinical care redesign (including simplifying and standardising care pathways)

- Forming provider partnerships and alliances (including GPs) to redesign and integrate services
- Developing new provider models
- Population health management
- covers 250-500k population (Usually Council/ Borough level)

It recommends that 'Place' should be sub divided into Neighbourhoods and should work alongside, and with Primary Care Networks (PCN) on population footprints of 30-50k

Neighbourhood aims are:

- Implementing integrated delivery models, forming Multi-Disciplinary Teams
- Forming PCNs, strengthening primary care, joining up primary & community care
- Implementing social prescribing

5. Integrated Place Based Care

The aims of integrated place base care systems are to:

a) Plan, manage and deliver services together for populations. This would enable neighbourhoods to focus on need be that a health need or a wider determinant of health need
b) Linking education, employment and service delivery in a Place/Borough to enable us to shape our workforce and build resilience and opportunity in communities
c) Linking health skills and knowledge with housing and care across our neighbourhoods to enable us to support our families in need or at risk of harm

The guidance suggests that partners should include - Primary Care Network Leads, Local Authority adult and children's social services leads, Community Health Provider, Mental Health Provider, Acute Provider(s), Public Health, Voluntary sector, Housing, Police, Education

Each area therefore must:

- Access clear advice on staying well; There is still a strong emphasis on individual responsibility and choice. The strength of a place-based approach is that we should be looking at the barriers that mean people don't act on the advice – even if it is clear and accessible. If we have prevention services – and we will need to create an environment that will help people put the advice into practice. The NHS as a huge employer can play a role here but the partners at place can take a lead.
- Access a range of preventative services;
- Access simple, joined-up care and treatment when they need it;
- Access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- Access proactive support to keep as well as possible, where they are vulnerable or at high risk; and to

- Expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in social and economic development and environmental sustainability.

Delivery will be through Local Government, NHS providers, Primary Care and the voluntary sector working together in each place in ICPs, built around Primary Care Networks (PCNs) in neighbourhoods.

The Council can really influence wellbeing and prevent ill-health. We already work as

- System leaders
- Mobilise resources across a diverse work force (Covid is a good example) and partners
- See health as an asset
- The Council already take a wider and social determinants approach – roads, traffic, air quality, housing, education, community safety, etc and deliver on population interventions such as screening and vaccination programmes – get that right and we could save 100s more lives
- Picking up and optimising management of those people with long term conditions – managing high blood pressure, diabetes care. It's about finding the missing patients.
- Building prevention and early intervention into their routine work, e.g. smoking cessation and vaccine promotion in maternity care.

There is much to gain from the synergy of the 8 CCG localities with the 3 Council locality areas and work has been accelerating through the Integrated Neighbourhood teams. Through transition over the next 12 months the leadership role of the Primary Care networks (PCNs) will gather momentum. These local footprints will be the vehicle for driving the approach to population health management (PHM).

6. Integrated Care Partnerships

The Department of Health and Social Care (DHSC) recognise that every area is different, but clearly highlight that common characteristics of the most successful systems are when there is the full involvement of all partners who contribute to the Place's health and care.

The DHSC recognise that there is a critical role for local Councils to work with health partners who will play a leading role for clinical primary care leaders, through Primary Care Networks; and a clear, strategic relationship with Health and Well Being Boards.

To support the above there are already well established and recognised governance arrangements in place, underpinned by Sefton's Health and Well Being Board. The governance set out below is a way of connecting the above roles together, whilst at the

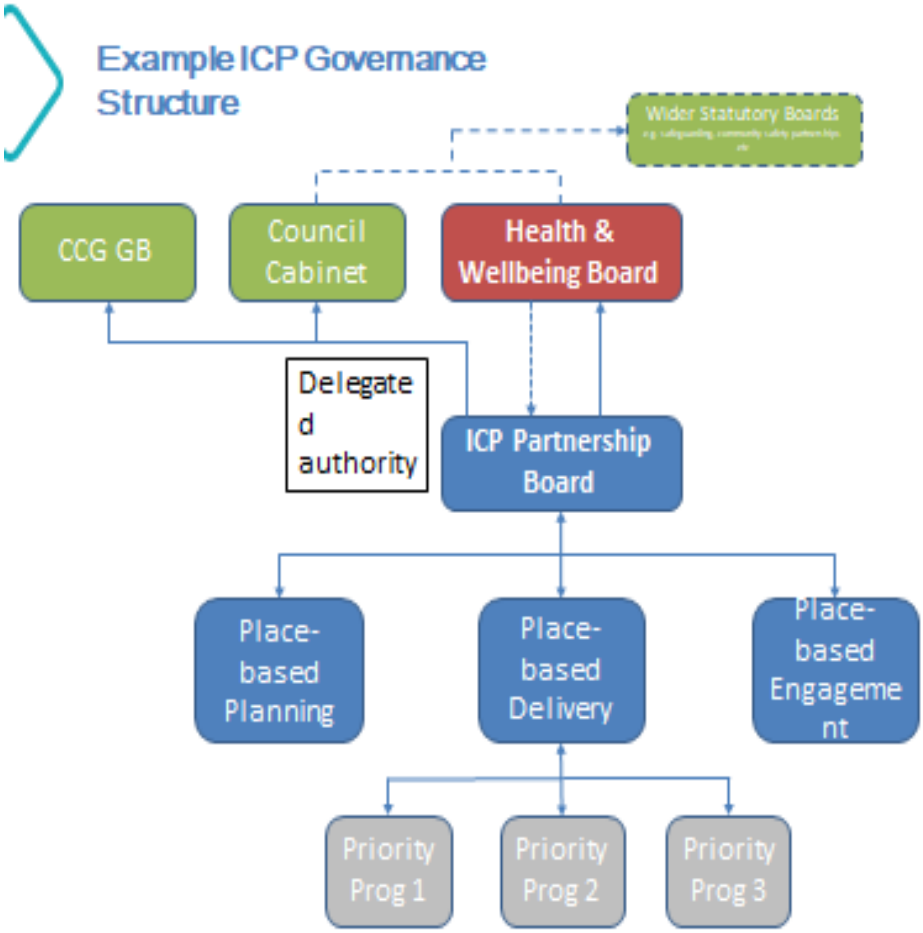
same time continuing with the adult forum, children and young people (CYP) and Special Educational Needs Board.

It is recommended that the adult forum is reviewed and developed into a fully functioning Board within the same model of the SEND and Children and Young People Boards. There will be an opportunity to shape local governance at Borough level with a focus on strengthening the Health and Wellbeing Board to support local system leadership and with a strong emphasis on improving population health.

Future transformation funding will focus on improving population health at scale across the Cheshire and Merseyside footprint and so the role of the HWBB will be pivotal. Systems of governance will change over time in line with legislative changes.

We also need to be nimbler and it is therefore also recommended that the TOR for the HWBB are reviewed with the existing CCGs, PCNs and NHS/Voluntary Sector, Healthwatch, Housing, Police and Education partners playing a pivotal role in its future development, and a memorandum of understanding is developed to ensure agreement from all partners.

As can be seen from the diagram below the C&M Partnership are beginning to consider the future governance and as can be seen from their position on place-based commissioning and integrated care it is heavily weighted to the roles and functions of Local councils and its role as system leaders in the ‘Place’.



Whilst this approach is the one recommended by the C&M Partnership it will be for the area to determine its own approach and the process is set out to achieve its own destination within the report. A key component of the success of the Integrated Care Partnership- place model is ensuring the planning and delivery function are working in a harmonious way at both strategic and operational level. Work will need to be undertaken to consider the development of a partnership plan that truly reflects this for Sefton.

7. Finance

The DHSC guidance states that systems should ensure that each Place has appropriate resources, autonomy and decision-making capabilities to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets. CCGs already receive 0.2% of their total resource allocation to support the move to place-based care and we would wish to work in partnership with the CCGs in the design of organisational structures for the future beyond 2021.

The devolved budget will include CCG Budget, PCN and majority of specialised commissioning such as mental health services, eventually devolved to place. Place leaders will have a duty to spend within the financial rules but also in line with local strategies. The white paper reinforces the focus on finance, value-for-money and capitated budgets (which aligns with PHM). As its uncertain currently what level of delegated resource Sefton may receive from the ICS, it is worth considering how this impact on pooled arrangements, specifically in relation to spend. This is important so that at ICP level there is a whole 'pathway' view taken in order to facilitate the 'left shift' in activity which will be needed to release spend from acute providers to facilitate reinvestment.

In Sefton we already have a £48M pooled budget, the ninth largest in the North West. However, it would not be described as a means of transforming the system and deliver the outcomes against the health and well-being strategy and in affect it is currently largely transactional with the main focus on the better care fund and programme.
However, with a change in focus and with more engagement and support of the NHS and other voluntary sector providers there is a significant opportunity to expand the Section 75 arrangement to cover children services, public health and housing and make this a transformation budget to deliver against the Health and Well Being strategy for the Sefton population.

Oversight will be required of the funding being made available to spend on Sefton residents Health & Social care. This resource needs to be considered in the context of outcome-based measures and potential for different and lengthier contracting mechanism e.g. Lead provider models, to move away from historical 'piecemeal' transactional methods.

8. Prescribed and Flexible elements

The DHSC guidance states that 'Place' leadership arrangements should consistently involve:

I. every locally determined 'Place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
II. the partnership involving, at a minimum, primary care provider leadership, Local Authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
III. agreed joint decision-making arrangements

They may flexibly define:

I. the configuration, size and boundaries of Places which should reflect meaningful communities and scale for the responsibilities of the Place partnership;
II. additional membership of each Place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;

III. the precise governance and decision-making arrangements that exist within each Place; and
IV. their voting arrangements on the ICP board.

The seniority of the leadership in the ICP should be commensurate with the roles and responsibilities, particularly if some of the CCG functions are to be delegated.

9. Collaborative Commissioning

The DHSC guidance states that each 'Place' must ensure there is a **single, system-wide approach to undertake collaborative strategic commissioning**.

The guidance clearly states that systems should also agree whether individual functions are best delivered at system or at Place, balancing subsidiarity with the benefits of scale working. Health Commissioners may, for example, work at Place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside Local Authorities.

Places will be expected to develop an integrated approach to commissioning between Health and the Local Authority, with shared posts, joint teams and pooled budgets to underpin and support the ICP. This role is described by C&M as place-based commissioning and co-ordination and must sit alongside the Health and Care Provider delivery parts.

The ICS will be required nationally to cultivate a strategic focus and ensure commissioning arrangements and decisions support and are aligned with system priorities in the context of shared commissioning decision making with Health and Local Authority in the ICP.

This will discharge core ICS functions at a local level through the ICP, which include:

- assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
- planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
- ensuring that these priorities are funded to provide good value and health outcomes
- Supporting a segmented and targeted approach to ensure we level up health inequalities
- Have contractual mechanisms for delivery
- Are able to ensure clinical input is a key part of Strategic Commissioning.

There must be minimal layers of decision making (some systems have a Joint Commissioning Board, but this is not prescribed). It must enable Integrated Commissioning arrangements for Health and Social Care, with local responsiveness

through the Health and Wellbeing Board. Whilst this already happens to various degrees in place, this is currently voluntary, but work is underway to make this legislation through the options proposed in the consultation. In 2021/22 work must be undertaken to layer residents' voices and the Voluntary Sector in the Governance process, with Health Watch involvement recommended. Involvement of Overview and Scrutiny is also referenced in proposed developments.

Within Sefton there is already a recognised commissioning structure and approach and it is believed that Sefton will be well placed to deliver against the DHSC priorities, be nimble, as well as form agreements developed with the C&M ICS.

10. Population Health Management, Digital & Quality assurance

The ICP should develop a system wide digital plan; a shared care record and a cross system Intelligence and analytical function. This needs to move from reactive business intelligence to a proactive PHM which supports the approach to early intervention and prevention and links to the system resource ensuring value for tax payer's money. This has to have strong connectivity to the CM ICS.

We have already invested heavily in shared care records and worked together in partnership, now we need to make sure this is more integrated and joined up with the Cheshire and Mersey HCP /ICS and the joint enabling programmes we wish to pursue are as follows:

- Shared networks – to enable colocation/multi agency teams
- Integrated case recording – to wrap services around customers
- Including Data protection requirements
- Joint approach to TECS strategy and priorities
- Digital inclusion strategy and connectivity
- A combined BI function would allow us to fulfil the requirement of the ICS to ensure that decisions and spending is predicated on evidence base and a inclusive and fully reflective needs assessment of the population of Sefton.
- Fulfil the requirement to have collective systems of management and performance at a place level.

In the ICP we have to fully utilise the capability of Combined Intelligence for Population Health Action (CIPHA) functionality and use it to understand population health needs and drive the change in delivery required to improve health outcomes and reduce health inequalities in Sefton.

The ICP will also need to develop a new quality assurance framework that will be to accommodate the elements of local authority work and previous functions of the CCG at a local level.

11. Place based leadership

The DHSC states that there should be a recognised and identified Place leadership to undertake the following tasks:

- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them;
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.
- to focus on the wider determinates of health across the population
- to support and develop Primary Care Networks (PCNs) which join up primary and community services across local neighbourhoods; and
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);

Based upon the above it is clear that in partnership with the existing CCGs, PCNs, NHS providers, Voluntary sector providers, Healthwatch, Police, Housing, Education, that the Local Authority should take the leadership role in local 'place' making arrangements and in January 2020 the Council introduced a new Executive lead for Adult Social Care and Health. This model is an accepted and recognised approach as the existing Cheshire and Merseyside state they recognise "the lead role of the Local authority in the integration of care and system design is recognised"; "place at the Local authority level is the primary building block for integration between health and care and other sectors of the system."

This role extends the role of the DASS set out in the 2006 legal framework and reflects the emerging national position on NHS policy. Key to this role are the following:

- Assessing local need.
- Delivering an integrated whole system approach to support local community inclusion and wellbeing.
- Ensuring that the role of DASS delivers to Council responsibility for assessing planning commissioning wellbeing provision and promoting social inclusion.
- Systems leadership and making sure the voice of social care social work and the social model is heard, particularly by working with NHS partners, the police, providers, voluntary organisations, the wider council and members of the community.
- Shaping care and health and wider public services in the area.
- Promote the inclusion and rights of disabled and older people.

Cheshire and Merseyside in their application to become an ICS make it clear they expect a lead role from the Local Authority in the integration of Care and System design and that

political engagement and democratic input will bring legitimacy to the current transformation.

The DASS role will ensure that the focus is not just on adult social care and a wider system leadership approach is undertaken with all Council areas and wider partners. It is also of note that Sefton is the only Place in Cheshire and Mersey that has split CCGs, this is highlighted in the ICS application and supports the need to provide LA based leadership to the place of Sefton.

It is therefore recommended that the Executive Director of ASC and Health be designated Place Leader, work alongside the existing CCGs, PCNs, other NHS, Council Officers and partner agencies to develop our strategic approach, policies and structures which should complement the existing Health and Well-Being Strategy 2020-2025. Any new responsibilities emerging will be discussed and agreed with the wider C&M ICS.

In moving from CCGs to the new ICP the knowledge and experiences of clinicians, which has been at the forefront of CCGs must not be lost. Clinical leadership and engagement is key to the continued success of the future ICP. Thought should be given to how current forums can be used to support the ICP going forward. There is a real opportunity and energy to take forward alignment of staff from the CCGs and local authority team to deliver our ambitions in Sefton.

12. Timeframe and Next steps

In 2021/22 there will be a requirement for the system to begin planning its recovery, performance, delivery and development in each of its 9 places, with an eventual requirement for firm 5-year plans. The partnership proposes to work with 2 or 3 places to as initial development areas to help define what good looks like the outcome being an agreed work plan, Development plan and Organisational Development plan. This work will begin in March 2021. This report therefore has set out its strategic approach towards this plan.

The Cheshire and Merseyside Health Care Partnership highlights emerging need to develop public engagement in planning and decision making, development plans to places taken us up to 2022, further clarity of place functions, efficacy plans for each place, enabling place to support challenged organisation and address systemic issues, design expectations and goals for system, place and neighbourhood integration. This will need to be considered as part of a task and finish programme management approach.

It is understood that ‘shadow’ arrangements must be in place by April 2021 and by September 2021 plans are expected of how this will be delivered in full by April 2022. The Local Authority is keen that their position is clearly outlined at the earliest possible stage and subject to discussions with CCG and other partner leaders it is proposed that a similar report will be presented to the HWBB on 10 March 2021.

Dependent upon the feedback by HWBB members the Council would intend presenting a report to Cabinet on the 1st April 2021 and this decision would be taken nearer the time,

as discussions about other partner Boards take place. In addition, there is an opportunity to scrutinise any further detail proposals on 22 June 2021 at the Health and Adult social care Overview & Scrutiny Committee. Subject to discussions and agreement the proposal is to seek full agreement with the wider C&M ICS in September 2021.

Work has begun on a high-level programme plan that has been formulated subject to governance approval. The workforce issues will be addressed concurrently following HWBB on 10 March 2021 and before September 2021.

13. Next steps

It is recommended that partners consider the strategic report and proposed ICP governance. From there the ICP Governance is considered by all key partners in February March / April / May at their decision-making forums and engagement with C&M ICS.

A communication and engagement plan and organisational development plan will need to be developed and regular reports to HWBB with a clear programme and timetable.

In order to facilitate the required work from now until April 2022 it is proposed to establish a strategic task and finish group. Its remit will be as follows:-

- Strategic leadership and oversight of the Place ICP – reporting to Informal Cabinet, other Boards and the Health and Wellbeing Board
- Oversees delivery of programme to establish place making at Borough level
- Approves the organisational development strategy and action plan for the Place ICP
- Approve system wide outcome measures
- Evaluates risk in relation to system change proposals
- Approves the communications and engagement strategy and action plan for the ICP
- Holds to account the Programme Delivery Group and System Resources Group – Primary Care Networks (PCNs)
- Oversees enabling systems and infrastructure workstreams
- Seeks the views of other Forums – Cabinet and the Health and Adult Social Care and Children Overview & Scrutiny Committees

With its membership drawn from the following; -

- Cabinet Member Health to Chair
- Leader and relevant Cllr Cabinet Members
- 4 x PCN Clinical Directors and CCG senior reps
- Director Public Health
- VCS/Education/Police/Healthwatch Rep
- NWB Rep/Acute/Mersey Care Rep
- Housing representative

- Council Chief Executive
- Exec Directors - to be confirmed
- Heads of Service – to be confirmed

Membership to be reviewed and developed as and when the priorities of the ICP change

This will be supported by two sub groups, namely: - the programme delivery group and the system resource group whose remits are described below: -

Programme Delivery Group remit

- Develop proposals for change to the delivery of services for the key priority areas identified by the ICS that will improve quality, outcomes and/ or sustainability of all services
- Resource delivery of the ICS Plan as advised by System Resources Group
- Ensure programmes are delivered through neighbourhood working
- Establish and agree the remit of working groups to focus on key priority areas
- Feedback and report to the ICP T&F Board in respect of the key priority areas
- Develop system wide outcome measures for collective performance reporting
- Report on progress to the ICP T&F Board

Membership

- CCGs and Council Commissioners / provider representation including PCNs / VCS Rep / Locality Leads / Stakeholder Forum Rep
- 1 x Rep from each PCN
- Strategic Estates Group rep
- Heads of Service
- Director of Public Health
- Executive Directors and senior CCG reps
- Mersey Care and NWB/Acute Rep
- Housing Rep
- VCS/Education/Healthwatch/Police
- Transformation support team

System Resources Group remit

- Strategic oversight of the collective resources of the Partners in Sefton
- Advises the ICP Task and Finish (T&F) Board to support effective and efficient decision making
- Reports on performance, financial and other resource risk across the ICS, including monitoring the system performance dashboard and recommending mitigating actions
- Identifies opportunities to shift/release resources – effective use of Sefton's £ and resources to further the ICS Plan, using population health intelligence and horizon scanning
- Advises on the development of mechanisms for risk/gain share amongst ICS Partners
- Makes recommendations to Programme Delivery Group on financial, performance and contractual implications of proposals before they go to the ICP T&F Board
- Feed into decisions to be made by the ICP T&F group, Health and Wellbeing Board which have a material impact on the resources of the ICP or any ICP partners

Membership

- Director of Finance/Chief Finance Officer CCG
- Council Executive Directors and CCG senior reps
- PCN Rep(s)
- Possibly Business Intelligence/Performance Reps