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Health & Wellbeing Board

Wednesday, 11th March, 2020
5.30 pm

AGENDA

1. Welcome and Apologies

To welcome those present to the meeting and to receive any apologies for absence.

2. Declarations of Interest

To receive any declerations of interest on items on the agenda.

3. Minutes of the Meeting Held on 4th December 2019

To receive the minutes of the meeting held on 4th December and to approve them as a correct record.

Minutes of the meeting held on 4th December 2019 **3 - 7**

4. Better Care Fund Update

To receive an update on the Better Care Fund from Katherine White, Head of Intergration, Community and Strategy.

ITEM 3_Better Care Fund **8 - 12**

5. Pharmacy Needs Assessment

To receive a report of the Consultant in Public Health.

ITEM 4_Pharmacy Needs Assessment **13 - 15**

6. Update: COVID-2019- Lancashire and Cumbria Response.

To receive and Update from the Director of Public Health.

7. Public Health Apprenticeships/Workforce Transformation: A Public Health Practitioner for every

Primary Care Network.

To receive a presentation from the Public Health Consultant.

8. Integrated Care System Strategy and Population Health Plan Priorities

To receive a report Dr Julie Higgins-Chief Officer and Claire Richardson- Director of Population Strategy and Transformation, Pennine Lancashire CCGs/Integrated Care Partnership.

ITEM 7 ICS Strategy_Population Health Plan Priorities **16 - 57**
ITEM 7_Appendix ICS Strategy

9. Integrated Care System Commissioning Reform

To receive a report from Dr Julie Higgins-Chief Officer and Claire Richardson- director of Population Strategy and Transformation Pennine Lancashire CCGs/Inetegrated Care Partnership

ITEM 8 ICS System Commissioning Reform **58 - 91**
ITEM 8_Appendix_LSC_Commissioning_Reform_Case_for_Change

10. Pan Lancashire Health and Wellbeing Board- next steps

To receive an update from Laura Wharton, Public Health Consultant.

11. Date and Time of the Next Meeting.

To note that the next meeting of the Board will be held on 3rd June 2020 at 5.30pm

Date Published: 3rd March 2020
Denise Park, Chief Executive

Health & Wellbeing Board

Start well | Live well | Age well

BLACKBURN WITH DARWEN HEALTH AND WELLBEING BOARD
MINUTES OF A MEETING HELD ON 4th DECEMBER 2019

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	Mustafa Desai
Clinical Commissioning Group (CCG)	Tony McDonald Dr Penny Morris
Voluntary Sector	Vicky Shepherd Sarah Johns
Council	Gifford Kerr
	Prof. Dominic Harrison
	Jayne Ivory
	Sayyed Osman
	Shirley Goodhew
	Laura Wharton
	Beth Wolfenden
	Phil Llewellyn

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were received on behalf of Angela Allen, Roger Parr, Martin Hodgson and Abdul Mulla. The Board were united in offering sympathies to Angela Allen for her recent bereavement, and passed on their best wishes.

Sayyed Osman advised that in light of some issues with the distribution list for agendas, in relation to the accuracy of who was receiving the papers, he would arrange for a review to be taken ahead of the next meeting.

2. Minutes of the meeting held on 4th September 2019

RESOLVED – That the minutes of the meeting held on 4th September 2019 be agreed as a correct record and signed by the Chair.

3. Actions from the Previous Meeting

Sayyed Osman advised that a Work-strand needed to be developed in relation to Poverty – Jayne Ivory advised that some initial ideas had been worked up and that these would be covered in the presentation later in the meeting on Start Well.

Jayne also reported that the SEND second stocktake had now occurred.

4. Update on the Pan Lancashire Health and Wellbeing Proposals

Dominic Harrison reported back on the recent event held to discuss proposals relating to Pan Lancashire Health and Wellbeing Board, advising that all three Lancashire Health and Wellbeing Boards had been invited. Members of the Board who had attended the event stated that there was no clear agreement on the appropriate way forward.

Sayyed Osman advised that the Age Well Board would be looking at this matter every other meeting, and that a Pennine Lancashire approach to resources needed to be developed, as well as common framework.

The Chair indicated that he felt the best way forward for the time being was to keep the existing Health and Wellbeing Board and develop a Pennine Lancashire approach with a view to forming a Pan-Lancs alliance as well as the need to have further discussions with the ICS.

RESOLVED – That the update be noted.

5. Start Well Update

Jayne Ivory delivered a presentation which provided an annual update on 'Start Well'.

The Board were reminded of three Start Well Priorities, Emotional Health & Wellbeing, Adverse Childhood Experiences/Trauma Informed Practice and Poverty & Neglect -and Jayne outlined the key issues emerging along with the initiatives in place to tackle the issues and improve outcomes.

The presentation also highlighted the challenges to delivery of Start Well services and also asked the Board Members to consider the opportunities for other Boards and partnerships to help address the challenges.

Members made comments and suggestions, highlighting the importance of early intervention, identification of a trail throughout school life and of the importance of a PLACE based approach. Additionally, the Police needed to be involved in terms of organised crime and the linkages to vulnerable young people and also links to Housing were also highlighted in terms of structural deficits in housing stock. The generosity of local people was highlighted as an important addition to the support available for young people in need.

RESOLVED – That the presentation be noted and that Jayne be requested to circulate the slides to the Board.

6. Healthy Weight Declaration

The Board was informed about progress to date on the joint Local Authority Declaration on Healthy Weight, along with an update on the key learning from the recently completed independent evaluation. The report submitted also highlighted key issues affecting the effective implementation of the joint Local Authority Declaration on Healthy Weight.

Further work was now planned to raise awareness of the Declaration and the need for a whole systems approach to tackling healthy weight for both elected members and senior managers across the statutory organisations to address this. Following the Declaration evaluation, it was timely to review and refresh the local commitments. Strategically led by the Shape Up sub group and following consultation with the Healthy Weight summit attendees a number of possibilities for inclusion have been identified for further consultation with stakeholders, partners and the public during 2020, which were outlined in the report.

RESOLVED - That the Health and Wellbeing Board:

- Note the contents of the report.

- Note that unhealthy weight remains a significant public health issue requiring ongoing senior level leadership and commitment to increasing physical activity levels, improving access to healthy and sustainable food and encouraging self-care from council, partners and stakeholders.

- Note the progress made to date and the key issues affecting the effective implementation of the joint Local Authority Declaration on Healthy Weight.

- Support a review and refresh of the local commitments in 2020.

7. Better Care Fund (BCF)

A report was submitted which provided Board Members with a summary for Quarter 2 of BCF performance and delivery, as well as providing an update for the same quarter on the BCF and iBCF finance position.

The report also provided an overview of the new National BCF Planning Requirements for 2019/20, and a summary of the BCF 2019/20 Plan for Blackburn with Darwen. The report also requested approval of the updated Section 75 agreement between the Council and the Pennine Lancashire Clinical Commissioning Group.

RESOLVED – That the Health and Wellbeing Members:

- Note the new national BCF planning requirements for 2019/20.

- Approve the Better Care Fund Plan for 2019/20.

- Approve the updated Section 75 Agreement.

- Note the Better Care Fund Quarter 2 2019/20 financial and performance position.

8. Vulnerable Person Strategy

Members of the Board were reminded that the Local Safeguarding Adult Board (LSAB) commissioned a Vulnerable People Review in 2018 to contribute to the understanding of the relationship between demand and agency responses to the needs of vulnerable adults from accidents, overdoses and diseases. The Vulnerable People Review outlined the recommendations for the Vulnerable People Strategy.

The Vulnerable People Strategy set out the developments, processes and tools for a better integrated system that would build on existing infrastructure, to support the most vulnerable adults with complex needs in Blackburn with Darwen.

The Board were asked to approve the Vulnerable Person Strategy.

RESOLVED – That the Vulnerable Person Strategy be approved and that the co-operation from agencies of the Board be sought to assist with the implementation of the strategy.

9. Child Death Overview Panel Annual Report 2018/19

An update was provided to members of the Health & Wellbeing Board of the work undertaken by the Pan Lancashire Child Death Overview Panel (CDOP) during 2018/19, which included key findings from child death data, progress made on last year's recommendations (2017/18), partnership achievements, and priorities and recommendations for 2019/20.

The death of all children under the age of 18 had to be reviewed by a Child Death Overview Panel (CDOP) on behalf of the relevant Local Safeguarding Children Board. The CDOP covered Blackpool, Blackburn with Darwen and Lancashire and was known as, the Pan-Lancashire CDOP, which reported annually to the Health & Wellbeing Boards, and Pan Lancashire Local Safeguarding Children's Board.

RESOLVED – That the Health and Wellbeing Board:

a. Note the content of this report, and in particular the priorities for 2019/20.

b. Ensure all professionals providing information to CDOP ensure that forms are returned within the statutory three week deadline and are completed as fully as possible before they are submitted; 20% of cases reviewed during 2018/19 did not have the child's ethnicity recorded.

c. Ensure that the Child Death Review (CDR) processes remain embedded in the new safeguarding arrangements until at least April 2020.

d. Transfer the responsibility for CDR/CDOP to Health and Wellbeing Boards at some point after April 2020.

e. Clarify what interagency initiatives are required to reduce the prevalence of modifiable factors identified in the under one population including:

- Safe sleeping
- Risk factors for reducing premature births including:

- High Body Mass Index (BMI) (including healthy diet and physical activity)
- High blood pressure (linked to high BMI)
- Smoking
- Alcohol use
- Substance misuse
- Domestic violence
- Mental health
- Diabetes (often linked to BMI)
- Lack of physical activity.

10. General Updates from Board Members

Sayyed Osman reported that he would circulate details of Severe Weather Accommodation Arrangements to the Board.

Councillor Maureen Bateson advised of an event at Ewood Park on 23rd December where homeless people would be provided with food.

11. Date of Next Meeting

The next meeting of the Board was scheduled to take place at 5.30pm on 11th March 2020.

Signed……..

Chair of the meeting at which the Minutes were signed

Date……

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Sayyed Osman, Director of Adult Services, Neighbourhoods and Community Protection, BwD LA Roger Parr, Deputy Chief Executive/ Chief Finance Officer
DATE:	11th March 2020

SUBJECT: Better Care Fund Update – Quarter 3

1. PURPOSE

The purpose of this report is to:

- Provide Health and Wellbeing Board (HWBB) members with a Better Care Fund (BCF) Q3 2019/20 summary of performance and delivery.
- Provide HWBB members with the BCF and Improved Better Care Fund, iBCF, finance position at the end of Q2 2019/20.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- Note the Better Care Fund Qtr. 3 2019/20 performance and financial position.

3. BACKGROUND

As outlined in previous reports, the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund Plan and managing performance against the required metrics and timetables from 2017-2020. The management of the plan is undertaken through Blackburn with Darwen's Joint Commissioning arrangements and governance structures.

A requirement of the BCF reporting is to complete quarterly template reports which have consistently been successfully submitted as per the national deadline and schedule. The report demonstrates the progress made against each performance metrics, scheme and financial expenditure throughout the year.

BCF Plan national and regional approval

The new Blackburn with Darwen Better Care Fund Plan for 2019/2020 was approved by the Health and Wellbeing Board on 4th December 2019. The Blackburn with Darwen BCF Plan was submitted to the regional and national assurance process and was ratified on 8th January 2020 and classified as '**Approved**'. The Blackburn with Darwen Integrated Care Team will work with all Partners and Stakeholders to deliver the milestones and outcomes outlined in the Blackburn with Darwen BCF Plan 2019/20 and begin to plan for 20/21 national requirements.

4. RATIONALE

The Better Care Fund has been established by Government to provide funds to local areas to support the integration of health and social care. Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions.

The Blackburn with Darwen Better Care Fund Plan for 2019-20 builds on the development and delivery of integration across neighbourhoods, districts and the wider Pennine Lancashire Health and Care economy, as set out in the plan approved by the Chair of the Health and Wellbeing Board on 4th December 2019.

In April 2019 the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government produced a Better Care Fund Policy Framework document for 2019-20 which sets out the way in which the BCF will be implemented in financial year 2019 to 2020. The Framework includes local guidance on finance, performance metrics, assurance and approval processes.

In addition, a BCF Planning Guidance 2019/20 document was published in July 2019 and provides a framework detailing requirements for local health and social care organisations on reviewing and implementing new BCF plans for 2019-20 as outlined in section 3 above.

The BCF plan 2019/20 will continue to support the local vision for Integrated Care to deliver effective, efficient, high quality and safe integrated care to enable the residents of Blackburn with Darwen to Live Longer and Live Better. The BCF vision contributes and builds on a whole health and care system which supports the Health and Wellbeing Board's Strategy.

In February 2020, NHS England is due to publish a 1 year Policy Framework which will set out the future expectations and plans for 20/21. The Policy Framework 2020/21 will be reviewed and approval for a local plan will be sought from the Health and Wellbeing Board in June 2020.

5. KEY ISSUES

This section of the report provides a financial and metrics performance summary of Qtr. 3 2019/20 and highlights the priorities and key work plan for this financial year.

Qtr. 3 2019/20 Finance Update

5.1 BCF and iBCF Pooled Budget Financial Summary for Qtr 3 2019/20

- The Clinical Commissioning Group ('CCG') minimum BCF pooled budget requirement for 2019/20 is £11,992,199.
- The Disabled Facilities Grant (DFG) capital allocation for 2019/20 is £1,876,999.
- The 2019/20 budget for the BCF and iBCF pool is £22,621,152 including carry forwards and the winter pressures grant.

The 2019/20 allocations as above plus carry forward amounts from 2018/19 are analysed as:

- Spend on Social Care - £7,003,391 (48%)
- Spend on Health Care - £4,690,426 (32%)
- Spend on Integration - £2,279,876 (16%)
- Contingency - £543,864 (4%)

The BCF budget for 2019/20 was set following joint planning across LA, CCG finance and Social Care Leads and includes inflationary uplifts. Joint review and monitoring of the budget is undertaken every month as we progress through the year and any further pressures or savings identified in year will be shared between the LA and CCG in accordance with the S75 agreement.

5.2 BCF and iBCF Allocations for 2020/21

The minimum allocations for the BCF from CCGs in 2020-21 have now been published ahead of the BCF

Planning Requirements 2020-21. The amount for Blackburn with Darwen CCG is set at £12.635 million. The NHS Operational Planning and Contracting guidance confirms the CCG minimum contribution to the BCF will increase by 5.3% across England, as will the contribution to social care from this funding. Work is underway to set the BCF budget for 2020/21 including inflationary uplifts and this will require joint planning across LA, CCG finance and Social Care Leads.

The provisional allocations for the iBCF for 2020/21 are also now available to enable local areas key information to support consideration of the BCF alongside the main NHS operational planning round and local authority budget setting. The amount of iBCF funding for Blackburn with Darwen BC is notified at £8.1 million for the new year, which is a combination of existing allocations for this year for the iBCF and the Winter Pressures Funding.

The Disabled Facilities Grant allocations for 2020/21 are still awaited.

Qtr. 3 2019/20 Performance Update

The table below provides a summary of performance against metrics BCF targets up to Quarter 3 2019/20 with a narrative summary:

BCF Metric No	BCF Metrics Measures	Performance measure	Plan/Target	Actual performance up to November 2019
1	**Reduction in non-elective admissions**	On track to meet target	22,773	14,525
2	**Rate of permanent admissions to residential care**	On track to meet target	192 annual numerator	112
3	**Reablement – proportion of over 65 still at home after 91 days from hospital discharge**	On track to meet target	90.5 %	88%
4	**Delayed Transfers of Care**	Not on track	Total delayed days - 3440	Total delayed days - 3292

Metric 1 Reduction in non-elective admission -

The non-elective admissions data shows a consistent improvement against the national BCF target for 2019/20 with activity levels in quarter 3 being below BCF target planned levels. It should be noted that the zero length of stay activity continues to build with an increase in activity due to the introduction of the Respiratory Assessment Unit (RAU), the Ambulatory Emergency Care Unit (AECU) together with further increases through the Older Persons Rapid Assessment Unit within secondary care. This is a result of planned changes to the urgent care pathways. This activity will continue to be closely monitored by the Urgent Care Team at the CCG.

Metric 2 The rate of nursing and residential care home admissions (over 65 years)

Quarter 3 represents a significant reduction of 23% long term residential/nursing care for people aged 65 years plus. Our changes in demographics are reflected in the activity plans for 19/20. Services such as the

Independent Living Service, Reablement (including planned nights), Home first and access to therapy services maximise the opportunity for individuals to receive care in their own home or in extra care schemes. Given Blackburn with Darwen's age demographics, this target will require continual review as the population ages. It is anticipated that should the level of performance continue into Quarter 4 we will achieve this target.

Metric 3 Proportion of older people who are still at home 90 days after discharge from hospital into reablement and rehab services

Progress against the target is positive and in line with planned levels and the local Integrated Care Vision is moving forwards to progress an agreed step up pathway for complex frail older adults to avoid hospital admissions, as well as Step down assessment, rehabilitation and recovery services. The BCF plan and local approach has been to increase the numbers of people who access a period of reablement to enhance personal independence and support people to live at home for as long as they wish and are able. Blackburn with Darwen planned for 457 people in the full year to be independent at 91 days, which would be 90.5% of all discharges in the full year. At the end of Quarter 3, we are currently achieving just below this at 87.6% which reflects the increasing challenge presented by managing multiple complex health needs. However due to steady increase of approximately 3% each quarter it is likely that we will achieve this target.

Metric 4 Delayed Transfers of Care

The BCF Plan and the schemes that have been progressed and commissioned via BCF through joint planning and implementation have contributed to supporting the delivery against DToC, however due to the continued increase in demand and growing complexity of patients it has been challenging. Overall Delayed Transfers of Care (DToC) performance for the Acute Trust, which has a separate measure of no more than 3.5% delayed days, continues to broadly achieve nationally set targets in this quarter. Dedicated collaboration via a new forum between organisations/teams (Integrated Discharge Service/Complex Case Team) has supported a more joined up and better approach to tackling some longer term impacts and enables a more positive recovering position against target towards the end of this financial year.

The BCF Plan 2019/20 continues to focus on delivery at all levels including people and place based within neighbourhood's (PCN's), Integrated Care Partnership (ICP) and Integrated Care System (ICS) reflecting the future role and evolution across the wider Pennine Lancashire and Lancashire/South Cumbria footprint to ensure linkages to future system growth.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements. New planning guidance is due to be published in February 2020 and impact and implications will be reported at the June Health and Wellbeing Board meeting.

7. FINANCIAL IMPLICATIONS

No further financial implications have been identified for quarter 3. This report outlines the budget position at month 9.

For 2020/21 financial year, the CCG minimum contribution for the BCF is announced at £12.635M and the provisional allocation for the iBCF is set at £8.1M.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery has been presented to Health and Wellbeing Board members in previous reports. An updated Section 75 agreement has been developed for 2019/20 between the Local Authority and CCG which outlines risk sharing arrangements

associated with the Better Care Fund and other funding streams aligned to integrated delivery locally. The general changes to Section 75 are:

- Legal Considerations – The Parties agree that the Framework Partnership Agreement is amended to incorporate the changes which came into effect as a result of the GDPR - General Data Protection Regulation (Regulation (EU) 2016/679);

- Finance contributions – The revised budget and financial plan to incorporate the increase to the new nationally BCF stipulated requirement of 5.3%.

The agreement has been approved at the BCF Joint Commissioning Recommendations Group and Executive Joint Commissioning Group in November 2019 with signatures from BwD Borough Council's Director of Adults and Prevention and BwD Clinical Commissioning Group's Deputy Chief Officer/Chief Finance Officer.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have been considered and reported to Health and Wellbeing Board members within the main body of this report and have been outlined in the updated Section 75 approved by the Health and Wellbeing Board in December 2019.

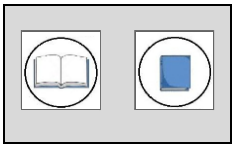
10. EQUALITY AND HEALTH IMPLICATIONS

Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.
Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business cases, and are integral to service transformation plans. An updated EIA has been completed as part of the refresh of the local BCF 2019/20 Plan.

11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF 2019/20 plan.

VERSION:	**2**
CONTACT OFFICER:	Samantha Wallace-Jones
DATE:	10.2.20
BACKGROUND PAPER:	



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Dominic Harrison, Director of Public Health and Wellbeing
DATE:	March 2020

SUBJECT: Pan-Lancashire Pharmacy Needs Assessment 2021-24

1. PURPOSE

The purpose of this paper is to update the Health and Wellbeing Board on the pan-Lancashire work that has started to review and update the current Pharmacy Needs Assessment (PNA), and the required period of public consultation.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is asked to

- Note this report
- Receive a further update in autumn 2020

3. BACKGROUND

Local Government took on a new role when Public Health transferred from the NHS in April 2013, including the production of a Pharmacy Needs Assessment (PNA).

The PNA aims to identify whether current pharmacy service provision meets the needs of the local population and considers whether there are any gaps in service delivery.

The PNA is used by NHS England in its determination as to whether to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

The PNA also informs commissioners, such as the clinical commissioning group (CCG) and local authority, of the current provision of pharmacy services and where there are any gaps in relation to the local health priorities.

4. RATIONALE

From 1st April 2013 every Health and Wellbeing Board in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmacy services for its local population, known as the Pharmacy Needs Assessment (PNA).

A published PNA has a maximum lifetime of three years.

The current pan-Lancashire PNA, undertaken on behalf of, and endorsed by, all three Health and

Wellbeing Boards in Lancashire, runs from April 2018 to the end of March 2021.

There have been no Local Authority organisation or boundary changes in the last 3 years and it is intended that a refresh of the current pan-Lancashire PNA is undertaken and an appropriate steering group has been set up to that effect.

5. KEY ISSUES

The key issues for the PNA are:

- It is a statutory responsibility of the Health and Wellbeing Board.
- Pharmacies provide a wide range of services beyond core contracts
- The PNA is the basis for future pharmacy commissioning intentions
- Pharmacies may challenge commissioning decisions and therefore the PNA must be robust to ensure decisions are made on relevant and appropriate evidence.

Matters which the Health and Wellbeing Board must have regard to when developing the PNA include :

- the demography of its area;
- whether there is sufficient choice with regard to obtaining pharmaceutical services;
- any different needs of different localities in its area;
- the pharmaceutical services provided in the area of any neighbouring HWB which affect the need for pharmaceutical services in its own area.

Process and Deadlines

As part of developing their PNA, Health and Wellbeing Boards must undertake a public consultation for a minimum of 60 days, which is planned for the autumn.

6. POLICY IMPLICATIONS

There are no direct policy implications

7. FINANCIAL IMPLICATIONS

The findings of the PNA have no financial implications

8. LEGAL IMPLICATIONS

The statutory responsibility for PNAs transferred from PCTs to the Health and Well-being Boards on the 1 April 2013, as a result of the changes introduced by the Health and Social Care Act 2012. At the same time, the responsibility for market entry decisions transferred from PCTs to NHS England. In particular, the Health and Well-being Board had a duty to deliver a Pharmaceutical Needs Assessment before April 2015 under Section 128A of NHS Act 2006 (as amended by the Health and Social Care Act 2012). Thereafter this assessment needs to delivered every 3 years The regulations setting out the responsibilities are contained in Part 2 National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ('the Regulations').

The PNA assists in the commissioning of pharmaceutical services for local priorities and will be used by NHS England when making decisions on applications to open new pharmacies. These decisions may be appealed by pharmacies and challenged via the courts. Therefore it is vital to comply with regulations and that systems are in place to keep the PNA up to date. The

Regulations prescribe the matters which the Health and Well-being Board must have regard to when undertaking the PNA.

Regulation 8 sets out consultation requirements.

9. RESOURCE IMPLICATIONS

The resources for producing the PNA have been incorporated into Public Health plans and therefore there are no additional resource implications.

10. EQUALITY AND HEALTH IMPLICATIONS

The PNA aims to

- Identify gaps in provision or accessibility, including by area or population group
- Help support a healthier population

11. CONSULTATIONS

A 60 day public consultation on the draft PNA will be undertaken.

Those being consulted will include :

- any relevant local pharmaceutical committee (LPC) for the Health and Wellbeing Board area
- any local medical committee (LMC) for the Health and Wellbeing Board area
- any persons on the pharmaceutical lists and any dispensing GP practices in the Health and Wellbeing Board area
- any local HealthWatch organisation for the Health and Wellbeing Board area, and any other patient, consumer and community group that, in the opinion of the Health and Wellbeing Board, has an interest in the provision of pharmaceutical services in its area
- any NHS trust or NHS foundation trust in the Health and Wellbeing Board area
- NHS England
- any neighbouring Health and Wellbeing Board

VERSION:	**0.2**

CONTACT OFFICER:	Dr Gifford Kerr, Consultant in Public Health
DATE:	17 February 2020
BACKGROUND PAPER:	

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Healthier Pennine Lancashire Integrated Care Partnership, ICP, and Healthier Lancashire Integrated care System, ICS,
DATE:	17/02/2020

SUBJECT: Integrated Care System Strategy and Population Health Plan Priorities

1. PURPOSE

The draft Integrated Care System (ICS) Strategy (Appendix A) has recently been discussed by the Integrated Care System Board. The draft strategy identifies the Population Health Plan priorities:

- Best start in life
- Healthy Behaviours
- Zero Suicides
- Neighbourhood Development
- Work and Health

These are aimed at improving the health and wellbeing outcomes of our communities. A system wide approach to develop the Implementation Plan is under way, managed through the Population Health Steering Group of the Integrated Care System.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is requested to:

(i) Receive, discuss and endorse the draft Integrated Care System Strategy.
(ii) Confirm commitment to the Population Health Plan priorities identified in the draft Strategy.
(iii) Engage with and support the development of the Integrated Care System Population Health Implementation Plan.
(iv) Endorse the alignment of the existing population health and prevention activity across the Integrated Care System work streams and Integrated Care Partnership/Multi-speciality Community Provider plans (in West Lancashire).

3. BACKGROUND

Background

1. Draft Strategy and Population Health Priorities

1.1 The draft Integrated Care System (ICS) Strategy (Appendix A) has recently been discussed by the Integrated Care System Board. The vision identifies the following ambitions:

- Healthy communities

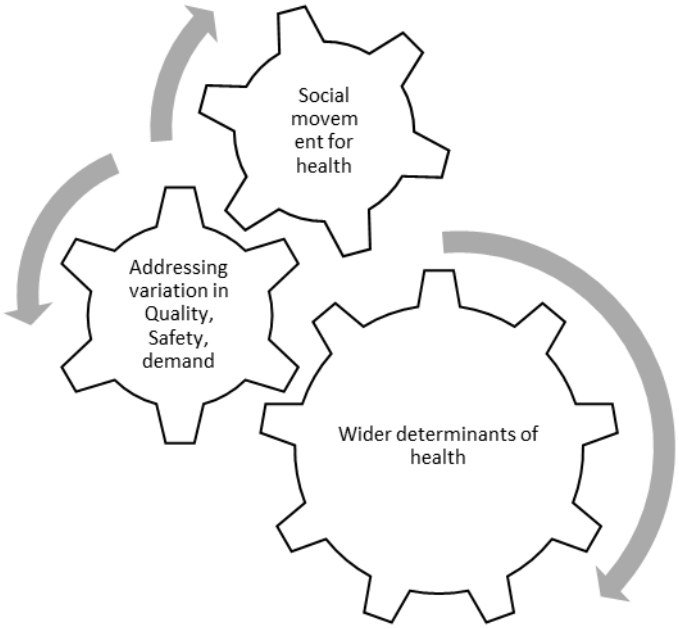
- High quality and efficient services
- Health and care service that works for everyone, including our staff

The strategy also identifies the Population Health Plan priorities, which are aimed at improving the health and wellbeing outcomes of our communities. Our overarching Population Health ambition is to achieve best health for all, with a focus on reducing health inequalities. The ambitions and objectives are informed by the latest national and local data and evidence based practice of what good looks like. The strength is our focus in places and neighbourhoods. We are building on a range of successful collaborations we already have across our system. The Strategy is well aligned to Blackburn with Darwen Health and Wellbeing Board priorities and Pennine Lancashire Integrated Care Partnership Strategic narrative.

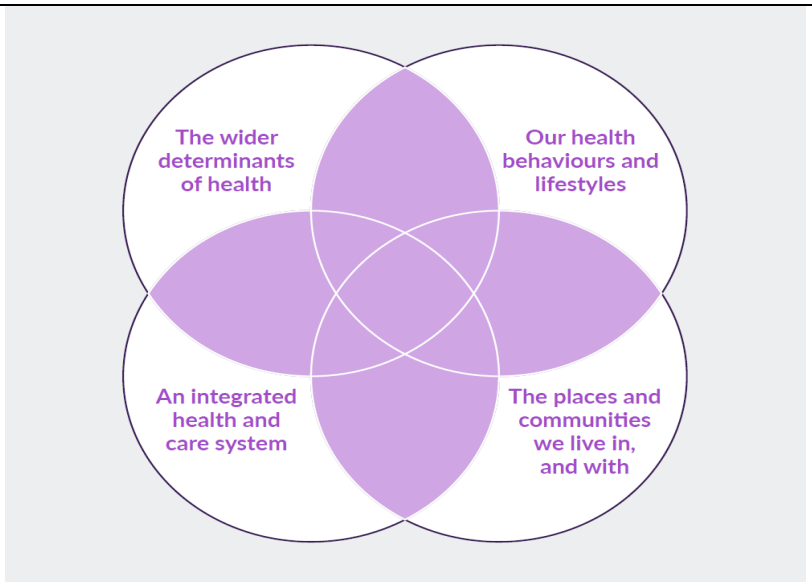
1.2 The Lancashire and South Cumbria Integrated Care System Board signed off our population health framework that includes our organising principles, strategic objectives and theory of change for improving health and care at scale in February 2018. These are aligned to the priorities identified by the four Health and Wellbeing Boards.

1.3 Our organising principle is to embed prevention in everything we do and provide place based, person centred care, by working with our residents.

1.4 Our theory of change for improving health and care outcomes at scale is illustrated below.



1.5 Our framework for population health is based on The Kings Fund Population Health Framework as well as Public Health England's (PHE) toolkit for place-based approaches to reduce health inequalities. This includes action to improve the wider determinants of health, healthy behaviours and lifestyles, the places and neighbourhoods we live in, and delivering person centred care.



The King's Fund. A vision for population health: Towards a healthier future. 2018. Available from: https://www.kingsfund.org.uk/publications/vision-population-health.

The Population Health approach will be embedded across every level of our system level as follows:

- Integrated Care System – whole system setting of quality, standards and population level health and wellbeing campaigns.
- Integrated Care Partnerships/Multi-speciality Community Provider – develop integrated population level prevention programmes tackling key health and care inequalities.
- Primary Care Networks – extend the Population Health Management accelerator to improve health outcomes and maximise the neighbourhood and community assets for local communities.

4. RATIONALE

The NHS Long Term Plan (LTP) was published in January 2019 and set out a range of ambitions for the NHS for the next 5 – 10 years. All 'Local health systems' were asked to produce local plans for implementing the commitments set out within the LTP. For South Cumbria, this means Lancashire and South Cumbria Integrated Care System.

Alongside this, and following an extensive period of engagement, the Healthier Pennine Lancashire Integrated Care Partnership (ICP) has agreed a forward plan.

The Lancashire & South Cumbria Integrated Care System (ICS) was required nationally to submit an ICS Strategic Plan by the 15th November, in response to the NHS Long Term Plan (LTP) and the local needs of our population over the next five years. The Plan has now been produced and a copy is attached – again the status of this is draft. Again, HWBB is asked to note development and consider the document.

5. KEY ISSUES

None.

6. POLICY IMPLICATIONS

None.

7. FINANCIAL IMPLICATIONS

None.

8. LEGAL IMPLICATIONS

None.

9. RESOURCE IMPLICATIONS

None.

10. EQUALITY AND HEALTH IMPLICATIONS

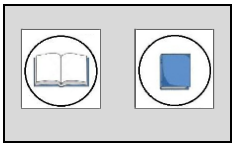
None.

11. CONSULTATIONS

None. Extensive engagement was undertaken over the last three years to develop the ICP Plan.

VERSION:	**3**

CONTACT OFFICER:	David Rogers, Head of Communication and Engagement, NHS East Lancashire and BwD CCGs.
DATE:	17/02/2020
BACKGROUND PAPER:	Appendix A ICS Strategy



Healthier Lancashire & South Cumbria

DRAFT VERSION

Our Integrated Care System Strategy

Published January 2020

Working together to improve services and help people in Lancashire and South Cumbria live longer, healthier lives

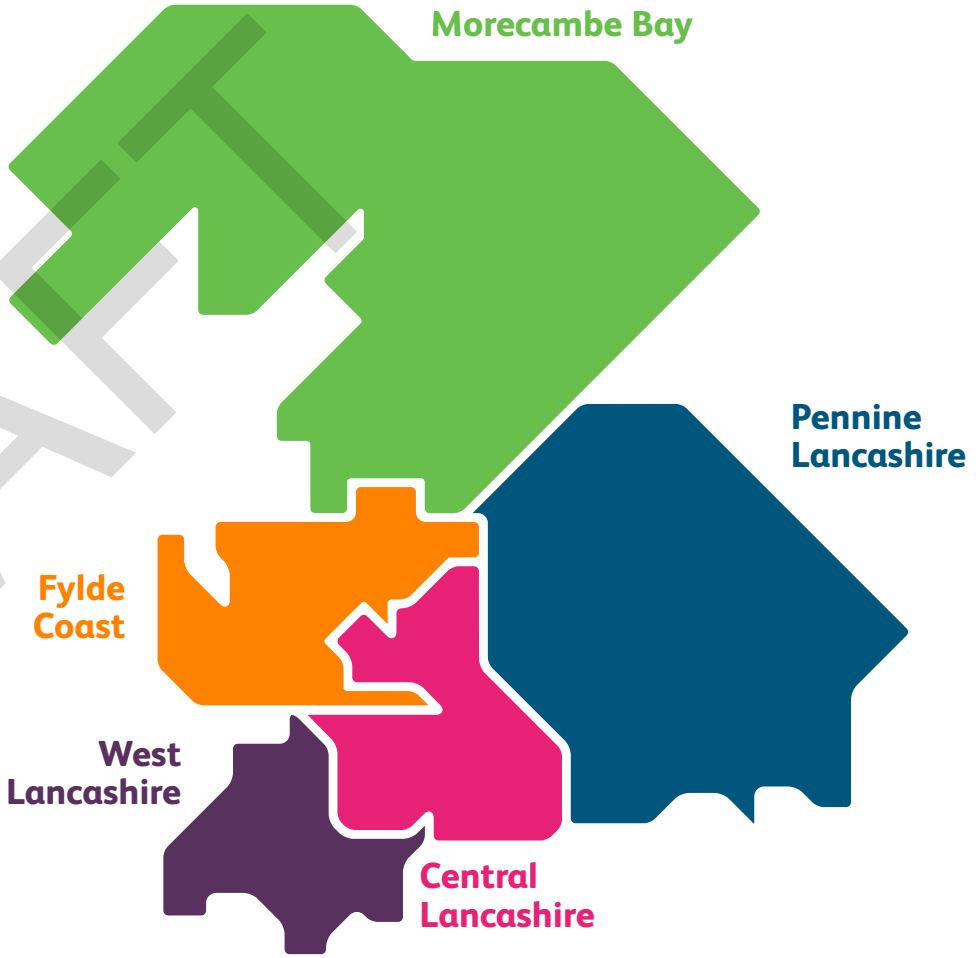
Welcome

We have an ambitious vision to empower and support healthy local communities, so that local people have the best start in life and can live and age well.

We are Lancashire and South Cumbria Integrated Care System (ICS), a partnership of NHS, local authority, public sector, voluntary, faith and social enterprise and academic organisations. We work together to join up health and care services, listen to the priorities of our communities, local people and patients and tackle some of the biggest challenges we are all facing.

Healthier Lancashire and South Cumbria is the name of our shared vision and five-year strategy for improving health and care services and helping the 1.8million people in Lancashire and South Cumbria live longer, healthier lives. To achieve this we will need to make difficult decisions about how and where our services are delivered and how we organise ourselves to achieve our aims as a partnership.

We have listened to local people and worked together to set out how we will deliver the aims of the NHS Long Term Plan and address the most urgent needs of our population.



Contents

This document is written for local people interested in developments in our health and care system, our staff and partners. It describes our plans for the future.

Our purpose – together we can make things better

The partnership of organisations working across the Integrated Care System have agreed a clear purpose for our work together.

This will happen in neighbourhoods, local places and across the whole of Lancashire and South Cumbria.

Our vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

Healthier Lancashire & South Cumbria

At the heart of this vision are the following ambitions:

We will have healthy communities

We will have high quality and efficient services

We will have a health and care service that works for everyone, including our staff

In your neighbourhood and community

- Health and social care will work together to support your social needs, physical and mental health and wellbeing
- You will be supported to care for yourself where you can, including using digital technology
- Community groups and local teams, including your GP, will work with you
- You will be encouraged to take an active role in managing your own health and wellbeing and to support others in your community

In your local area

- Most care will be locally delivered, managed and planned
- We will make the best use of all the expertise and staff skills available to us
- We will talk to you and your community about how best to provide care
- You know best what you and your community needs

Our vision for Lancashire and South Cumbria

Across Lancashire and South Cumbria

- We will work together on issues like mental health, stroke, cancer and urgent care
- Our hospitals will work together so you have the best treatment possible
- We will use technology to share health records and make it easier to book appointments
- As much of our finances as possible will be spent in local places
- We will manage our spending better

Tackling our biggest challenges together

Our partners across Lancashire and South Cumbria are committed to taking coordinated action to improve health and wellbeing, provide clinically sustainable services and to do this within available resources.

We need to accelerate changing the way we provide services across Lancashire and South Cumbria over the next four years.

We will take action as a partnership to:

- Reduce health inequalities
- Improve our performance on national targets, particularly for waiting times for urgent treatment, cancer services and routine surgery
- Provide more consistent, high quality care for everyone
- Deliver more care in our local communities
- Ensure good care at the end of life
- Make better use of our collective resources and stop overspending on our budgets.

To tackle these challenges, the partners across Lancashire and South Cumbria recognise that we need to change how services are provided to offer more joined-up, proactive care that is organised in neighbourhoods.

This change needs to be led by clinicians – including doctors, nurses and health professionals, who know that tailored and personalised care will support local people, carers and families to live healthier lives within their communities. We will fully involve local people and patients in changes to services.

This cannot be done without significantly changing the way organisations invest in, provide and manage the whole health and care system including GPs, A&Es, specialist centres, hospitals and care services.

A change in the way we use our resources is required to enable us to increase our focus on promoting good health and preventing illness as we work with local residents, as well as ensuring we can provide safe and effective treatment when people do become unwell. There are already dynamic examples of this starting to happen in Lancashire and South Cumbria.

There are currently a number of fragile services, which are unsustainable in their current form. The required workforce for the service structures simply does not exist. Despite a number of national and local workforce initiatives, the likelihood is that for the medium term the prospects for filling staffing vacancies remains poor. If the partnership does not change the way in which these services are organised, they will fail.

The evidence for financial unsustainability in some services is also clear. NHS trusts in Lancashire and South Cumbria are spending more than the income they receive, meaning that they are increasing their level of debt and spending money that should go to other parts of England.

Key facts about our population and communities

We now have a good understanding of our population's health and care needs.

It will enable us to provide the right services, in the right place, at the right time to improve care and ensure the best use of resources.

This will help us to plan care more effectively and deliver better results for local people.

Our population

National average

Population over 65 **19.9%**

Percentage of population over 65 is **19.9%**, national average for England is **18.2%**

One person households with people age 65+ **14%**

Number of one person households with people aged 65 or over is **14%**, national average for England is **12.4%**

Rural communities **20.4%**

Percentage of population in rural communities is **20.4%**, national average for England is **17%**

Reference details to be added here

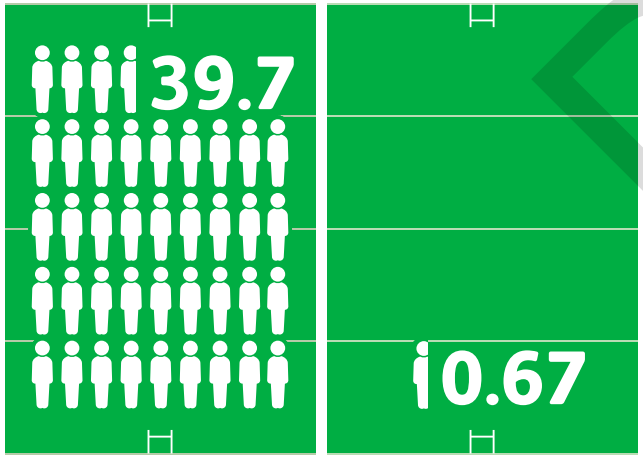
Our geography is varied across Lancashire and South Cumbria

The number of people per hectare (the size of a rugby pitch) is high in:

- Blackpool: **39.7**
- Hyndburn: **11.03**
- Blackburn with Darwen: **10.73**
- Preston: **9.99**

Compared to more rural areas:

- Wyre: **3.91**
- West Lancashire: **3.27**
- Lancaster: **2.49**
- South Lakeland: **0.67**



Deprivation

Nearly a third of our residents live in some of the most deprived areas across England.

The percentage of people living in fuel poverty and unable to afford to heat their homes, is higher than the national average: **13% for Lancashire and South Cumbria**, national average is 10.6%.

A significant proportion of children experience **adverse living conditions**, including child poverty. This leads to significant variation in their development and school readiness.

The percentage of children living in poverty ranges from a low of 12% to **as high as 38% in Lancashire and South Cumbria**, the national average is 30%.

13%

of people in Lancashire and South Cumbria are living in fuel poverty.

The national average is 10.6%.

Between

12 to 38%

of children in Lancashire and South Cumbria live in poverty.

The national average is 30%.

Reference details to be added here

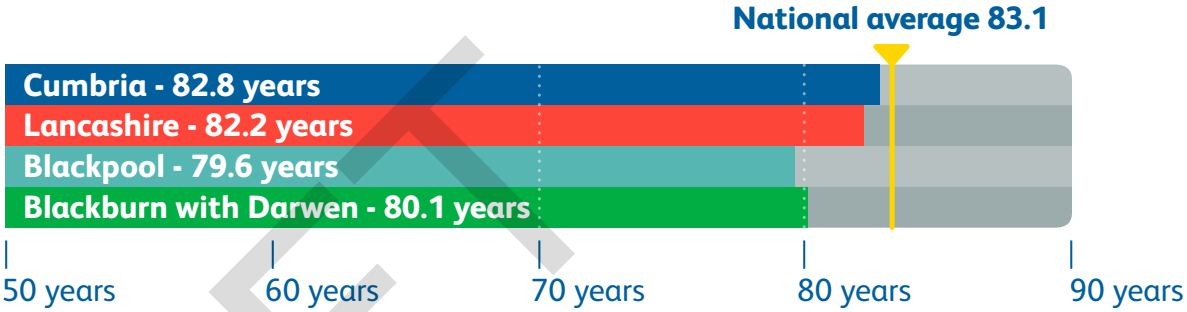
Life expectancy in Lancashire and South Cumbria is lower than the national average

There is a significant level of unwarranted variation in the number of years people can expect to live a healthy life.

Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of **68 years** for children born today.

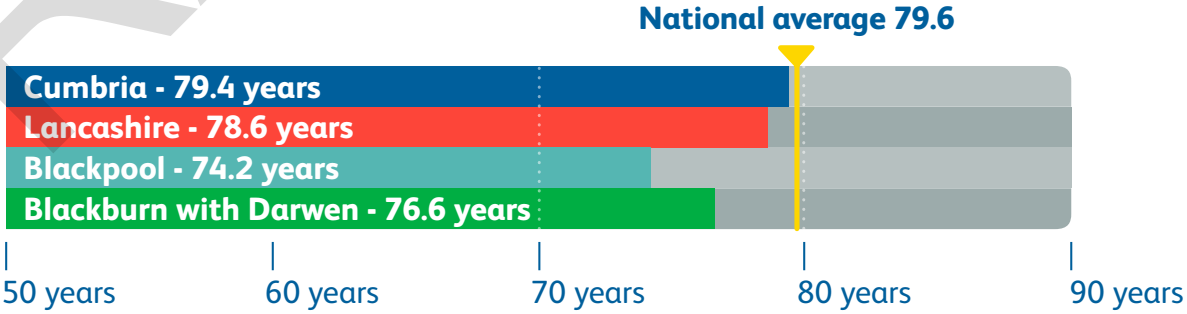
In some neighbourhoods, healthy life expectancy is just **46.5 years**.

Female life expectancy by council area



The number of years females **live in good health** is above the national average of **63.8 years** in Cumbria (**65.4 years**) and Lancashire (**64.5 years**). It is below the national average in Blackburn with Darwen (**58.6 years**) and Blackpool (**57.8 years**).

Male life expectancy by council area

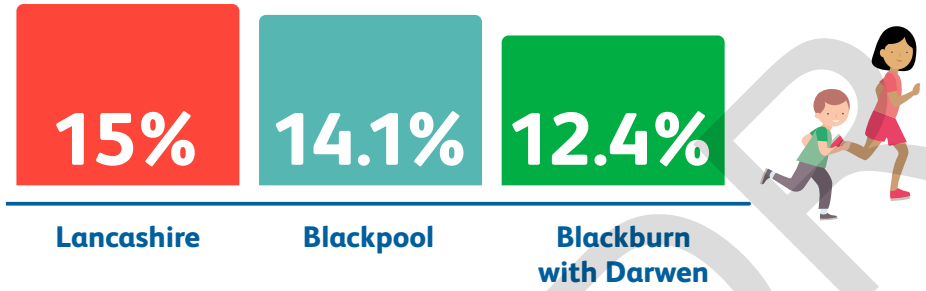


The number of years males **live in good health** is above the national average of **63.4 years** in Cumbria (**64.4 years**). It is below the national average in Lancashire, (**61.2 years**), Blackburn with Darwen (**57.3 years**) and Blackpool (**54.7 years**).

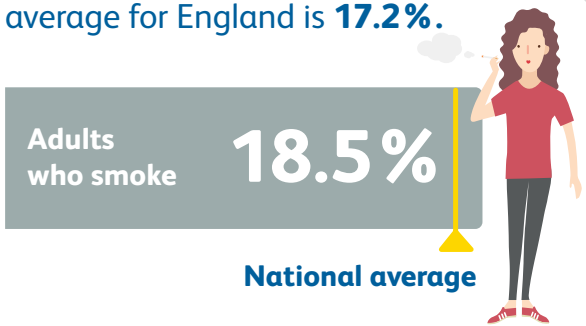
Health and wellbeing

Only around **a fifth** of adults are meeting the recommended levels of physical activity.

Much more needs to be done to encourage children to be active: just **15%** of young people aged 15 in Lancashire are meeting the recommended levels of physical activity, **14.1%** in Blackpool and **12.4%** in Blackburn with Darwen.



18.5% of adults smoke, the national average for England is **17.2%.**



The main causes of ill-health are cancer, cardiovascular, respiratory, mental health, and neurological conditions.

Suicide rates are significantly higher than average in Lancashire and South Cumbria, particularly in Barrow in Furness, Blackpool, Chorley and Wyre.

The estimated prevalence of common mental health disorders is higher than the England estimate.

Approximately

40%

of ill-health in Lancashire and South Cumbria is due to **smoking, physical inactivity, obesity** and **substance misuse**.

Reference details to be added here

Lancashire and South Cumbria health service performance

In 2018/19, we had:

358,590
NHS 111 calls

More than
7.5million
GP appointments

More than
330,000
attendances at A&E

281,173
local planned admissions for treatment or surgery

2,880,582
outpatient appointments

...with more than
697,022
missed appointments

211,315
emergency admissions

Reference details to be added here

The NHS in Lancashire and South Cumbria is spending more than the budget available to it

In 2020/21, the total budget for health services in Lancashire and South Cumbria is **£3,525million**.

Lancashire and South Cumbria receives around **10%** more per person in funding compared to the average for England because of the higher level of need in our communities.

Lancashire and South Cumbria will receive an average growth in funding of around **£150million** per year between 2019/20 and 2023/24.

In contrast, local authority funding for county councils and unitary authorities has reduced by **around 40%** over the last decade and growth for social care and public health budgets is uncertain.

Further work needs to be completed to create a plan that will see the health services in Lancashire and South Cumbria return to financial balance.

Our neighbourhoods and local areas

To respond to what we can see in our population statistics, we have looked at how we can address the needs of our local populations within our five local areas and all of our neighbourhoods.

About our neighbourhood approach

We are defining neighbourhoods as communities where all aspects of health and care services will come together: with local people, local authorities and voluntary and community organisations.

Within each neighbourhood is a primary care network, these are a key part of the NHS Long Term Plan and are based on populations of between 30,000 and 50,000. They build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more joined-up health and social care within neighbourhoods.

There are **248 GP practices** in Lancashire and South Cumbria, working in partnership within our **41 primary care networks**.

Five local partnerships

There are five local health and care partnerships: Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire.

These local partnerships include primary care networks linked together with other care providers such as hospitals, care homes, mental health and community providers, local government, voluntary and community organisations – alongside health and care commissioners.

Together, these partnerships assess local need, plan how to use their collective assets and join up what they offer – including how to make best use of overall public and community resources.

You can find out more about the work of our five local partnerships at: **healthierlsc.co.uk/Local**

Numbers of people living in each area
Morecambe Bay: 352,000 people
Pennine Lancashire: 566,000 people
Fylde Coast: 354,000 people
Central Lancashire: 399,000 people
West Lancashire: 114,000 people
Total: 1,785,000 people live in Lancashire and South Cumbria

Source: NHS Digital. Figures as of December 2019.

Lancashire and South Cumbria Integrated Care System

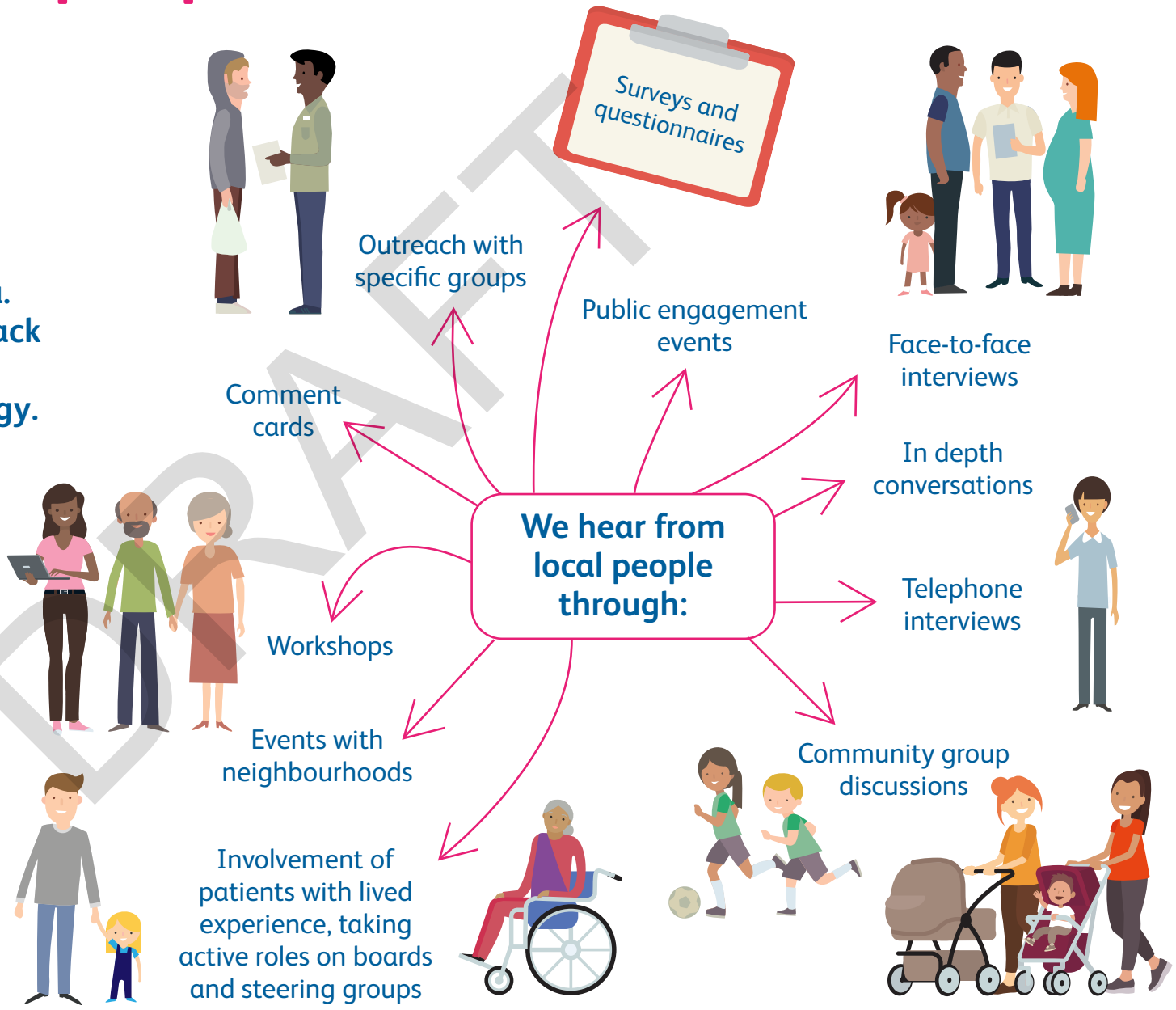
The Integrated Care System is a partnership, which provides strategic leadership across our whole population.

The partnership includes:

- Local authorities
- NHS organisations
- Voluntary, community, faith and social enterprise organisations
- Academic institutions, such as our universities
- Public sector organisations, such as police and other emergency services
- Our local communities.

Involving local people

Our partners continue to work with, engage and involve local people in changes and new ways of delivering services in neighbourhoods, in local partnerships and across Lancashire and South Cumbria. We have listened to the feedback of local people as we have developed this five-year strategy.



Local people have told us

- They were not aware and did not recognise the changes and developments that are being made to the health and care system
- They are positive about the inclusivity of the vision but raised concerns over a focus on the elderly at the expense of younger people
- Opinion was divided over whether changes to the health and care system were a positive development, although it was evident that understanding of primary care networks and local partnerships and how they work is low
- They felt positive about links being formed between different healthcare services
- They felt positive about work taking place in some of our neighbourhoods where communities, health and care services and local organisations are working together
- They are positive about intentions to improve community services
- They feel there is a lack of support for mental health issues and lengthy waits for referrals.

Read more about our engagement with local people at **healthierlsc.co.uk/GetInvolved**

We value this feedback and have used it to shape this strategy and how we will deliver partnership working across Lancashire and South Cumbria. We are committed to continue to involve people and put them at the centre of everything we do as a partnership.

To get involved and find out what is happening in your local area, visit **healthierlsc.co.uk/Local**

Integrating health and care

The NHS Long Term Plan, published in January 2019, set out an ambitious programme of service improvement for health and care in England. It describes how Integrated Care Systems will work in new, more coordinated ways to:

- Join up health and care for local people – especially those with multiple and long term conditions
- Be proactive about prevention – stopping people getting ill in the first place
- Make the very best use of the whole health and care resource across an area

This document builds upon the foundations of partnership working which have been developing over the past four years.

We have listened to local people and worked together with colleagues across the health and care sector to develop a five-year strategy to deliver the aims of the Long Term Plan and to address the most urgent needs of the 1.8million people living in Lancashire and South Cumbria.

Examples of how we are already successfully working in partnership are available on pages 32 to 35

Our journey towards partnership working

Improving the health and wellbeing of local communities

Delivering better, joined-up care, closer to home

How we will deliver our strategy

Delivering safe and sustainable, high quality services

Improving the health and wellbeing of local communities

We will take action to improve the underlying issues that impact health, healthy behaviours, the lifestyle choices we make and the places and neighbourhoods we live in. We will deliver care tailored to meet the needs of individuals.

Five key priorities will be our focus to improve the health of the population and to reduce health inequalities.

Giving the best start in life

National evidence tells us that development begins before birth and that the health of a baby is crucially affected at this early stage. We need to make changes to policies to eradicate health inequalities and make sure children and families receive support in the first 1,000 days after birth.

To do this, we will:

- Focus on reducing infant mortality
- Close the gap in communication skills between disadvantaged children and their classmates when they start school
- Address child poverty and its impact on the health and wellbeing of children and families
- Develop plans to get every child ready to learn at the age of three.

Healthy behaviours

Tobacco use, obesity, alcohol consumption and inactivity are issues which can result in disability and early death and directly affect physical and mental health.

We will work with communities to:

- Deliver our ambition to become smoke free in our premises across Lancashire and South Cumbria
- Reduce childhood obesity, learning from partnership work in Pennine Lancashire and spreading the learning to support local residents to have a healthy weight throughout their lives
- Improve oral health in all age groups
- Put in place alcohol care teams where they are needed
- Support the voluntary, community, faith and social enterprise sector (VCFSE) and wider partners to strengthen and expand the social prescribing offer available in communities.

Zero suicides

We have an ambitious goal of working towards having zero suicides in Lancashire and South Cumbria. The impact of suicide is far-reaching and remains with family, friends, colleagues and many others long after the individual has gone.

The bereavement is often detrimental to personal relationships, behaviour, wellbeing and work.

To achieve our ambitious goal, we will:

- Put policies and services in place to improve mental wellbeing, identify people at risk of suicide and better support families with specialist bereavement services
- Use real-time intelligence from the police, local authorities and NHS to support the partnership in taking action in the right areas to reduce suicides to zero over a number of years.

Neighbourhood development

People should be able to live, work and prosper in their neighbourhoods. Understanding what matters to people where they live and by working with them on the challenges they face can help find creative solutions to seemingly insurmountable problems.

Neighbourhoods are where people spend most of their time. We will work with local communities to co-create solutions through local partnerships where people live. In these areas, people will be supported to manage their own health and wellbeing and receive social support by integrating health and care services with local authorities and other voluntary and community groups.

To achieve this all 41 of the primary care networks will be supported to deliver care centred around the person and detect and diagnose conditions such as diabetes, cancer and heart disease early.

Work and health

Having a healthy and capable working age population has major positive benefits for local people, organisations, the local economy and wider society.

This means it is important to support people to achieve their potential in life by enabling them to work, maintain financial independence and security for themselves and their families, especially as they age. This includes people with long term conditions and disabilities, a large number of whom, want to work and live independent lives.

To achieve this, the partnership is already working with local economic partnerships, wider public sector leaders and universities to create opportunities through the development of a local industrial strategy and sharing good employment practices between large organisations in Lancashire and South Cumbria.

We will support our current and future workforce to have the best possible health, and in turn improve the local economy.

Delivering better, joined-up care, closer to home

Our neighbourhood approach aims to deliver better care planning and outcomes for local people. This builds upon positive local and national examples where GPs, community nurses, therapists, social workers, voluntary, community, faith and social enterprise sector partners and the communities themselves have worked together more closely.

This approach to working in neighbourhoods allows partners to make use of a multidisciplinary workforce and offer opportunities to create a sustainable future for primary and community services, which have been under significant pressure in recent years.

We want to use neighbourhood working to continue learning about how best to engage with local people about their health and wellbeing, using the assets of each community to do so. The aim is to make this approach one of the most recognisable characteristics of the partnership in Lancashire and South Cumbria.

We are supporting the development of the **41 primary care networks** at the heart of wider public and voluntary sector integrated neighbourhoods.

Primary care networks are a vital component of the neighbourhood model, with ambitions to:

- Stabilise general practice
- Help solve the capacity gap and improve the skills mix by growing the wider workforce
- Invest in our local communities
- Be the connection point between primary and community care
- Deliver new service improvements and achieve clear, positive, quantified impacts that benefit people.

The five local health and care partnerships are where:

- Local authorities can take an active, lead role in system redesign
- System redesign can be built on community approaches
- Integration between health and care and other sectors can be best delivered
- Political engagement and democratic input can be undertaken most effectively
- Partners can determine how they can best work together to achieve outcome improvement and system change.

You can find out more about the work of our five local partnerships at: **healthierlsc.co.uk/Local**

Each local health and care partnership is developing an integrated model of:

- Primary and community services
- Physical and mental health services
- Integration of health and social care services.

Where things are best undertaken once, we will do them in partnership across Lancashire and South Cumbria.

Delivering safe and sustainable, high quality services

It is clear that the way local NHS hospital services are delivered is both clinically and financially unsustainable. Across the four providers of acute services, there is significant variation in the quality, access and outcomes of services received by people living in Lancashire and South Cumbria. System leaders recognise that variation exists and that plans are now needed to address this.

Clinical leaders will be supported to work beyond the boundaries of their organisations to set out what the future of service delivery will look like and work together to influence how services will be delivered over the next four years and beyond.

Integrated Care System partners are working together to overcome these challenges through three key programmes:

1. **Increased collaboration between providers**
2. **Efficient and sustainable service delivery**
3. **Integrated pathways.**

1. Increased collaboration across providers

We will explore the benefits of our hospitals and community services working together as a Provider Collaborative and describe what this will mean for local people and staff. This will be to enable services to deliver the highest quality, safe and sustainable care to people in Lancashire and South Cumbria.

To achieve this, the four NHS trusts providing acute services will increasingly work more closely together, transforming the ways in which some more specialised services and patient pathways are organised. This could involve changes to current models of care, locations of care, or the number of hospitals which provide care. Local communities and stakeholders will be involved in shaping these models of care and, where appropriate, further engagement and formal consultation will take place.

Examples of early work are redesigning how services are delivered for head and neck, cancer, and vascular services, paediatrics and diagnostics.

2. Efficient and sustainable service delivery

In line with the expectations of the NHS Long Term Plan and more local analysis of unwarranted variation and efficiency opportunities, partners have identified a range of potential schemes to improve the clinical and financial sustainability of services. It is recognised that these opportunities can only be realised with the leadership and support of clinical and other professional leaders working together across the system.

The following areas will be prioritised as they demonstrate the greatest opportunities for improving efficiency:

- Outpatient appointments
- Musculoskeletal (MSK) services
- Theatre efficiency
- Back office functions
- Management of medicines
- Interventions of limited clinical value
- Innovation and quality.

3. Integrated pathways

The NHS Long Term Plan identifies integrated pathways across a number of services that are intended to enhance clinical outcomes for local people. As well as working towards the implementation of these pathways, ICS partners have identified a number of local priority pathways for redesign across Lancashire and South Cumbria.

Our priority pathways for improvement are:

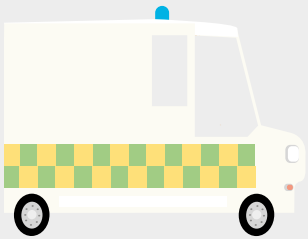
- Mental health – adults and children and young people
- Learning disabilities and autism
- Urgent and emergency care
- Cancer
- Stroke services
- Planned care
- Maternity services.

Urgent and emergency care

We are committed to providing highly responsive services for adults and children with urgent care needs, which deliver care as close to home as possible and are high quality, safe and sustainable.

This will be achieved by:

- Using the same approach across partners to collecting and using intelligence about how services are working
- Improving how ICS partners and the ambulance service share information
- Improving patient safety and experience due to quicker response times
- Using resources and teams appropriately, so that paramedic crews are able to respond to life threatening emergencies.



Cancer

We aim to improve early diagnosis for patients with cancer, offering greater opportunities to make personal decisions about cancer treatment.

We are taking forward bold actions to improve lung cancer screening, introduce rapid diagnostic centres and increase our workforce.

Stroke services

We plan to improve stroke services – right across the pathway from prevention through to rehabilitation. Our aim is to reduce the number of people having a stroke in our population, but for those who do, we need to reduce variation in the outcomes of the care that we provide.

We will work in partnership with care professionals, public health and wider partners such as the Stroke Association, and local people to reduce the likelihood of experiencing a stroke.

Mental health – adults and children and young people

Working with communities to improve the mental health, resilience and wellbeing of people in Lancashire and South Cumbria is one of our partnership priorities.

Our ambition is that mental health and wellbeing is considered of equal importance to physical health in all of our communities. When local people require more support, they should be able to access an effective range of age-appropriate mental health services. At present, there is variation in access, provision and clinical outcomes.

Learning disabilities and autism

We will redesign and deliver effective, streamlined community services and develop specialist assessment and treatment beds, community admission avoidance placements and alternatives to hospital admission for people with learning disabilities and/or autism.

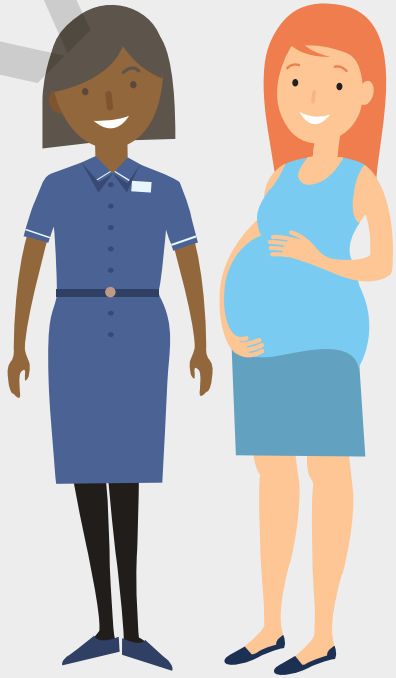
The partnership will:

- Ensure the safe and effective discharge of people who do not require the use of inpatient services
- Ensure that the right number of beds are delivered in the right places, meeting the needs of individuals
- Ensure that public sector resources are being used effectively to support people with a learning disability or autism
- Ensure that action is taken to reduce health inequalities.

Planned care

We have reviewed how all our hospital operating theatres are used to improve efficiency and reduce waiting times for patients. Across the ten specialties with the highest volume of activity, we have identified an opportunity for an additional 18,000 theatre hours per year, but recognise that there are significant challenges in achieving all of this.

We will enable earlier and more accurate diagnosis to make sure we get patients on the right planned pathway first time. To do this, we will work in partnership to deliver improved diagnostic services, which use tests and evaluations to help detect, diagnose and treat diseases, injuries and other physical conditions.



Maternity services

We aim to better deliver consistent care for families. As a partnership, we are committed to removing boundaries, improving choice, safety and experience of maternity services and improving outcomes.

This will result in:

- Reduced number of stillbirths and neonatal deaths
- Reduced number of brain injuries between labour and delivery of the placenta
- Personalised care records
- Most people receiving continuity of carer during pregnancy, birth and postnatally
- Reduced number of newborn babies separated from their parents
- Reduction in people smoking during pregnancy and at the time of delivery
- Improved support and education around infant feeding.

Making this happen

This strategy will be enabled by our plans to:

- Create a great place to work and develop
- Use technology and innovation to deliver great care
- Make the most of public sector investment
- Inform, involve and engage local people, staff, partners and stakeholders

Creating a great place to work and develop

- We are committed to developing employment opportunities for local communities within health and care services
- We will develop the volunteer workforce, which includes partnership working with the voluntary, community, faith and social enterprise sector
- We will recruit new members of staff – we want to attract new staff to the region
- We will improve the experience of staff currently working within the partnership
- We will develop new roles and skills and use technology to better support staff
- We will create stable and sustainable clinical and frontline teams working across more than one trust/site in order to ensure that there are sufficient staff to deliver quality and safety for patients.

Using technology

We will mobilise our workforce to harness the technology revolution and bring about a radical transformation, that will:

- Empower people to be more active in managing their health and wellbeing
- Enable more patients to self-care and live independently for longer
- Pinpoint, predict and prevent disease through better use of data
- Increase the amount of time for care on the frontline
- Create a flexible working environment that helps retain the workforce
- Improve operational efficiency across back office services.

Innovating to deliver great care

- The partnership will contribute to the development of the Lancashire and South Cumbria economy, promoting a wide range of benefits to the population from this approach to collaboration, mutual learning and investment in new ideas. This allows us to respond locally to the global impacts of technological, social, scientific and environmental changes.
- The partnership will establish a public service enterprise and innovation alliance, bringing together the health and care sector across Lancashire and South Cumbria with universities and economic development partners.

Making the most of public sector investment

We will significantly change the way organisations invest in, provide and manage the whole health and care system including GPs, A&Es, specialist centres, hospitals and care services.

To achieve this, we will:

- **Develop a more radical approach** to planning and making changes to services across providers. This needs to result in much faster change than partners have been able to do in the past
- **Increase our collective ability** to achieve efficiencies and services changes. We need a higher level of ambition, peer support and challenge, leadership and the application of the right techniques
- Ensure we are quick to **adopt best practice** across the whole system
- **Make the most of new ideas and opportunities**, which lead to faster change and improve the efficiency of our services.

Inform, involve and engage local people, staff, partners and stakeholders

We will involve people when designing how we deliver services and work together to improve people's experience of health and care locally.

What this means for communities and our staff

In five years' time…

Local people will be:

- More active in managing their health and wellbeing and decisions they make that affect them
- Supported to improve their long-term health and wellbeing
- Living well before they die, in the place of their choice in peace and dignity
- Using technology to manage their health
- More involved in decision making in their area
- Making best use of local housing and leisure services by connecting with integrated community teams
- Living in dynamic, empowered communities where people can live, work and thrive
- Benefiting from more coordinated and joined-up care
- Receiving care from hospitals, which provide networks of services, with sustainable staffing levels and consistent pathways
- Supported to live longer, healthier lives with earlier diagnosis of conditions and advice on prevention.

Staff will be:

- Happier, healthier and more resilient
- Provided with a wider range of roles and support to develop new skills and capabilities
- Working in integrated community teams, delivering targeted and coordinated physical and mental health care to their local neighbourhoods
- Better able to support people they care for, through greater access to data shared by partners
- Attracted into working and living in Lancashire and South Cumbria.

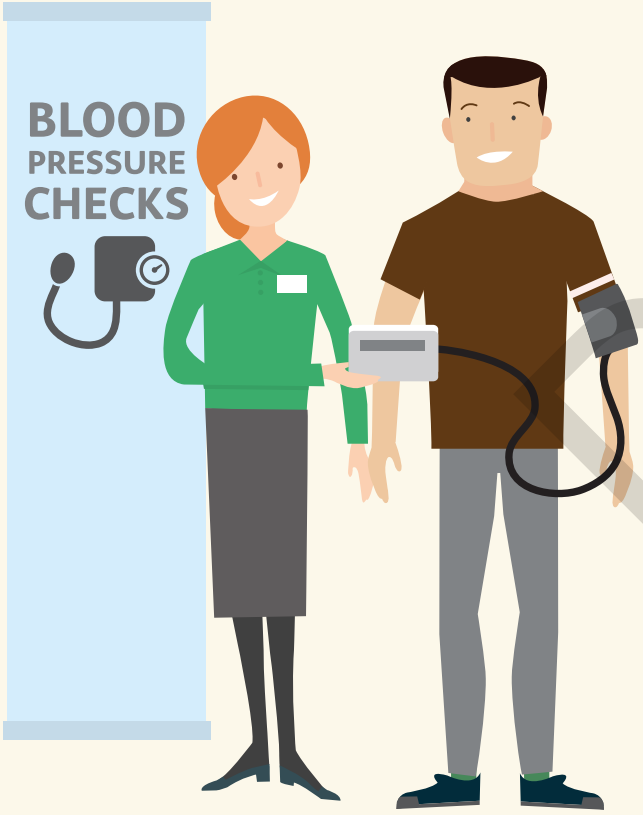
Partners will be:

- Able to demonstrate how public sector organisations have supported economic development and innovation, resulting in employing local people into new and different jobs in health and care
- Able to demonstrate that they are getting the best value health and care
- Confident in the evidence of improving life expectancy and reducing inequalities in the most deprived neighbourhoods through our approach to population health
- Able to demonstrate how health and wellbeing has been considered in public policies such as education, housing, economic development, transport and retail.

The impact of working in partnership

Lancashire and South Cumbria Integrated Care System is seen as a maturing partnership.

There is much that has already been achieved, which health and care system partners are proud of.



Early detection and prevention

- **£7.6million funding** from NHS England and NHS Improvement (NHSE/I) will help to diagnose lung cancer earlier in Blackpool and Blackburn with Darwen. Lung health checks will begin in early 2020, targeting smokers or ex-smokers between 55 and 74 years of age. In addition, **£9million** is being invested in early diagnosis of other types of cancer.
- Partners are working with the British Heart Foundation to deliver **12,000 blood pressure tests in local communities by 2021** with football clubs, leisure centres and pharmacies so that people know their numbers and what they mean. This is identifying individuals much earlier who are at risk of a heart attack, kidney disease and stroke.
- A partnership approach to **reduce suicides** has seen the development of a dashboard of live intelligence on suspected suicides. The insight is helping to identify trends, which is being used to deliver a campaign to reduce suicides by encouraging people to talk, create stigma free working environments where people can seek help and reach out to colleagues and to provide support for those bereaved by suicide.

Developing partnerships with the voluntary, community, faith and social enterprise (VCFSE) sector

- The VCFSE sector, local authorities and NHS in Lancashire and South Cumbria have worked together to develop better relationships. This has seen **consistent models of VCFSE engagement** within and across all local health and care partnerships and the development of a VCFSE leadership group across Lancashire and South Cumbria.

Supporting thriving local communities

Leading the way nationally in developing a population health management approach resulted in five neighbourhoods tackling issues in their communities:

- In **Blackpool**, people living in houses of multiple occupancy have been provided help related to issues with where they live and empowered to become more actively engaged in managing their own health and wellbeing.
- In **Skelmersdale**, people with respiratory conditions often have other health conditions such as diabetes or depression and anxiety. More personalised care has been provided to a group of patients by looking at the whole person rather than just one condition at a time, as well as developing group consultations to provide peer support.
- In **Chorley**, it was identified that residents known to the GP surgeries as living with frailty also needed help to have their bins collected. People have been connected with link workers who visited and interviewed them in their own homes to provide support for their mental health, physical and social needs in one assessment. This has resulted in connecting people with local groups to help combat loneliness or obtain support and tips for healthy eating.
- In **Barrow and Millom**, people most at risk of serious mental health conditions have been supported by improving the consistency and quality of the Severe Mental Illness (SMI) checks they receive.
- In **Burnley**, a group of people aged 50 and over living with frailty have benefited from their neighbourhood team using a peer-to-peer model of support. This has helped individuals to meet people with a similar condition and learn from each other how best to manage and self-care as well as getting the best from services.
- In **Fleetwood,** partners have joined initiatives together, which have contributed to a significant reduction in the number of residents attending Blackpool's A&E, down **11.5%** in a year. There has also been a reduction of **9.4%** in the number of people being admitted to hospital in an emergency. The primary care network has received multiple awards.

Strengthening the health and care workforce

- A programme called **EPIC** has been established to share and adopt best practice; celebrate the achievements of staff; and connect individuals and teams across the partners of Lancashire and South Cumbria Integrated Care System. **More than 500 staff and volunteers** from health, social care, public sector and community organisations have participated in the first two events in 2019. EPIC stands for **E**ngaging communities, **P**romoting partnerships, **I**nnovation for improvement and **C**ollaborating to develop services.
- Nurse recruitment is being developed through the Global Health Exchange Programme to attract new staff from overseas. All trusts have taken part in an initial recruitment exercise with more than **200 nurse** posts filled.

Joining up health and social care services

- **78% of our care homes** are actively using a tool that allows bed vacancies to be tracked. This is helping to reduce avoidable and unnecessary lengthy stays in hospital.
- A Lancashire-wide joined-up **response and falls lifting service** has been launched. This is designed to divert calls from ambulance services in cases where older and vulnerable people have fallen within their own home (this includes care/nursing homes and extra care sheltered housing). The service has teams based in every locality and is averaging a response time of around 30 minutes, comparing favourably to what was often a four hour plus wait.
- Partnership work across **maternity** services has resulted in **29.2%** of people being booked onto pathways, which can offer continuity of carer, exceeding the national target of 20%.

Innovations in digital health

- Almost **500,000 people** across Lancashire and South Cumbria have **downloaded an app** that helps them connect with their GP surgery. **More than one million** local people have been enabled to use **online consultation**. Patients are now able to contact their practice online to ask about a new or ongoing problem and get advice or an appointment if needed. **More than four fifths** of all GP practices across Lancashire and South Cumbria are now offering online consultations.
- A **shared care record** is now fully operational across Lancashire and South Cumbria, supporting clinical staff to deliver care to patients. Thousands of clinicians use it routinely to ensure continuity and consistent care for the people they treat. There are currently more than **2.5million care documents** available to view, with more than **100,000 new documents** published every month. This means that patients do not have to repeat information to different care teams and more joined-up care can be provided thanks to easier access to an individual's medical history.

Thank you

We would like to say a huge thank you to all the local people, staff and partners who have been involved in developing this strategy and our plans for the next five years.

We are also grateful to our universities, voluntary, community, faith and social enterprise sector, police and local Healthwatch who have all actively contributed to this strategy for the partnership.

Our next steps

We will continue to work together across health and care to develop and deliver these priorities in partnership.

This version of our strategy is a draft because we would like to get further feedback from local people and stakeholders.

To find out how to share your comments, please visit:

healthierlsc.co.uk/Strategy

Get involved

In your local area: **healthierlsc.co.uk/Local**

Visit our website: **healthierlsc.co.uk**

Join in the conversation on Twitter: **/HealthierLSC**

Like us on Facebook: **/HealthierLSC**

Email us at: **healthier.lsc@nhs.net**

Our partners

Lancashire and South Cumbria Integrated Care System is a partnership of the following organisations:

NHS organisations

- NHS Blackpool CCG
- NHS Blackburn with Darwen CCG
- NHS Chorley and South Ribble CCG
- NHS East Lancashire CCG
- NHS Fylde and Wyre CCG
- NHS Greater Preston CCG
- NHS Morecambe Bay CCG
- NHS West Lancashire CCG
- NHS Midlands and Lancashire Commissioning Support Unit
- Blackpool Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- North West Ambulance Service NHS Trust
- NHS North West Regional Specialised Commissioning Team
- The Innovation Agency, the Academic Health Science Network (AHSN) for the North West Coast

Local authorities

Upper tier/unitary councils

- Lancashire County Council
- Blackburn with Darwen Borough Council
- Blackpool Council
- Cumbria County Council

District councils

- Preston City Council (Central Lancashire ICP)
- Chorley Council (Central Lancashire ICP)
- South Ribble Borough Council (Central Lancashire ICP)
- Fylde Council (Fylde Coast ICP)
- Wyre Council (Fylde Coast ICP)
- West Lancashire Borough Council (West Lancashire MCP)
- Barrow-in-Furness Borough Council (Morecambe Bay ICP)
- Lancaster City Council (Morecambe Bay ICP)
- South Lakeland District Council (Morecambe Bay ICP)
- Burnley Borough Council (Pennine Lancashire ICP)
- Hyndburn Borough Council (Pennine Lancashire ICP)
- Pendle Borough Council (Pennine Lancashire ICP)
- Ribble Valley Borough Council (Pennine Lancashire ICP)
- Rossendale Borough Council (Pennine Lancashire ICP)

Voluntary, Community, Faith and Social Enterprise (VCFSE)

The ICS has established strong partnerships with the VCFSE sector. A Voluntary Sector Partnership Alliance has been formed by the sector comprising chairs of VCFSE networks in each of the five local health and care partnerships.

Accessibility

If you would like this document in an alternative format, please email us at **healthier.lsc@nhs.net**

Glossary

For definitions of health and care words and phrases used in this document, please visit **healthierlsc.co.uk/glossary**

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Healthier Pennine Lancashire ICP and Healthier Lancashire ICS
DATE:	17/02/2020

SUBJECT: Commissioning Reform

1. PURPOSE

This paper seeks to update Blackburn with Darwen HWBB members on upcoming discussions about the evolution of NHS commissioning in the Blackburn with Darwen CCG and Pennine Lancashire area, and across Lancashire and South Cumbria over the next two years.

In recent months, the Chairs and Chief Officers from all of the Lancashire CCGs have been reviewing the progress made in conjunction with NHS providers, local authorities and other partners to introduce new models of integrated care in local areas and across Lancashire and South Cumbria. Over time this has begun to change the roles undertaken by commissioners and for this reason, colleagues have agreed a road map for commissioning reform.

A case for change and options appraisal document has therefore been drafted and is attached. This document sets out how commissioning organisations can work to continue the development of these local integrated health and care partnerships.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is requested to:

(i) Receive the paper and,
(ii) Provide feedback on the proposals

3. BACKGROUND

Based on the collective vision to continue this journey of integrated care in neighbourhoods, local places and across Lancashire and South Cumbria, commissioning leaders have identified a number of options for the commissioning arrangements which can best support this next stage of development. Each option has been assessed against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in Primary Care Networks, local health and care partnerships and (where there is value in acting collectively) across the Integrated Care System
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes

- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each Integrated Care System area.

The Case for Change document (appendix) recommends an option which would lead to the creation of a single CCG for Lancashire and South Cumbria. This option is also clear that the single CCG will discharge a range of its functions through locality-based commissioning teams working with partners in each of the five localities: Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire.

The place based commissioning teams will be the key commissioning link with each locality and will retain many of the benefits the member practices have indicated are important to them including; local clinical leadership, engagement and commissioning of primary care, population health improvement, local performance, quality and financial management.

Following an agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February to April 2020 with member practices, CCG/CSU staff and other stakeholders including providers, Local Authorities and patient/public groups.

No decisions have been taken at this point in time about future configuration of CCGs. The formal decision about any option to change the number of CCGs will be taken according to each CCG's constitution through a vote of member GP practices which is planned to take place in May 2020.

If the outcome of this vote is to support the creation of a single CCG, then a full set of merger submission documents will be prepared in line with NHS England guidance. A formal merger application will be submitted to NHSE by 30 September 2020 with the aim of a single CCG for Lancashire and South Cumbria operating in shadow form from October 2020 and being fully established on 1 April 2021.

Feedback on the attached case for change is requested from HWBB members so this can be taken into consideration in the detail on which the GP membership will vote.

4. RATIONALE

Commissioning leaders have a clear intention of building on the best work undertaken with our partners to improve health and join up health and care services and community assets in neighbourhoods, five local health and care partnerships (Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire) and across the whole of Lancashire and South Cumbria.

This work aims to create a focus for the health and care system to work very differently, agreeing plans to improve the whole population's health, using partnerships to improve the quality of health services and bringing the system back into financial balance.

We have also acknowledged that there is a need to address several examples of fragmented or variable commissioning in the current system. Examples include our approach to complex, individual packages of care, cancer services and the care of people with learning disabilities.

5. KEY ISSUES

None.

6. POLICY IMPLICATIONS

None.

7. FINANCIAL IMPLICATIONS

None.

8. LEGAL IMPLICATIONS

None.

9. RESOURCE IMPLICATIONS

None.

10. EQUALITY AND HEALTH IMPLICATIONS

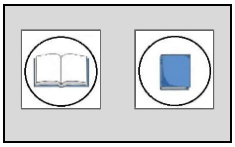
None.

11. CONSULTATIONS

The draft proposals are currently the subject of engagement. Should the proposal be agreed, a period of formal staff engagement will be undertaken in line with our statutory obligations.

VERSION:	**V3**

CONTACT OFFICER:	David Rogers, Head of Communication and Engagement, NHS East Lancashire and BwD CCGs.
DATE:	17/02/2020
BACKGROUND PAPER:	Appendix: ICS Commissioning Reform Case for Change



Lancashire and South Cumbria CCGs

Supporting Commissioning Reform and Integrated Care in Lancashire and South Cumbria

A Case for Change

Executive Summary

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out a case for changing the way that commissioning organisations work in order to accelerate the development of local integrated health and care partnerships. These increasingly ambitious partnerships offer a vehicle for commissioners, providers, local authorities and other partners to work very differently together, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and agreeing priorities to bring the system back into financial balance.

The context for the document is the work led by CCGs since 2013 to respond to a number of significant challenges in each area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability [section 1]. This work has led to a broad consensus of the need for partners to work effectively together in neighbourhoods, in local places and across Lancashire and South Cumbria.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of these integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing. As PCNs develop, they will have an increasing influence on the priorities of our evolving Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. Where there are opportunities across Lancashire and South Cumbria for collective action, learning and development, these are also being taken forwards by the wider Integrated Care System (ICS) partnership.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called "integrated care organisation" could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability. The "integrated care organisation" would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

Currently, however, the 8 CCGs in Lancashire and South Cumbria are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to

develop at the pace that is needed - and to tackle the challenges we face. This is in spite of the examples of joint decision-making and shared management arrangements which have developed over the last seven years.

In section 4, this paper begins to review the way that commissioning is currently organised and evaluates a number of potential future options against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

As a consequence of the ambitions to reform the commissioning arrangements, the option recommended is to form a new single CCG from April 2021 with aligned local commissioning teams to each Integrated Care Partnership / Multispecialty Community Provider, to support this next stage of development.

Key issues

A number of key issues have been raised by Governing Body representatives and member practices during the development work which has led to the production of this document. These issues [section 5] clarify and confirm how the process of change in commissioning arrangements would build on the existing strengths in Lancashire and South Cumbria and can be summarised as follows:

Governance, leadership and local decision-making

The single CCG will have a constitution approved by member practices across Lancashire & South Cumbria and will ensure strong local commissioning remains in each place.

It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The method of appointment to the CCG governing body and place-based commissioning teams would be agreed as part of the new constitution.

The place-based commissioning teams will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board. Local authority membership of local partnership boards will also drive this place-based approach.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

It is proposed that the new single CCG Chair and the Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP.

Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

The CCG also expects that PCN leaders will be formally represented within the ICP partnership arrangements.

Financial allocations for commissioning

There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.

Overarching financial principles would be developed and agreed as part of the engagement process, but we propose that:

- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as being in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

Commissioning general practice services

The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.

Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.

Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Engagement and Next Steps

Once this case for change has been approved, a formal process of engagement will commence with member practices, CCG staff, partner organisations, patient and public groups. [section 6] More details on the proposed timeline for this process are set out in section 7.

Contents

Introduction

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out the challenging context facing commissioners and communities. It also confirms the opportunities to continue a journey of integrated care which builds on the best work undertaken by CCGs and our partners in recent years. The document contains an options appraisal for future commissioning arrangements which is based on a number of criteria and recommends a preferred option for change. The paper also includes next steps and a high-level timeline for implementation of the preferred option.

This version of the Case for Change has been written for initial consideration by CCG governing bodies, member practices and the Joint Committee of CCGs. Wider engagement with commissioning staff, providers, local authorities and other partners will also be essential as this process develops.

Section 1: The Challenges We Face

As local commissioners, CCGs have been working with other partners since 2013 to respond to a range of familiar challenges:

Inequalities and Poor Health Outcomes

In Lancashire and South Cumbria, people in many of our communities experience ill health from an early age and die younger, especially in areas with higher levels of deprivation. There are high levels of physical and mental health problems, and we have seen increased levels of suicide in some of our communities. Cardiovascular disease, heart failure, hypertension (high blood pressure), asthma, dementia and depression are more common than the national average.

Persistent inequalities in health, employment, education and income are damaging the life chances of many citizens. There is increasing recognition that we need to support people and communities to help them to make changes in their own health and wellbeing. In future, therefore, commissioners will need to co-create a sustainable response from a range of public bodies to these issues, working with communities themselves.

Fragmented services and systems

There are multiple examples of fragmented pathways and services across the health and care system which leave patients uncertain as to where to access the most appropriate care or health professional.

At a systemic level in Lancashire and South Cumbria, the NHS model of commissioners and providers created nearly 30 years ago appears to have reinforced fragmentation in spite of the best efforts of many frontline professionals and leaders. Multiple contracts between several commissioners with the same provider e.g. for mental health services have created differential expectations and outcomes; competing organisational strategies have not enabled a clear focus on standards and outcomes. There are several examples e.g. improving stroke services, where decision-making on critical improvements has been painfully slow to achieve as individual organisations reconsider the proposals. These are not isolated examples: many have been discussed over the years in each Governing body and in our collective meetings across the whole of Lancashire and South Cumbria.

Our local providers are committed to working differently to repair this fragmentation: groups of general practices are working in neighbourhoods with other community and social care services to develop primary care networks. Attention will increase on these services with the

imminent publication of national standards/specifications for a range of community-based services.

Our major NHS providers are also exploring new models of collaboration, working firstly with general practice and community services to integrate care pathways in ICPs. They are also considering how "group" models of provision across Lancashire and South Cumbria can, for example, increase the sustainability of fragile services, create efficiencies in diagnostic and operating theatre services and improve the performance of cancer services.

Commissioners need to be working at the heart of these new models of delivery – but there is neither capacity nor resources to support these new approaches and maintain the infrastructure of eight separate CCGs.

Increasing Demand

Our health and care services are struggling to tackle the level of illness and poor overall health we face in Lancashire and South Cumbria. As demand for care increases, some people don't receive the quality of care they need and commissioners cannot afford to fund escalating levels of activity.

Workforce

Workforce pressures in the health and care sector are well documented – traditional multidisciplinary models of care are increasingly hard to sustain and this requires new thinking about workforce roles and support for frontline staff. The full benefits of new technology can only be realised if they are introduced into more integrated services, pathways and teams.

Financial Sustainability

In 2019/20 there is an estimated financial gap of £200m across the L&SC ICS, based on the allocations received by the 8 CCGs. Whilst funding for the NHS is set to increase over the next few years, tackling the challenges of persistent inequalities, fragmentation, increasing demand and workforce change is more urgent than ever. We need to consider every opportunity to streamline our systems and processes, and reduce duplication. Our aim has to be to make our financial position sustainable and our collaborative work on the Long Term Plan is progressing with that aim.

Over the last twelve months, all CCGs have been required to plan for a 20% reduction in running costs and this has already led to decisions to integrate management functions between CCGs and within ICPs/MCPs, hold staffing vacancies, review clinical leadership roles, reduce accommodation costs and work differently with the CSU.

The direction of travel towards 5 local place-based commissioning teams working through a single CCG will free up a proportion of running costs, particularly in relation to the costs of 8 Boards as well as taking further opportunities to consolidate or share management functions.

Some simple examples of where a single CCG would be more productive without affecting local clinical leadership and decision making include:

- We currently have to procure extrernal and internal auditors eight times and produce 8 sets of statutory accounts.
- As eight separate CCG's we hold collectively over 100 meetings per year to meet our statutory and constitutional duties. This could be vastly reduced freeing clinical time to focus on local place-based work.

- Commissioning areas like Ambulance services, cancer services and CHC would be much more effectively managed improving patient care and releasing savings and staff to reinvest locally.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

The table below summarises the pattern of running costs across the 8 CCGs:

Organisations	**Population**	**No. of Practices**	**2019/20 Allocation £m**	**201/20 Running Cost Allocation £m**
NHS Blackburn with Darwen CCG	177,841	23	271.3	3.5
NHS Blackpool CCG	175,012	20	333.1	3.5
NHS Chorley and South Ribble CCG	186,154	30	287.2	3.9
NHS East Lancashire CCG	387,324	50	647.6	7.8
NHS Fylde and Wyre CCG	178,682	19	310.5	3.6
NHS Greater Preston CCG	210,857	23	311.8	4.4
NHS Morecambe Bay CCG	348,208	35	570.0	7.2
NHS West Lancashire CCG	113,532	15	177.8	2.4
TOTAL	**1,777,610**	**215**	**2,909.3**	**36.3**

In summary, maintaining the costs of eight separate statutory bodies at a total cost of £36m is difficult to justify when there is such financial pressure on health spending.

Section 2: Our Journey to Develop Integrated Health & Care in Lancashire and South Cumbria

We know that tackling the challenges set out in Section 1 is not something that any single commissioning organisation can achieve in isolation. For this reason, the CCGs in Lancashire and South Cumbria have a long history of working collaboratively together and with partners across the Integrated Care System (ICS) footprint. The publication of the NHS Five Year Forward View in 2014 achieved a new level of consensus that commissioners, providers local authorities and other partners should pursue approaches to integrating health and care – joining strategies, partnerships, resources and leadership to respond to the triple aim of better health, better care, delivered sustainably.

By 2018, this journey of integrated care development was accelerating the development of 4 maturing Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for providers, commissioners, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.

CCGs have also begun to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.

At the same time, a Joint Committee of CCGs was established "to carry out the functions relating to decision-making on pertinent L&SC wide commissioning issues" arising from the ICS's main change programmes. This means the CCGs across L&SC already act together as the Commissioning Board (NHS) of the ICS. The terms of reference for the Joint Committee have recently been reviewed and updated and an annual work programme has been agreed. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or decisions arising from our main work programmes will take place.

The evolution of commissioning set out in this paper is not therefore a sudden jolt in our current arrangements. Our direction of travel builds on the place-based approaches being endorsed by CCGs in neighbourhoods, ICPs and across Lancashire and South Cumbria.

Recognising that the development of integrated care models would impact on the future of commissioning arrangements, in January 2018, the Joint Committee approved a Commissioning Development Framework for Lancashire and South Cumbria. The framework gave a system wide commitment to

- Listen to our communities about their priorities for health and wellbeing, connecting up the natural assets in each neighbourhood with the resources available across the public sector;
- Make shared, strategic decisions, with key partners and clinical leaders about the allocation of resources;
- Implement new, integrated models of service provision which can make significant improvements in the quality and outcomes of health and care;

- Streamline the way we do things to reduce waste and make the most efficient use of our resources.

Following approval of the Commissioning Framework, CCG commissioning colleagues across the system worked together to apply it to their workstreams and develop recommendations for place-based commissioning activity in the future. Their work addressed several examples of fragmented or variable commissioning in the current system which are leading to poor outcomes for many people. Examples include our approach to complex, individual packages of care, the availability of robust community services for people with learning disabilities and the variability of performance in cancer services. The Joint Committee agreed the recommendations and asked workstreams to develop operating and support models.

We have therefore made significant progress on our journey to develop integrated health and care for the people of L&SC and in doing so have established solid foundations for further development. ICPs/MCP and PCNs/neighbourhoods, are the fundamental foundations for a strong and effective health and care system going forward.

However, CCGs are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to develop at the pace that is needed - and tackle the challenges, work with our communities, improve the overall quality of our health and care services and achieve better financial outcomes.

There is significant duplication in operating eight membership councils and governing bodies and the associated governance, many CCGs have similar groups to solve the same problems. Individual members of staff are trying to maintain work on several critical priorities at the same time and the work to implement new collaborative commissioning operating models across L&SC is progressing, though slowly. We therefore need to review the way we are currently organised, building on and accelerating our joint working to date, agree how best to organise ourselves to meet our challenges and deliver our vision to create a health and care system that is fit for now and the future.

Section 3: Vision

Our published vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

At the heart of this are the following ambitions:

- We will have healthy communities
- We will have high quality and efficient services
- We will have a health and care service that works for everyone, including our staff.

Over the next 4-5 years, we expect our system to continue its journey of integrated care, joining up the priorities of health and care organisations to achieve consistent standards of service performance and improved outcomes for patients and the public.

We are placing a premium on:

- Developing partnerships across the public sector (education, employment, housing, business, local government and NHS) in order to reduce the generational inequalities in health and life chances between our communities.
- Working with each of our communities to understand the assets available which can help people to become more engaged in their own health and well being.
- Joining up primary, community, mental health and social care services in local areas whilst at the same time ensuring that sustainable and efficient models of specialised services can be offered to the whole population.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called “integrated care organisation” could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability.

The “integrated care organisation” would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

In moving towards our vision, over the next 2-3 years we will continue to strengthen our partnerships in local places and across the whole Lancashire and South Cumbria system. Our priorities here are to:

- Ensure our clinical and other frontline leaders are able to lead the work to create sustainable care models in our neighbourhoods, place-based partnerships and across Lancashire and South Cumbria.

- Demonstrate to patients and communities that the ways in which we organise health and care services are leading to improved access and outcomes.
- Tackle our most difficult challenges (workforce, finance, service resilience) by agreeing clear priorities across the ICS and the decision-making arrangements we will use.
- Sustaining an open dialogue with the public about our future models of health and care.

The proposals for commissioning reform which are laid out in this document are therefore designed to help us make the next steps on this ambitious journey.

Section 4: Options for Commissioning System Reform

In developing and considering options for future commissioning reform, it is important that we do so in the context of the challenges we face, the progress made to integrate care and our commitment to build on the partnerships which commissioners have already developed. The following criteria have therefore been developed to support these considerations. If we are going to organise ourselves differently, any new model must:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

Options Appraisal

Current Arrangements

There are currently eight CCGs within the L&SC ICS footprint with a number of CCGs operating shared commissioning arrangements that are aligned to the ICP footprints:

- NHS East Lancashire CCG and NHS Blackburn with Darwen CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements
- NHS Blackpool CCG and NHS Fylde & Wyre CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- West Lancashire CCG shares the same Accountable Officer as the two Fylde Coast CCGs (from January 2020).
- NHS Chorley & South Ribble CCG and NHS Greater Preston CCG have a single Accountable Officer, a single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- NHS Morecambe Bay CCG was formed in 2018 following a boundary change process to incorporate South Cumbria. There is a single Accountable Officer and Governing body and clinical and executives are increasingly taking "system roles" within the ICP.

Across the ICS footprint, the CCGs oversee collaborative programmes of work and are able to make joint decisions relating to L&SC-wide issues through the formally constituted Joint Committee of CCGs, in line with an agreed annual work programme. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or

decisions arising from our main work programmes will take place. The work programme is also used to seek appropriate delegations from CCG Governing Bodies into the Joint Committee where appropriate. The scope of delegation to the Joint Committee is limited at the current time.

Drawing on the criteria set out above a number of options for future commissioning system reform have been generated and appraised:

Option 1	*No change to current arrangements*
Option 2	*Merger to create five CCGs aligned with ICP footprints*
Option 3	*Single Accountable Officer and Executive Team for all eight L&SC CCGs*
Option 4	*Single CCG (all functions)*
Option 5	*Single CCG which aligns commissioning functions to each Integrated Care* ***Partnership/****Multispecialty Community* ***Partnership***
Option 6	*Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care* ***Provider/*** *Multispecialty Community* ***Provider***

A detailed appraisal of these options is set out in Appendix A. In the light of this assessment, option 5 is recommended to commence from April 2021. The details of this option are shown below.

Our Preferred Option and Benefits

Option five is our recommended option to commence from April 2021. In advance of this, shadow arrangements would be developed during 2020/21.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them

including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Merging into a unified, more strategic commissioning organisation with a strong local focus delivered through locality commissioning teams aligned to the five ICPs/MCP best supports our ambitions as described below:

1. Tackle inequalities and improve outcomes for patients

We know there are significant health inequalities across L&SC which create challenges for services and result in poorer outcomes for some of our most vulnerable and deprived communities. Our work to tackle health inequalities will be better supported by having Locality Commissioning Teams aligned to the five ICPs/MCP. This will enable us to:

- Maintain strong links and engagement with the local population;
- Ensure specialist analytics and population health capabilities can develop across L&SC and be available for each ICP/PCN to support local priorities
- Undertake service planning and targeted delivery to reflect the specific needs of local communities – working closely with local authorities;
- Ensure effective communication and engagement with local populations including seldom heard groups of people to enable them to share their views and concerns which will shape not just what services are provided but how they are delivered.

Only by organising ourselves differently can we begin to deliver the improvements that are needed for our patients

2. Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPS, MCP and (where there is value in acting collectively) across the ICS

Locality commissioning teams will be aligned to the five ICPs/MCP. They will exercise an agreed set of commissioning functions on ICP/MCP and PCN footprints, working collaboratively with partners through ICP Partnership Boards to agree plans for population health improvement, improved service quality and financial recovery. The Local Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning with the ultimate aim of supporting ICPs/MCP and PCNs to reach a level of maturity over the next 2-3 years whereby commissioning functions and budgets can be contracted for through an Integrated Care Provider Contract. The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will have specific linked roles to local ICPs and neighbourhoods.

3. Reduce duplication

There will be a significant reduction in duplication both in terms of the capacity required to support the existing eight CCG governance structures and that deployed to support commissioning activity across eight CCG footprints. We know that our commissioning workforce is finding it increasingly challenging to balance the demands of collaborative commissioning activity across L&SC with ICP/MCP commissioning work to support the development of PCNs and neighbourhoods.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

4. Support a consistent approach to standards and outcomes

As a strategic commissioner the CCG will focus on a key set of commissioning functions and activity related to standard setting for the whole population. It will focus on macro-level population health management and improving outcomes for patients.

Further development work is now being led by CCGs to set out the commissioning functions which will be exercised by Locality Commissioning Teams.

5. Be affordable, reduce running costs and support longer term financial sustainability

By streamlining our decision-making infrastructure and commissioning activity, doing things once where it makes sense to do so (e.g. finance, corporate services, committee meetings) we will reduce running costs. By re-focussing commissioning time and energy for those service areas in which recommendations have already been made to commission at L&SC level, we will make better use of clinical and managerial time and be better placed to deliver the financial efficiencies as required by NHS England and Improvement.

6. Offer the potential for further development of integrated commissioning between the NHS and Local Authorities

We will establish Locality Commissioning Teams to exercise key commissioning functions through ICP Partnership Boards, of which Local Authorities are key members. The new arrangements will support the continued journey towards more integrated health and social care at place level with ICP Partnership Boards being well placed to explore practical ways of integrating health and social care commissioning and delivery.

7. Be deliverable

Creating a single CCG with a combination of system-wide and locality-based leadership offers a deliverable and affordable model of commissioning in an integrated care system.

8. Be congruent with the NHS Long Term Plan expectation that there will typically be a single CCG for each ICS area

The NHS Long-Term Plan (LTP) is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. It talks about CCGs becoming leaner, more strategic organisations that support care providers through ICPs/MCP to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. It also talks about CCGs developing enhanced management capability for more specialist functions, such as estates, digital and workforce. Option five will allow us to bring together CCG clinical and managerial time to respond to the requirements of the LTP, and ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP, to support place-based commissioning, allowing time and support for ICPs/MCP maturity to further develop.

In summary, a single CCG which operates as a strategic organisation, working with well-resourced local teams aligned to each of our local partnerships is recommended for the next stage on our journey of integrated care.

Section 5: Governance and Decision Making

As indicated above, the importance of effective governance and decision-making will be a critical success factor for this next stage of commissioning development in Lancashire and South Cumbria. This is particularly the case in order to build on the legacies of existing CCGs, move away from competition to partnership models of healthcare delivery and ensure that local organisations remain accountable to their communities.

Under the option for a single CCG, this will clearly operate as a membership organisation with a formal Constitution and scheme of reservation and delegation agreed with the members and approved by NHS England.

Membership of the Governing Body of the CCG will include the roles formally required including Accountable Officer, Chief Finance Officer, Secondary Care Doctor, Nurse and Lay members.

Locality-based decision-making

In order to emphasise the importance of place-based leadership and decision-making in Lancashire and South Cumbria, the governance of the new CCG will include a formal approach to leadership and decision-making in each locality. It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director for each of the 5 places (Central Lancs, Fylde Coast, Pennine, West Lancs and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

Local authority membership of ICP/MCP partnership boards will also drive this place-based approach and working relationships are expected to become increasingly close.

Given the size of the CCG, there need to be practical arrangements for ensuring member practice involvement in the accountability arrangements and governance of the organisation, particularly as many practices also want to be engaged effectively in the development of local Primary Care Networks (on the basis of 30-50000 population) as well as in their ICPs/MCP.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

Effective clinical leadership has been at the heart of clinical commissioning in recent years. There is an explicit commitment to retain these benefits in the leadership and governance of any reformed commissioning arrangements agreed for the future.

In line with current legislation, the single CCG will remain a membership organisation with all general practices as members. We recognise that clinical leaders will continue to be involved in developing the strategy, governance and accountability of a new commissioner

(e.g. through membership of the Governing Body), as well as working with provider colleagues to drive change and improvements across the health and care system.

In the next stage of our system's development, we also know that a group of GPs and other clinicians have been asked to lead our integrated PCN models in neighbourhoods: a key driver for reorganising the resources which are currently available within CCGs. It is understood that plans are being developed in each area for PCN leads to play a full part in the governance of each ICP/MCP.

Whatever option is agreed for changes in commissioning, there will be an obligation to operate under a formal constitution with a clear model for clinical leadership which is developed and agreed with member practices.

It is proposed that the new CCG Chair and the 5 place-based Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP. Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

Finance & Allocations

As indicated above, many of the NHS organisations within the ICS are currently projecting substantial deficits. These will require effective, strategic decisions to be taken if the system is to return to a stable financial base. It is recognised that existing CCGs are in different financial positions and spending on services will be variable. Much of this will be driven by historic funding variations.

It is also understood that Governing Bodies and member practices have concerns about the impact of commissioning reform on existing allocations and commitments. At this stage, therefore, it is vital therefore that the following explicit commitments are made.

In relation to commissioning allocations:

- There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.
- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

In relation to the commissioning of general practice services:

- The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.
- Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.
- Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

- In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Section 6: Stakeholder Engagement

Since June 2019, CCG Chairs and Chief Officers have worked together with ICS colleagues to draft a roadmap and a statement of intent, setting out a direction of travel for commissioning development. These have been shared with each CCG's Governing Body and take forward a dialogue to understand concerns, answer questions and consider the options outlined in this paper. In addition, a written briefing has been cascaded to staff working in CCGs and the Midlands and Lancashire CSU which has been supported in regular staff briefings held within organisations.

It is vital that a clear approach to communication and engagement now takes place, particularly with our member practices and to ensure staff in CCGs are informed and involved at each stage. CCGs wishing to consider organisational change are also required by NHS England to demonstrate effective engagement about the plans with other key system partners and the public.

To support this process, a communications and engagement plan will be developed to deliver the following objectives:

- Demonstrate we have been able to take account of the views of key stakeholders – in particular our staff, GP membership and four local Healthwatch organisations- in developing our plans for a strategic commissioner
- Ensure key audiences are aware of our plans and in particular what this might mean for them
- Ensure stakeholders – and existing CCG staff in particular – are able to ask questions and give comments, with a robust feedback mechanism
- Ensure stakeholders – and existing CCG staff in particular – are engaged in bringing the new organisation together
- Ensure staff and members are aware of any additional roles and responsibilities they may have in helping to create the new strategic commissioner.

Our communications and engagement principles are

- The communications and engagement plan is based on clear, consistent messaging that describes both the benefits of merger and any dis-benefits
- Employing a principle of 'early communication and engagement' so there are 'no surprises' particularly amongst key stakeholders
- With effective and meaningful engagement channels to capture views, timely responses to questions and feedback and published FAQs (regularly updated)
- The plan covers both internal and external audiences across all eight CCGs, including staff, memberships and practice staff, the LMC, leaders/staff across the ICS, our regulators, Healthwatch, PPGs and engagement fora, the community/ voluntary sector, other local partners, media and wider public
- With messages and approach tailored appropriately
- Underpinned by a clear activity plan and timeline which uses existing communications/engagement channels wherever possible

Section 7: Next Steps and Timeline

This Case for Change and the Options Appraisal contained in appendix A have undergone a number of iterations during the past two months based on feedback from CCG Chairs and Chief Officers, Governing Bodies and member practices. In particular, work has been undertaken to set out a vision for the continued development of integrated care in neighbourhoods, local places and across the system. More detailed proposals have been set out relating to governance, local decision-making, clinical leadership including commitments relating to financial allocations and the commissioning of general practice services.

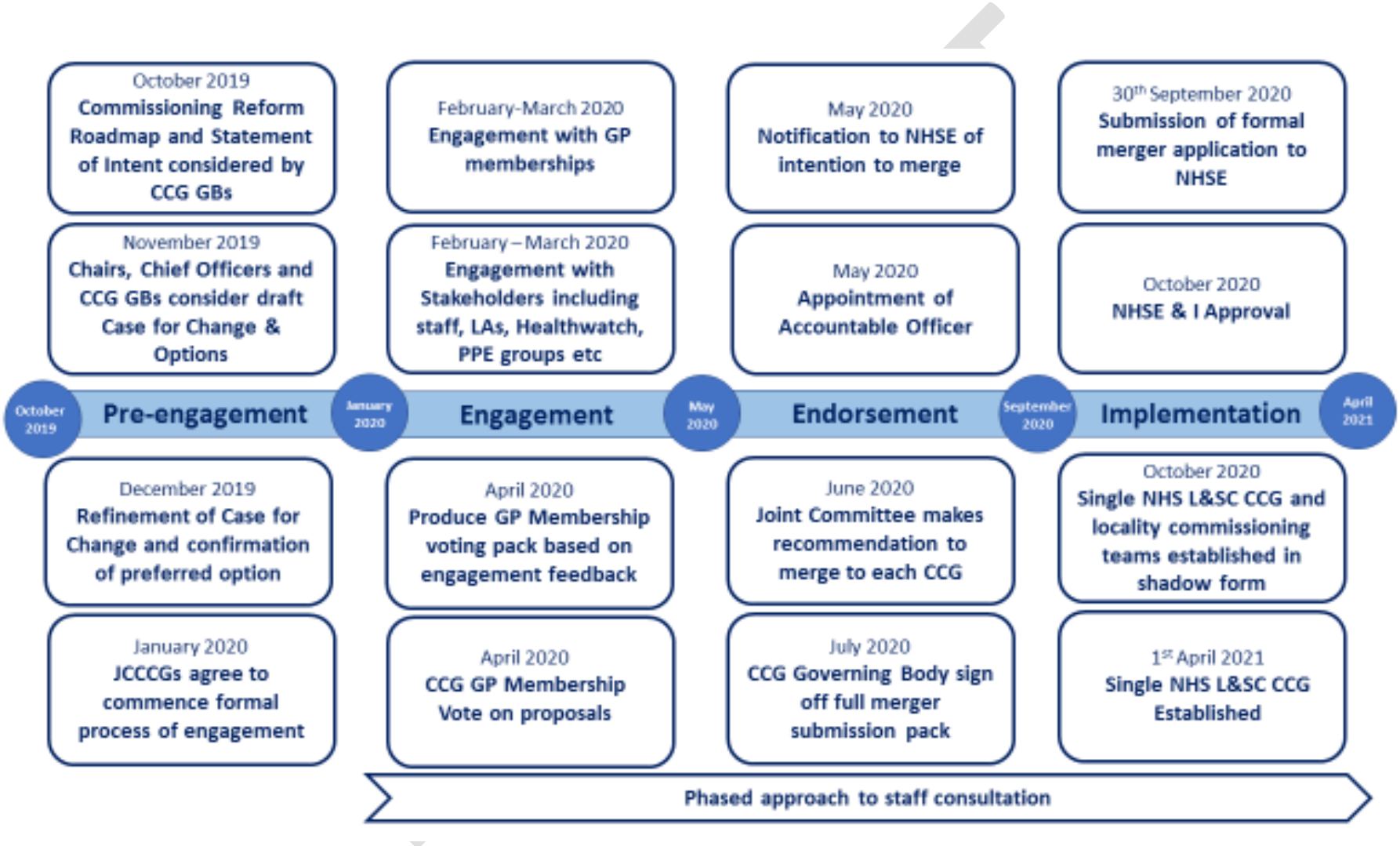
Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including Local Authorities, Healthwatch and patient/public groups.

Work will also be completed in early January to develop proposals for the future delivery of commissioning functions at place and system levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

Following the engagement process, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs prior to a CCG GP Membership vote in May 2020. Subject to the outcome of this vote, a full set of merger submission documents will be developed in line with NHSEI guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE on 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

A high-level timeline for the process described above is set out below. Work is underway to develop a detailed programme plan which will incorporate development plans for the ICPs/MCPs.

Commissioning System Reform – High Level Timeline



APPENDIX A - Commissioning System Reform Options Appraisal

Option	Number of CCG's	Pro's	Con's
1. No change to current arrangements	8	Local commissioning focus continues Minimum structural change	Continuing duplication Limits capacity to support ICP and PCN development, place-based commissioning Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning
2. Merger to create five CCGs aligned with ICP footprints	5	Local commissioning focus continues Some structural change Partial release of capacity and resource to support ICPs/MCP and PCN development and place-based commissioning Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Continuing duplication of resource maintain five CCG governance structures Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning

Option	Number of CCG's	Pro's	Con's
3. Single Accountable Officer and Executive Team for all 8 L&SC CCGs	8	Local commissioning focus continues Limited structural change May offer small efficiencies in management costs Offers potential to support a consistent approach to standards and outcomes	Continuing duplication Limits capacity to support ICP/MCP and PCN development, place-based commissioning Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning Not deliverable, unworkable for a single Exec Team to relate to eight Governing bodies
4. Single CCG (all functions)	1	Reduces duplication Supports consistent approach to standards and outcomes across L&SC Economies of scale Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Limits capacity to support ICP/MCP and PCN development, place-based commissioning Significant structural change

Option	Number of CCG's	Pro's	Con's
5. Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Significant structural change
6. Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care **Provider/** Multispecialty Community **Provider**	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP	Significant structural change Requires Integrated Care Providers /Multispecialty Community Provider to have reached a stage of maturity to be able to take on commissioning functions on behalf of the single CCG

Option	Number of CCG's	Pro's	Con's
		Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	

Option 1: No Change to Current Arrangements

The eight existing CCGs continue to take individual responsibility for their statutory functions and the operation of their local system, whilst at the same time working with other CCGs and with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would not require structural change. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option is increasingly unaffordable whilst also being inconsistent with the expectations set out in the NHS LTP. This option also holds limited potential for further development of integrated commissioning with Local Authorities.

Option 2: Merger to create five CCGs aligned with ICP footprints

A number of the existing CCGs would merge to form five CCGs across the L&SC ICS footprint which are aligned with the five ICPs/MCP:

- Morecambe Bay
- Central Lancashire
- Fylde Coast
- West Lancashire
- Pennine Lancashire

The new CCGs would continue to take individual responsibility for their statutory functions and the operation of their local system, whilst working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. Each CCG would retain a separate governing body and governance structure, AO and Executive Team.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee in line with an agreed work programme, though accountability would remain with the existing CCGs

This option would mean that commissioning activity is focussed on the local ICP footprints and offers the partial release of capacity to support ICPs/MCP and PCN/Neighbourhood development and place-based commissioning. The potential for further integration with Local Authorities would be based on sharing priorities and resources (rather than straightforward co-terminosity). This option does not support a more consistent approach to standards and outcomes across the ICS footprint and would see duplication of governance structures and commissioning activity continue. This option does not benefit from opportunities for greater collaboration and economies of scale offered by other options. In the context of expectations that all CCGs will achieve 20% running cost savings this option

would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

Option 3: Single Accountable Officer and Executive Team for all L&SC CCGs

The eight existing CCGs appoint a single Accountable Officer and Executive Team for the whole Lancashire and South Cumbria footprint. Individual CCGs would retain responsibility for the delivery of statutory functions but Accountable Officer (AO) decision making would be held at the Lancashire and South Cumbria level. The AO and Executive Team would be responsible for working with their local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. The single AO would be responsible for providing assurance to each governing body for statutory functions that continue within the CCG and for appropriate adherence to standards, targets and performance expectations.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions make through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would require limited structural change. It also offers the potential to support a more consistent approach to standards and outcomes across the ICS footprint and may offer small efficiencies in management costs. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

The key issue with this option is that it would be undeliverable in practical terms for a single AO and Executive Team to relate to eight Governing bodies.

Option 4: Merger of CCGs to form a single NHS L&SC CCG (all functions)

The eight L&SC CCGS would merge to form a single new CCG which would take responsibility for all the statutory functions of the current eight CCGs and the operation of the system across L&SC working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would be subsumed within the governance arrangements of the single CCG.

This option would see all commissioning activity focussed on the ICS footprint and would benefit from economies of scale. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP. However, with all commissioning functions focussed on ICS level activity this would limit the extent to which capacity and resource could be redirected to better support the development of PCNs/Neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to

address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. It would also require significant structural change.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Option 6: Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care Provider/ Multispecialty Community Provider

The eight L&SC CCGs would merge to form a single new CCG which would initially take responsibility for all the statutory functions of the current eight CCGs. An agreed set of commissioning functions, which it makes sense to undertake on ICP and PCN footprints, would be contracted for, alongside a capitated budget with each IC Provider/MC Provider through an Integrated Care Provider contract.

Collaborative commissioning programmes would be overseen and managed through the governance structures of the new CCG.

This option would require significant structural change. It would see the majority of commissioning activity focussed on the ICP footprint, would reduce duplication and would maximise economies of scale. It would also support a consistent approach to standards and outcomes. This option would ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at the Lancashire and South Cumbria level will retain links with local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

This option requires ICPs/MCP to have reached a level of maturity whereby integrated care provider contracts could be established and budgets delegated. At this point in time, it is proposed that further development of local partnerships is required to reach this stage of maturity.