Working paper – PBP Collective Response version 3, incorporating comments from the Place Development Work Stream discussion

Place Based Partnerships (PBPs)

Description of arrangements with the Integrated Care Board from 1st April 2022

This paper sets out proposed arrangements for PBPs from 1st April 2022. The proposed arrangements are intended to be a starting point. It is fully expected that PBPs will continue to flourish, taking on increased levels of autonomy for decision making and associated accountabilities.

PBPs are comparatively well developed in Nottingham and Nottinghamshire. This paper aims to provide further clarity on how they will operate within the ICS family as a whole and how they will interface with the ICB (for NHS accountabilities). Our Councils may also wish to develop interfaces / delegations with the PBPs for their statutory duties and the operating model for PBPs will continue to develop accordingly.

Whilst this paper concentrates on the PBP and ICB relationship it should be noted that the ICP will have a significant role to play with the PBPs.

There will be four PBPs: Bassetlaw, Mid-Nottinghamshire, City and South Nottinghamshire.

1. The function and purpose of PBPs

Partners will come together in PBPs to develop and deliver community facing joined up services and care. Partners will work across sectors to tackle health inequalities by improving access and adopting a population health approach incorporating consideration of the wider determinants of health. PBPs will therefore provide the engine room to support the ICS priorities in delivering improved outcomes and supporting their communities to become healthier through building on community assets and ownership of their health and social needs, mitigating the demand on medical services and long term care.

They will also **coordinate the health and care sector's contribution to social and economic development** to prevent future risks to ill-health and wellbeing within different population groups.

Partners will come together in PBPs to **develop and deliver community-facing joined up care**. This includes consideration of those factors that impact on overall health and wellbeing such as education, employment, lifestyle choices and housing. They will also support economic vitality at Place through leveraging social capital. PBPs will be able to achieve this through working collaboratively via a broad range of partnerships, bringing together statutory and voluntary organisations that serve a local population.

Our ambition is for PBPs to take on a broad range of responsibilities, so that they have a demonstrable impact on the health and wellbeing of their populations. PBPs, and their constituent neighbourhoods, will have a unique impact on areas that require a population-sensitive approach to care delivery. PBPs and PCNs will also be the delivery mechanism for services that mainly depend upon local relationships and interactions and that are provided within their local footprint.

As PBPs develop over 2-3 years, they will increasingly:

- Support the development of modern integrated community-based health and care services, with high functioning Primary Care Networks and using technology;
- Ensure Population Health Management approaches are being used to identify people and families at risk and to organise proactive support for them;
- Coordinate the health and care sector's contribution to social and economic development to prevent future risks to ill-health within different population groups;
- Partners will work together to:
  - Develop an in-depth understanding of local communities and neighbourhoods;
  - Develop or progress new approaches to working in partnership with local communities;
  - Work in partnership across multiple agencies to coordinate high-quality service delivery;
  - Plan and oversee service delivery;
- Implement service transformation;
- Mobilise the local community and building community leadership capacity;
- Make use of local assets;
- Enable local organisations to use their resources and decisions to support health, social and economic development;
- Improve health outcomes through targeted PHM interventions.

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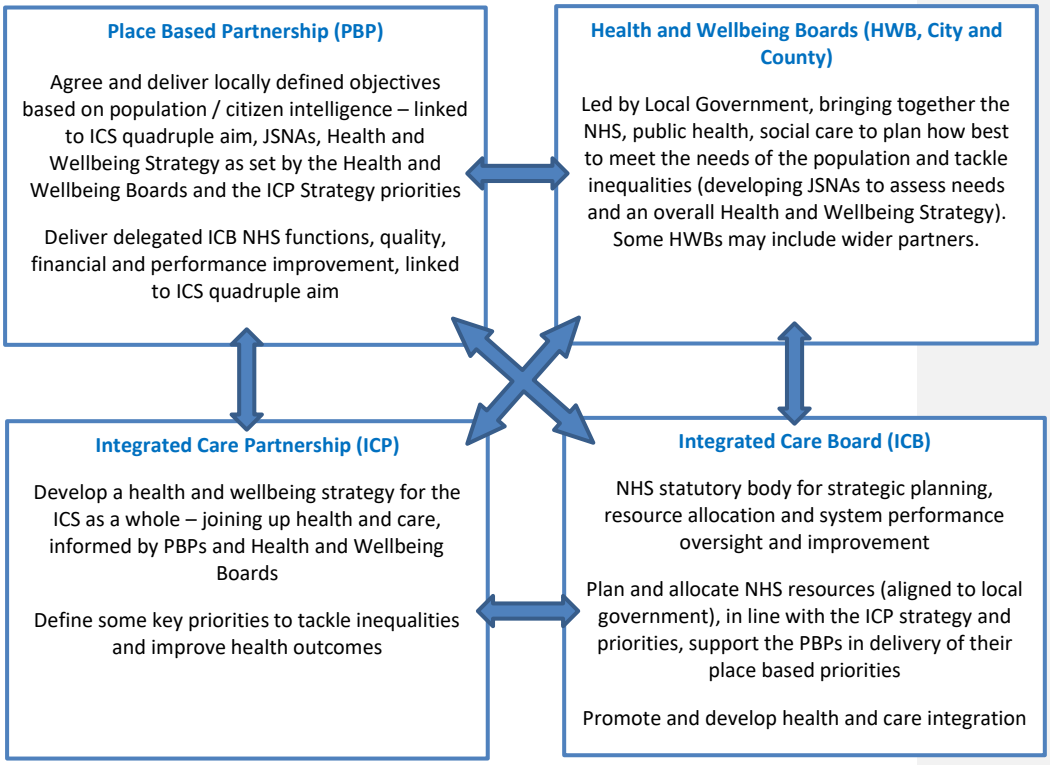
2. PBP contributions to system delivery (ICB delegated NHS functions and responsibilities)

PBPs will define and deliver locally determined objectives and priorities, linked to their specific population requirements. They will also have responsibility to support delivery of agreed NHS strategic priorities and deliverables, identified with the ICB. PBPs will have some specific NHS delegated resources to enable them to undertake delegated functions. There will be considerable support from the ICB, though designated and shared resources (depending on the most effective use of resources and knowledge). Other key PBP partners will also be expected to contribute towards delivery, through the alignment of objectives and workforce.

PBPs will also work closely with Health and Wellbeing Boards and delivery plans will be based on JSNAs and Health and Wellbeing Strategies. They will inform and be informed by the Integrated Care Partnership Strategy for the system as a whole. The partnership agendas will incorporate some defined local government and NHS delivery objectives and some initiatives may be executed via joint local government and NHS budgets.

Key functions and inter-relationships between PBPs and other parts of the ICS are shown below:



2.1 PBP locally determined priorities and ICB deliverables

PBPs have considerable focus on developing strong partnerships and inclusive cultures. Each PBP has a current set of identified priorities, linked to local population needs and building upon existing partnership arrangements. These may be developed in one PBP and then rolled out in other areas where appropriate. Further work to specify outcome measures and milestones will be undertaken in quarter three. There are also some common areas, which will be delivered across all PBPs.

PBP priorities will be informed by the Health and Wellbeing Strategy refreshes in both the City and the County.PBPs have identified some local priorities for 2022/3 which are:

Bassetlaw • Sustainable and effective services enabled by an integrated workforce, digital and estates infrastructure and making the best use of the Bassetlaw £ • Same Day Urgent Care (providing the right support at the right time, through integrated health and care pathways) • Mental Health (focussing on SMI and CYP) • Reducing Health Inequalities (focussing on our most vulnerable groups encompassing welfare, housing, social activities, employment and health support) • Inclusivity (promoting citizen engagement, selfcare, digital inclusion, reducing social isolation including community-based, person-centred approaches)	**City** • Develop and integrate pathways to improve health outcomes in people who experience severe multiple disadvantage, incorporating homelessness • Improve an integrate support for care leavers to ensure better outcomes • Increase Flu vaccine uptake in specific population cohorts • Develop and coordinate efforts and services to increase levels of smoking cessation across the place and support the wider ICS health prevention programme on smoking cessation • Reducing inequalities in health outcomes in BAME communities • Support Nottingham citizens to better access preventative support to improve mental health and wellbeing (working title)
South Nottinghamshire • Develop multi-agency community hubs and services • Develop MDTs and care planning • Using a population health management approach to identifying cohorts of citizens at risk of loneliness and social isolation during COVID-19 & working with LA colleagues to connect & target support • Improve our proactive support offer to south Notts care home residents • Improving equity of offer for community heart failure services. • Improving quality of care for bone health and falls prevention across south Notts	**Mid-Nottinghamshire** • The development of a programme budget approach to MSK and EOL Services and to include fast track services as one seamless model • The development of an integrated care home model • Identify and develop the role of the PBP in supporting and delivering transformation of community services • Develop and build the relationship between the PBP and the PCNs and to develop and build community assets within our place • Using population data and intelligence to identify opportunities for the future where the PBP can design and deliver value focusing on prevention and the wider determinants of health • Support the delivery of the Community Mental Health Transformation

For 2022/3, the functions of the PBPs and the PBP locally developed priorities will support the ICB/ICS-wide NHS deliverables:

- Implement PHM across all PCNs, proactively using data and intelligence to tackle inequalities in access and outcomes.
- Use data to address unwarranted variation & support system demand management.

- Lead and coordinate the development of PCNs (neighbourhoods) where the PBPs can influence and support the work of the PCNs, including the implementation of national requirements, working alongside the ICB.
- Participate in the community services review and implement the core care model to meet local population needs.
- Develop and implement IAPT pathways, integrating talking therapy pathways within community and secondary care pathways.
- In addressing the wider determinants of health, prevention and building resilient communities, contribute to planned care, supporting demand management, advice and guidance and health optimisation in line with ICS developed pathways. Population-specific requirements may be built into access and interfaces with elective services.
- In addressing the wider determinants of health, prevention and building resilient communities, support the management of urgent care demand and flowthrough long-term condition management, community crisis response, timely discharge from hospital and integrated support for people to remain at home if possible.
- Contribute to COVID-19 recovery, in line with national, local and regional priorities.

During 2022/23 the PBPs will work with the ICP, ICB and Provider Collaboratives at scale to determine other opportunities where the PBP functions can support the “left shift” that could include services and funding streams, outside of traditional health boundaries to reduce pressure on medical models of care, with a focus on the wider determinants of health, prevention and keeping the population well.

2.2 ICB delegated functions

The ICB will delegate a range of functions to PBPs including:

- PCN development in their role in the building of resilient communities
- Operational support for primary care that interfaces with the wider neighbourhood-level teams in supporting the development of the PCNs
- Local service development and improvement as delegated by the ICB and including the delegation of programme budgets
- Medicines optimisation (to be developed with the medicines optimisation team)
- Design, planning and implementation of programmes of work aligned to the delivery of strategic system priorities and locally defined priorities identified by the PBP intelligence and population need (e.g. local priority areas, service areas within delegated programme budgets)
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2.3 ICB delegated resources

Partner organisations will work together to pool resources in priority areas, building on approaches developed as part of the developmental stages of the PBPs and learning from the COVID-19 response. This includes community teams working in an integrated manner across community and primary care services, as well as PCN and service development support that exists within constituent organisations.

Additionally, the CCG (ICB) will delegate running cost resources to PBPs in line with the delegated functions (people and premises). Some delegated resources will be based exclusively within a PBP, whilst others will be part of a single ICB-wide team, but have designated time, people and outputs / resources that PBPs can rely on and integrate into their operating models.

CCG (ICB) delegated resources exclusive to each PBP (113 WTE in total are currently aligned to locality working, excluding Bassetlaw):

- NHS Locality Director
- Clinical Leadership (in the City and South this includes access to a Deputy Clinical Director and Clinical Lead for Inequalities allocated by the CCG)
- Locality team (for service transformation, primary care support, development and improvement)
- Primary care pharmacists

Resources designated / shared as part of a single ICB functional team (teams working across the system and interfacing with all systems):

- Quality
- Safeguarding
- Continuing healthcare
- Care homes support.
- Area Prescribing Committee (strategic medicines management)
- Finance
- Contracting
- System Analytics and Intelligence
- System transformation and efficiency programme support for implementation
- Clinical Transformation Partnership
- Communications

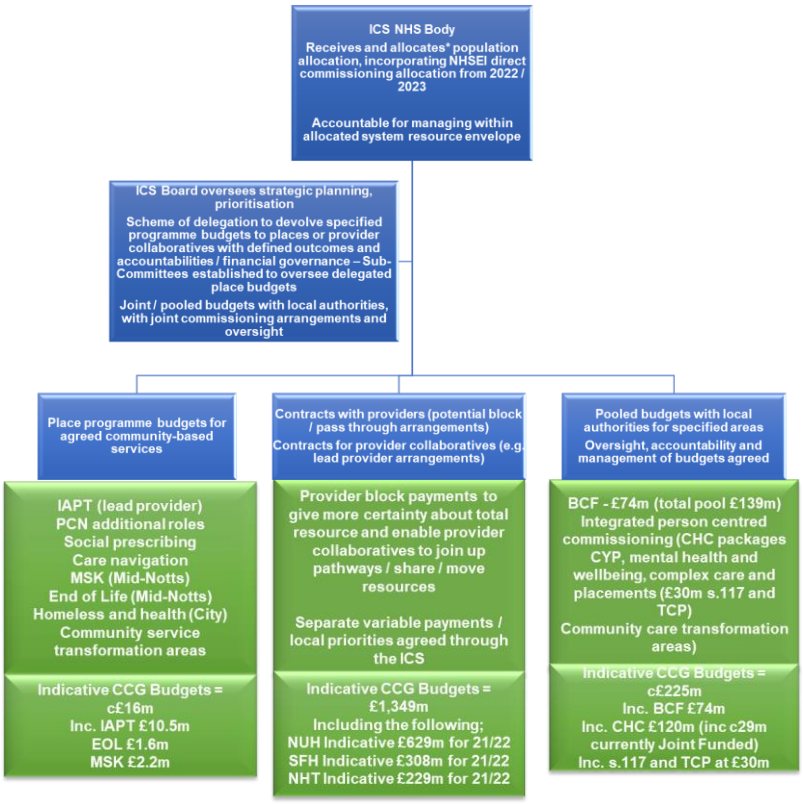
Specific allocations, time commitments and working arrangements will be agreed in quarter three with the potential for locally based line management and centralised professional accountability.

As part of this process consideration will be given to the cross boundary working arrangements for Bassetlaw into the South Yorkshire ICS as well as the Nottinghamshire ICS

2.4 ICB delegated budgets and funding streams

The ICB will delegate running cost allowance for the ICB funded roles and premises. Non-pay budgets will also be agreed as part of ICB budget setting arrangements for 2022/3. So long as running costs remain within agreed levels and resources are used to meet delegated ICB functions, resources can be used flexibly.

Programme budgets will also be delegated in line with agreed service areas and outcomes. NHS funding flows are shown below:



- Some elements of allocations may be fixed, pass through or mandated for a specific purpose. National business rules apply, included in annual NHS planning guidance.

We will continue to develop joint commissioning arrangements between the ICB and local authorities. Clear governance arrangements with the ICB and local authorities will be put in place to accommodate this way of working.

3. PBP leadership arrangements

PBP leadership arrangements will have some commonality, particularly in relation to the execution of delegated ICB functions. Councils may also wish to define accountability arrangements for areas that they delegate into PBP arrangements. These should sit alongside each other as part of an overall PBP team and operating model.

Currently Mid Notts, City and South PBPs have:

- Executive Lead
- Clinical Leadership
- Programme Director
- NHS Locality Director

The Clinical Leadership and an NHS Locality Director are funded within the CCG (ICB) running cost allowance. The Executive Lead and Programme Director roles are funded from within the other partner organisations. The CCG (ICB) is committed to maintaining the level of resource, matched by partner contributions for an Executive Lead and Programme Director. Further work is required to confirm the Bassetlaw PBP team alignment from April 2022.

Additionally, PBPs have project directors and managers drawn from other partner organisations, akin to the model distributed leadership model that has been adopted for system-wide transformation and efficiency programmes. This way of working should be increasingly embedded in PBPs, in order to make the best use of our collective skills, talent and resources for overall population gain and to foster innovative approaches that are agreed across sectors.

As the PBPs develop and undertake more collective responsibility there will be a need to review the resource allocation to ensure it is in the right place and at the right level to enable the responsibilities to be discharged, recognising there will be a need for PBP dedicated roles to provide the required capacity

The national guidance for PBP development gives scope for different roles. For each PBP, it is proposed that there is:

- An Executive Lead for the partnership.
- A Programme Director with responsibility for convening the partnership and overseeing programmes of work across the partnership.
- A Clinical Lead and any other clinical leadership as determined by the PBP within resource provided by the ICB for clinical leadership.
- NHS Locality Director.
- An NHS officer who takes formal responsibility for ICB functions and deliverables that are delegated to the PBP (this could be combined with another PBP leadership role if necessary).

The NHS officer with accountability for delivery of ICB delegated functions and deliverables will work as part of the PBP team and does not have to be the overall PBP lead. Their job description will be aligned to NHS and broader role requirements and they will be included in relevant NHS Standing Orders and line management arrangements. This will co-exist alongside broader partnership objectives and PBP leadership teams will take collective action to secure overall PBP objectives.

Currently it is proposed that appointment of the Executive Lead would be a PBP decision, with ICB approval. The NHS officer with responsibility for ICB delegated functions and deliverables would be appointed by the ICB, with PBP approval.

4. Governance arrangements for ICB delegated functions and deliverables

The ICB retains accountability to NHS England and Improvement for PBP delegated functions. The ICB will establish a sub-committee for each PBP to oversee PBP development and ICB delegated functions. This will provide a safe and developmental approach to joint commissioning with local authorities, delegated and shared budgets that are in line with the overall functions of PBPs. The NHS officer with responsibility for ICB delegated functions and delivery will be part of and accountable to the PBP sub-committee.

The ICB will also have a named executive who is accountable to the ICB for PBP development and performance across the ICS.

PBPs will determine their partnership and operational arrangements.

The relationship between PBPs and Local Authorities will develop over time and the respective councils may choose to delegate some functions or programmes of work to their respective PBP.

5. Recommendations for implementation

Recommended action	Timescale for completion
PBP functions, as described, are built into PBP Committee terms of reference	November 2021
PBPs operate in shadow form from quarter 4, in line with other ICS timelines	January 2022
Specify local PBP priority health outcomes and delivery milestones for 2022/3, refining the priority areas into specific outcomes and incorporating local authority priorities / delegations into the PBPs	January 2022
Agree ways of operating and approaches to the joint PBP deliverables	December 2021
Define PBP specific and ICB functional support working arrangements and governance	January 2022
Define ICB delegated budgets and deliverables as part of running costs and programme budgets for 2022/3	March 2022
Define PBP committee terms of reference, membership and reporting arrangements, for shadow operating from quarter 4	December 2021