GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Integrating care - Next steps to building strong and effective integrated care systems across England

RESPONDING TO THE NATIONAL ENGAGEMENT EXERCISE

1 Introduction

This document provides a response on behalf of the Greater Manchester Health & Social Care Partnership to the engagement questions in the national document, "Integrating care - Next steps to building strong and effective integrated care systems across England", published by NHSI/E on 26 Nov[1].

2 National Changes Proposed

2.1 NHSEI has now published its intentions for Integrated Care Systems across England. It details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective integrated care system (ICS) and the immediate and long-term challenges presented by the COVID-19 pandemic.

2.2 From April 2021 this will require all parts of the health and care system to work together as Integrated Care Systems, involving:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes;
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

3.3 This document also describes options for giving ICSs a firmer footing in legislation likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally.

3 Legislative proposals

[1] https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

- Current legislation[2] does not have a "sufficiently firm foundation for system working"
- NHSEI made recommendations on legislation change in Sep 2019 (the NHS Bill3). They are not detailed here (see paper, section 3.3) but NHSE believe they still stand.
- One of the recommendations was for a new statutory underpinning to establish ICS boards through 'voluntary joint committees' - "an entity through which members could delegate their organisational functions to its members to take a collective decision". Engagement about this raised questions as to whether such a voluntary approach would drive system working.
- The COVID-19 response has increased the desire from the system for clarity about ICSs and the organisations within them, and an NHS Bill was included in the Queen's speech in Jan 2020 and so NHSE believe the time is appropriate to achieve clarity and establish a legislative basis for ICSs.
- The paper outlines two options for "enshrining ICSs in legislation" without "triggering a top-down reorganization".
- Both options (models) have broad membership and joint decision-making, responsibility for the system plan, operating in accordance with a new 'triple aim' duty[4] for all organisations - 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer" - duty and a lead role in relating to national level bodies.
- Both models identify local government as an integral part of the ICS through planning and shaping services, delegation of functions to committees including NHS and local government and exploiting existing flexibility for pooling functions and funding.

3.1 Option 1: a statutory committee model

- This model would include an Accountable Officer (AO) and bind together current statutory organisations.
- The AO would be chosen from the board's mandatory members. Individual organisations would retain their own AOs/CEOS but the ICS AO would be a role recognised in legislation and would have formal duties in relation to delivering the ICS board's functions.
- This is close to the original proposal in Sep 19, and would enable joint decision-making
- There would be one aligned CCG per ICS footprint, and new powers to allow that CCG to delegate many of its population health functions to providers. Current accountability structures for CCGs and providers would remain.
- Downsides to this model include:
    - Lack of clarity of leadership and accountability – especially for patient outcomes and financial matters
    - An ICS and a CCG AO may add to this confusion
    - CCG governing body and GP membership is retained, but it is questionable whether these are sufficiently diverse to fulfil the different role of CCGs in an ICS

3.2 Option 2: a statutory corporate NHS body

- This model would bring CCG statutory functions into the ICS. Additional functions would be conferred on ICSs and existing CCG functions modified to create a new framework of duties and powers.

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2 National Health Service Act 2006 and the Health and Social Care Act 2012

3 https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf

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- CCG governing body/membership would be replaced by an ICS board consisting of representatives from system partners, without a power of individual organisational veto.
- Minimum board membership
    - Chair
    - Chief Executive
    - Chief Financial Officer
    - Representatives of NHS providers, primary care and local government
- ICS Chief Executive would be a full-time AO role, strengthening lines of accountability and with a key leadership role in system delivery.
- ICS would have a primary duty to "**secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations**" with the flexibility to make arrangements (through contracts with providers) or delegating responsibility for specified services to one or more providers.

3.3 Response requested

NHS organisations are asked to consider 4 questions relating to the legislative proposals in the paper (see Table) and to respond with views on the proposed options by 8 January 2021.

Table 1

3.3.1 Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4 Greater Manchester Response

4.1 Colleagues across Greater Manchester believe the national document is a significant and positive contribution to the integration of health and social care and to meaningful action to improve health and improve healthcare. We strongly support the document's proposed characteristics for each ICS:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale;
- Developing **strategic commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

4.2 We also strongly support the four fundamental purposes of an ICS:

- **improving population health and healthcare**; because "decisions taken closer to the communities they affect are likely to lead to better outcomes"
- **tackling unequal outcomes and access**; because "collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people"
- **enhancing productivity and value for money**; because "collaboration between providers across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity."
- **helping the NHS to support broader social and economic development**.

4.3 The characteristics and purpose for ICSs proposed strongly match the ambitions for health and social care which each GM district has been pursuing locally over many years and which we have pursued together as the GM Health & Social Care Partnership since 2016. We believe therefore, that the proposals outlined in the document provide the basis for a positive next stage off our journey across Greater Manchester.

4.4 Engagement Questions

Q1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

We agree. In proposing the devolution agreement in 2015 we sought the means to bring the resources and decisions affecting care for local residents closer to them. We also elevated the value of collaboration across organisations, across sectors and between localities as a necessary characteristic of a system organised to pursue shared objectives or a population served jointly. We believe, that the proposals in the national document to establish those through statutory means recognise and fix those objectives for the long term.

The other legislative proposals we believe will help create the conditions for effective place based working both through the duty to collaborate and through the adjustment proposed for the consequent legislative framework.

However, the benefits of this change can only be fully realised if they are genuinely able to support models for comprehensive, place based working with the most local possible control of the range of resources to make that happen. The facility to establish locally accountable place based system boards with the authority and flexibility to jointly control the full range of resources for the populations they serve is the key condition the ICS should be expected to enable.

The risk without this recognition is that decision making actually becomes more distant from communities, is disconnected from those wider public and VCSE services which is the only way to unlock preventative potential and affect patterns of demand on formal health and care services.

Greater Manchester will continue to create the conditions for the deep integration of the local NHS, Local Government, wider public services, the VCSE and local communities in order to improve health as well as health services.

The establishment of the ICS on a statutory footing must therefore, be on the basis of bringing the 10 place based arrangements together in pursuit of shared system wide objectives. This could mirror the arrangement established across the Greater Manchester Combined Authority and the ten GM Councils. In the same way we would envisage an equivalent arrangement to establish the ICS Board to include the leadership in the ten localities. This is, we believe, the right means to

ensure a two tier system does not emerge; and to maintain an alignment between locality and system level activities and priorities.

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We agree, subject to the condition that the ICS Board model is constructed on the basis of place based membership alongside members representing system level accountabilities as proposed above. We believe that model is strengthened by being rooted in place and set to avoid the creation of a two tier, or hierarchical system. We would be concerned that option 1 risks creating confusion through a dual leadership for ICS level functions. Option 2 provides or a clearer structure which will minimise the potential or unnecessarily complicated governance which would undermine the means o supporting the system level collaboration.

The primary statutory duty to "secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations" is very helpful in supporting clarity on obligations to the NHS between the ICS and Parliament. This must not overlook the purpose and objectives however to improve health, reduce health inequalities and tackle unequal access and outcomes.

Option 2 would allow for a more streamlined arrangement to progress the commissioning and delivery of system level services where it is judged that those services are best planned and delivered at the system level for the whole population of 2.8m. Additionally it would confirm a clear vehicle for those services currently commissioned by NHSE to be done at a more local level through the ICS.

Option 2 provides a clearer opportunity to reduce or remove the commissioner/provider separation at the system level and reduce both the associated costs and the time and delay embedded into those avoidable transactional processes. The ambition in localities is to establish local governance and financial lows which similarly reduces the transactional burden of the commissioner provider split and this should be replicated at the system level.

Option 2 could be strengthened further by having clear recommendation about an enhanced role of local authority scrutiny functions to build these into place based whole system scrutiny of quality, finance and other mattes requiring more granular review than can occur at the level of the ICS.

Q3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

We agree. We have clear ambitions for the membership and governance to be broad and open to wider public services and civil service partners from the VCSE sector and welcome the opportunity that a permissive framework allows. This is true at both place/district level and at the GM level.

At the same time we have seen the value of blending political, clinical/professional, patient/resident and expert managerial leadership. This also, therefore, provides the necessary flexibility to allow us to establish and benefit from that breadth of leadership.

The potential for place based provider collaboratives is immense. New models spanning social, emotional, psychological and medical approaches are the key to public service transformation and the ability to improve health.

Those models maximising the social value they bring to local places over the coming decade will be central to the nation's recovery from the social and economic effects of the pandemic.

This is potentially a radical development of the FT model and will require regulators to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

Q 4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

We agree. Our ambition is to fully join pathways so that coordinated decisions are made locally and funding is used in the most effective way possible to improve outcomes for the population. When the Greater Manchester Health and Social Care Partnership (GMHSCP) formally took charge of the £6bn health and social care budget on 1 April 2016, it also assumed delegated responsibility for a wide range of specialised services.

Working through integrated local arrangements, including Lead Providers, we have been able to plan and build more comprehensive service models through wellbeing, integrated community provision, and GM models of service which span locality boundaries and more specialist services. This has already delivered benefits which we would hope to build on, including:

This plan has led to closer integration commissioning arrangements supporting acute and mental health service transformation to deliver:

- The Improving Specialist Care Programme Investments into Specialised Commissioned level 1 Neurorehabilitation to deliver the new standards within the Model of Care.
- GM Population Health Priorities such as supporting plans to roll out Lung Health checks in localities and joint planning for increased tertiary lung resections as a consequence of increased CCG screening initiatives. Specialised commissioning recommendations have also informed the case for change to reshape services for people living with HIV in GM within the GM Sexual and Reproductive Health Strategy.
- GM Mental Health Transformation Programmes through supporting the development of new delivery models for Tier 4 Child and Adolescent Mental Health Service and Adult Secure service provision.
- Regional and national specialised service developments (non-delegated services) within Greater Manchester such as the establishment of of the GM level 2 adult Congenital Heart Disease service as an integral part of a North-West CHD Network at MFT and establishing new CAR-T treatments therapies for children and young people with B cell acute lymphoblastic leukaemia.
- NHS England national policy service developments such as the implementation of 5 year delivery plans for Intra Arterial Thrombectomy (IAT) across GM to achieve a 24/7 service by 2021/22.
- New Innovations such as GM's Early Adopter Status for Primary Care-led Transgender Health Service development.

The delegation and transfer of responsibilities is the means rather than the ends of course. It should follow the broader principle outlined in the national document, and supported here, to continually seek to bring decisions as close to communities as possible and to bring together physical and mental, social and medical approaches to support comprehensive care and recovery focussed approaches.

Ends