GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Care Board

Date: 26th March 2021

Subject: Building on GM's Devolution Integration Experience – Creating the Integrated Care System (ICS)

Report of: Warren Heppolette, Executive Lead, Strategy & System Development, Greater Manchester Health & Social Care Partnership

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SUMMARY OF REPORT:

The approach to developing the statutory Integrated Care System for Greater Manchester builds on the ways we have been working since the devolution agreement was signed with Government and NHS England in February 2015. The national documents intend to solidify and ensure we build on the integration and improved collaboration we, and others, have developed over the past five years.

For Greater Manchester therefore, the national proposals can be seen to represent a mid-point in a ten year journey towards integrated health and social care delivered through place based partnerships connected to communities and mature system wide collaboration building on decades of joint working.

It is important that we reflect this history in our approach to developing as an ICS and state those key beliefs that will inform the model we implement.

In stating those objectives we would confirm our alignment with the national objectives but also emphasize specific opportunities and features within GM which we have developed since devolution. For example the alignment to the Greater Manchester Strategy; the population health potential as the only Marmot City Region with a Mayoral Combined Authority and dedicated Population Health Board to coordinate capacity at the GM level; and the existence of Health Innovation Manchester connected to the Local Industrial Strategy to help the NHS, academic and the GM industry base support broader social and economic development.

The next stage of our development will keep and enhance the integration of health, care and wider public services in localities. This place-based approach is central to our local experience, the thrust of the White Paper and an area where we should acknowledge that GM has influenced national thinking.

We will build on the mechanisms for provider collaboration both as part of place based working and GM level joint working.

In developing the governance for the ICS, and given the degree of connectivity and track record established over many years across GM, we are determined to move forward governance terms in a way that maintains the principle that health and care in GM is one system; a system made up of the ten localities and the organisations that work across these localities.

The development and inclusion of clinical and professional leadership at strategic, network and operational levels is a critical part of our evolution in GM.

How money will move across the system in-line with agreed priorities will be critical to success and system stability. An outline of our current understanding of this is being developed by GM finance leaders, PEB Financial Leadership Group and FAC.

As the White Paper makes clear data and digital strategies will have a key role to play in driving innovation, improvement and efficiency.

There needs to be a programme of comprehensive engagement with all 10 localities and system leaders (clinical, political, organisational) leading to further refinements of the proposals outlined in this paper aligned to the Parliamentary process.

KEY MESSAGES:

The approach to developing the ICS will build on the ways we have been working since the devolution agreement was signed with Government and NHS England in February 2015.

The place-based approach and our mature collaboration at the GM level is central to our local experience, the thrust of the White Paper and an area where we should acknowledge that GM has influenced national thinking.

There now needs to be a programme of comprehensive engagement with all 10 localities and system leaders (clinical, political, organisational) leading to further refinements of the proposals outlined in this paper aligned to the Parliamentary process..

PURPOSE OF REPORT:

The purpose of this document is to bring together the progress made in developing the GM ICS, to highlight the key issues and set out the proposed next steps to develop our collective approach to build upon all that has been achieved in our journey so far.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to support the proposal.

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GM Health & Care Board 26 March 2021

Building on GM's Devolution Integration Experience – Creating the Integrated Care System (ICS)

1. Purpose of Document

1.1 The purpose of this document is to bring together the progress made in developing the GM ICS, to highlight the key issues and set out the proposed next steps to develop our collective approach to build upon all that has been achieved in our journey so far.

2. Background

2.1 Our Health and Care Devolution deal in 2015 saw Greater Manchester given greater freedom and flexibility over the £6.4bn spent on health and social care services here, to transform how we work with, and for, our population to improve their health and the services we provide.

2.2 Our five year strategic plan was published in early 2016: Taking Charge of our Health and Social Care. Supported by many other more detailed plans, and forming an integral chapter in the city region's blueprint, the Greater Manchester Strategy, this plan has been overseen since April 2016 by a Health and Care Partnership Board, comprising all NHS organisations in GM, all ten councils, GMCA, NHSE and the community and voluntary sector.

2.3 The purpose of this journey of greater freedoms, integration and collaboration has remained to enable us to achieve our collective vision of delivering the greatest and fastest improvement to the health and wellbeing of the people here, reducing inequalities in a city region which has some of the greatest in the country.

2.4 We have not been alone on this journey. The NHS across England has developed partnerships across local systems and deepened integration through place based working. The development of Sustainability & Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) informed the proposals in NHS England's recent document "Integrating care: Next steps to building strong and effective integrated care systems across England" and the Government's White paper, "Integration and innovation: working together to improve health and social care for all".

2.5 Those national documents intend to solidify and ensure we build on the integration and improved collaboration we, and others, have developed over the past five years. The national objectives for ICSs coincide those we have ourselves prioritised:

- Secure better health and wellbeing for everyone
- Tackle unequal outcomes, experience and access to health and care services
- Enhance productivity and value for money; and
- Support broader social and economic development

2.6 For Greater Manchester therefore, the national proposals can be seen to represent a mid-point in a ten year journey towards integrated health and social care delivered through place based partnerships connected to communities and mature system wide collaboration building on decades of joint working.

3. A Greater Manchester Approach to ICS Development

3.1 It is important that we reflect this history in our approach to developing as an ICS and state those key beliefs that will inform the model we implement:

- Change is done with, not to, people. We want to develop a new relationship between public services and people, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services.
- We adopt an asset-based approach that recognises and builds on what individuals, families and our communities can achieve rather than focusing on what they lack.
- We encourage behaviour change in our communities that builds independence and supports residents to be in control.
- A place-based approach redefines services and puts people, families and communities at their heart
- Improving health requires action on the social determinants alongside the delivery of clinical care. This has guided our pioneering work with the VCSE, our approaches to reducing worklessness and improving school readiness, our efforts to change lives through physical activity as part of GM Moving, our work in tackling homelessness and increasing supported living.
- The opportunity of bringing those contributions together in neighbourhoods with proactive primary care supported through Primary Care Networks (PCNs) is at the heart of our model and is delivering now
- We do not believe everything can be delivered in place and have decades of experience in collaborating at scale across Greater Manchester to deliver consistent standards of care. New approaches through the ICS and Provider Collaboratives – such as the Primary Care Board (PCB) and Provider Federation Board (PFB) which are regarded as nationally leading examples - will strengthen and spread those approaches to reducing variation in access and outcomes.
- We expect to be a place which innovates and ensures our residents benefit quickly from that innovation. We value therefore the strong position of our Universities, healthcare providers and industry base, and using the partnerships between them through Health Innovation Manchester (HInM) to deliver at pace.
- Our entire system understands its contribution to local economic potential and the role individual organisations can make to growth and an inclusive economy.

4. Building on Our Achievements to Date: The Ambition and Purpose of the GM ICS

4.1 In stating those objectives we would confirm our alignment with the national objectives but also emphasize specific opportunities and features within GM which we have developed since devolution. For example the alignment to the Greater Manchester Strategy; the population health potential as the only Marmot City Region with a Mayoral Combined Authority and dedicated Population Health Board

to coordinate capacity at the GM level; and the existence of Health Innovation Manchester connected to the Local Industrial Strategy to help the NHS, academic and the GM industry base support broader social and economic development.

Vision

- To improve the health and wellbeing of all the residents of Greater Manchester (GM).

Objectives

- to use social value to tackle the inequalities around us and create lasting benefits for the people of GM, improve the local economy, whilst positively contributing (or at least minimising damage) to the environment;

- To close the health inequalities gap within GM and between GM and the rest of the UK faster;

- To deliver effective & efficient integrated health and social care across GM;

- To continue to redress the balance of care to move it closer to home where possible;

- To strengthen the focus on wellbeing, including greater focus on prevention and population health;

- To ensure equality, diversity and inclusion are reflected in our leadership and guide our priorities and all areas of our work

- To harness the breakthrough opportunities of digital technology for enhancing existing services and crafting novel services to give better outcomes to citizens and improved value for money;

- To secure clinical & financial sustainability across the whole of the health and social care landscape;

- To contribute to growth and connect people to growth and maximise impact from health innovation and digital;

- To further develop our partnership between the NHS, local government, universities and science and knowledge industries for the benefit of the population.

4.2 The Board is asked to confirm that this statement of future ambition and purpose is a good starting point for further engagement with partners and stakeholders in order to build understanding and support for the development of our GM model.

5. **Place-Based Working**

5.1 The next stage of our development will keep and enhance the integration of health, care and wider public services in localities. This place-based approach is central to our local experience, the thrust of the White Paper and an area where we should acknowledge that GM has influenced national thinking.

5.2 Place-based working will remain a cornerstone of integrated local systems. In most localities this has been underpinned by significant pooled budget arrangements to incentivise integration and create greater flexibility in the coordination of care. Whilst the flow of NHS resources will change in the new arrangements, our objective is to retain the scale and scope of place-based pooled budgets. The pooled budgets in localities will be commensurate with the scope of services coordinated and planned at that level.

5.3 As a system, we are absolutely clear that we will ensure that future ways of working will enable to continuation and developments of these arrangements. The section on financial flows later in this document sets out the current thinking on this.

5.4 Our future ways of working in localities will continue to:

- Align local leadership, combining organisational, political and clinical viewpoints
- Agree local strategy for health and care, to deliver the outcomes, performance and financial ambitions
- Use the neighbourhood as the building block for the integration and person centred model of delivery
- Oversee the co-ordination and transformation of local health and care services
- Strategically oversee joint working arrangements including the integration of budgets across NHS and LA partners
- By working in partnership, improve population health and reduce inequalities in a way that has greater impact than the sum of the individual organisations
- Be represented on the GM ICS Partnership Board by the person they locally choose to do so
- Establish place-based governance with a membership defined locally.

5.5 To take this approach to the next stage each locality is working on the transition from current to new forms of working. The development of the GM ICS will therefore be led by localities as well as at GM level. A key issue is ensuring there is agreement on the services where the planning and decision making is in the locality and for which services this makes more sense to do so at a GM level.

6. Provider Collaboratives

6.1 Also central to the White Paper is a reduced emphasis on market mechanisms in the NHS and an enhanced role for providers working together in collaboration at both the Place level and at the ICS level across the NHS and with wider public services.

6.2 GM has pioneered the creation of place-based collaborations which bring together providers of health and care through Local Care Organisations (LCOs) and Integrated Care Partnerships (ICPs). This will further evolve and strengthen as part of place-based working.

6.3 Throughout the pandemic the role of providers collaborating through the GM Hospital Gold Command and Community Co-Ordination Cells, building on the history of joint working in PCB and PFB, and other mechanisms has been critical to our response and enabled support to be provided across GM and mutual aid to be offered to organisations across both the wider North West and the rest of England.

6.4 These will also evolve and strengthen to deliver system wide transformations as an integral part of future GM working.

6.5 Provider Collaboratives will support the vision and objectives shared across the ICS and, specifically:

- Represent providers, including primary care
- Facilitate joint planning and collective decision making
- Support provider development, including PCN development
- Support the identification and tackling of unwarranted variation
- Manage specific transformational programmes

6.6 Provider collaboratives are working through their proposed future delivery programmes. As with place-based working the key issue is ensuring there is agreement on the services where the planning and decision making is in the locality and for which services this makes more sense to do so at a GM level.

7. The GM ICS

7.1 Health and care in Greater Manchester is one system. A system made up of the ten localities and the organisations that work in and across these localities.

7.2 Whatever choices are made about future governance structures and membership the following are critical to making arrangements work:

- Having a common purpose, as outlined above
- A focus on improving population health
- The quality of the relationships between individuals and organisations
- Maintaining trust between partners
- A culture of transparency

7.3 Nationally, the White Paper proposes that ICSs will be made up of two elements – an ICS Partnership Board and an NHS ICS Board - that will work together to deliver the agreed ambition. As part of the Devolution Agreement GM has a single Health and Care Board. Given the degree of connectivity and track record established over many years across GM, we are determined to move forward governance terms in a way that maintains the principle that health and care in GM is one system; a system

made up of the ten localities and the organisations that work across these localities. The White Paper descriptions of an ICS Partnership Board and an NHS ICS Board are included as annexe A.

7.4 Our work in shaping our future GM governance, guided by our own experience and any statutory requirements which emerge, will need to be guided by the following design principles in order to ensure connectivity between all parts of the system:

- To ensure that GM continues to operate as one system there will be a common core of political, clinical and organisational leadership in any two Board model
- Any wider Partnership ICS Board provides an opportunity to bring together a "broader church" of partners.
- All parts of our new GM governance will need to be clear in terms of purpose, role and accountability

7.5 Further work and engagement needs to be commissioned to develop these options.

7.6 Further work is also needed to map out how localities, provider collaboratives and the wider GM functions will work together to develop our partnership arrangements.

8. Clinical and Professional Leadership

8.1 The development and inclusion of clinical and professional leadership at strategic, network and operational levels is a critical part of our evolution in GM.

8.2 With the transition from CCGs to ICSs some key parts of the current system will change with the ending of the roles of Clinical Chairs and Governing Body Clinical Leads and uncertainty around how their skillset and expertise will be retained in the new GM ICS at both place level and GM level.

8.3 Other parts will continue to develop with the likely further development of PCN Clinical Directors working collectively in localities and as an integral part of local provider collaboratives, building on their critical role in the delivery of the Covid-19 vaccination programme.

8.4 PCB and PFB will continue to provide reach into clinical leadership and engagement, delivering end to end transformation programmes, building on learning and approaches established in the pandemic.

8.5 Dr Tom Tasker, Chair of the GM Medical Executive is leading on this work with sponsorship from the rest of the GM Medical Executive team which includes Primary Care, Mental Health and Acute Provider medical leads. A group of multi-professional clinical and professional leaders representing a cross section of sectors, organisations and localities in GM have now met for 3 workshops in order to develop the why, what and how clinical and professional leadership will input and work with the emerging GM ICS. Key principles, functions and ways of working have been

explored in detail. The group is mindful of the development of clinical and professional leadership arrangements in place and is determined that this work will complement. We anticipate having a draft proposal available shortly which we will seek to engage widely with key stakeholders on before it is finalised.

9. Financial Flows

9.1 How money will move across the system in-line with agreed priorities will be critical to success and system stability. An outline of our current understanding of this is being developed by GM finance leaders, PEB Financial Leadership Group and FAC.

9.2 It is clear that from April 2022 the GM ICS will receive almost all of the NHS funds allocated to GM and be accountable for using these resources to meet national NHS requirements and our GM health and care ambitions. These funds will be deployed in three ways:

- Funds to support GM ICS running costs and programmes of work.
- Funds delegated to support place-based arrangements
- Funds that flow directly to NHS Providers and Primary Care providers

9.3 The actual flow of the funds depends on the agreement achieved as to the agreement of where services are planned and delivered. It is recommended by Finance Directors that the principles of efficiency and effectiveness are considered when making these decisions and that reducing bureaucracy and transactions is a focus. It may be that consideration needs to be given to a short term and medium term set of proposals to ensure the system concentrates on key deliverables in the short term.

9.4 The development of a medium term financial strategy needs to be considered for delivery in 2022/23 as the current system is spending more than the allocation it is receiving, and has done for a number of years.

10. Data and Digital

10.1 As the White Paper makes clear data and digital strategies will have a key role to play in driving innovation, improvement and efficiency.

10.2 Throughout the pandemic a blended team digital and innovation team working on behalf of the GMH&SCP and Health Innovation Manchester responding to the needs of the GM Hospital Gold cell and other mechanisms has made an important contribution to our response and enabled support to be provided across GM. We need to build on this approach through the next stages of our ICS

10.3 There is a strong track record of developing and implementing industrial strategy in GM that has data and digital at its core.

11. Next Steps

11.1 There needs to be a programme of comprehensive engagement with all 10 localities and system leaders (clinical, political, organisational) leading to further refinements of the proposals outlined in this paper aligned to the Parliamentary process. All parties to these discussions are clear that each component of the system is both important and interrelated, so an agreed programme is needed.

11.2 It is proposed that this programme of engagement will focus on the key issues that have emerged from the work so far. A series of engagement events during April will enable a broader group of stakeholders to engage in developing our system thinking on to the next stage. These key issues are:

Theme	Outcome
What Spatial Level to Plan and Decide Services?	Proposals for which functions/services are best placed and developed at place level or at the GM level.
How will NHS Resources be Allocated from 2022/23?	What we know about the funding process for revenue and capital resources and how we ensure the continuation of place-based pooled budgets at the current level
Clinical and Professional Leadership	Proposals for the development and transition of clinical and professional leadership
Locality and GM Working	Options on the way localities will work with the GM ICS in future. Working arrangements for the ICS Partnership Board and an NHS ICS Board

11.3 We recognise the need also to develop the programme approach to support the finalisation of, and transition to, this model. We will establish a representative programme board to oversee each element of the work and deepen system involvement in each.

12. Recommendations:

It is recommended that the Board agree to:

- R1: to confirm that the statement of future ambition and purpose is a good starting point for further engagement with partners and stakeholders in order to build understanding and support for the development of our GM model.

- R2: to support the development of the options set out in 11.2 above by the end of April.

Appendix A (Extract from the White Paper)

6.18 These considerations have led us to the following model:

(a) Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues.

(b) Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to. We will support HWBs and ICSs, including with guidance, to work together closely to complement each other's roles, and to share learning and expertise.

(c) A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local Government and partners e.g. community health providers. We would expect the public name of each ICS NHS Body to reflect its geographical location – for example, NHS Nottinghamshire or NHS North West London.

(d) The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCG's responsibilities in relation to Oversight and Scrutiny Committees. It will not have the power to direct providers, and providers' relationships with CQC will remain unchanged.

(e) Each ICS NHS body will have a unitary board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives. ICSs will also need to ensure they have appropriate clinical advice when making decisions. NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed.

(f) The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:

- developing a plan to address the health needs of the system;
- setting out the strategic direction for the system; and

- explaining the plans for both capital and revenue spending for the NHS bodies in the system

6.19 Discussions with a number of stakeholders including the Local Government Association has led us to the conclusion that there is a strong case for the governance arrangements for an ICS to include an ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS Body. This Partnership would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system. Each ICS NHS Body and local authority would have to have regard to this plan. The Health and Care Partnership will be promoting collaboration and it would not impose arrangements that are binding on either party, given this would cut across existing local authority and NHS accountabilities.

6.20 Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Our intention is to specify that an ICS should set up a Partnership and invite participants, but we do not intend to specify membership or detail functions for the ICS Health and Care Partnership - local areas can appoint members and delegate functions to it as they think appropriate.

6.21 The ICS Health and Care Partnership could also be used by NHS and Local Authority Partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation. We will, working with NHSE and the LGA, also issue guidance to support ICSs in establishing these bodies. This, along with the flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts. We know that this element of flexibility has been of value to the early wave ICSs where there are many (and different) examples of partnership boards and of arrangements at place level. In many cases, partnership boards have served as a way to identify, develop and drive shared priorities and projects between local government and NHS partners.

6.22 Taken together, we think these arrangements provide the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, local authorities and other partners while also strongly encouraging areas to go further in developing joint working and decision-making arrangements that deepen and improve over time in the interests of local people.