Classification Open	Item No.

Meeting:	Cabinet
Meeting date:	24 March 2021
Title of report:	NHS White Paper – Integration and Innovation: working together to improve health and social care for all – February 2021
Report by:	Cllr Simpson – Executive Member Health and Wellbeing
Decision Type:	Non-Key Decision
Ward(s) to which report relates	All

Executive Summary:

On February 11th, 2021 the Government published draft legislative proposals for a new health and care bill. The White paper – "Integration and Innovation: Working together to improve health and social care for all" – describes an intent to create opportunities for strengthened collaboration and integration within the NHS, and between the NHS and local government. The White paper reflects many of the objectives and working relationship in place across Greater Manchester and in Bury. However, the paper also changes elements of NHS structure, including the replacement of CCGs with "Integrated Care Systems" (ICSs) which for us would be Greater Manchester.

This paper provides an overview of the white paper, the connection to the strategic intent and delivery in Bury and across Greater Manchester, the issues of concern with the restructure across Greater Manchester, and a framework for a transition subject to the passage of the legislation

Recommendation(s)

That the Cabinet

1) Note the update on the NHS White Paper 2021

2) Recognise the ambition to ensure new governance arrangements allow the continuation of the transformation journey described in the Bury Locality Plan
3) Support the new partnership arrangements under development
4) Note the content of the transition programme to be managed through the Bury System Board
5) Recognise the areas of concern around the governance of the GM ICS if it is to support the direction described

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Community impact/links with Community Strategy

The objectives of the Locality Plan – the strategy for the transformation of the health and care system in Bury – align fully with 'Let's Do it'.

Equality Impact and considerations:

Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

> *A public authority must, in the exercise of its functions, have due regard to the need to -*
>
> (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
>
> (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
>
> (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*
This paper is provided for information in relation to the local implications of potential forthcoming legislation – which itself will be subject to an equality impact assessment. Further work will on an equality impact assessment will be undertaken when further clarity on the legislation is provided.	

Assessment of Risk:

The following risks apply to the decision:

Risk / opportunity	Mitigation
Report is for information	.

Legal Implications:

The proposals referred to in the report identify a number of changes, particularly in relation to the current structures, delegations and therefore consequential changes in governance arrangements need to be considered. This will require a review of the current system of decision making and delegations and appropriate legal advice will be required. Consideration will also need to be given as to who facilitates and services the meetings of the proposed boards going forward and any cost/resource implications.

Financial Implications:

This is an update paper and financial implications will be developed as legislation and further guidance becomes clearer.

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Background

1. On 11th February 2021 the government produced a white paper on the future of the NHS. The NHS confederation summarised the key points as follows:

    a. The paper signals a step away from the Health and Social Care Act 2012 with a broad move away from competition and internal markets and towards integration and collaboration between services.
    b. Integrated care systems (ICSs) are to be established on a statutory footing through both an `NHS ICS board' (though this will also include representatives from local authorities) and an ICS health and care partnership. The ICS NHS body will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions. The partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector to address the health, social care and public health needs of their system.

c. A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. This will apply to all partners within systems, including local authorities.

d. There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority.

e. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.

f. There will be significant changes to procurement. It is proposed that section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime.

2. A key change will be that an ICS would take on the commissioning function of Clinical Commissioning Groups (CCGs) and the CCG's Governing Body and 'membership' model would be replaced by a board consisting of representatives from the system partners. For Bury this means that the Greater Manchester ICS will take on the responsibilities of the each of the 10 CCGs in Greater Manchester and they, including Bury CCG, will cease to exist from 1/4/22 (subject to legislation).

Context

3. It is important to root the consideration of the impact of the NHS White Paper in our on-going strategic development plan for health and care in Bury. The Bury Locality plan 2019-2024 described a vision.

- for a step change in the health of the population of the borough,
- for residents and communities to be supported to be connected, well and independent from services if possible,
- for residents to have improved and joined up community-based health and care services connected to primary care,
- for a joined-up approach between the Council and CCG on commissioning services that focus on the individual not the organisations,
- and securing for Bury residents' best outcomes from health and care services.

4. This work was driven both by a shared moral imperative to improve opportunity and outcomes for all residents, and also a belief that financial sustainability of the health and care system was at least in part dependent on reducing unplanned and preventable and reactive health and care system cost. This vision still holds true, and can be supplemented by an appreciation of the key characteristics of any future system we seek to deliver
   - Residents in control of their health and the way services are organised around them

- Population Health and Inequality should be core to our work
- Neighbourhood Working is 'currency of integration' and as a foundation for scaled prevention and early intervention – in health and care, with wider public services, and with communities
- Services delivered closer to home/in home where possible
- Person and Community Centred Care is central to health and care transformation
- Clinical and political leadership should be central – not advising but leading
- Collaboration at a North East Sector and across GM required to transform hospital wide services
- Timely and effective access pathways for more specialist health and care services when required.

5. The Locality Plan pre-dates but is fully in line with "Lets Do it" as the strategy for the borough to 2030. The health and care transformation described in the locality plan – with its focus in local services, on inequality, on integrated services, on strengths-based working, and on partnerships working together differently to support residents and communities – makes a full contribution to Let's Do It.

Progress in developing integrated partnership arrangements in Bury

6. In order to deliver the vision and system characteristics described the partnership arrangements in the Bury health and care system have developed over time to become more collaborative, locally sensitive, and focused. At this point we have:

- Joined up commissioning arrangements between the Council and CCG including the operation of an integrated care fund (pooled, aligned and 'in view'), a joint strategic commissioning board of political and clinical leadership, joint executive level appointments, and the philosophy of a 'one commissioning organisation' with increasingly consistent operating protocols, working arrangements and joined up teams.
- The Bury Local Care Organisation (LCO) – an independently chaired focal point for joined up working arrangements in the provision of community-based health and care. The LCO has a small, dedicated management team and leads on a number of key implementations plans such as Urgent Care reform, and new end of life care pathways The LCO – operating as an alliance of partners - includes representation from key stakeholders including Pennine Acute, Pennine Care, BARDOC, GP Federation, Council, CCG, VCFA, and Persona.
- An increasing focus on neighbourhood working as a unit of delivery and common currency for service design for integrated health and care (through the LCO), the alignment of wider public services, and the role of community and voluntary capacity (e.g., community hubs). In each of 5 integrated neighbourhood teams we have community health staff and adult social care staff working together under single management arrangements – reducing duplication and joining up delivery for patients.

- The establishment of 4 Primary Care Networks, supporting resilience and service delivery for primary care and building maturity and working relationships to respond to national expectations on future role.
- A Health and Wellbeing Board, recently recast as focusing on the wider population health system – working with and challenging partners on the wider determinants of health, on behavioural change, on community connectedness, and on the operating of preventive public services.
- Northern Care Alliance (managing acute hospital services in Salford, Bury, Rochdale and Oldham) (NCA) refocused on a place-based footprint with named senior management and clinical leadership at a 'Care Organisation' for each borough
- Pennine Care Foundation Trust (Mental Health Service Provider) (PCFT) has also introduced a local leadership structure with Bury having a named / dedicated Assistant Director, the NES having a dedicated leadership triumvirate and a dedicated Exec link to Bury
- A whole System Board meeting for key stakeholders in the health and care system, with oversight of the comprehensive health and care recovery and transformation programme.
- System wide enabling programmes reflective of key health and care partners e.g., Strategic Finance Group, Strategic Estates group, and others.
- Bury Voluntary and Community and Faith Alliance (VCFA) as a key partner on System Board, Health and Well Being Board and LCO
- Active partnership with CCGs in the North East Sector of GM
- High quality clinical leadership leading transformation of services and pathways

7. These strengthened partnerships based, and integrated arrangements have made a tangible difference to the way services are delivered, and in the focus on addressing the determinants of poor health and wellbeing. For example
    a. Residents now get care that is more joined up e.g home care by a team not separate service.
    b. Our urgent care system is working well with patients being seen in the most appropriate setting for their condition and spending less time unnecessarily in hospital
    c. Our intermediate care services have worked effectively to provide alternatives to hospital admission and to support improved discharge arrangements

8. In particularly the strength of the partnership working in Bury has been a key factor in the response to the Covid 19 pandemic. We have for example delivered ability of the system to rapid changes to the organisation of community service to protect the hospitals through the first peak, primary care supporting Care Homes, increased but safe discharges and safe control of admissions to help hospitals cope with the Jan / Feb surge and of course all the testing and vaccination programmes delivered by the NHS and Council and with partners such as the VCFA working together seamlessly.

Greater Manchester Context

9. The Greater Manchester Health and Care Partnership review commenced in early autumn and deployed a mixture of independent expertise and reflections from within the partnership. The review sought clarify and support the next iteration of the ambition of 'Taking Charge'. The review identified 8 clear statements of intent:
   - We are part way through a journey we are still committed to.
   - The breadth of our ambition is broad, but our delivery will be focussed on fewer objectives. These will address both the essentials of a high performing system and the unique opportunities which GM can excel at.
   - Our Greater Manchester (GM) model is consistent with the NHS ICS definition and provides us with the structures to ensure that we continue to work in a way that encompasses the widest possible definition of integrated public service delivery
   - We believe there is merit in the establishment of a statutory entity at the GM level to provide a vehicle through which further delegation and devolution can take place
   - We need to ensure that we have a consistent definition of our place-based arrangements
   - There are a limited, but critical, number of key enablers central the ambitions of collaboration and integration (these include Digital Transformation, Financial Flows and Reform, Workforce, Estates, Sustainability and Climate Change, for our Boards and Committees to reflect the communities we serve, engagement and involvement of our communities in our work)
   - We strongly support an expanded role for Provider Collaboratives
   - We will commit to a single decision-making board (joint committee) in each locality, bringing together provision and commissioning that can deliver accountability for decisions and budgets at place level.

Maintaining our Local transformation Journey

10. The white paper is permissive in the sense of supporting those parts of the country where substantial progress has been made in the transition to more integrated models of health and care transformation. Greater Manchester is explicitly recognised in the White Paper, and the GM framework – creating integrated working at the conurbation level and in each of the 10 places is regarded nationally as leading edge. Nevertheless, there are key questions to be addressed as we work across Greater Manchester to develop the arrangements for the GM Integrated Care System.

    - There are concerns about the extent to which the decision-making authority of the GM ICS will be reflective of the 10 districts as well as 'sectoral' interests. Greater Manchester has always worked best when the GM tier is 'of the 10' rather than 'above it' – as for example in the model of the unique potential of a Partnership in a Mayoral Combined Authority Area

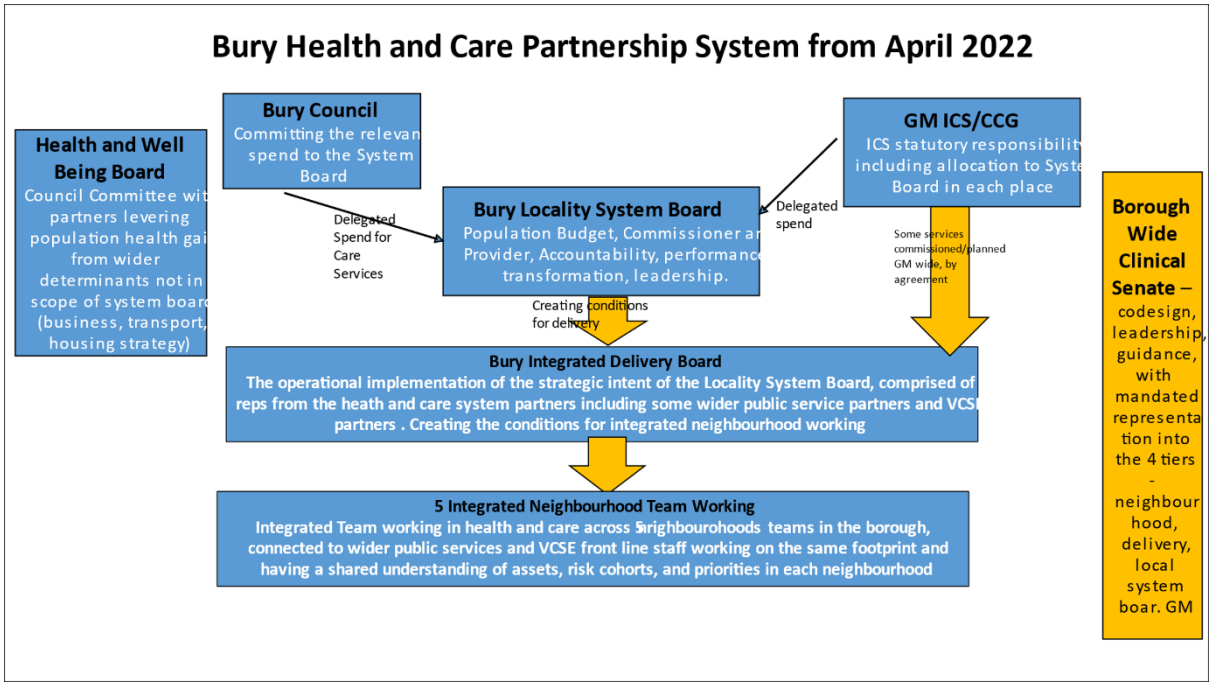
- It is important that the GM ICS facilitates and supports **place-based working** through the delegation of NHS budgets & aligned governance with districts. For this to work there needs to be clarity o the financial flow from a GM ICS into localities in a way that supports a pooled and integrated view of total health and care spend in each place.

- There is a concern about the **'2 boards' of an ICS** – an NHS ICS and a Health and Care Partnership ICS. This is a step backwards from current working across the Greater Manchester Health and Care Partnership

11. Clinical, political, and officer leadership continues to work closely with partners across Greater Manchester to engage and challenge on these points as the GM ICS arrangements are developed.

Proposed Partnership Arrangements in Bury

12. Subject to the clarification of the arrangements across Greater Manchester, and in particular to the need to ensure each of the ten districts have the authority and accountability to continue to drive the model of integration forward, the following arrangements are proposed in Bury.



13. The key elements for consideration.

a. Locality System Board

We should seek to establish a new Locality System Board for Bury operating in shadow format in the year 2021/22 and fully operational by 1/4/22. This system board will be a development of the existing Strategic Commissioning Board by including key providers and will operate as a single and transparent strategic forum. We would disestablish the current and relatively informal System Board and reduce the number of members of the SCB that transition

into the new Locality System Board. Its functions will be a relatively small board, setting strategic direction for the health and social care system in Bury

a. Recommitting and amplifying the key strategic direction and intent of health and care reform in the borough
b. Agreeing high level resource allocation based on the allocation from the GM ICS and the contribution of the Council to pooled budgets.
c. Agreeing transformation plan objectives (and having the current health and care recovery and transformation programme reporting to it)
d. Setting out and ensuring delivery of outcomes for borough residents.
e. Co-ordinating the intersection between GM wide provider collaborative strategic intent and locality strategy.
f. Align the borough strategic connection to Greater Manchester, North West, and national arrangements
g. A focal point for the alignment and integration of enabling functionality across the borough as described in the locality place – system estates group, system IM&T strategy, System workforce reform.

The System Board is essentially the apex of the health and care partnership in Bury – the design, delivery and assurance vehicle – a partnership (an integrated care partnership or ICP) convened by a place leader and governed by a formal committee with power, responsibility and accountability, and providing a mandated vote into the GM ICS.

b. Bury Health and Well Being Board

The board is a statutory function of the Local Authority. In Bury we have worked to recast the role of the Health and Well Being to focus on the steps required to create Bury as a Population Health System. This uses the Kings Fund 4 quadrant model of a population health system – wider determinants, behaviours and lifestyles, community, and the operation of public services.

Addressing population health and health inequalities is of course core to the work of the Locality System Board, but it is recognised the System Board is unlikely to provide the necessary airtime for, for example addressing the crucial wider determinants of poor health – quality employment, freedom from abuse, clean air, health promoting environments, housing.

Health and Well Being Board membership has been recently refreshed to include representation from wider public services including Housing and GMP and would benefit from wider representation from the business sector and other key stakeholders.

Health and Well Being has recently considered the establishment of a number of small subgroups, including one on a particular focus on inequalities and secondary care – access, outcomes etc.

c. An Integrated Delivery Board

A single system blind to provision and commissioning needs not only a single strategic authority (the proposed Locality System Board) but a single

integrated delivery framework co-ordinating the delivery of services and the delivery of transformation programmes. This is essentially a place-based provider collaborative for Bury.

In developing this it is recognised that the Bury LCO has made good progress in building improved working relationships between delivery partners in health and care, in leading particular transformation programmes, and in creating strong foundations and emergent proof of concept for neighbourhood working. However, it should be recognised that both the scope and formality of the LCO has some limitations, including for example.

- The limited connection to Primary Care Networks
- The lack of connection to children's services
- Some potential duplication of management capacity with providers and OCO

An integrated delivery board could be an extension of the current LCO Board and would recognise it operates across the breadth of the system including those services not necessarily currently considered to be in the scope of the LCO. It would recognise that the opportunity of binding partners together more formally (though joint assurance and formalised financial risk and gain share arrangements) for a particular subset of all service delivery (e.g., the urgent care system), and the scope of such formality may increase over time. However, the ambition of the LCO as the co-ordinator and integrator of services in the collaborative tier is not limited only to those services that are within its formal scope and accountability agreement.

An important role of the Integrated Delivery Board would be to take responsibility for creating the conditions for neighbourhood working to develop and thrive, connected to the Primary Care Networks

d. Neighbourhood team Delivery

The focus on neighbourhood team as the unit of currency for integrated health and care and connections to communities and wider public services is recognised by our own locality plan, by the NHSE Next Steps guidance, and by an increasing confidence in initiatives like integrated neighbourhood teams. In addition, we recognise the weight being attributed by national guidance to the future role of Primary Care Networks.

- as a mechanism of securing the sustainability and clinical critical mass in primary care,
- the mechanism by primary care becomes central to the model of neighbourhood working
- Increasingly a mechanism for receipt of money directly from ICS to strengthen local and integrated functions.

To deliver fully on the opportunity of neighbourhood team working we need to routinely conceive of neighbourhood teams as comprised of three significant and related sectors

1) integrated and all age health and care,
2) wider public services such as DWP, GMP, Housing and others that have within their gift a significant influence on health and wellbeing and demand for health and care services
3) Community and voluntary sector capacity and connectedness – recognising its communities and voluntary organisations and friendships that keep people well, connected and safe. This element of a comprehensive model of neighbourhood team working has been best exemplified by the development of the community hubs during the pandemic – providing support and assistance to vulnerable residents.

It may be that we wish to recognise an ambition neighbourhood boards for health and social care that could themselves make decisions about neighbourhood resources, priorities and assets. Ultimately, we might have a framework of delegated matters to neighbourhoods, the integrated provider board and the system board, based on the principle of transferring decision making closest to those affected by the decision.

e. A Clinical and Professional Senate for the Borough

One of the particular strengths of the CCG as a membership organisation has been the mandated and elected representation of GPs and other professional leaders into clinical leadership positions as clinical directors and clinical leads. The absence of a local CCG constitutes a significant risk to the continuation of such leadership – not only influencing but leading transformation and reform both locally and at a GM level.

Senior Clinical leadership can also be seen in professional groups such as Local Medical Committee (LMC), Local Pharmaceutical Committee (LPC), Local Optometry Committee (LOC), and in the role of Medical Director in the LCO, as well as in the Primary Care Networks Clinical Directors and neighbourhood clinical leadership. Key providers such as Pennine Care and Pennine Acute have also worked to confirm borough based medical director leadership

In addition, clinical leadership recognises and respects other professional and statutory leadership such as in social care and public health.

In the absence of being able to confirm mandated and authoritative clinical leadership at both a local and GM level there is a risk of losing clinical and professional perspectives into service transformation proposals, and furthermore having clinical leadership that is not mandated, or connected to Bury making decisions on our behalf.

It is proposed that Clinical and Professional Senate for the borough is convened reflective of the breadth of such leadership in the borough, operating with a senior 'board' bringing together those with mandated

leadership roles – e.g., PCN clinical directors, NCA Bury Care Organisation medical director, Bury Director of Adult Care, Director of Childrens Services – and with a wider membership reflective of all relevant stakeholders. A key function would be to secure mandated (through election) representation to all 4 tiers of the new partnership arrangements – neighbourhoods, integrated delivery board, locality system board, and the GM ICS.

f. Enabling Infrastructure

A single health and care system needs system wide collaboration and partnership on key enabling architecture. Progress has already been made in some of these areas, but further work is required to assess their position and weight in relation to influence across the system and the connections to a revised governance. Key areas of focus include but are not limited to.

- Strategic Health and Care Finance Group
- Strategic Estates group – adopting a one public service estate mentality and in particular create opportunities for integrated hubs rooted to models of neighbourhood working
- Digital Board – driving compatibility between systems and also models of risk stratification and identification, and on securing patient/resident control of records.
- Strategic Workforce Group – exploiting opportunities across sectors and services to build sustainable, supported, and flexibly workforce deployment across the system
- System Information Governance Board

Transition Planning

14. The existing System Board is operating as the Transition Programme board - tasking working groups, specifying expected outcomes, reconciling emergent themes, and holding all groups to account for delivery. The Senior Responsible Officer (SRO) for the programme is Geoff little – CCG Accountable Officer/Bury Council Chief Executive, supported by Will Blandamer – Exec Director of Strategic Commissioning. Seven task and finish groups are in place and reporting routinely to the System Board, covering; Clinical and Professional Senate, Integrated Delivery Arrangements, Neighbourhood Team Development Plan for health and care, CCG Staffing Transition, Financial Flows, Patient and Public Involvement, and Powers and Governance

Recommendations

The Council Cabinet is invited to

1) Note the update on the NHS White Paper 2021;
2) Recognise the ambition to ensure new governance arrangements allow the continuation of the transformation journey described in the Bury Locality Plan;
3) Support the new partnership arrangements under development;

4) Note the content of the transition programme to be managed through the Bury System Board;
5) Recognise the areas of concern around the governance of the GM ICS if it is to support the direction described.