Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Consider
Item No	6c	**Confidential / Freedom of Information Status**	No
Title	NCA Footprint working arrangements		
Presented By	Geoff Little		
Author	Carnall Farrar		
Clinical Lead	Jeff Schryer		
Council Lead	Cllr Andrea Simpson		

Executive Summary

The 4 GM districts of Bury, Salford, Rochdale and Oldham are connected through the relationship with the Northern Care Alliance delivery of acute and community services. NCA have worked hard to develop a unit of managerial and clinical leadership in each of the 4 districts ('Care Organisation') that has been invaluable during the response to the pandemic.

This paper is the outcome of a brief joint commission between the 4 districts and NCA. It seeks to describe the degree of consistency between the partnership arrangements in each of the 4 districts in response to the pandemic, as a necessary precondition to continued partneship working between each District, the NCA Care Org, and the NCA organization as a whole.

In doing so it creates opportunities to accelerate transformation of in scope acute and community services in each of the 4 districts, confirms a shared ambition and philosophy – particularly around the pre-eminence of place based working and integrated neighbourhood team delivery.

The partnership and its shared approach has been helpful in the meantime in contributing to the emergent model of ICS for GM as a whole.

The paper does not commit to collective decision making on thisfootprint, does not limit the soverienty of the Bury localty, and is not a comprehensive model (in the sense that we have important working relationships with other key providers e.g MFT). It does however create the conditions for the important relationship with NCA partners to flourish.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receive the report and comment on the approach described.

Links to Strategic Objectives/Corporate Plan	Choose an item.

Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Yes					
How do proposals align with Locality Plan?	Core					
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality	Yes	☐	No	☐	N/A	☐

Implications						
Impact Assessment been completed?						
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.		

Proposition for locality working in the context of the GM ICS

March 2021

NHS Bury Clinical Commissioning Group

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

NHS Salford Clinical Commissioning Group

NHS Oldham Clinical Commissioning Group

Bury Council

Rochdale Borough Council

Salford City Council

Oldham Council

Contents

Executive summary (1/3)

This document sets out our **proposals for future arrangements within the new ICS** to **feed into and contribute towards the development of plans** at a GM level. In coming together to undertake this work, our aim is to **contribute towards to the means of securing greater consistency in the place based arrangements** across GM. It has been developed over the month of March in parallel to the evolving thinking underway at the GM level, taking the emerging ICS proposals and design principles into account. Leaders of health and care, including politicians, clinicians and executives across all four of our localities and the NCA have been involved in inputting to these proposals through a combination of one-to-one interviews, locality meetings and pan-locality workshops.

Our localities of Bury, Rochdale, Oldham and Salford make up four of the ten localities across Greater Manchester (GM) with a combined population of approximately 1 million. Whilst each of our populations have differing demographic profiles, the health of people has been generally worse than the England average and life expectancy for both men and women is lower than the England average. This means we need to work extra hard to tackle inequalities and improve outcomes, by designing our health and care system based around people, communities and their specific needs, and maximising the potential for economic contribution. We share a single acute and community healthcare provider – the Northern Care Alliance NHS Group (NCA). The NCA is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust, in April 2017.

Following the publication of the White Paper in February 2021, work is underway at the GM level to design the architecture that will enable GM to operate as an ICS – holding the statutory ICS responsibilities but pursuing broader objectives, including population health, social determinants and public service reform. In these proposals, place is described as the “cornerstone of integrated local systems”. We support this concept and believe that a focus on place is pivotal: it is widely accepted that this should be the default setting for the vast majority of care and decision-making.

Although our four localities have been on distinctive and separate journeys towards making integrated care a reality for our populations, there is much commonality across the arrangements we have put in place. In each of our localities, we have a **strategic joint commissioning board** (or equivalent) and an **integrated Local Care Organisation.** We all have **integrated funds** for health and care in place using a Section 75 agreement. The scale of these ranges from £449m (Oldham) to £607m (Salford). We are all firmly of the belief that it is the blend of **political, clinical and professional leadership** that makes our collaborations a success, and we are all keen to build on what we already have in place which includes building on the scope of our existing pooled and aligned budget arrangements under any future proposals. This is because we have seen significant progressive benefits from our increasing levels of integration over the years.

Our overarching principles have informed the development of this proposition. Our core principle is that **place-based working is the cornerstone** of integrated local systems – this is where most care is provided and there is greatest opportunity to improve population health outcomes. Our approach supports **primacy of place**, as we believe decision-making should be as close to the 'issue', problem or population as possible and follow the **principle of subsidiarity**, with place-level decision-making and solution-finding putting the community served as the focus. However, we recognise that **not everything can be planned and / or delivered** at a neighbourhood or locality level and that we have decades of experience in collaborating at a **GM level** to plan and deliver consistent standards of care.

Executive summary (2/3)

We have considered three different spatial levels in the new system architecture, each with a distinctive purpose: **GM-wide, locality and neighbourhood (the latter two referred to as 'place')**. We have aligned on a proposition for the optimal scope of services to be **planned** at different spatial levels. This is based on the principle that nearly all community-based services and a significant proportion of acute services are best planned at locality level to ensure flexibility to meet the needs of the local population, to manage demand for health and care, and enable local people, communities and organisations to be part of plans, decisions and solution-finding. We have also considered the optimal scope for services to be **delivered** at different spatial levels, recognising that not all services best planned at one level are best delivered there – for example, some elements of primary care will be best planned at GM level but need to be delivered on a neighbourhood and locality level.

We also recognise that GM has benefited from working on **pan-locality basis**, particularly for acute physical and mental healthcare, with different footprints being relevant dependent on the nature of the service being planned or delivered. We see opportunity to build on this to **enhance collaboration,** ensuring it is effective in the context of the ICS and supports the delivery of system-wide goals. Our four localities are keen to work together in the future, but we also think there could be benefit in different pan-locality footprint configurations depending on the nature of the opportunity identified, for example working with Bolton FT. We believe that pan-locality collaboration would work well for **planning** some services. The main rationale for these services to be planned at a footprint that is wider than locality is around scale and population size. These are services which benefit from being planned and purchased for a larger population than locality to drive maximum benefits in support of GM-wide strategic goals, but not as large as GM. The NCA already delivers acute health services across our four localities, with significant opportunities to improve service resilience and outcomes across this delivery footprint. Every opportunity should be explored to secure the benefits of pan-locality collaboration (either across our four localities or in different configurations as appropriate) as part of the new ICS architecture.

In terms of governance, our shared view is that the GM ICS NHS Board should be organised as a **Committee in Common** with the GM Partnership Board to ensure that health and care are not divided. Each of the **ten localities should be represented** on this Committee in Common in order to reflect the interests of all places that make up GM, and not go backwards from our partnership intentions. Each Locality should then have a **Joint Committee** that is responsible for setting the strategic direction and decision making on the integrated fund. Each locality should establish an **Integrated Delivery Collaborative** as a formal alliance to include partners from the VCSE, wider public services and wider care services e.g. care homes, based on the requirements of the locality.

Political, clinical and professional leadership should be part of the core membership for each of the governance groups. Funding should be delegated from the ICS NHS Board to the Locality System Partnership Board (name TBD). The intention is to **retain the scale and scope of place based population health budgets commensurate with the scope of services coordinated and planned at that level**. Provider collaborative funding should be aligned with localities' strategic plans. Over time, we would expect funding to be devolved down to the Neighbourhood level where this is feasible.

Executive summary (3/3)

The next steps for further development of this work include:

- Refining the overarching principles with all partners, including primary care and the VCSE
- Conducting further engagement on these proposals e.g. with primary care providers and public health commissioners
- Working with with all partners (including Councils) to refine propositions for the Neighbourhood-level, including the governance, staff and skill mix required and how this will be organised
- Further reviewing the benefits and alternative propositions for mental health community services with relevant organisations
- Developing a proposition for how the Health and Wellbeing Boards should interact with the Locality System Partnership Boards
- Ensuring leadership alignment behind this proposition (including political support)
- Identifying potential challenges that need to be worked through and develop mitigating strategies recognising the specific complexities of each locality
- Sharing this proposition more widely with colleagues in GM
- Identifying specific areas, programmes or opportunities to take forward at a pan-locality level – agreeing the footprint and nature of the arrangements required to do so
- Beginning to implement governance proposals and establish new / amend existing governance groups as required in each locality
- Identifying any capability gaps at locality level and working with GM ICS to resolve these ahead of formal transition to the new arrangements

Background and context

Purpose of this document

This document sets out our proposals for future arrangements within the new ICS to feed into and contribute towards the development of plans at a GM level. In coming together to undertake this work, our aim is to contribute towards to the means of securing greater consistency in the place based arrangements across GM

It has been developed over the month of March in parallel to the evolving thinking underway at the GM level, taking the emerging ICS proposals and design principles into account. Leaders of health and care, including politicians, clinicians and executives across all four of our localities and the NCA have been involved in inputting to these proposals through a combination of one-to-one interviews, locality meetings and pan-locality workshops. For full details of all engagement undertaken, please see Appendix pp.40-41. A key principle of the work has been to build on what we already have in place and the progress we have made to date individually as localities, drawing on the strength and commonality across the four of us. This document starts by describing in more detail the journeys we have been on to date, where we are different and where we have much in common.

The document covers:

- Where we are on our integration journeys
- How we want to work in the future, including our proposition for:
  - The overarching principles we should be adhering to
  - The purpose of each spatial level
  - The future scope of each spatial level
    - Planning and strategic coordination
    - Delivery alliance
  - Potential for pan-locality collaboration
  - The future governance arrangements
    - Overarching system architecture, including how localities will work with GM
    - Proposition for localities
    - Proposition for pan-locality
  - The associated financial flows
- Next steps, including identifying areas where we know there is further work to be done

Source: Developing the GM ICS (Merged PEB 23.03.21)
https://www.northerncarealliance.nhs.uk/about-us/; https://www.gmhsc.org.uk/;

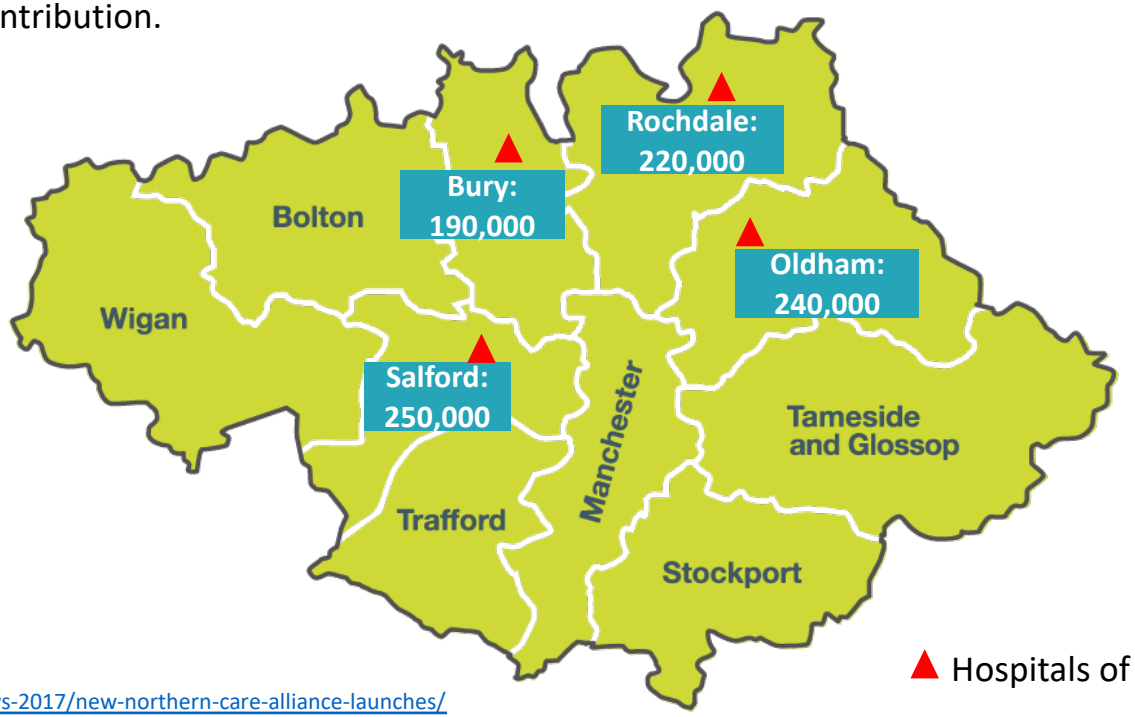
Who we are

Our localities of Bury, Rochdale, Oldham and Salford make up four of the ten localities across Greater Manchester (GM) with a combined population of approximately 1 million. Across the four, there is significant deprivation with examples below:

- In Bury there is a wide range between the least and most deprived communities, and this has a notable effect on health outcomes
- Salford is one of the 20% most deprived districts/unitary authorities in England and 21.1% (10,460) of children live in low income families
- Almost a third of the population of Rochdale live in areas amongst the 10% most deprived in the country, an increase on the proportion seen in 2010. In contrast, only 24,350 people live in areas in the least deprived quartile
- Oldham currently has four areas within the borough which are among the top 1% of the nation's most deprived areas. Only three wards do not contain any areas that fall within the nation's top 20% most deprived

Whilst each of our populations have differing demographic profiles, the health of people has been generally worse than the England average and life expectancy for both men and women is lower than the England average. This means we need to work extra hard to tackle inequalities and improve outcomes, by designing our health and care system based around people, communities and their specific needs, and maximising the potential for economic contribution.

We share a single acute and community healthcare provider – the Northern Care Alliance NHS Group (NCA). The NCA is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust, in April 2017. The Group provides a range of healthcare services including four hospitals and associated community services - Salford Royal, The Royal Oldham Hospital, Fairfield General Hospital in Bury, and Rochdale Infirmary (marked in red on the map).



Sources: https://www.srft.nhs.uk/media-centre/latest-news/news-archive/news-2017/new-northern-care-alliance-launches/

Background context

Since 2001, GM has been at the forefront of integrated care in the UK. In November 2014, GM reached a historic milestone: leaders across the ten local authorities signed a unique deal with Government to devolve a wide range of powers, budgets, and responsibilities to GM Combined Authority (GMCA) and an elected GM Mayor. In April 2016, GM took control and responsibility for its £6bn health and social care budget and has been working to deliver sustainable, integrated health and care.

In February 2021, the Secretary of State for Health and Care set out before Parliament a White Paper describing a blueprint for the future of health and care, including a number of reforms to the Health and Care Act centred on the creation of Integrated Care Systems nationally. We very much see these changes as an extension of the journey we have been on to date given the aim to make it easier to work across boundaries and remove barriers. The White Paper describes how place arrangements will be supported by the principle of subsidiarity, with allowances for joint committees at place level and strengthened clinical leadership and makes it clear that ICSs and local places will be able to arrange this as best fits local circumstances rather than being prescribed through legislation.

Work is underway at the GM level to design the architecture that will enable GM to operate as an ICS – holding the statutory ICS responsibilities but pursuing broader objectives, including population health, social determinants and public service reform. In these proposals, place is described as the "cornerstone of integrated local systems". We support this concept and believe that a focus on place is pivotal: it is widely accepted that this should be the default setting for the vast majority of care and decision-making.

Alongside this, we recognise the benefits of collaboration across all partnerships, particularly new models of provider collaboration across GM. We are all proud to be part of the make up of GM and recognise the significant experience and capability that operating at scale over all ten localities affords. Significant progress, recognised on a national stage, has been made through the GM partnership and we want to continue to support and build on this.

Within this overall framework, our four localities have a history of working together on common agendas. Initially, Bury, Oldham and Rochdale came together as the North East sector given the shared relationship with the Pennine Acute. Since 2016, relationships have extended to include Salford given the creation of the Northern Care Alliance (NCA). During the Covid pandemic we have all had to work together in a new and more urgent way, and we achieved this successfully as a result of the relationships we have built.

As GM considers how to take the next steps of development in response to the White Paper, we have come together to align on the arrangements that we think will be most effective in order for each of our localities, and GM as a whole, to deliver on our common goals.

Source: Developing the GM ICS (Merged PEB 23.03.21)
https://www.northerncarealliance.nhs.uk/about-us/; https://www.gmhsc.org.uk/;

Where we are on our integration journeys

Summary: whilst we are all at different stages of our integration journeys, there is much we share in common

Although our four localities have all been on distinctive and separate journeys towards making integrated care a reality for our populations (see Appendix pp.28-39), there is much commonality across the arrangements we have put in place.

In each of our localities, we have a **strategic joint commissioning board (or equivalent)** which allows Council Cabinet members and CCG Governing Body members to come together and take joint decisions about health and care. We each aspire to **devolve as much work as possible to the neighbourhood level**, with PCNs co-terminous with majority but not all of our neighbourhood footprints (a result of differing historic arrangements in each locality). We all work with the Northern Care Alliance, which provides acute and community services through its place-based **Care Organisations** (and, in Salford, also provides adult social care). In the North East Sector, we work with Pennine Care as our main mental health provider, with Greater Manchester Mental Health providing this role in Salford. In each locality we have strong relationships with a variety of VSCE organisations. In all four localities we have developed strong provider partnerships; in Salford, an Integrated Care Organisation governed through the partnership, in Rochdale a lead provider model for adults, and in Bury and Oldham we are working on the basis of an alliance model.

We all have integrated funds in place, including pooled budgets for health and care using a Section 75 agreement. In some places we treat the BCF separately because of the national reporting requirements, and in some places it is rolled into our pooled budget arrangements. We use the following common terms to define how our budget is allocated:

- **Pooled:** anything covered under S75 in formal pooling arrangements and decided jointly (Bury: £340m; Oldham: £449m; Rochdale: £402m; Salford: £424m)
- **Aligned:** anything that cannot be pooled or is not yet formally pooled but is decided jointly by the Joint Commissioning Board (or equivalent) and then signed off by the relevant organisation (Bury: £139m; Oldham: £0m; Rochdale: £110m; Salford: £182m)
- **'In view':** services or budgets which are not pooled or aligned (so are effectively independent) but for which decision making and spending is reported to the Joint Commissioning Board
- **Independent:** services which are currently separate budgets and commissioned separately by the CCG / Council respectively where the Joint Commissioning Board does not have sight routinely

We are all firmly of the belief that it is the blend of political, clinical and professional leadership that makes our collaborations a success. We are all keen to consolidate and build on what we already have in place which includes not diminishing the overall scope and breadth of our existing integration arrangements under any future proposals.

We have seen progressive benefits from our increasing levels of integration over the years

In each of our localities, we have:

- A genuine **shared and strategic vision** across partners, with **high levels of trust** and **positive relationships**
- Combined **political, clinical and executive expertise, skills and experience** – this is very powerful and, in our experience, greater than the sum of the parts
- No unilateral decisions – **we all have a voice** which means there is greater buy-in and ownership of decisions made and the impact of decisions on other parts of the system are jointly understood, owned and managed
- Greater focus together on **prevention, early intervention, tackling inequalities**, **asset based neighbourhood support**
- **Improved patient and service user experience** through more seamless services and pathways
- **Improved opportunities for engagement, co-design and co-production** with people with lived experience
- **Stronger VCSE infrastructure** and recognised value of the sector by all partners
- **Protected frontline services** through an increased ability to make the best use of limited resources – spending money smarter
- Created **efficiency savings** from joint working
- Been able to **manage peaks and troughs more effectively** through the ability to plan over a longer time period
- Benefitted from **increased flexibility to invest/disinvest disproportionately** across health and social care (to deliver outcomes)
- **Minimised financial risk** as a result of the increasing size of our pooled budget arrangements
- **Eliminated the debate** as to who should fund the “grey areas” of health and social care

We would be happy to share any of the learning from our respective journeys’ with other localities in GM and vice versa

Source: Salford’s Journey of Integrating Health and Social Care March 2021 v0.3

How we want to work in the future

Introduction

In this section, we set out our proposition for:

- The **purpose** of the different spatial levels: Neighbourhood or Locality ('Place') and GM
- The **services in scope** for the remit of the Locality and GM partnerships i.e. those services that should be **planned** at a locality level versus those services that would be better planned at a GM level
- The **services in scope** for the remit of the Local Delivery Collaboratives and GM Collaboratives i.e. those services that should be **delivered** at a locality level versus those services that would be better coordinated at GM. Our proposal recognises that some services, such as core primary care contracts, are better planned at GM level but delivered locally
- The potential to **build on existing pan-locality collaboration efforts**, to maximise the effectiveness of both planning and delivery in support of GM-wide goals
- The **role and core membership** of each of the key groups in the new system governance
- The **financial flows** from GM to locality

We also describe the **principles** we have co-developed which we have used as the basis for all of our proposals.

We intend these proposals to **feed into and contribute towards** the system design work that is ongoing at GM level.

It is important to note that these proposals represent **our thoughts at a point in time** and as such should be treated as a starter for ten. We are cognisant that **they will evolve** and be refined over time and further developments progress both within our localities and across the wider GM system.

Our emerging overarching principles have informed the development of this proposition

- A place-based approach has **people, families and communities at its heart**. We will adopt an **asset-based approach** that recognises and builds on what individuals, families and communities can achieve, encouraging behaviour change that builds independence and supports residents to be in control
- By working in partnership, we aim to **improve population health** and **reduce inequalities** in a way that has greater impact than the sum of the individual organisations
- Our approach will maximise our **contribution to local economic potential** and the role individual organisations can make to growth and an **inclusive and sustainable economy**
- **Place-based working is the cornerstone** of integrated local systems – we believe this is where most care is provided and there is greatest opportunity to improve population health outcomes. Our approach will support **primacy of place.** Neighbourhoods will be used as the building block for the integration delivery model
- There is recognition that **not everything can be planned and / or delivered at a neighbourhood or locality level** and we have decades of experience in collaborating at **GM level** to plan and deliver consistent standards of care. Decision-making should, however, be as close to the 'issue', problem or population as possible, following the **principle of subsidiarity**, with place-level decision-making putting the community served as the focus
- Whilst the flow of NHS resources will change in the new arrangements, our objective is to **generally retain and build on the scale and scope of existing place-based integrated funds**. Specifically, this will enable decisions to invest in early intervention and prevention in communities despite the time lag between that investment and the return on investment in the form of reduced demand for late intervention; and decisions to invest in improvements by organisations in one part of the system when the financial and performance benefits fall to different organisations elsewhere in the system. These are decisions that can only be taken when there are shared objectives, a long term version and trust at place level alongside the appropriate mechanisms to move resources across agency boundaries and to plan financially across multiple years. The integrated funds in localities will be **commensurate with the scope of services** coordinated and planned at that level under future arrangements. Our ultimate ambition is for resources to be allocated based on need and not adversely impact upon areas that have the greatest health inequalities
- It is essential to our success that any new structures align local leadership, combining **political, clinical and organisational** viewpoints
- We will **actively build relationships**, fostering strong relationships between organisations at all levels, and between communities and organisations. We will adopt an **uncompromising commitment to trust, honesty, collaboration, innovation and mutual support** to enable people to speak openly and free of jargon
- We recognise the **platform we have to collaborate** across our four localities and are also committed to working across other pan-locality footprints where this beneficial
- We will share our data to build a shared understanding of key issues and population needs

Source: 'Localising decision-making', Local Government Association
Developing the GM ICS (Merged PEB 23.03.21)

We started by defining the purpose of the different spatial levels in the ICS

Place (locality or neighb-ourhood)

- Use local intelligence to create a genuine shared vision by engaging and co-producing with local communities and people with lived experience
- Set the system strategy for place-based care and service reform, and agree resource allocation to deliver the outcomes for the people of the locality, as well as performance and financial ambitions
- Pool budgets and maximise use of limited resources to ensure financial sustainability, strategically overseeing joint working arrangements for the locality and all locality providers, including the integration of budgets across NHS and LA partners
- Lever the influence of wider partners on population health and wellbeing, with a focus on early intervention and prevention
- Target inequalities and promote inclusion with communities and residents, working in partnership in a way that has greater impact than the sum of the individual organisations
- Develop locality wide and neighbourhood teams, including PCN development and supporting neighbourhood working
- Ensure staff are empowered to actively shape and co-design services, increasing satisfaction and wellbeing in their roles
- Ensure the voice of place is heard in GM
- Create a system information sharing agreement to enable better information flows and joined up data for population health
- Make a positive contribution towards social and economic development

GM-wide

- Ensure a coherent strategy and manage the impact of changes across GM, ensuring the needs of the population are being met, acting as a 'sum of the parts' of all ten localities
- Secure clinical and financial sustainability across the whole of the health and social care landscape
- Streamline commissioning and set outcomes for consistent roll out across localities
- Ensure adequate funding for strategic planning to address inequalities by delegating money, responsibility and accountability to localities
- Have impact on system leadership, including national influence
- Tackle service planning where there have been resilience or safety issues, including reconfiguration of acute care at scale
- Ensure a strategic approach to securing a workforce for GM, supporting wider employment opportunities
- Maximise impact from health innovation and digital by harnessing the breakthrough opportunities of digital technology
- Further develop the partnership between the NHS, local government, universities and science and knowledge industries

Source: Workshop discussions and 'Developing the GM ICS (Merged PEB 23.03.21)'

We have aligned on an emerging proposition for the optimal scope of services under the remit of the Locality and GM partnerships (planning)

Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality							
• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Some General & Acute planned care (adults) (e.g. outpatients) • Maternity community • Paediatric outpatients	• Ambulance Services - emergency • Patient Transport
• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• Some General & Acute planned care (adults) • All planned and urgent & emergency specialised services (see Appendix p.41), including: – Major Trauma, Critical Care, Paediatric Intensive Care, NICU – Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	
GM ICS							

NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Source: Spatial level planning template returns 2021

We have also aligned on an emerging proposition for the optimal scope of services to be delivered by Local Delivery Collaboratives and coordinated by GM Collaboratives (delivery)

Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality							
• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Maternity community • Paediatric Outpatients	• Ambulance Services - emergency • Patient Transport
• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• General & Acute planned care (adults) • All planned and urgent & emergency specialised services (see Appendix p.41), including: – Major Trauma, Critical Care, Paediatric Intensive Care, NICU – Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	
GM ICS							

NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Source: Spatial level planning template returns 2021

We recognise that GM already operates on a number of pan-locality footprints under current arrangements, and propose to enhance this in the context of the ICS

GM has a successful **history of working on a pan-locality basis**, particularly for acute physical and mental healthcare, with different footprints being relevant dependent on the nature of the service being planned or delivered. Examples include the provision of Major Trauma services (delivered on a GM footprint through a lead and key provider model), the configuration of high acuity and emergency General Surgery (through a sector collaboration model) and the provision of Renal services (delivered through two aligned models, covering the north and south of GM).

We believe, as part of the **new ICS construct**, we should **build on and enhance these arrangements** to drive **maximum benefits in support of GM-wide strategic goals** within the new ICS architecture. We recognise that there will be different pan-locality configurations, depending on the nature and scope of the opportunity being pursued, particularly given that each locality has a unique set of relationships based on provider footprints, patient flows and geography.

Opportunities for pan-locality collaboration (either across our four localities or in different configurations as appropriate) include:

- Making **effective use of resources**, leveraging capacity across localities – both workforce (clinical and non-clinical) and buildings
- **Identifying** and **targeting inequalities across localities**
- **Co-ordinating change and improvement programmes** that impact on more than one locality
- Developing **Single Shared Services** that ensure the sustainability and resilience of inpatient services across our shared footprint (and, where applicable, with neighbouring localities) including the delivery plan for the Pennine transaction
- **Planning acute service across the NCA footprint** (excl. complex, tertiary and quaternary) in the context of GM models of care
- Acting as a **delivery vehicle for services best delivered on a larger footprint** than locality without requiring GM level delivery
- **Co-ordinating service improvement, pathway transformation and standardisation to best practice**, with knowledge sharing and cross locality learning
- Acting as one voice to support **effective and streamlined** decision-making, leveraging **combined brainpower**

Pan-locality collaboration could support the effectiveness of both planning and delivery of services

Potential for joint planning

In exploring the opportunities, we identified that some **joint planning** could be done on pan-locality basis, such as intermediate care bedded facilities. There is also potential to consider the development of key enablers, such as workforce, IT / digital, BI functions.

Given the Northern Care Alliance is one of our shared acute providers, we think it makes sense to consider any potential site reconfiguration in the future on this footprint. Working together and planning how we use all the hospital sites within the NCA has worked well for us during Covid, allowing us to create a 'cold' site in Rochdale that can be used by each of our localities and the rest of GM. We want to explore future opportunities in this vein, making sure they work for and provide an asset for GM as well as the four of our localities.

There is also the opportunity to share best practice, standardise models and work towards consistent outcomes. We already have a five-year NCA-wide Cancer Plan in development, outlining how we will address cancer priorities, creating locality alignment and system commitment. We want to avoid unwarranted variation in services. Drug and alcohol services and sexual health services are already commissioned jointly across Bury, Oldham and Rochdale. We propose that this remains the case under the future arrangements.

Potential for joint delivery

Operating at the pan-locality level, either across specific localities or multiple providers, could also provide a good **delivery vehicle** for GM-level planning in some areas. This could include some elements of general and acute care, particularly given the NCA already delivers acute services across our combined footprint.

The main rationale for these services to be delivered at a footprint that is wider than locality is around scale and population size. There are some services which benefit from being delivered across a larger population than locality given the minimum volume thresholds to attain the highest quality, and the need to meet specific workforce standards, but should not necessarily be delivered at GM level which could cause access problems for our local populations.

Operating pan-locality could act as a vehicle for delivery of some GM-wide decisions. It could also support the delivery of other GM-wide service strategies that impact all ten localities, including future plans for mental health provision and planned care. It is recognised, however, that the footprint for pan-locality delivery will vary. For example, Salford, Bolton and Wigan have a history of close working, with a particularly strong relationship between Salford and Bolton due to population flows and previous decisions regarding the configuration of paediatric and maternity services.

There will be other opportunities for partnerships beyond our four localities, for example with Manchester or Tameside.

We have developed a governance proposition, setting out the roles of each of the key groups in the new system

GM ICS Partnership Board | GM ICS NHS Board

- Committee in Common*
- Develop and agree the overall strategy (including financial strategy) for health and care

- Develop and agree the priorities and approaches to improving population health and reducing health inequalities
- Allocate NHS funds with regard to the overall strategy for health and care and facilitate Councils and the NHS to be able to bring budgets together as part of place-based arrangements
- Drive innovation and digital best practice in health and care
- Make effective links to wider public sector services, budgets and reform e.g. OPE
- Maximise the contribution of health and care to the wider social and economic recovery from the pandemic and the wider Local Industrial Strategy, and hold NHS providers to account for the delivery of constitutional and other standards

Council

Statutory duty to provide a range of services to the community

- Represent the electorate
- Statutory duty to provide education services; children's safeguarding and social care; adult social care; waste collection; planning and housing services; road maintenance; and library services

Locality System Partnership Board (name TBD)

- Joint Committee
- Setting strategic direction for locality, form the locality's strategic relationship with GM ICS and others

- Align local organisational, political and clinical leadership
- Lead the development of a local strategy for health and care, to meet outcomes, performance and financial ambitions
- Oversee the co-ordination and transformation of local health and care services
- Strategically oversee the integrated budgets across NHS and LA
- Influence improved population health and reduction in inequalities in a way that has greater impact than the sum of the individual organisations

Clinical & professional senate

- Advisory group to Locality System Partnership Board
- Influencing policy and pathway design

Locality Integrated Delivery Collaborative

- Formal Alliance
- Oversee implementation of the strategy

- Lead strategic development of delivery arrangements within the locality, including provider evolution for partnership working and technology
- Have devolved / delegated decision making within an agreed scheme of delegation for the locality

Pan-locality Management group

NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Locality integrated neighbourhood delivery team

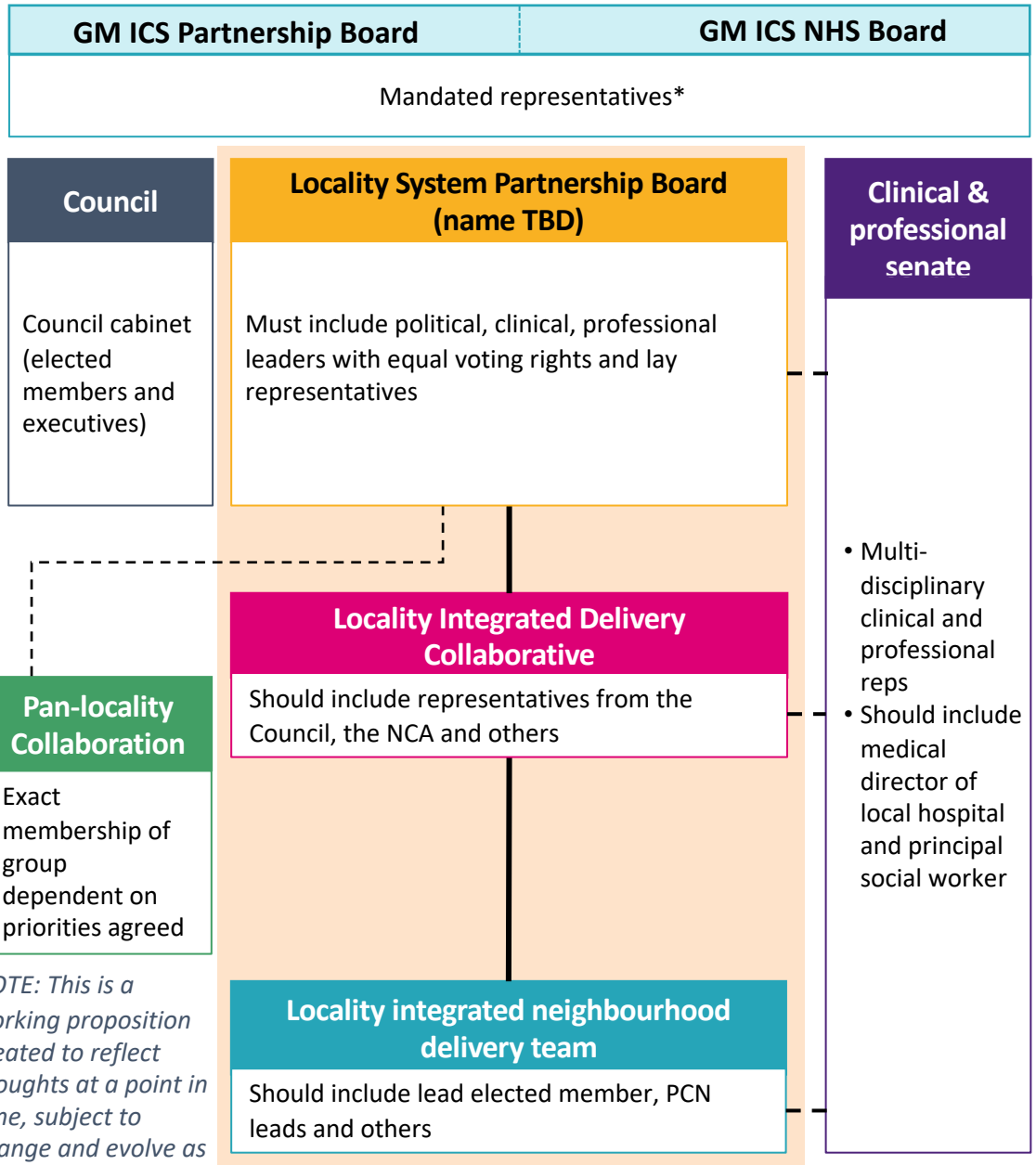
- Sub-committee of Integrated Delivery Collaborative

- Integrated Teams delivering 'next generation' neighbourhood provision, built on PCNs and the LCO
- Bringing together wider public services and VCSE frontline staff in neighbourhoods to tackle social determinants of health outcomes (e.g. debt, social isolation and physical inactivity).
- Shared understanding of assets, risk cohorts, and priorities in each neighbourhood

- Platform for collaboration across wider footprint than locality based on common purpose and a common set of values
- Facilitates opportunity to share, learn and co-design
- Supports the identification and delivery of pan-locality transformation opportunities that have not yet been taken advantage of
- Enables a common voice within GM where this is required

* We recognise that the design of the GM-level governance will need to be discussed and resolved by parties across GM – this proposal represents our shared view

This is supplemented by a proposition for the core membership of each of the groups



NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Mandated representatives from*:
- The GM ICS
- The provider collaboratives (Provider Assembly, PBC, PFB)
- The GM Combined Authority
- The political leaders of the ten Councils
- The clinical leaders of ten Locality System Partnership Boards

- Should include representatives from the Council (adult's, children's and public health), the NHS ICS (locality leadership), the NCA, the mental health provider(s), primary care provider leadership, the VCSE, Healthwatch
- Should include at a minimum the Accountable Chief Executives or Chief Officer (NCA) of the Local Authority and statutory NHS organisations
- Should include pooled fund manager as a representative of the Finance Directors from all partners organisations
- **Each locality will supplement the proposed core membership with their own identified members**

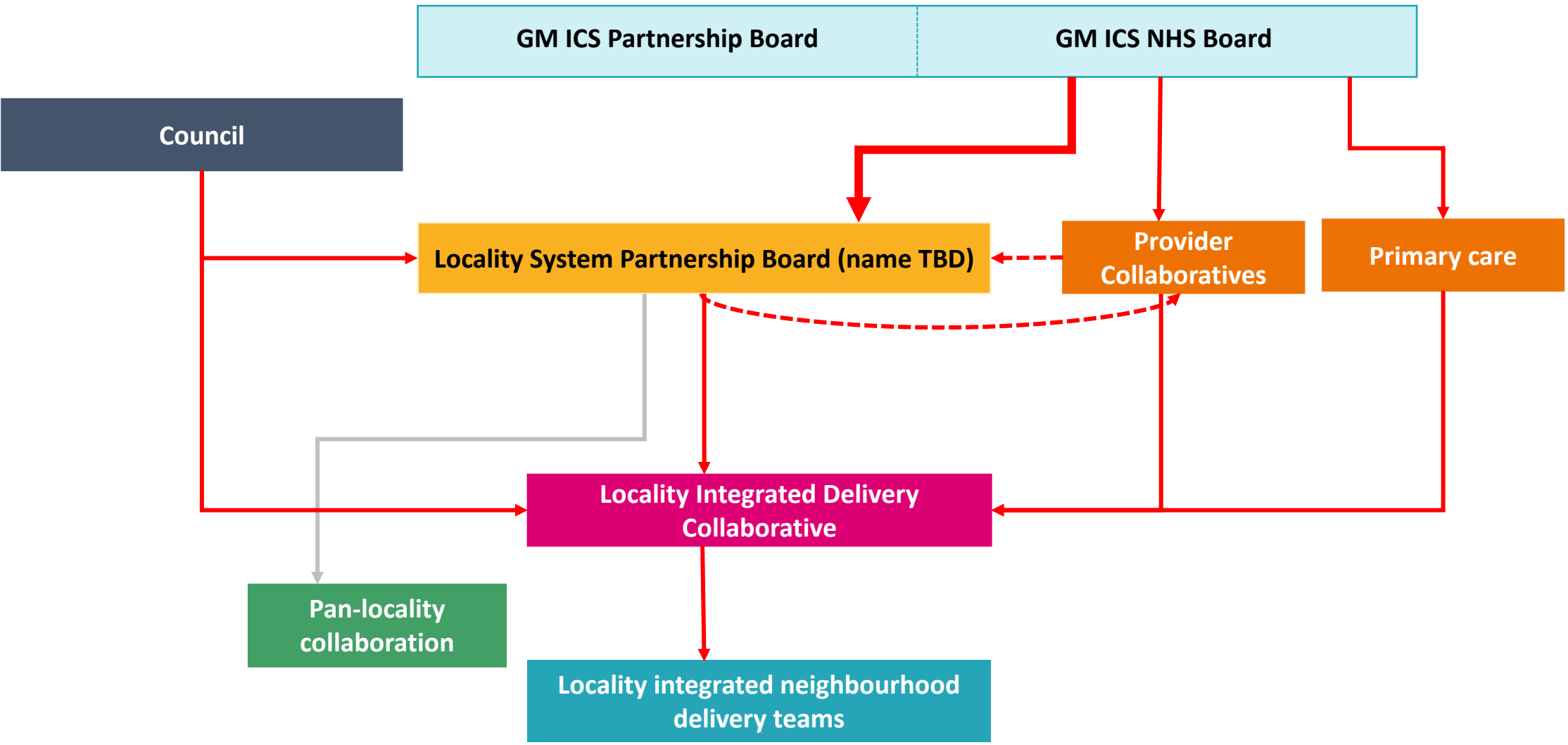
- Should include representatives from the Council (adults', children's and public health), the NCA (Care Organisation), the mental health provider, primary care, the VCSE
- Should include at least some wider public service partners (e.g. DWP, housing, fire service etc.)
- Should include Neighbourhood leads from every Neighbourhood
- **Each locality will supplement the proposed core membership with their own identified members**

- Lead elected member
- PCN lead
- Neighbourhood leadership from adults' and children's community services
- **Each locality will supplement the proposed core membership with their own identified members**

From organisations in the defined footprint:
- Chief Executives / Accountable Officers; Chief of Strategy / Directors of Strategic Commissioning or equivalent
- Local Directors of Commissioning, relevant leads from clinical and care organisations

* We recognise that the design of the GM-level governance will need to be discussed and resolved by parties across GM – this proposal represents our shared view

Funding should be delegated from the ICS NHS Board to the Locality System Partnership Board (1/2)



NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Funding should be delegated from the ICS NHS Board to the Locality System Partnership Board (2/2)

Body	Financial flows
GM ICS Partnership Board / GM ICS NHS Board	• Receives NHS budget allocation for the system • Delegates funds to localities – these should be commensurate to the scope of the Locality System Partnership Board (see p.16) • Provides some funding directly to provider collaboratives • Provides some funding directly to primary care
Council	• Councils fund the Locality System Partnership Board directly, contributing to the integrated fund for the locality • Councils can fund the Locality Integrated Delivery Collaborative directly if they choose
Locality System Partnership Board (name TBD)	• Receives funding from the GM ICS Partnership Board / GM ICS NHS Board and the Council to create an integrated fund for the locality • The integrated fund is used to fund the Locality Integrated Delivery Collaborative • The Locality System Partnership Board can decide to 'passport' some of its funding to provider collaboratives • The Locality System Partnership Board can decide to spend some of its budget on pan-locality initiatives
Provider collaboratives	• Receive funding from the GM ICS Partnership Board / GM ICS NHS Board • The provider collaboratives have a responsibility to align budgets with localities and indeed will make up part of the relevant Locality System Partnership Board membership
Primary care	• Receives funding from the GM ICS Partnership Board / GM ICS NHS Board
Locality Integrated Delivery Collaborative	• Receives funding from the the Locality System Partnership Board • Provides funding for the locality integrated neighbourhood delivery teams
Locality integrated neighbourhood delivery teams	• Receive funding from the Locality Integrated Delivery Collaborative • The ultimate aim is to work towards delegated funding at a neighbourhood level
Pan-locality collaboration	• May receive some funding from the Locality System Partnership Boards for pan-locality initiatives, but does not hold its own budget

Conclusion

Drawing on our shared principles, we believe the following proposition will best serve our local populations and a provide a proposition for GM that aligns with our ambition to facilitate delivery of health and care consistently in our localities:

- Each locality should form a **strategic partnership board between political, clinical and professional leaders** of health and care
- The board should hold an **integrated fund ,** including resources directly delegated from the GM ICS NHS Board, proportionate to cover the full scope of services as set out on p.16. This will enable decisions that can only be taken when there are shared objectives, a long term version and trust at place level alongside the appropriate mechanisms to move resources across agency boundaries and to plan financially across multiple years
- The integrated funds should build on the total budget that is **pooled or aligned** in each locality currently
- Each locality should establish an **Integrated Delivery Collaborative** as a formal alliance to include partners from the VCSE, wider public services and wider care services e.g. care homes, based on the requirements of the locality
- Provider collaboratives should be **aligned** with localities' strategic plans
- Funding should be **devolved to the Neighbourhood level** as far as possible
- **Pan-locality collaboration** (either across our four localities or in different configurations as appropriate / required) should be progressed where this delivered benefit for localities or GM or both

This would be supported by the following proposition for GM: The GM ICS NHS Board should be organised as a **Committee in Common** with the GM Partnership Board to ensure that health and care are not divided. **Each of the ten localities should be represented on the GM ICS Committee in Common** in order to reflect the interests of all places that make up GM, and not go backwards from our partnership intentions. We recognise that the design of the GM-level governance will need to be discussed and resolved by parties across GM, however this proposal represents our shared view.

Next steps

Next steps

- Refine overarching principles with all partners, including primary care and the VCSE
- Conduct further engagement e.g. with primary care providers and public health commissioners
- Work with all partners (including Councils) to refine propositions for the Neighbourhood-level, including the governance, staff and skill mix required and how this will be organised
- Further review the benefits and alternative propositions for mental health community services with relevant organisations
- Develop a proposition for how the Health and Wellbeing Boards should interact with the Locality System Partnership Boards
- Ensure leadership alignment behind this proposition (including political support)
- Identify potential challenges that need to be worked through and develop mitigating strategies recognising the specific complexities of each locality
- Share this proposition more widely with colleagues in GM
- Identify specific areas, programmes or opportunities to take forward at a pan-locality level – agree the footprint and nature of the arrangements required to do so
- Begin to implement governance proposals and establish new / amend existing governance groups as required in each locality
- Identify any capability gaps at locality level and work with GM ICS to resolve these ahead of formal transition to the new arrangements

Appendix

Transforming health and care in Bury

The refreshed Bury Locality Plan 2019 described a series of key strategic priorities; To secure a step change in Population Health and addressing health inequality , including addressing the wider determinants of population heath, To create the conditions for residents in control of their health and care, To create conditions for residents to be in control of how services are organised around them , To ensure services are delivered closer to home/in home where possible, and reduce reliance on institutional care, To Staff support front line staff in working together in 5 Neighbourhood teams in health & care, and connected to wider public services, and with communities, To secure timely and effective access pathways for more specialist health and care services

The Locality Plan 2019 was also a milestone in creating new models of partnership and collaboration in the Bury health and care system. This included a "one commissioning organization" ethos describing a series joint strategic commissioning arrangements, with joint posts, integrated teams (for example business intelligence and communications), the establishment of the Strategic Commissioning Board with a large pooled budget with S75 arrangements (including adult social care, community health services and some children's services) and all other relevant budgets are aligned or "in view".

The new partnership arrangements also included the launch n 2019 of the Bury Local Care Organisation – a formal alliance of provider partners operating as if a single provider accountable for delivering financially sustainable, joined up all age services at a neighbourhood level: The alliance included Bury Council, GP Federation, Voluntary, Community and Faith Alliance, NCA, Pennine Care, BARDOC Ltd, and Persona Care Ltd.

We have an increasing focus on neighbourhood working as a unit of delivery and common currency for service design for integrated health and care, the alignment of wider public services, and the role of community and voluntary capacity. At the neighbourhood level, community nursing, mental health, voluntary sector, pharmacy and social care work together in joined up teams. There are four Primary Care Networks, supporting resilience and service delivery for primary care.

Our well-established system partnership were relied upon through the Covid period, enabling us to increase and improve out of hospital care; urgent care, accelerated discharges, outpatients which in turn significantly reduced hospital activity to release capacity for Covid patients.

We have also continued our programme of recovery and transformational – bringing system wide focus to transforming elective care, mental health, primary care, and other important themes. And we have recast our Health and Well Being board to operate as a focal point for the population health system programme addressing wider determinants, behaviours change, community connectedness and the contribution of the health and care system to addressing health inequalities.

Case study – active case management

- Patients with long term conditions, particularly vulnerable patients and high intensity users of health and social care, can be at risk of requiring hospital care
- In 2019, Bury set up an active case management (ACM) programme, actively managing care to improve health and wellbeing, enabling patients to remain at home longer and use less reactive specialist care, using a MDT of health, social, voluntary and community professionals
- Outcomes include positive feedback from GPs, improved patient care, efficiency and money-saving for GPs (for example through referrals to Bury Council's Staying Well Team for Older People and pharmacy review), improved access to and communication between services
- ACM may have contributed to the ~~25%~~ decline in Fairfield A&E self-presenting attendances observed in Urgent care data from January 2020 to January 2021

Source: https://burylco.org.uk/wp-content/uploads/2020/11/ACM-Presentation-web-version-1.pdf; https://www.buryccg.nhs.uk/download/governing_body_papers/2017/2017-03-22/08a-Locality-Plan-2017-2021-DRAFT-v1.0.pdf

Our current integration arrangements in Bury

Council

CCG

CCG committees (finance and contract, performance)

Health and wellbeing board

- Works with partners on the wider determinants of health and wellbeing
- Includes senior leaders from Bury council, NHS, Healthwatch, GM Fire, Police, and voluntary and community sectors

Strategic commissioning board (SCB)

- Makes decisions about the priorities and money, with recovery/transformation programmes reporting in
- Includes the clinical cabinet of the CCG, political cabinet of the council, and reps from joint appointments

System board

- Drives strategy, transformation and shared commitment to the work
- Includes leaders from the council, CCG, LCO, Voluntary, Community & Faith Alliance (VCFA), Bury Care Organisation

LCO partnership board

- Drives the joined-up services in out of hospital service
- Is an independently chaired focal point for joined up working arrangements in the provision of community based health and care
- Includes leaders from the council, GP Federation, VCFA, Persona Care Ltd, NCA, BARDOC Ltd and Pennine Care

Recovery and Transformation Board

System-wide oversight of the the programme of health and care transformation

Source: 200812 Health and Care Recovery and Transformation - Overview

In Bury we have an integrated fund (pooled or aligned) of £479m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total	**340.0**	**Total**	**139.0**	**Total**	**38.6**	-	-
Total CCG contribution:	**236.9**	**Total CCG:**	**77.1**	**Total CCG:**	**38.6**		
Acute Services	83.6	Acute Services	76.6	Acute Services - Ambulance Services	8.7		
Community Health Services & Intermediate Care	34.9	Other Programme Services including transformation	0.5	Primary Care Co-Commissioning	28.9		
Continuing Care Services	20.2			Prescribing & Drugs	1.0		
Mental Health & LD Services	36.0						
Other Programme Services inc. transformation	15.8						
Prescribing & Drugs	33.5						
Primary Care Services - Other	9.3						
CCG Running Costs (including staffing)	3.8						
Total LA contribution:	**103.0**	**Total LA:**	**61.8**				
CYP**	12.5	CYP***	29.2				
Department of Operations	1.1	Department of Operations	15.1				
OCO - Adult Social Care Operations	7.6	Art Gallery & Museum	0.7				
OCO - Commissioning & Procurement	56.8	Housing General Fund	0.6				
OCO - Public Health	10.4	Business, Growth & Infrastructure	3.4				
OCO - Departmental Support Services & Workforce Modernisation	4.7	Corporate Core Services	5.6				
Corporate Core Services	7.9	Non-Service Specific	7.2				
Non-Service Specific	2.0						

Of the total CCG budget (£350m), £314m (89%) is pooled or aligned

**including Early Help & School Readiness, Social Care & Safeguarding, Education & Inclusion, Children´s Commissioning
*** including Social Care & Safeguarding and Education & Inclusion

Source: Pooled Budget Breakdown for CF Q3 SCB report (2021)
OCO: Oldham Care Organisation

Building an alliance in Oldham to enable a tailored neighbourhood approach

Oldham has a strong history of working together, a place where everyone is encouraged to do their bit to create a confident, prosperous and ambitious place to live and work. Oldham Cares was set up in 2016 as a one-system approach bringing together Oldham Council, CCG, GPs and other health and social care providers together. Oldham Cares covers all CCG commissioning, adult social care, children's services, public health, mental health and learning disabilities as well as primary, community and acute care.

The model has three interdependent goals: building thriving communities that are resilient and supported, through co-operative services which focus on delivering social value, helping work towards an inclusive economy. By working in this way, we aim to:

- Support people to be more in control of their lives
- Have a health and social care system that is geared towards wellbeing and the prevention of ill health
- Ensure good access to health services at home and in the community

Until recently Oldham was set up as an alliance of 13 different organisations but has recently moved to describe the partnership core as comprising five main entities: the Council, CCG, NCA (acute and community), the mental health trust and 5 GP networks. There is a strategic joint commissioning board with S75 arrangements in place to pool budgets between health and social care. This has enabled us to move resources around to meet urgent needs of the population, for example our discharge hub, digital hub and Emergency Department streaming. More recently, local flexibility, openness and existing integration have also enabled a faster Covid response including deployment of teams in a fast and organisational employer neutral way.

Oldham has worked hard on developing a neighbourhood approach and enabling care closer to home. Flexibility in local decision-making has enabled us to deliver a more holistic and tailored approach for the local population, for example the introduction of Oldham's Health Check which includes specific checks on diabetes and mental health, and gives patients a quick route into follow-up services. Our care delivery teams are fully integrated at PCN level.

Case study – Vaccination

- The JSNA highlights Oldham's large and growing BME communities, as well as high deprivation levels
- Insight into the population using the Thriving Communities Index has enabled risk stratification and active engagement of people least likely to take up the vaccine
- Clinical, political and community leadership have supported targeted interventions, including GPs and politicians going door-to-door, some of the UK's biggest vaccine pop-up clinics, very early vaccination of homeless people and steps to increase vaccine uptake in BME communities
- These proactive steps have resulted in Oldham's 1st vaccine uptake % being close (within 2%) to the GM average, despite Oldham's high levels of deprivation and associated barriers

Source: http://www.oldham-council.co.uk/jsna/wp-content/uploads/2018/11/Oldham_in_Profile_2019.pdf; https://www.local.gov.uk/oldham-council-and-unity-partnership

Our current integration arrangements in Oldham

Council

CCG

CCG committees (finance and contract, performance)

Health and wellbeing board

- Owner and responsible body for driving the work and priorities outlined in the Health and Wellbeing Strategy and the Oldham Locality Plan and producing the Joint Strategic Needs Assessment
- Includes CCG, local authority, housing and police representation

Strategic joint commissioning board / Commissioning partnership board

- Supported by a joint commissioning team with pooled delegated budgets through a section 75 agreement.
- Includes representation from the council (including Leader, Children's Services and Health and Social Care), CCG (including chair, clinical and financial officers)

ICO alliance board

- Oldham Cares Alliance Board operates as a joint executive management team overseeing the delivery of the alliance agreement and service transformation

In Oldham we have a total integrated fund (pooled or aligned) of £449m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total	**448.7**	-	-	**Total**	**29.0**	**Total**	**206.1**
CCG total:	**360.2**			**CCG Total:**	**29**	**CCG Total:**	**56.7**
Acute Services	194			Acute Services	18.4	Primary Care Services	12.9
Community Health Services	42.5			Acute - Emergeny Transport	10.6	Primary Care Co-Commissioning	39.5
Continuing Care Services	16.4					Running Costs	4.3
Other Programme Services	17.5						
Mental Health Services	43.9						
Prescribing	45.9						
Council Total:	**88.5**					**Council Total:**	**149.4**
						People and Place	61.3
Better Care Fund	11					Childrens Services Inc. Social Care	54.1
Community Equipment	0.7					Communities and Reform Inc. Public Health	34.3
DFG (Capital)	2.1					Commissioning	9.4
Learning Disability	18.8					Chief Execs	6.9
Mental Health	13.5					C and T	10.2
Physical Support	29.3					Community Health and Social Care	-26.8
Sensory Support	1						
Support with Memory & Cognition	3.1						
Other Adult Social Care	9						

Of the total CCG budget (£446m), £360m (81%) is pooled or aligned

All CCG budgets are Integrated Single Finance System

Source: S75 Split for Carnall Farrar 31.3.21 (2020/21)

Working together to provide the best care we can in Rochdale

We started work on integrated care in Rochdale back in 2013 due to the reconfiguration of acute care. Commissioners tendered for some out-of-hospital services, and Pennine Acute saw the opportunity to deliver both hospital and community services in a streamlined an integrated way. When the contract went live in 2015, it did so through a partnership board, with involvement of primary and mental health care, carers' services, local authority, housing, voluntary and the third sector. We were therefore already on our integration journey prior to the GM devolution deal, and we now have a mature locality system with a strong history of partnership working.

Our Integrated Commissioning Board is made up of the Local Authority and CCG, and is responsible for oversight of plans to make best use of resources in Rochdale. We have a pooled budget in place covering adult's and childrens' services, including a joint savings programme. In addition we have also established a joint LA/CCG Executive leadership team which works across the whole remit of the LA and CCG. Our Integrated Commissioning Directorate, with single leadership across the CCG and LA, has been in place for three years, further enabling the bringing together of political, clinical and managerial leadership. This integration has also allowed for more consistency across organisations e.g. Real Living Wage, sick pay, maternity leave etc.

Our Local Care Organisation was established in 2017. There is a contract in place with the LCO, with Pennine Acute as the lead provider. The LCO contract currently includes Integrated Neighbourhood Teams, Intermediate Tier of Service and primary care discretionary spend. The LCO has a partnership agreement in place which includes Primary Care, Mental health, Adult Social Care, Community and Acute Care and voluntary sector. Primary care is represented in this agreement through the GP Federation, the out of hours provider and primary care network directors.

Our plans to include the programme budget for urgent care into the LCO Contract were hampered by command and control arrangements implemented through Covid. However, as a locality we have operated as though we have contracted in this way with the LCO taking a lead on urgent care system development. An LCO Executive Leadership Group has been established which has provided a mechanism to unblock organisational barriers and implement system change quickly and effectively.

The reasoning for all these closer links across commissioners and providers is very simple: we all want to work together to provide the best care we can within the Rochdale pound for the Rochdale people, and improve their health and wellbeing. As a result, we have seen some impressive improvements. We have halved our intermediate care length of stay by changing the delivery model and supporting self-care and community resilience. Our lengths of hospital stay and delayed transfers of care are reduced and we are turning the curve compared with other areas and are managing the growth in A&E attendances.

Case study – Discharge

- Different pathways, access criteria, protocols and discharge arrangements exist across the localities
- Building on previous pilots, Rochdale's 'Discharge to Assess' scheme is fully mobilised, aiming to get people home as soon as they are fit (or to a specific Discharge to Assess bed if the patient is not ready), to reduce the number of excess bed days
- Joint working between health and care colleagues has meant Rochdale has well established and successful discharge mechanisms
- Changes in discharge arrangements have been beneficial, alongside news ways of working for neighbourhood teams and joined up communication

Source: https://improvement.nhs.uk/resources/discharge-assess-home-day/; https://www.england.nhs.uk/blog/bold-moves-towards-integrated-care/
Integrated Commissioning Board Annual Review; https://www.england.nhs.uk/blog/bold-moves-towards-integrated-care/

Our current integration arrangements in Rochdale

Council

CCG

CCG committees (finance and contract, performance)

Health Overview and Scrutiny Committee

- Reviews and scrutinises local health services and matters relating to the planning, provision and operation of local health services
- Includes Rochdale Borough Councillors

Integrated commissioning board (ICB)

- Overseeing a pooled budget and with delegated authority for all health and care spend where possible to delegate
- Includes CCG governing body members and Rochdale Borough Councillors

LCO Board

- Responsible for organising and delivering care locally for the people of Rochdale
- One Rochdale Health and Care Board includes health and care sectors, including voluntary and leaders from across the system (commissioner and provider)

Strategic Place Board

- Works with partners on the wider determinants of health, with specific focus on tackling health inequalities
- Formerly the Health and wellbeing board
- Includes local authority and CCG representatives and the local HealthWatch

Clinical and Professional Advisory Board

- Ensures clinical and professional advice is provided across the health, public health and social care agenda

Bridging team

- In place since January 2020, works across commissioning and the LCO to facilitate joint working, and has contributed to joint ownership across the system

Source: Framework partnership agreement relating to the commissioning of integrated health and social care services (S75 Pooled Budget 20202021 Final.pdf)

In Rochdale we have a total integrated fund (pooled or aligned) of £512m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total (pooled or BCF)	**401.9**	**Total***	**110.4**	-	-	**Total**	**23.7**
Total Pooled budget:	**361.7**	**Total from CCG**	**100.7**			**Total from CCG**	10.7
Acute Services	139.2	Acute Services	49.3			Ambulance Service	9.9
Learning Disability / Mental Health	66.1	Primary Care & Co Commissioning	45.9			Continuing Health Assess/Supp	0.8
Adults, Older People & Physical Disability	43.7	Core Running Costs	4.1				
Primary Care Prescribing	40.9	Other CCG	1.3				
Other Adults services	14.5						
Cared for Children and Safeguarding	30.7						
Children's Health Community Services	7.2	**Total from council**	**9.7**			**Total from council**	13.0
Other Children's services	19.4	Health Protection	0.2			Children's Social Care/Schools	13.0
		Physical Activity	0.5				
Total Better Care Fund	**32.9**	Other Public Health	1.2				
		Link4Life	2.4				
Adult Social Care**	3.0	Management and Strategy	0.2				
Public Health**	0.3	Shared Services with Bury	0.6				
Children's Social Care**	4.0	Sufficiency and Access	0.0				
		School Improvement, Org. and Personnel	0.9				
		Educational Psychology/ coordinator	0.5				
		Regional Adoption Agency	1.3				
		Public Health**	1.6				
		Children's Social Care**	0.5				

Of the total CCG budget (£385m), £374m (97%) is pooled or aligned

* planned figures for services which sit outside of the pooled budget, not under the control of the ICB. Decision making around these budgets remains with the LA or CCG

** uncontrollable budgets such as depreciation and internal recharges within the LA

Source: S75 Pooled Budget 20202021 Final.pdf; Direct communication with Jonathan Evans

Salford's journey of integrating health and care

Salford has a strong history of planning and delivering integrated health and care services, working in partnership in an ever-increasing way. Our boundaries are coterminous and we have benefited from a healthy financial position historically, placing us in an ideal position to take forward arrangements for integrated care. We are proud to have been recognised for our good practice: this includes a CCG rated outstanding for 5 years, an outstanding hospital (with a customer care focused experience), 3 outstanding GP practices and council and very good mental health services. Salford is the only area in GM with a specific care homes practice, which is run by SRFT. We also have our own local clinical assessment system (LCAS), which is flagged as gold standard within GM.

Our journey towards integration started with a shared vision: Salford people will start, live and age well . This means people in Salford will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health into their older age and die in a dignified manner in a setting of their choosing. Our aim is for people across Salford to experience health on a parallel with the "best" in GM and for the gaps between communities to be narrower than ever. Aligning around this has enabled successful interchange of views, innovation, and effective and joined-up solutions to problems.

We have had a pooled budget between the NHS and the Council since 2001 for adult learning disabilities and community equipment. We then expanded our approach to integrated commissioning and integrated resourcing to cover all of Older People's Services in 2013. In 2015, we became one of eight national Primary and Acute Care NHS England Vanguards to test new models of care. We subsequently expanded the scope of integration to all Adult services in 2016, with the provision of Adult Social Care transferring to Salford Royal Foundation Trust from the Council, integrating with community health services and establishing the Salford Integrated Care Organisation (ICO), one of the first ICOs in England (now Salford Care Organisation).

In the same year, we increased our pooled budget to over £300m, covering public health and health and care service budgets for all adults. This was then extended to children and public health in 2019, meaning we now have a single integrated health and care fund for children's, public health, adults and primary care spend. Whilst we have had an integrated commissioning team for joint decision making between the CCG and the Council in place since 2010, we have since revised our governance structures and commissioning architecture to reflect the latest Integrated Fund developments. As a result of our efforts we have seen many benefits, including a 5% reduction in A&E admissions (pre-Covid), Adult Social Care outcomes above national benchmarks, social prescribing reducing prescription medicines, rapid and significant improvement in Care Home CQC ratings.

Case study – Adult's Integrated Care programme

- Salford has had a 5-year invest to save approach to resourcing, integrated planning and delivery, investment in community support and prevention and sophistication of risk sharing arrangements in social services
- A specific initiative was Salford's Adults Integrated Care Programme (ICP), made up of 12 projects testing new ways of integrated working from 2017-2020
- Evaluation of the ICP found a reduction in non-elective admissions of 3.7%, and a reduction in A&E attendances of 0.7% (3,400 fewer per year than a comparison group). Both are signs of success across many of the 12 projects
- In addition, the ICP evaluation found examples of improvements in quality of life measures and both patient and staff experience across the 12 projects

Source: Salford's Proposed Place Based Approach
Evaluation of Salford Together: Adults Integrated Care Programme (ICP)
Salford Integrated Commissioning Partnership Agreement V1.0.pdf

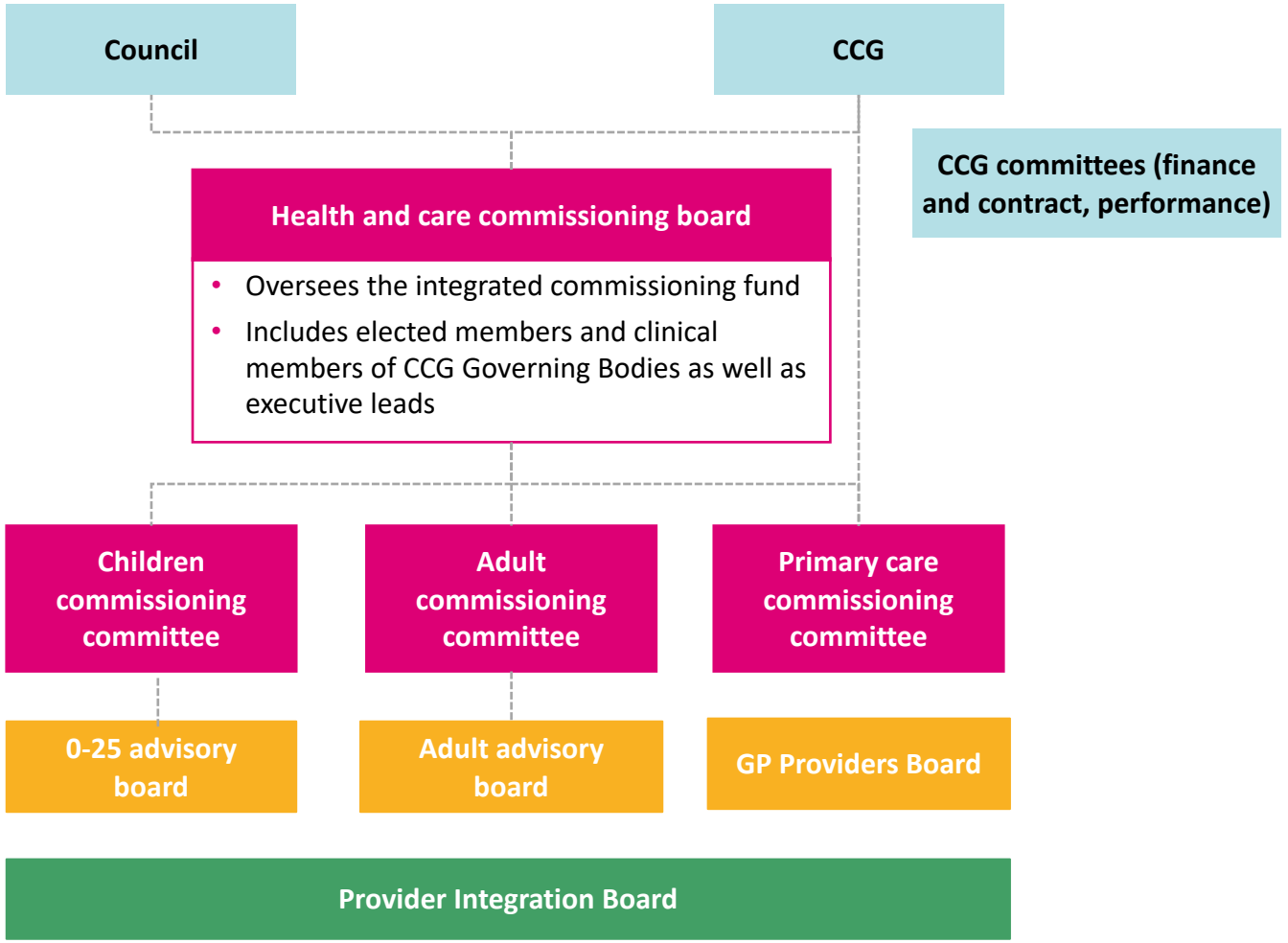
Our current integration arrangements in Salford

Health and Social Care Scrutiny Panel

- Scrutinises committees and monitors the performance of the authority and reviews policies against the strategic plan
- Includes Councillors, Healthwatch and Salford CVS representation

Health and Wellbeing board

- Works with partners on the wider determinants of health and ensures Salford has a Joint Strategic Needs Assessment
- Includes representation from the local authority, CCG, Healthwatch, Salford Primary Care Together and the voluntary sector, among others



Source: Salford Integrated Commissioning Partnership Agreement V1.0.pdf

In Salford we have an integrated fund (pooled or aligned) of £607m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total	**424.4**	**Total***	**182.3**	**Total***	**30.8**	-	-
		*All CCG funded		*All CCG funded			
Acute services	139.0	Acute services	78.4	In view series	20		
Community services	42.5	Adults Community Services	0.1	Committed developments	4.8		
Adult Social Care	100.5	Adults Ambulance Services	10.3	Running costs	5.9		
Adults Mental health services	43.4	Adults NHS 111	0.8				
Adults Continuing Health Care & Nursing Care	6.7	Termination of Pregnancies	0.6				
Adults Public Health Services	8.4						
Adults Committed Developments	3.3	Total Primary Care:	**92.1**				
Other children's services**	89.8	Co-Commissioning	40.5				
		Locally Commissioned Services	8.0				
		Prescribing	40.9				
		Out of Hours	1.7				

Of the total CCG budget (£474m*), £443m (94%) is pooled or aligned

* Total CCG budget is the sum of the CCG funded Aligned and 'In view' services with the Total Pooled services, minus the Council income to the integrated fund. The Total Council income into the integrated fund was £163.3m (£79.8m Children's services, £83.5m Adults services)

**including Safeguarding, Looked After Children, Localities, Complex Needs SEN, Partnerships, Asset Management & Delivery, Transforming Learning, Skills & Work / Careers, Helping Families, Resources & Investment, Children's Administration, Specific Grants, PH Looked After Children (next steps post), PH 0-19 Services, Home Safety, Early Years, Youth Service, Placements/Non Contracted Activity

Source: SFG Finance Papers 2019-20 Final.xlsb (2019/2020 figures)

Note: Total Council income into the integrated fund is £163.3m (£79.8m Children's services, £83.5m Adults services)

Engagement - Interviews

Name	Role	Organisation
Dr Jeffery Schryer	Chair	Bury CCG
Will Blandamer	Executive Director for Strategic Commissioning	Bury CCG / Council
Cllr Eamonn O'Brien	Leader	Bury Council
Geoff Little	Chief Executive & Accountable Officer	Bury Council / CCG
Tyrone Roberts	Chief Officer & Nursing Director	Bury Care Organisation (NCA)
Warren Heppolette	Executive lead for Strategy & System Development	GM Health and Care Partnership
Sarah Price	Chief Officer	GM Health and Care Partnership
Neil Thwaite	Chief Executive Officer	Greater Manchester Mental Health NHS FT
Raj Jain	Chief Executive	NCA
Ian Moston	Director of Finance and Information	NCA
Judith Adams	Executive Chief Delivery Officer	NCA
Jack Sharp	Chief of Strategy	NCA
Jo Purcell	Director of Strategy	NCA
Bill McCarthy	North West Regional Director	NHS England / Improvement
Mike Barker	Strategic Director of Health and Resources & Chief Operating Officer	Oldham CCG / Council
Cllr Dr Zahid Chauhan	Cabinet Member for Health & Social Care	Oldham Council
Dr Carolyn Wilkins	Chief Executive & Accountable Officer	Oldham Council / CCG
Claire Molloy	Chief Executive Officer	Pennine Care NHS FT
Steve Taylor	Chief Officer and Managing Director	Rochdale Care Organisation – NCA
Chris Duffy	Clinical Chair	Rochdale CCG
Claire Richardson	Director of Strategic Commissioning & DASS	Rochdale CCG / Council
Cllr Allen Brett	Leader of Council	Rochdale Council
Cllr Daalat Ali	Lead member for Health	Rochdale Council
Steve Rumbelow	Chief Executive Officer / Accountable Officer	Rochdale Council / CCG
Karen Proctor	Director of Commissioning	Salford CCG
Dr Tom Tasker	Chair	Salford CCG
Steve Dixon	Accountable Officer	Salford CCG
Cllr John Merry	Deputy City Mabyor	Salford City Council
Tom Stannard	Chief Executive	Salford City Council
Dr Peter Turkington	Chief Officer and Medical Director	Salford Care Organisation (NCA)
David Jago	Chief Officer & Finance Director	Salford Care Organisation (NCA)

Engagement – Workshops and meetings

Workshop	Date	Attendees
Initial locality proposition development session	15/03/2021	Jack Sharp, Jo Purcell, Karen Proctor, Will Blandamer, Mike Barker, Claire Richardson
Bury	23/03/2021	Geoff Little, Cllr Eamonn O'Brien, Dr Jeffrey Schryer, Will Blandamer, Pat Crawford, Lisa Kitto, Kath Wynne Jones, Julie Gonda
Oldham	17/03/2021	Mike Barker, Bal Duper, Dale Phillipson, David Jago, Elizabeth Foster, Ben Galbraith, Karl Dean, Julia Veall, Karen Maneely, Mark Warren, Salim Mohammad, Rebekah Sutcliffe, Claire Smith, Tamara Zatman
Rochdale	19/03/2021	Steve Rumbelow, Claire Richardson, Cllr Daalat Ali, Dr Bodrul Alam
Salford	18/03/2021	Dr Tom Tasker, Paul Dennett, Karen Proctor, Charlotte Ramsden, Tom Stannard, Muna Abdelzaziz, Cllr Merry, Raj Jain, Dr Peter Turkington, Alison Page, Neil Thwaite, Cllr Reynolds, Gillian McLaughlan
Locality proposition refinement session	24/03/2021	Raj Jain, Dr Carolyn Wilkins, Steve Rumbelow, Tom Stannard, Steve Dixon, Jack Sharp, Jo Purcell, Karen Proctor, Will Blandamer, Mike Barker, Claire Richardson

Finance mtg	Date	Attendees
Bury	22/03/2021	Carol Shannon-Jarvis, Lisa Kitto, Sam Evans, Pat Crawford, Simon O'Hare
Oldham	19/03/2021	Alistair Ross, Ben Galbraith, Amanda Fox
Rochdale	17/03/2021	Sam Evans, Jonathan Evans
Salford	22/03/2021	Phil Kemp

In addition, representatives from each locality and the NCA (Mike Barker, Will Blandamer, Karen Proctor, Jo Purcell, Claire Richardson, Jack Sharp) have met on a weekly basis as a task and finish group to oversee the development of this work.

Detail of specialised services to be planned at the GM level

NHS England

GM: Devolved Specialised Services

Internal Medicine	Cancer	Blood & Infection	Trauma	Women's & Children's	Mental Health (from April 2018)
Cardiac Surgery Cardiac ICD/CRT Cardiac MRI Cardiac EP and Ablation Cardiac PPCI Vascular Surgery Complex IBD Faecal Incontinence TEMS Surgery Acute Kidney Injury Renal Dialysis	OG Cancer Kidney Bladder Prostate Cancer Chemotherapy (Adult) PET-CT Head & Neck Cancer Thoracic Surgery	HIV (Adult) Specialised Immunology Specialised Allergy	Specialised Rehab Neurosurgery (Adult) Specialised Neurosciences Specialised Orthopaedics Specialised Ophthalmology Complex Spinal Surgery Major Trauma Implantable Hearing Aids (BAHA)	Paed Rheumatology Paed Endocrinology & Diabetes Paed Respiratory Paed Allergy Neonatal Critical Care Gynae: Endometriosis Gynae: Urogenital/Anorectal Gynae: Incontinence/Prolapse Gynae: Cancer	**CAMHS Tier 4 General Adolescent** **CAMHS Tier 4 Eating Disorders** **Adult Inpatient Eating Disorders** **Specialised Perinatal Mental Health – Mother and Baby Unit** **Low Secure Mental Health** **Low Secure and Forensic Support Team Services - Learning Disabilities**

Key:
•New Specialised Mental Health Services added to the GM Devolution Portfolio From April 2018

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