GM ICS Funding Flows

August 2021

Context

- This draft has been developed by FAC and discussed and will be agreed by FAC and then FLG and the GM ICS Transition Board as the basis for initial discussions with colleagues in GM as part of the ongoing development of the GM ICS

- The funds flow must be preceded by, and be seen in the context of plans for governance and spatial levels of activity and decision making, as part of the workstreams overseen by the GM ICS Transition Programme Board, PEB and emerging governance

- The draft has no formal status at this stage and no decisions have been made. A worked up proposal is planned for the FLG on 24th August and then the Transition Board on 26th August

- The next worked up proposal will be developed from the current draft, comments received during August, national guidance, legal proposals and the outputs from other workstreams

- Many views from stakeholders have already been incorporated but groups are continuing to provide constructive input and this work will need to be re-visited in the light of other outputs, particularly from the Spatial Levels and Financial Strategy work.

- Whilst the financial flows are important, the system also needs to develop a robust financial strategy and medium term financial plan. This work will start in September.

Introduction – What we know…

- We expect approximately 2/3 of GM NHS Funds to come into the GM ICS Board from NHS E. However, the other 1/3 will be received directly by NHS Providers, e.g. from HEE for training posts or for specialist services, and the funds flow for these is TBC.

- The GM system is starting from a position of a significant recurrent financial gap, which was estimated to be at £650m (based on H1 planning). Over recent years this has been managed through non-recurrent solutions and re-prioritisation of funding. Permanent solutions will be needed through improved delivery of recurrent savings from all parts of the Health and Care system.

- We expect contract funds to flow directly, once, from the GM ICB to acute and community and mental health trusts, primary care providers and independent sector. We expect this to be nationally mandated. In the first year at least we expect each individual trust to receive a direct contract and funds. It is possible over time for provider collaboratives, e.g. PFB or PCB, to collectively receive some funds for GM wide programmes.

- The Locality System Partnership Boards will have wide representation and be the decision making body for Locality responsibilities. The Locality System Board will collectively determine the pooling arrangements, the success of these groups will be based upon the strength of the trust and relationships within the Locality

- We know that we will be allowed to determine the financial governance and flows within the GM ICS subject to agreeing clear lines of accountability along with our ability to provide financial reporting and meet NHS financial governance

What is Financial Flows?

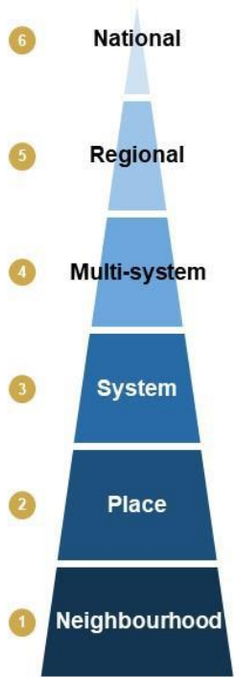
Financial Flows work describes

- Where financial decisions are made – in line with other GM ICS development work on spatial levels work and governance
- How funds / allocations will move around the system

There are a number of things it will not describe:

- The Spatial Levels work will define the responsibilities of GM and of Localities in designing and managing service pathways and funding. Initial guidance from National Provider Collaborative guidance is shown on the next slide
- The Financial Strategy will describe our approach to Budget setting, savings delivery and how we address health inequalities
- The Governance work will define the pooling and decision making arrangements in each Locality and explore how these will fit with current Section 75 arrangements

Spatial Levels



Services	Predominant collaboration partners	Collaboration arrangements	Activities
• Life sciences • Highly specialist services	• Specialist providers • Research universities • Industry	• AHSCs, AHSNs • Public-private partnerships	• Services need to be planned and coordinated on a broader footprint than a single ICS, working with neighbouring ICSs, other providers and national commissioners. • Provider collaboratives might span levels 4 and 5 but even when they are not, they must be sighted on decisions relating to the delivery of services at levels four to six in order to understand and calibrate the use of its collective resources for the delivery of all provider collaborative priorities. • Linked to commissioning of 999, 111 and IUC over multi-ICS as a Lead Provider model
• Highly specialist services • Specialised services	• Specialist NHS providers across a large geographic footprint	• Specialist clinical networks • Provider collaboratives	
• Specialist and specialised services • Community and mental health • Access to UEC	• Providers working over multiple ICSs	• Specialist clinical networks • Provider collaboratives	
• Elective and non-elective secondary care • Inpatient, crisis and specialist mental health, learning disability and autism • Community	• Providers working across an ICS • Providers with patient flow into an ICS	• Provider collaboratives	• Services in Level 3 are primarily delivered on an ICS footprint. • These services therefore particularly lend themselves to planning, coordination and delivery through a provider collaborative.
• Community health • Community mental health • 'Front door' acute • Social care	• Providers • GPs • LAs • Voluntary sector	• Place-based partnerships • ICP contracts	• Services in levels 1 and 2 are likely to be planned and coordinated at borough (place) level and delivered at neighbourhood or borough level, depending on the service in question. The primary "vehicles" for collaboration in these layers are place-based partnerships (of which the members of provider collaboratives are key partners). • Provider collaboratives play a role in areas where they can add value for at scale collaboration, across multiple places. but they should not duplicate work within each place.
• Primary care • Public health and wellbeing • Prevention • Community health • Social care	• Providers • GPs • LAs • Voluntary sector	• Primary Care Networks (PCNs) • Integrated multi-disciplinary teams	

- This is taken from the NHS E/I guidance on provider collaboratives, "Working together at scale"
- There is an ongoing GM piece of work on Spatial levels which will determine the decision making responsibilities of each part of the system

Locality Strategic Partnership Boards

We expect Localities to be able to influence service delivery through decision making at the Locality Partnership Boards over the pooled funds.

"Pooled" *services and budgets are where one organisation holds funding from a number of different sources to commission/deliver a single integrated service.*
"In Sight" *budgets are those reported alongside pooled budgets because improved understanding of the investments, cost pressures or savings will aid understanding of how best to deploy the pooled budgets.*

- Section 75 legal agreements can help systems deliver a common goal by merging funding from different sources and allowing the most appropriate vehicle to be utilised. The act of pooling budgets does not in itself deliver savings or improve outcomes. But it can remove barriers to achieving those goals.

- Section 75 agreements across GM have a range of approaches across different aspects :
    - Which organisations are party to the Section 75 agreement
    - Which services and budgets are pooled
    - How overspends are dealt with
    - Which organisation hosts the pooled budget

  Currently undertaking baseline work to capture the variation in agreements across GM and yet to describe where consistency of approach will be needed

- The nature of Section 75 agreements and the role that different partners play within the arrangements are likely to be evolve significantly in the future. In particular, Providers have historically not been signatories in most Localities in GM.

GM Integrated Care Board (A)

- All NHS funding must be received into the GM ICB and it holds the statutory authority and responsibilities for the ICS, with delegation to other bodies made from here.

- The GM ICB will be supported by the future governance model as agreed including the Health and Care Partnership and the Joint Planning and Delivery Committee

- The Finance Strategy will set out our approach to budget setting, responsibility for delivery of savings and how we address health inequalities. This will balance the need to fund the costs already in the system and fairly address the System Financial Gap estimated to be at £650m (based on H1 planning)

- NHS Funding to be allocated across Localities, Providers and GM Central functions. In line with our agreed principles we need to start with funding the costs structures that we already have in place.

- The GM ICB will formally set out the responsibilities expected accountabilities and NHS funding agreements through contracts (for provider organisations) and accountability agreements (for Localities). There will be one such agreement for each organisation encompassing all historic funding streams and responsibilities.

Local Strategic Partnership Board (F)

We expect that the Local Strategic Partnership Board will operate as a Joint Committee arrangement (although there may be other options as this has not yet been agreed across GM) with the GM ICB and other Locality partners and be responsible for driving improvements for the health of the local population. The role of the Locality Strategic Partnership Board in relation to Finance and Financial Governance is:

- It has a mechanism for engagement with all Locality stakeholders and clinical disciplines, including all wider primary care disciplines

- It has delegated authority from the GM ICB and ensures terms of accountability agreement with GM ICB are met (e.g. delivery of financial targets)

- It may oversee the financial performance of those services agreed to be "Pooled" and "In Sight". The cash will follow the route specified in the accountability agreement which could be pooled through GM ICB, NHS Provider or Local Authority – subject to the necessary transparency, reporting and financial governance. Further national guidance is expected in this area.

- It makes decisions on changing the utilisation and/or deployment of local resources, taking into account the impact of those services and budgets which are "In Sight" but not pooled

- It is the mechanism through which Localities make decisions on delivery of savings plans and agree local investments, respecting how each Locality agrees the balance of responsibilities held by the system and by individual organisations

Provider Trusts (B) + GM Central Functions (C) + Primary Care core contracts (D) + GM ICS Localities (E)

There will only be one contract per organisation, although depending on the outcome of the Spatial Levels work, this may encompass services for which decisions are made in different places.

- "NHS Provider Trusts", box (B), are currently expected to continue to operate as separate legal entities, but with co-operation and joint decision making on specified areas through provider collaboratives, e.g. the GM NHS Provider Federation. It is expected that NHS Provider Trusts will take on an expanded role for combining and managing existing sub-contracts and leading Locality Provider collaboratives.

- The "GM Central Functions" box (C) represents all staff and operating budgets, both for those functions which will be undertaken at GM level and for those functions which will be deployed back into Localities. These would not be pooled or delegated to Localities.

- The "Primary Care Core Contracts" box (D) represents the GP Practices, Dentists, Community Pharmacies and Optometrists. This includes all funding streams, both "core" and "additional" – although work is ongoing to categorise the funding streams and consider how these flows will operate in future. Use of the 'Additional' funding to be agreed at LSPB.

- The "GM ICS Localities" box (E) represents all other contracts and budgets which will be managed through the Locality Strategic Partnership Board

GM ICS REVENUE FUNDING FLOWS
DECISION MAKING AND CASHFLOWS – DRAFT

SPEC COMM, HEE & OUT OF AREA FUNDING

A

GM INTEGRATED CARE BOARD – ALL ALLOCATIONS

B

NHS PROVIDER TRUSTS

GM ICB contracts/works with each Provider Collaborative and contract directly (once) with each individual Provider

* ACUTE & COMMUNITY
* MENTAL HEALTH

C

GM ICB FUNCTIONS

INCLUDING ASSOCIATED RUNNING COSTS

D

PRIMARY CARE

GM ICB contracts/works with Provider Collaborative and contracts directly with each individual Provider

ALL FUNDING 'CORE' AND 'ADDITIONAL' PAID DIRECT TO PROVIDERS. USE OF THE 'ADDITIONAL' FUNDING TO BE AGREED AT LSPB.

E

GM ICB LOCALITY DELEGATIONS

Services and budgets agreed to be delegated to Locality level for decision making

Encourage collaboration across Localities on pathways and contracting to ensure consistency of offer to residents and workforce

Section 75 could be Hosted by any mix of GM ICB, Local Authority or an NHS Provider Trust

** As part of agreed integrated local care organisation arrangements*

F

LOCAL STRATEGIC PARTNERSHIP BOARD
(Operating as a Joint Committee)

ALL LOCAL RESOURCES IN SIGHT THROUGH S75 POOLED/ALIGNED BUDGET ARRANGEMENTS BETWEEN RELEVANT KEY PARTNERS

LOCAL AUTHORITY DELEGATED FUNCTIONS & ASSOCIATED BUDGETS

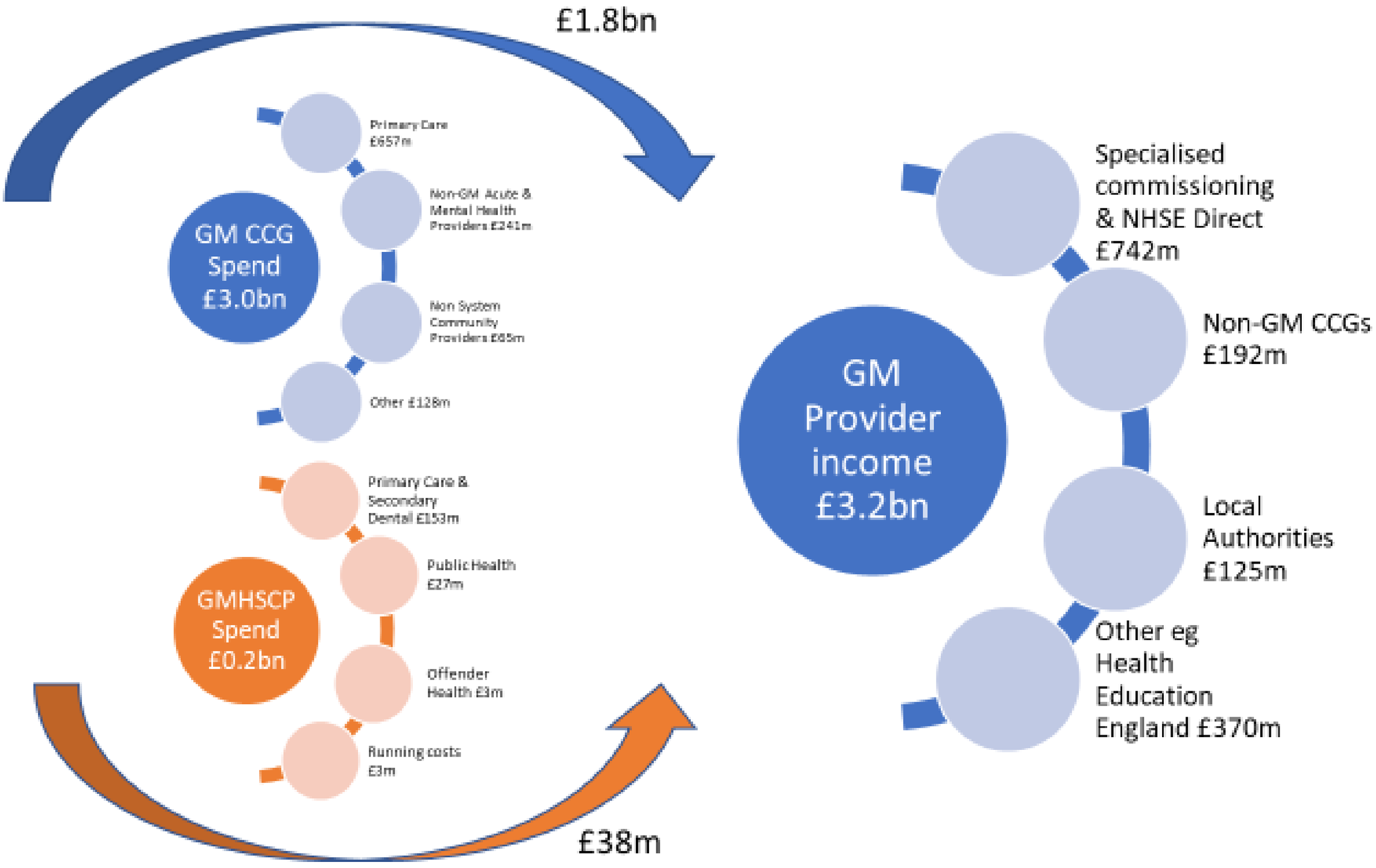
ENSURES SOCIAL CARE AND WIDER DETERMINANTS OF HEALTH AND POPULATION HEALTH MANAGEMENT IS AT THE HEART OF LOCAL DECISION MAKING

Flow of funding / allocations
Alignment of funding
S75 pooled funding opportunities

LOCAL SUPPORTING GOVERNANCE ARRANGEMENTS

THE WHOLE SYSTEM IS THE INTEGRATED CARE ORGANISATION

GM NHS H1 funding (ie half-year)



Key messages

- Financial Flows describes the places financial decisions are made and the way cash moves in the system
- Financial Strategy describes the way that the GM ICS will set budgets, deliver savings and address health inequalities. This work will start in September
- Outcome of the Spatial Levels work will determine the decision making to be undertaken at GM ICB, Local Strategic Partnership Boards and in the GM Provider collaboratives.
- GM ICS has an overall System Financial Gap estimated to be at £650m (based on H1 planning). The H2 Planning guidance will require us to develop and deliver recurrent savings programmes.

Next Steps

- This draft has been considered in a wide range of groups and the views of those groups incorporated into this updated version
- It is only able to serve as a simplification of the eventual financial governance – which will also be subject to local nuance
- This work will need to move into a more detailed stage of development once the outputs of the Spatial Levels work is available to give greater specificity to the ideas set out here
- These slides will be presented at the GM ICS Transition Programme Board on 26th August