Report to OVERVIEW AND SCRUTINY BOARD / COMMITTEE

HEALTH & CARE BILL IMPLEMENTATION UPDATE

Portfolio Holder:
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Purpose of the Report

To provide an update to Overview and Scrutiny Committee for Health on the progress in relation to the implementation of the Health & Care Bill.

Executive Summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we continue to respond, Integrated Care Systems (ICSs) will now play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities. Throughout the pandemic people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation

created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

This comprehensive paper provides members with an update on the implementation of the Health and Care Bill at Greater Manchester level and an Oldham level.

Recommendations

The Committee is asked to ‘NOTE’ the update.

Implementing the Health & Social Care Bill

Background

1. Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area.

2. They exist to achieve four aims:

   - **improve outcomes** in population health and healthcare
   - **tackle inequalities** in outcomes, experience and access
   - enhance **productivity and value for money**
   - help the NHS support broader **social and economic development**.

3. Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government set out plans to put ICSs on a statutory footing.

4. Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

   - improving the health of children and young people
   - supporting people to stay well and independent
   - acting sooner to help those with preventable conditions
   - supporting those with long-term conditions or mental health issues
   - caring for those with multiple needs as populations age
   - getting the best from collective resources so people get care as quickly as possible.

5. A target date of 1 July 2022 was agreed for new statutory arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. That replaced the previously stated target date of 1 April 2022. It was agreed to provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

6. Under the Health & Care Bill, a statutory ICS would be led by two related entities operating at system level – an **'ICS NHS body'** and an **'ICS health and care partnership'** – together, these will be referred to as the ICS.

7. Each **ICS partnership** is responsible for agreeing an integrated care strategy for improving health care, social care and public health across their whole population, using the best insights from data available, built bottom-up up from local assessments of needs and assets identified at place level and focusing on reducing inequalities and addressing the consequences of the pandemic for communities.

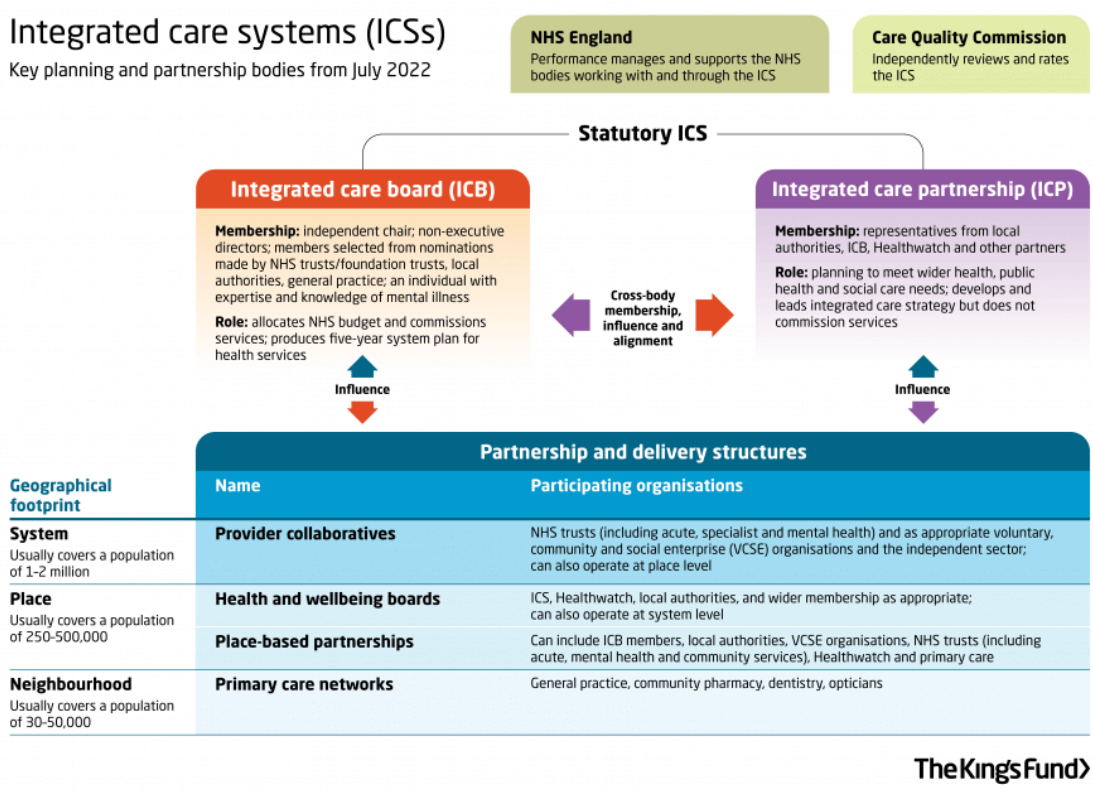
The ICS partnership is expected to be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Local authorities that provide social care services in the ICS area and NHS organisations must be included. Beyond this, members may be from health and wellbeing boards, other statutory organisations, VCSE sector partners, social care providers and organisations with a relevant wider interest such as employers, housing and education providers. The membership may change as the priorities of the partnership evolve.

8. By comparison, each **ICS NHS body** is the employer and recipient of the national allocation and is specifically responsible for:

- Developing a plan to meet the health needs of the population within their area, having regard to the partnership's strategy and the local health and wellbeing strategy, ensuring NHS services and performance are restored following the pandemic and that constitutional standards (including statutory duties for quality) and Long Term Plan commitments are met.
- Allocating resources to deliver the plan by deciding how its national allocation will be spent across the system.
- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities. The ICS NHS body may choose to commission jointly with local authorities across the whole system; at place where that is the relevant local authority footprint.
- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a 'system financial envelope' set by NHSEI.
- Arranging for the provision of health services in line with the allocated resources across the ICS footprint through a range of collaborative leadership activities, including: putting contracts and agreements in place to secure delivery of its plan by providers; convening and supporting providers to lead major service transformation programmes; and putting in place personalised care.
- Leading system implementation of the People Plan by aligning partners across each ICS to develop and support the 'one workforce'.
- Leading system-wide action on digital and data to drive system working and improved outcomes.
- Use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.
- Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support these wider goals of development and sustainability.
- Leading the preparation and execution of emergency response.

9. All relevant clinical commissioning group (CCG) functions and duties transferred to the ICS NHS body on 1 July 2022 when they were established, along with all CCG assets and liabilities, including their commissioning responsibilities and contracts. The board of the ICS NHS body is responsible for ensuring that the body meets all its statutory duties.

10. The national implementation framework also states that all systems should a) establish and support place-based partnerships, with configuration and catchment areas reflecting meaningful communities and geographies that local people recognize; and b) from April 2022, Trusts providing acute and/or mental health services will be expected to be part of one or more provider collaboratives.



11. The remainder of this paper seeks to provides members with an overview of progress in establishing the Greater Manchester ICS and the Oldham place based partnership.

Progress with the Greater Manchester ICS

12. It was agreed nationally that Greater Manchester would become an NHS ICS especially as such joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of statutory Integrated Care Systems. As such all CCG functions, assets, liabilities and responsibilities transferred to the new NHS Greater Manchester Integrated Care System at midnight on 30 June 2022.

13. The Greater Manchester ICS Body (ICS Board) received all CCG functions on time and officially went live on 1 July 2022 at which point it held its first ever in public Board meeting which received and approved a number of key governance documents to enable it to function effectively

14. In terms of key points to note around progress:

- The entire Board and Executive Management and Wider Leadership Team have now been appointed and are listed as follows:

  - Chair, Sir Richard Leese
  - Chief Executive, Mark Fisher, OBE

  Management
  - Chief Finance Officer – Sam Simpson
  - Chief Nurse – Mandy Philbin
  - Chief Medical Officer – Manisha Kumar
  - Chief People Officer – Janet Wilkinson
  - Chief Delivery Officer – Steve Dixon
  - Chief Officer for Strategy & Innovation – Warren Heppolette
  - Chief Officer for Population & Health Inequalities – Sarah Price

  Non-Executive Directors and Partners
  - Non Executive Director – Audit Committee – Richard Paver
  - Non Executive Director – Remuneration Committee – Shazad Sarwar
  - Non Executive Director – Quality Committee – TBC
  - Non Executive Director – Finance Committee – TBC
  - Partner – Acute Sector – Dr Owen Williams
  - Partner – Local Authority Sector – Geoff Little
  - Partner – Primary Care – Dr Vish Mehra
  - Partner – Acute Mental Health – Neil Thwaite
  - Member – VCSE – Leigh Vallance
  - Integrated Care Partnership Chair – Paul Dennett

  Place Leads
  - Bolton – Fiona Noden, Chief Executive of Bolton NHS Foundation Trust
  - Bury – Geoff Little, OBE, Chief Executive of Bury Council
  - Heywood, Middleton and Rochdale – Steve Rumbelow, Chief Executive of Rochdale Borough Council
  - Manchester – Joanne Roney, OBE, Chief Executive of Manchester Council
  - Oldham – Mike Barker, Executive Director of Oldham Council
  - Salford – Tom Stannard, Chief Executive of Salford Council
  - Stockport – Caroline Simpson, Chief Executive of Stockport Council
  - Tameside – Sandra Stewart, Interim Chief Executive of Tameside Council
  - Trafford – Sara Todd, Chief Executive of Trafford Council
  - Wigan – Alison Mckenzie-Folan, Chief Executive of Wigan Council

- A series of Board sub committees have been established covering remuneration; audit; finance; performance and quality

- Work is well underway on organisational design which will when complete ensure staffing structures are populated within the GM ICS Body as well as the Place-based Partnerships and the Greater Manchester Provider Collaborative. That is unlikely to fully conclude until 2023 and will be iterative throughout the rest of this financial year.

15. The **Greater Manchester Integrated Care Partnership**. This has been a second order priority up to this point whilst the establishment of and legal transfer of duties and powers to the NHS ICS Body has needed to be progressed given that is where all the risk has lay in the system. However, design work is now well underway and a number of key points are worthy of note in this report by way of updating members.

- It has been agreed with Local Authorities Chief Executive's including GMCA that the Chair of the GM ICP should be the lead portfolio holding member and therefore Cllr Paul Dennett, Mayor of Salford, will undertake this role
- Draft Terms of Reference outlining membership details, meeting frequency, scope of authority and decision-making and quoracy have now been developed and again Local Authorities Chief Executive's and Leaders are being consulted for their views on those in order to agree a final version to enable the first meeting to take place
- The first meeting is planned for late September and it is envisaged that this will largely be a procedural meeting to sign off the requisite governance
- A working group has been established to co-ordinate and drive the development of the integrated care strategy and the Oldham Place Lead is a member of that working group. It is envisaged that this will conclude with a strategy prior to Christmas

Progress on Oldham's Place-based Partnership

16. There are two important points that have been used to drive our designs locally in Oldham.

    i. Firstly, local partners will agree the form of governance that place-based partnerships adopt, having regard to existing local configurations and arrangements. Depending on the context and functions to be carried out at place level, governance arrangements may include the following, possibly in combination: consultative forum; (joint) committee of the NHS ICS body; individual directors of the NHS ICS body; lead provider and so on.

    ii. Secondly, the roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body chief executive or relevant local authority.

17. To that end, we have developed an operating model for Oldham's Integrated Care Partnership. To guide that development the shadow NHS GM ICS set out a series of core characteristics that every locality operating model would be required to meet. These were as follows:

i. A place-based lead for integrated health and care
ii. A Locality Board
iii. A place-based provider collaborative/alliance or local care organization and neighbourhood working arrangements
iv. Agreed arrangements for the joint management of the pooled budget
v. A clear accountable relationship with the NHS GM ICS
vi. A clinical and professional model that supports decision making
vii. A population health management system

18. We have undertook a self-assessment at the end of June prior to go live of our proposed model against these criteria and a summary of the key findings of that self-assessment are presented below for Committee members reference.

Neighbourhood Model:

- The emergence of five multi-agency district place boards are in place
- Multi-agency district operational leads groups in place
- Connectivity between district place boards and key networks (e.g. Youth Alliance)
- Developing community engagement methods embedding at neighbourhood level
- Positive evaluation of Thriving Communities and the approach to social prescribing
- Districts / neighbourhoods are coterminous footprints that are the right size

Local Provider Collaborative/Alliance:

- Long running Alliance of providers and commissioners
- Integrated Delivery Board established in May 2021
- Integration Agreement in place since July 2021
- Response-led multi-agency working
- Intensive programme of development engagement underway
- Integrated transformation programme –need to agree priorities & timeline
- Formalise a new arrangement –this could, for example, be decision-making in the first instance followed by additional pooling of provider budgets
- Agree the form of the Collaborative –'Provider Leadership Board Model'

Locality Board:

Form & Composition

- Oldham Health and Care System Board becomes: "Oldham Integrated Care Partnership Board"
- A Joint partnership Committee underpinned by a Strategic Partnership Agreement meets with a Section 75 Committee –evolved from the existing Commissioning Partnership Board with separate Terms of Reference and restricted decision-making
- Expanded S75 for 1 July onwards

- Oldham Health and Care System Board in place since September 2021
- Integration Agreement in place since July 2021
- Sub-groups established

Role

- Locality Plan in place
- Social value work established with a focus on workforce and employment
- Multi-agency quality assurance, surveillance and improvement groups established
- Finance and Sustainability Group established
- Financial flows discussed at Board
- Various Partner strategies and themed plans discussed at Board, including social children and young people
- Review all health and care strategies and plans –how do we ensure they are cohesive and connected?
- Consider regular checks that Board business addresses wealth business, social value and health inequalities –for example, via standardised paper cover templates
- Consider how oversight of unwarranted variation in performance and outcomes can be achieved
- Work with Health and Wellbeing Board to establish plans to tackle health inequalities

Place-based Lead:

- Oldham CCG AO put forward and appointed
- Accountable for ICB decisions into the 'Place'
- Leader of the 'Place' ICB team
- Part of GM Management Board
- Leader of the Partnership's development
- Dual reporting line

Population health management system:

- Governance reviewed to ensure clear definition in role of Locality Board and Health and Wellbeing Board
- Health and Wellbeing Board will focus on wider determinants and overseeing delivery of the health inequalities plan
- System-wide health inequalities plan developed based on GM Marmot recommendations
- Self assessment against Population Health Characteristics Framework undertaken in November 21 and is informing development of plans and priorities
- Provider strategies have strong focus on population health and inequalities (incl. NCA, Pennine Care)
- DPH is a member of Locality Board and Provider Collaborative Board, and is the recognised system lead for population health
- Social prescribing well established and opportunities identified to further develop approach in line with place based working
- Door-to-door engagement teams and community champions work continuing beyond COVID to focus on wider determinants and other key health issues
- Strong VCSFE infrastructure and presence on partnership boards

- Covid testing and vaccination programmes co-designed with communities, and learning is being taken into other programmes
- PCN Population Health Management Plans in place
- Continued NHS investment in improving health/wider determinants e.g. warm homes
- Examples of joint commissioning across Council and CCG in response to local need e.g. health improvement and weight management, and genetic outreach services
- NCA work on social value also well developed with a particular focus on workforce and employment
- Public health input into licensing process and working with planning on development of Local Plan to ensure improving health is embedded in policy
- Some contracts with health inequalities performance measures in place

Clinical and professional leadership model

- A clinical and care professional leadership model established that aligns with best practice and the latest research
- Health and Care Senate established
- Initial priority pathway change areas established
- Transfer planned of existing CCG clinical lead posts into the new organisation place team
- Agreement of additional and time-limited roles
- Clinical and care professional leads embedded into Boards and working groups

Recommendations

19. The Committee is asked to 'NOTE' the update.