NHS
Bolton
Clinical Commissioning Group

NHS BOLTON CLINICAL COMMISSIONING GROUP
Public Board Meeting

AGENDA ITEM NO: ………..…11……………………..

Date of Meeting: ………8th January 2021…………………………..

TITLE OF REPORT:	Reflection on the benefits of CCGs - Response to NHSE/I Engagement Document	
AUTHOR:	Su Long, Chief Officer	
PRESENTED BY:	Su Long, Chief Officer	
PURPOSE OF PAPER: **(Linking to Strategic Objectives)**	Board members requested a summary of learning from Bolton CCG to share with local and Greater Manchester partners as new integrated system models are developed in response to the NHS England engagement. Bolton CCG is rated 'outstanding' by NHS England, performing well on outcomes indicators, commissioning of high quality services, public engagement, financial management and overall leadership. This report provides a headline summary of the approaches that have worked effectively in contributing to this achievement. It should be noted that this document cannot possibly cover the full breadth of the work of the CCG over its 9 years since it started in shadow form in 2012 so focuses on some elements that made CCGs unique and Bolton CCG a high performer nationally.	
LINKS TO CORPORATE OBJECTIVES **(tick relevant boxes):**	**Deliver the outcomes in the Bolton Joint Health and Care Plan**	X
	Ensure compliance with the NHS statutory duties and NHS Constitution.	X
	Deliver financial balance.	
	Regulatory Requirement.	
	Standing Item.	
RECOMMENDATION TO THE BOARD: **(Please be clear if decision required, or for noting)**	Members are requested to note and comment on the report.re required, to improve performance.	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED:	CCG Executive	
REVIEW OF CONFLICTS OF INTEREST:	N/A	
VIEW OF THE PATIENTS, CARERS OR	Patients' views are included within the report.	

THE PUBLIC, AND THE EXTENT OF THEIR INVOLVEMENT:	
OUTCOME OF EQUALITY IMPACT ASSESSMENT (EIA) AND ANY ASSOCIATED RISKS:	EIA included within the report.

Reflection on Learning by Bolton CCG - Response to NHSE/I Engagement Document

1. Introduction

Board members requested a summary of learning from Bolton CCG to share with local and Greater Manchester partners as new integrated system models are developed in response to the NHS England engagement.

Bolton CCG is rated 'outstanding' by NHS England, performing well on outcomes indicators, commissioning of high quality services, public engagement, financial management and overall leadership.

This report provides a headline summary of the approaches that have worked effectively in contributing to this achievement. It should be noted that this document cannot possibly cover the full breadth of the work of the CCG over its 9 years since it started in shadow form in 2012 so focuses on some elements that made CCGs unique and Bolton CCG a high performer nationally.

2. Summary of Beneficial Approaches

2.1 Triple Aim Objectives

Bolton CCG has always set its annual objectives using the Triple Aim: Improving population health outcomes, improving the quality and experience of care and delivering value for money. The triple aim is proposed in the NHS England engagement document as providing objectives for Trusts and integrated care systems. This development should be welcomed.

2.2 Equitable Funding

CCGs are the statutory bodies charged with the responsibility for deciding the prioritisation of expenditure of the NHS budget for Bolton people. The important elements we have learned from and would encourage to be built upon in future models have been:

2.2.1 Arguing the case for fair funding for Bolton

The NHS England funding formula for CCGs is based on need of the population, incorporating age, deprivation and other characteristics. The target level of funding based on need has not yet been met for Bolton due to the slow rate of change in budgets that was set by NHS England. This target level of funding should still be fought for in Bolton

2.2.2 Parity of esteem for Mental Health

The Board of Bolton CCG focused early on increasing expenditure on mental health due to our very low starting point. Mental Health remains a priority for the CCG and continuing to focus on appropriate funding levels should remain a Bolton priority.

2.2.3 Fair funding for General Practices

In response to the differential historic levels of funding for general practices across Bolton and, in order to improve standards and outcomes in Bolton, investment in the Bolton Quality Contract was achieved several years ahead of NHS England contract alterations.

2.2.4 Prioritisation of all expenditure

A successful approach undertaken by Bolton CCG has been to review all expenditure in order to identify priorities for investment and for savings. The easy approach would have been to simply prioritise the new NHS funding each year after inflation was applied to services but this would not have enabled the more ambitious investments that Bolton CCG has achieved. The Quality, Innovation, Productivity and Prevention (QIPP) approach undertaken by Bolton CCG has been praised by auditors for its inclusivity across the organisation and clear process.

2.2.5 Prioritising early intervention and prevention

Investment decisions have prioritised prevent and early intervention to deliver the best Triple Aim impact. Examples in primary care include the achievement of the highest NHS health check rates, the development of the Health Improvement Practitioner role from the success of health trainers, and incentivisation of achievement of the Best Care scores for several long term conditions in through the Bolton Quality Contract. Other examples include the support for more home based care in mental health, app access for young people to mental health support, and investment in early years support.

2.3 Public Engagement

Bolton CCG has taken very seriously the statutory responsibility for public and patient involvement in commissioning decisions. We have achieved the highest scores across all domains of the 2019-20 NHS Oversight Framework Patient and Community Engagement Indicator assessment. This reflects an approach that is about regular and ongoing engagement with community groups and equality target action groups, in addition to communication and engagement using social media and more traditional methods.

2.4 Clinical Engagement in Commissioning

Bolton CCG was set up to value the important role of GPs in commissioning that was aspired for in the Health Act 2012. The understanding of GPs of the full pathways of care, the feedback they receive in their consulting rooms from patients about experience of care, and their role in referring for and prescribing healthcare are all

critical to the intelligence applied to improving the outcomes, quality, experience and value for money of care commissioned. Clinical engagement has been successfully achieved through the following methods:

2.4.1 Member Practice engagement

Regular monthly engagement with every General Practice is undertaken via a Practice Clinical Lead for each Practice, with a calendar of events in the diagram below.

2.4.2 Clinical Leadership

The organisational structure of Bolton CCG was developed with clinical and managerial skills working together at all levels. Skills development for clinical leaders at different levels is offered through development support and through the roles available, as shown in the diagram below:

All Board and Commissioning Lead roles have job descriptions and appointment processes in the CCG Standing Financial Instructions. Each of these roles are expected to meet the Nolan Principles of public life, follow NHS England conflicts of interest requirements, focus on the Triple Aim and act in the best interests of Bolton people.

2.4.3 Primary and secondary care clinical interface

An important area for focus for improving the quality and experience of care is the interface between hospital and primary care. The Clinical Standards

Board involves CCG, LMC, Bolton FT and GMMH FT members in order to agree clinical responsibilities for elements of care pathways and implement them.

2.4.4 Clinical Incident Reporting
Clinical incident reporting is encouraged by practices, nursing and care homes and all commissioned services in order to share quality concerns or near misses. The CCG quality team themes and identifies improvements as a result of this important reporting.

2.5 Transparent performance improvement

The approach to quality and performance improvement undertaken by the CCG has, at its most successful, been data driven and supportive rather than oppositional. Examples have included transparent data presented on all Practices, the support offered to nursing and care homes in response to CQC recommendations and the involvement of CCG staff on key quality groups within local providers.

Data is analysed using an understanding of population need. For example, Practices are peer clustered according to the demographics of their registered population (using age, ethnicity, and deprivation) ensuring we are comparing like with like when encouraging practices to improve.

2.6 Working in partnership

As a commissioner, the CCG has always understood that the quality of services delivered to local people is reliant on effective delivery by member practices and health and care providers. Good relationships with our partners are therefore valued.

Bolton’s response to the COVID-19 pandemic has been an example of the benefit of good relationships and close working across the locality in order to support local people during the greatest health and care challenge we have met. Bolton CCG staff, member practices and partner organisations should be praised for stepping up and working so hard to meet the ever changing and very challenging requirements as the pandemic continues.

Bolton’s approach to integration, embodied by the Bolton Locality Plan for the last four years, is clear that health and care integration and prioritisation of early intervention and prevention in Bolton is more important than organisational interests. The direction of travel Bolton partners have been taking with Bolton CCG is supported by the NHS England engagement document. Examples include:

- Pooling of budgets with joint decision making involving political, clinical and professional skills. This commenced with the Better Care Fund, characterised by support to social care, and widened to £180 million budget with risk sharing between the CCG and Bolton Council.

- Strong focus within the CCG on improving the quality of individual case management for highly complex individual cases, and expanding personal health budgets, working in partnership with Bolton Council on relevant children, learning disability and adult cases.
- The use of Greater Manchester transformation funding to cluster practices together for introduction of a new shared workforce to support Primary Care. This pre-dated the introduction of Primary Care Networks and made this an easier process.

The commonality between the NHS England direction for integrated systems and Bolton's ongoing work leads to a strong belief that the positive approaches outlined in this document should, be built upon during the ongoing transition locally, and within Greater Manchester.

3. Recommendation

Members of the CCG Board are requested to comment on and note this summary.

The following paper is the Greater Manchester Health & Care Partnership response to the NHS England engagement document, representing a coordinated view across all health and care organisations.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Integrating care - Next steps to building strong and effective integrated care systems across England

RESPONDING TO THE NATIONAL ENGAGEMENT EXERCISE

14th December 2020

1 Introduction

This document proposes a GM response to the engagement questions in the national document, "Integrating care - Next steps to building strong and effective integrated care systems across England", published by NHSI/E on 26 Nov[1].

2 National Changes Proposed

2.1 NHSEI has now published its intentions for Integrated Care Systems across England. It details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective integrated care system (ICS) and the immediate and long-term challenges presented by the COVID-19 pandemic.

2.2 From April 2021 this will require all parts of the health and care system to work together as Integrated Care Systems, involving:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes;
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

3.3 This document also describes options for giving ICSs a firmer footing in legislation likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally.

3 Legislative proposals

1 https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

- Current legislation[2] does not have a "sufficiently firm foundation for system working"
- NHSEI made recommendations on legislation change in Sep 2019 (the NHS Bill3). They are not detailed here (see paper, section 3.3) but NHSE believe they still stand.
- One of the recommendations was for a new statutory underpinning to establish ICS boards through 'voluntary joint committees' - "an entity through which members could delegate their organisational functions to its members to take a collective decision". Engagement about this raised questions as to whether such a voluntary approach would drive system working.
- The COVID-19 response has increased the desire from the system for clarity about ICSs and the organisations within them, and an NHS Bill was included in the Queen's speech in Jan 2020 and so NHSE believe the time is appropriate to achieve clarity and establish a legislative basis for ICSs.
- The paper outlines two options for "enshrining ICSs in legislation" without "triggering a top-down reorganization".
- Both options (models) have broad membership and joint decision-making, responsibility for the system plan, operating in accordance with a new 'triple aim' duty[4] for all organisations - 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer" - duty and a lead role in relating to national level bodies.
- Both models identify local government as an integral part of the ICS through planning and shaping services, delegation of functions to committees including NHS and local government and exploiting existing flexibility for pooling functions and funding.

3.1 Option 1: a statutory committee model

- This model would include an Accountable Officer (AO) and bind together current statutory organisations.
- The AO would be chosen from the board's mandatory members. Individual organisations would retain their own AOs/CEOS but the ICS AO would be a role recognised in legislation and would have formal duties in relation to delivering the ICS board's functions.
- This is close to the original proposal in Sep 19, and would enable joint decision-making
- There would be one aligned CCG per ICS footprint, and new powers to allow that CCG to delegate many of its population health functions to providers. Current accountability structures for CCGs and providers would remain.
- Downsides to this model include:
    - Lack of clarity of leadership and accountability – especially for patient outcomes and financial matters
    - An ICS and a CCG AO may add to this confusion
    - CCG governing body and GP membership is retained, but it is questionable whether these are sufficiently diverse to fulfil the different role of CCGs in an ICS

3.2 Option 2: a statutory corporate NHS body

- This model would bring CCG statutory functions into the ICS. Additional functions would be conferred on ICSs and existing CCG functions modified to create a new framework of duties and powers.

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2 National Health Service Act 2006 and the Health and Social Care Act 2012
3 https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf
4 https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf

- CCG governing body/membership would be replaced by an ICS board consisting of representatives from system partners, without a power of individual organisational veto.
- Minimum board membership
  - Chair
  - Chief Executive
  - Chief Financial Officer
  - Representatives of NHS providers, primary care and local government
- ICS Chief Executive would be a full-time AO role, strengthening lines of accountability and with a key leadership role in system delivery.
- ICS would have a primary duty to "**secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations**" with the flexibility to make arrangements (through contracts with providers) or delegating responsibility for specified services to one or more providers.

3.3 Response requested

NHS organisations are asked to consider 4 questions relating to the legislative proposals in the paper (see Table) and to respond with views on the proposed options by 8 January 2021.

Table 1

3.3.1 Questions
Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?
Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?
Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?
Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4 Proposed Response

4.1 Colleagues across Greater Manchester believe the national document is a significant and positive contribution to the integration of health and social care and to meaningful action to improve health and improve healthcare. We strongly support the document's proposed characteristics for each ICS:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale;
- Developing **strategic commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

4.2 We also strongly support the four fundamental purposes of an ICS:

- **improving population health and healthcare**; because "decisions taken closer to the communities they affect are likely to lead to better outcomes"
- **tackling unequal outcomes and access**; because "collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people"
- **enhancing productivity and value for money**; because "collaboration between providers across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity."
- **helping the NHS to support broader social and economic development**.

4.3 The characteristics and purpose for ICSs proposed strongly match the ambitions for health and social care which each GM district has been pursuing locally over many years and which we have pursued together as the GM Health & Social Care Partnership since 2016. We believe therefore, that the proposals outlined in the document provide the basis for a positive next stage off our journey across Greater Manchester.

4.4 Engagement Questions

Q1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

We agree. In proposing the devolution agreement in 2015 we sought the means to bring the resources and decisions affecting care for local residents closer to them. We also elevated the value of collaboration across organisations, across sectors and between localities as a necessary characteristic of a system organised to pursue shared objectives or a population served jointly. We believe, that the proposals in the national document to establish those through statutory means recognise and fix those objectives for the long term.

The other legislative proposals we believe will help create the conditions for effective place based working both through the duty to collaborate and through the adjustment proposed for the consequent legislative framework.

However, the benefits of this change can only be fully realised if they are genuinely able to support models for comprehensive, place based working with the most local possible control of the range of resources to make that happen. The facility to establish locally accountable place based system boards with the authority and flexibility to jointly control the full range of resources for the populations they serve is the key condition the ICS should be expected to enable.

The risk without this recognition is that decision making actually becomes more distant from communities, is disconnected from those wider public and VCSE services which is the only way to unlock preventative potential and affect patterns of demand on formal health and care services.

Greater Manchester will continue to create the conditions for the deep integration of the local NHS, Local Government, wider public services, the VCSE and local communities in order to improve health as well as health services.

The establishment of the ICS on a statutory footing must therefore, be on the basis of bringing the 10 place based arrangements together in pursuit of shared system wide objectives. This could mirror the arrangement established across the Greater Manchester Combined Authority and the ten GM Councils. In the same way we would envisage an equivalent arrangement to establish the ICS Board to include the leadership in the ten localities. This is, we believe, the right means to

ensure a two tier system does not emerge; and to maintain an alignment between locality and system level activities and priorities.

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We agree, subject to the condition that the ICS Board model is constructed on the basis of place based membership alongside members representing system level accountabilities as proposed above. We believe that model is strengthened by being rooted in place and set to avoid the creation of a two tier, or hierarchical system. We would be concerned that option 1 risks creating confusion through a dual leadership for ICS level functions. Option 2 provides or a clearer structure which will minimise the potential or unnecessarily complicated governance which would undermine the means o supporting the system level collaboration.

The primary statutory duty to “secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations” is very helpful in supporting clarity on obligations to the NHS between the ICS and Parliament. This must not overlook the purpose and objectives however to improve health, reduce health inequalities and tackle unequal access and outcomes.

Option 2 would allow for a more streamlined arrangement to progress the commissioning and delivery of system level services where it is judged that those services are best planned and delivered at the system level for the whole population of 2.8m. Additionally it would confirm a clear vehicle for those services currently commissioned by NHSE to be done at a more local level through the ICS.

Option 2 provides a clearer opportunity to reduce or remove the commissioner/provider separation at the system level and reduce both the associated costs and the time and delay embedded into those avoidable transactional processes. The ambition in localities is to establish local governance and financial lows which similarly reduces the transactional burden of the commissioner provider split and this should be replicated at the system level.

Option 2 could be strengthened further by having clear recommendation about an enhanced role of local authority scrutiny functions to build these into place based whole system scrutiny of quality, finance and other mattes requiring more granular review than can occur at the level of the ICS.

Q3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

We agree. We have clear ambitions for the membership and governance to be broad and open to wider public services and civil service partners from the VCSE sector and welcome the opportunity that a permissive framework allows. This is true at both place/district level and at the GM level.

At the same time we have seen the value of blending political, clinical/professional, patient/resident and expert managerial leadership. This also, therefore, provides the necessary flexibility to allow us to establish and benefit from that breadth of leadership.

The potential for place based provider collaboratives is immense. New models spanning social, emotional, psychological and medical approaches are the key to public service transformation and the ability to improve health.

Those models maximising the social value they bring to local places over the coming decade will be central to the nation's recovery from the social and economic effects of the pandemic.

This is potentially a radical development of the FT model and will require regulators to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

Q 4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

We agree. Our ambition is to fully join pathways so that coordinated decisions are made locally and funding is used in the most effective way possible to improve outcomes for the population. When the Greater Manchester Health and Social Care Partnership (GMHSCP) formally took charge of the £6bn health and social care budget on 1 April 2016, it also assumed delegated responsibility for a wide range of specialised services.

Working through integrated local arrangements, including Lead Providers, we have been able to plan and build more comprehensive service models through wellbeing, integrated community provision, and GM models of service which span locality boundaries and more specialist services. This has already delivered benefits which we would hope to build on, including:

This plan has led to closer integration commissioning arrangements supporting acute and mental health service transformation to deliver:

- The Improving Specialist Care Programme Investments into Specialised Commissioned level 1 Neurorehabilitation to deliver the new standards within the Model of Care.
- GM Population Health Priorities such as supporting plans to roll out Lung Health checks in localities and joint planning for increased tertiary lung resections as a consequence of increased CCG screening initiatives. Specialised commissioning recommendations have also informed the case for change to reshape services for people living with HIV in GM within the GM Sexual and Reproductive Health Strategy.
- GM Mental Health Transformation Programmes through supporting the development of new delivery models for Tier 4 Child and Adolescent Mental Health Service and Adult Secure service provision.
- Regional and national specialised service developments (non-delegated services) within Greater Manchester such as the establishment of of the GM level 2 adult Congenital Heart Disease service as an integral part of a North-West CHD Network at MFT and establishing new CAR-T treatments therapies for children and young people with B cell acute lymphoblastic leukaemia.
- NHS England national policy service developments such as the implementation of 5 year delivery plans for Intra Arterial Thrombectomy (IAT) across GM to achieve a 24/7 service by 2021/22.
- New Innovations such as GM's Early Adopter Status for Primary Care-led Transgender Health Service development.

The delegation and transfer of responsibilities is the means rather than the ends of course. It should follow the broader principle outlined in the national document, and supported here, to continually seek to bring decisions as close to communities as possible and to bring together physical and mental, social and medical approaches to support comprehensive care and recovery focussed approaches.

5 Recommendation

5.1 Partnership Executive Board is asked to:

i. Discuss the proposed response and agree any amendments or additions.

ii. Agree intentions to confirm local and organizational support to the response.