Manchester united

The Greater Manchester partnership could shift the paradigm for health, care and wellbeing services but, as Seamus Ward reports, there are many issues to overcome

At the end of February, a potentially seismic change was announced in the way health, care and wellbeing services are commissioned and delivered. About £6bn of health and local authority funding throughout Greater Manchester will be pooled and spent in a planned way across the city region.

It is not, as some media outlets initially headlined, a council takeover of NHS budgets. But the devolution of powers – awkwardly dubbed Devo Manc – presents huge opportunities for streamlining and integrating care. Though not due for implementation until April 2016, the deal raises lots of questions.

The partners are now working on the detail, based on a memorandum of understanding signed by the region's 10 local authorities,12 clinical commissioning groups, NHS England and the government. The area's 15 NHS providers have signed a letter supporting the memorandum.

Joanne Newton, chief finance officer for Manchester's North, South and Central CCGs, says workstreams are being finalised. The memorandum of understanding identifies seven high-priority workstreams, the majority of which will call for finance staff expertise:

- Governance
- Resources and finance
- Clinical and financial sustainability
- Primary care
- Specialised services
- Research and innovation
- Capital and estates.

Governance and finance are two big issues to be overcome, according to King's Fund assistant director of policy Richard Humphries. 'Much depends on the detail of how it will work, which has yet to be agreed,' he says. 'The biggest concerns are about accountability – who carries the can for the big sums of public money involved? Will decisions still be made by clinical commissioning groups and local authorities locally or will the new joint body be another layer of bureaucracy that will reduce local control? How will risks be shared across organisations in Greater Manchester – for example, if a major service runs out of money?

'And with both the NHS and councils struggling to make ends meet, there are bound to be worries that Greater Manchester is being handed a poisoned chalice.'

Ms Newton says the partnership will have an impact on the efficiency of the local health and care economy, as well as the care of patients. 'By working together across Greater Manchester, we aim to reduce unnecessary duplication of services, which will help with working more effectively and efficiently.'

Does this mean back-office services will be consolidated? 'Back office functions such as IT support or emergency planning are already delivered over a Greater Manchester footprint,' she says. 'This may increase over time where it can improve efficiency, but we have no specific plans at the moment.'

Thinktank Reform said Manchester health and social care bodies anticipated a recurrent shortfall of more than £500m by 2017/18. But if the benefits of devolution were realised, the city could save half that through reduced admissions and health and social care integration.

Governance and finance are interlinked. According to the memorandum, the Manchester partnership will be based on subsidiarity – decisions will be taken at the most appropriate level. While we do not have detailed governance arrangements for the partnership, we do know

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that local NHS bodies will remain subject to the NHS Constitution and Mandate, while CCGs will retain their statutory functions and existing accountabilities for funding flows. NHS England funds added to the Greater Manchester pool, for specialised commissioning, for example, will remain the national body's responsibility.

From this month, the Greater Manchester Strategic Health and Social Care Partnership Board will begin to shape the development of the local health and care economy. This will include the development of a cross-city strategic sustainability plan and related funding proposals, which will be underpinned by local plans. Commissioners and providers will sit on the partnership board, together with NHS England and potentially other national bodies, such as Monitor and the NHS Trust Development Authority.

Also this month, a shadow joint commissioning board – made up of the local authorities, CCGs and NHS England – will be formed, sitting under the partnership board in the proposed governance structure.

Over the financial year, it will be launched formally and operate under the section 75 pooled budget arrangements. The members will agree on the accountable body under the NHS accountability framework. There may be legal issues – the government is consulting on a legal change to allow s75 pooled budgets to be spent on primary care services. More generally, Ms Newton says the partners are undertaking due diligence work to understand legal arrangements on Greater Manchester services.

Collective response

Where do providers sit in the new set-up? All 15 have signed a letter of support for the memorandum of understanding. They will work together to 'provide a collective and positive response' to the joint commissioning board's requirements by underpinning the provider element of the governance structure with an agreement with Monitor and the Trust Development Authority and by creating a provider forum.

The forum will include the 15 trusts and representatives of primary care, social care and public health providers. It will sit alongside the joint commissioning board and under the Greater Manchester partnership board.

One local finance manager says many questions remain. 'Will providers have access to Department of Health distress funding or will they have to go to the Greater Manchester partnership board? How will the changes fix the financial issues in the health economy?'

Perhaps the biggest changes for providers will be decided locally rather than city-wide, in conjunction with their lead commissioner or through greater collaboration and integration with other providers. Each health and wellbeing board will agree a strategy for integrated health and social care, working with the Greater Manchester partnership board to ensure that plans are coherent and consistent from a cross-city region perspective. Budgets will be pooled for use by a local joint commissioning board, building on existing arrangements such as the better care fund.

'Each of the 10 health economies in Greater Manchester has significant plans to integrate care, outside of hospitals, so that care is provided as close to people's homes as possible,' Ms Newton says.

Some areas are already well advanced. Two in the Greater Manchester partnership have been awarded vanguard status to develop models outlined in the *Five-year forward view* (see box). While the vertically integrated primary and acute care systems will be piloted in Salford, Stockport will develop the multispecialty community providers model.

Payment mechanisms under the Greater Manchester setup will be under scrutiny. But decisions are likely to be made on a locality or

Provider integration

By the time the Greater Manchester partnership is launched next year, two of its member areas will be piloting models of service delivery outlined in the *Five-year forward view*. If offers the prospect of new integrated services being delivered under the umbrella of a wider city region partnership. But how will these elements fit together?

One of the schemes, Salford Together, will operate a primary and acute care system (PACS); the other, in Stockport, will run the multispecialty community provider model – though in Salford, local health and social care organisations prefer the term integrated care organisation (ICO).

Jack Sharp, director of service strategy and development at Salford Royal NHS Foundation Trust, says this is because the scheme is an extension of the collaborative work done in the borough for years.

Salford has a population of 240,000 and the ICO partners are Salford Clinical Commissioning Group, Salford City Council, Salford Royal and Greater Manchester West Mental Health NHS Foundation Trust.

'The four organisations have a history of working together, both in section 75 pooled budget arrangements for older people,

Integrated care for older people – in action in Salford

mental health and learning disabilities and in terms of redesigning care pathways and shifting care out of hospital,' Mr Sharp says.

Three years ago, Salford introduced integrated care for older people, adopting the triple aim approach of better outcomes, better user experience and reduced costs.

By April last year, the co-commissioning budget for these services was £98m, excluding GP services. Mr Sharp says it has a four-year investment and disinvestment plan, with the aim of reducing preventable admissions to care homes and hospitals, and developing community assets such as support groups to their potential.

It now wants to take this a step further, with the ICO covering all adult services under a prime provider model.

'The ICO would be part of Salford Royal, which would act as the prime provider, functioning on behalf of the whole health and social care economy. We are not creating a legal entity here; it will be a dedicated part of Salford Royal.' **continued overleaf**

service basis. Salford sees a move away from the national tariff to capitation-based payments, but Ms Newton says this is not so for the city region as a whole. 'Greater Manchester has no plans at present to change national tariffs,' she says.

With all NHS bodies in Greater Manchester still subject to the regulatory controls, Monitor must approve any variation from tariff.

Clearly, there is a lot of work to be done over the coming months and many questions to be answered. But for those outside the city region, the key question will be whether the model could be replicated.

Ms Newton says: 'Greater Manchester has a strong history of partnership working within and between councils and clinical commissioning groups. This has meant that we have existing structures which we are confident can be refined and developed to manage our new responsibilities.'

There are strong relationships elsewhere, of course, and in last month's Budget, chancellor George Osborne announced preliminary deals had been struck with councils in West Yorkshire and South Yorkshire to devolve greater powers to the regions. While the health service is not included in these deals at this stage, it is a similar first step to the one taken by the Greater Manchester councils that paved the way for devolved budgets on transport and housing and then the NHS.

The King's Fund's Richard Humphries says the model is not right for every area. 'All parts of the country need to work out how best to join up public services so they meet the changing needs for health and care that many more of us will have in future and how to keep the whole population healthier,' he says.

'But what works for a densely populated conurbation like Greater Manchester will not work for smaller towns and cities or for dispersed rural communities. Greater Manchester's progress has been helped by good working relationships between local government and the local NHS. Elsewhere these are patchy. The best examples of integrated care owe more to good relationships than they do to organisational structures.'

In Greater Manchester, councillors will not be taking over health budgets, but working in partnership with NHS commissioners to shape health, care and wellbeing services across the city region. There will be new structures, such as the partnership and joint commissioning boards, but wholesale organisational reform – to create a single, integrated system for planning and provision, for example – does not appear to be on the cards.

In the absence of such a single body, there are questions in a range of areas, including governance, accountability and payment mechanisms. Finding solutions for these is the Manchester team's challenge for the coming months, while keeping their eyes on the prize of better, more efficient services for patients.

"The best examples of integrated care owe more to good relationships than to organisational structures"

Richard Humphries, King's Fund

Provider integration (continued)

Mr Sharp says each authority area in Greater Manchester has been working on their own integrated care plans as part of the overall city region approach.

'There is a strong commitment from the CCGs, the local authorities and providers on the reconfiguration of hospital services to ensure there is a better offer, there is joined up community health and social care and improved primary care,' he says.

The Greater Manchester devolution is based on the principle of subsidiarity and this will continue, with decisions being made at the most appropriate level, says Mr Sharp. 'Decisions will be taken at local level, but we recognise where action should be taken at a Greater Manchester level – clearly in the case of reconfiguration of hospital services, that may well be the case.'

Warren Heppolette, Greater Manchester strategic director of health and social care reform, says devolution and the ICO are not the end, but the mechanisms to achieve the ambitions of better, more cost-effective care.

'Any locality implementing integrated care currently has to navigate a fairly complex and fragmented commissioning system and a fairly complex and fragmented provider system. Devolution will help us address that fragmentation by prioritising a focus on people and place, rather than through individual organisational perspectives.'

Salford CCG will receive its allocation as usual and will then pass on funding for services covered by the ICO to the pooled budget. The council will do the same with social care funding.

In addition, NHS England will add funding for services it currently commissions or, in the future, services it will co-commission.

Mr Sharp says: 'It may be it is elected to pool and commission some services at Greater Manchester level, but I anticipate this will be mostly services commissioned at scale – more specialised services and hospital-based inpatient services.

'I would not anticipate that responsibility for commissioning integrated health and social care services would move away from the locality where they are provided. As a provider, Salford Royal may find some services commissioned by NHS England move as a result to the ICO, while elective and specialised services are commissioned through Greater Manchester and the CCGs.'

"A capitation or year-of-care model is likely to be the most suitable"

Jack Sharp, Salford Royal

He adds that collaboration between providers on services that are currently commissioned by individual CCGs could lead those commissioners to come together to jointly commission the services.

Payment mechanisms will change under the new model. 'We have a combination of tariff, block contract and hybrid cap and collar arrangements,' Mr Sharp says. 'But we believe that ultimately a capitation or year-of-care model is likely to be the most suitable for our aim of creating an ICO responsible for improving population health, with a focus on an integrated health, social care and wellbeing service.

'We need to move away from a payment mechanism largely focused on inputs or activity to one focused on outcomes. None of us underestimates the complexity of moving down that route. We are working on establishing a capitation payment mechanism to support the ICO (likely to be established between October 2015 and April 2016). New payment arrangements will need to be phased with some form of shadow arrangement in the first instance to manage risk between commissioners and providers.'

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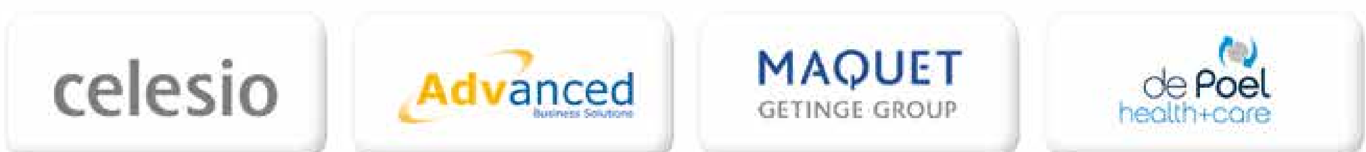

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