Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 2 February 2017

Subject: Single Commissioning Organisation

Report of: Strategic Director of Adult Social Care

Summary

The three Manchester CCGs and Manchester City Council have agreed to establish a single commissioning organisation for the City of Manchester by April 1st 2017. Attached is the report which is going to the Council's Executive.

The paper sets out progress in the merger of the three Manchester CCGs and the development of a partnership agreement with Manchester City Council, thus bringing together health, social care and public health commissioning. This new organisation will be called Manchester Health and Care Commissioning (MHCC).The paper then outlines the key next steps to establish MHCC by April 1st 2017.

Recommendation

To note and comment on the establishment of the Manchester CCG and the development of the Commissioning Partnership with Manchester City Council.

Wards Affected: All

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Background documents (available for public inspection):

None

Manchester City Council
Report for Resolution

Report to: Executive – 8 February 2017

Subject: Single Commissioning Organisation

Report of: Strategic Director of Adult Social Care

Summary

The three Manchester CCGs and Manchester City Council have agreed to establish a single commissioning organisation for the City of Manchester by April 1st 2017. This paper marks a significant step in this arrangement through seeking the Executive's support for the merger of the three Manchester CCGs and approval of the development of a partnership agreement with Manchester City Council, thus bringing together health, social care and public health commissioning. This new organisation will be called Manchester Health and Care Commissioning (MHCC).

The paper sets out the rationale for establishment of MHCC, the progress to date, the proposition for CCGs to merge and the partnership arrangements with Manchester City Council. The paper then outlines the key next steps to establish MHCC by April 1st 2017.

Executive is recommended to

Note the merger and establishment of the single Manchester CCG

Agree to enter into a partnership agreement with the Manchester CCG and NHSE (if required) to establish single commissioning for health and social care for the City of Manchester.

Agree to delegate to the CCG those adult social care and public health commissioning functions as set out in this report that are capable of delegation by way of a partnership agreement with the Manchester CCG when established and authorise the CCG to enable those commissioning functions to be carried out by the MHCC Board.

Delegate authority to the DASS, DPH, City Solicitor and City Treasurer in consultation with the Executive Member for Adults to agree the terms of the partnership agreement.

Wards Affected
All

Manchester Strategy outcomes	Summary of the contribution to the strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Supporting the growth agenda with an integrated system which will make more efficient use of available resources and provide greater opportunities for local jobs and career progression.
A highly skilled city: world class and home grown talent sustaining the city's economic success	A single commissioner of Integrated health and social care will bring social value to local communities, connecting people to community assets, promoting independence and reducing worklessness.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The focus is on changing behaviours to promote self care and involving local people in the design and delivery of new care models.
A liveable and low carbon city: a destination of choice to live, visit, work	Addressing the wider determinants of health will be a strong feature of all three pillars of the Locality Plan.
A connected city: world class infrastructure and connectivity to drive growth	N/A

Full details are in the body of the report, along with any implications for

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences – Revenue

The new arrangements and agreement to enter into a partnership agreement is an integral element to delivering the Locality Plan three year budget strategy reported elsewhere on the agenda. The creation of MHCC and associated commissioning arrangements will realise direct efficiencies and will be a key enabler to the delivery of the significant savings required.

Financial Consequences – Capital

There are no capital implications arising directly from this report. Any capital and estates proposals will be jointly developed with the CCG and in conjunction with the councils capital strategy and budget process.

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

1.0 Introduction

1.1 A Healthier Manchester (Manchester's Locality Plan) sets out a clear vision for the health and social care system in Manchester. This requires both service changes but also organisational change in all parts of the system. New organisational arrangements will drive transformation of services better and faster.

1.2 Bringing together the commissioning roles of the three Manchester CCGs and Manchester City Council into a single organisational organisation will bring benefits including:-

- A single commissioning voice
- Commissioning for integrated and proactive health and social care
- A more strategic role enabling larger scale transformation of services
- Better utilisation of our collective assets

1.3 Establishment of Manchester Health and Care Commissioning (MHCC) has been set as a direction of travel by the three CCG Boards and Manchester City Council. This organisation will commission health, adult social care and public health. This will require the merger of the three Manchester CCGs and the merged CCG then to hold a partnership agreement with Manchester City Council.

1.4 Significant progress has been made in developing the mission, vision and values of the new organisation, establishing a vision and model for clinical leadership, establishing suitable governance arrangements, appointment of a single Accountable Officer; staff engagement; and progressing the CCG merger application with NHS England.

1.5 As part of the development of MHCC the CCG Boards, and the respective membership, need to approve the merger of the three CCGs.

2.0 Strategic context

2.1 The Manchester Locality Plan 'A Healthier Manchester' sets a clear strategy for the health and social care system in Manchester. The system faces an unprecedented financial challenge, challenges with regard to quality and performance of services and persistently poor population health. The Healthier Manchester strategy sets out how to meet these challenges and is a plan that is shared by providers and commissioners; health and local authority.

2.2 The strategy sets out a series of service transformations which will change the way care is delivered and the relationship statutory organisations have with the public. The strategy sets out strengthened system level governance, building on existing Health and Wellbeing Board arrangements which will bind organisations to deliver for Manchester together.

2.3 The strategy also recognises that the system needs new organisational arrangements to implement these plans. These comprise a single hospital

service which will create a single hospital trust for the City of Manchester; a local care organisation (LCO) as a single provider of integrated out of hospital care and a single commissioning organisation spanning health, social care and public health. These will enable the service transformations to be implemented better, faster and at sufficient scale to meet the financial, quality and population health challenges.

2.4 A Healthier Manchester sits as part of broader City strategies, most notably the 'Our Manchester' strategy which sets out an asset based approach to transformation in the City of Manchester for its health and wellbeing but also for its economy, skills, culture etc. This will form a new relationship between health and social care organisations and the population, building on the strengths and assets of people and communities, as drivers to improve health and wellbeing.

2.5 A Healthier Manchester is placed strongly with the Greater Manchester 'Taking Charge' strategy. Taking Charge is the strategy which sets out how Greater Manchester will meet the same challenges as set out above. It is the key strategy developed as part of the devolution of health and social care decision making to Greater Manchester.

3.0 The development of a single commissioning organisation

The service transformation, the strengthened system governance and the integrated provision requires a strong and well co-ordinated commissioning organisation which can commission all health, social care and public health for the City of Manchester.

A single commissioning voice:- given the changes to the provider arrangements in the City we will have fewer, larger, longer term contractual arrangements. As providers start to work on increasing geographical footprints, at the City level and larger, commissioners need to work effectively together to create a clear strategic and operational direction, means of quality assurance and synergy of commissioned services.

Co-ordinated and proactive care:- is essential to achieving population health improvements and to meet the needs of an ageing population with increasing frailty and co-morbidity. Integrated provision is dependent upon integrated commissioning and a unified investment strategy.

A more strategic role:- is needed to ensure we can lead the scale of change required and have a new relationship with providers. Through working with the Council there will be a stronger connection to strategy relating to the wider determinants of health such as housing, education and employment.

Optimising our assets:- will bring together the finance, people and other resources to create a more efficient and effective means of commissioning. It will also create wider networks to organisations and groups who can support our work.

4.0 High level programme plan

The programme plan follows six workstreams established on behalf of the CCGs and MCC. The programme has been overseen by a Steering Group representing the four organisations:

- Mission, vision and values led by Mike Eeckelaers and Philip Burns
- Governance led by Nick Gomm and Liz Treacy
- Strategy led by Hazel Summers, Leigh Latham and Jo Purcell
- Finance led by Joanne Newton and Simon Finch
- HR and OD led by Sharmila Kar and Kath Smyth
- Programme management led by James Williams.

5.0 Progress update

Significant progress has been made on the development of MHCC. Key achievements are set out below.

5.1 Appointment of a single Accountable Officer

Ian Williamson has been appointed as the Chief Accountable Officer for the merged CCG and for MHCC. Recruitment to the CCG Board and Executive Team will take place during February/March. A fully integrated staffing structure will then be developed and populated.

5.2 NHS England approval of merger

The merger has been approved by NHS England subject to a number of conditions. Pre-requisite conditions to authorisation are subject to the Boards and their membership approving the merger. These need to be confirmed by the 10th of February. Further requirements, which would not prevent authorisation, but would be conditions of authorisation are submission of the constitution, appointment of Governing Body members, completion of an equality assessment and a risk assessment. These need to be submitted by the 15th of March. The intention is to be satisfy both sets of conditions in order to be authorised without conditions by April 1st and this is considered achievable.

5.3 Staff engagement

5.3.1 The merger of the three CCGs will be achieved by TUPE transfer. The CCGs are carrying out consultation with the staff affected. Although MCC are not affected by this transfer, there has been parallel staff engagement in readiness for the establishment of MHCC.

5.3.2 Clinical and professional leadership

Clinical and professional leadership and engagement is a key feature of the new organisation. Clinical leadership has been widely recognised as one of the key strengths the establishment of CCGs has brought to commissioning. CCG Boards, member practices and other stakeholders have stated its

importance in establishment of MHCC from the outset. As the scope of commissioning broadens the same principles should apply to professionals from social care and public health.

The shifting role of commissioning in parallel to establishment of the LCO will change the role of clinical and professional leadership within MHCC. It is critical that:

- Clinical leadership is a strong feature of the new organisation.
- There needs to be a clear line of communication, influence and accountability between the Board and its member practices.
- Clinical leadership is not just limited to GPs but to other health, social care and public health professionals.
- The development of clinical leadership will evolve and adapt as the LCO is established and matures.
- It is important that a City organisation does not become distant from the local level.

Within the structures, governance, working arrangements and organisational development plan there are a number of arrangements which have been established to ensure these views are reflected in the organisational design.

6. Mission, vision and values

One of the important outputs of the engagement work with staff and other stakeholders has been to agree what the MHCC will do, how it will be done and how it will function as an organisation. Whilst the statutory name of the merged CCG will be NHS Manchester CCG the organisation will need a name by which it is known which reflects the partnership with Manchester City Council. Then from Board to Team level all staff will work under one banner and not as CCG or MCC staff. As a result of this engagement work the organisation will be known as Manchester Health and Care Commissioning 'MHCC'.

One of the things everyone agreed during the engagement process is the value of a plain English approach and the need to avoid coming up with new phrases and slogans to describe what it is we stand for. So with this in mind 'Working for a Healthier Manchester' will be adapted as the strapline, 'A Healthier Manchester' is the name of the Locality Plan, as well as what it is agreed all organisations are working together to achieve.

There has been significant discussion as to what MHCC's vision should be. It was concluded that our vision, and that of the partners in the city, is described in the Locality Plan and to come up with a separate one would be confusing. Instead a mission statement, distilled into five statements, has been put together. This describes in more detail our ambition, what we do, how and why:

- *We are determined to make Manchester a city where everyone can live a healthier life.*

- *We will support you, and your loved ones, investing in what you tell us is important to you.*

- *We will make sure you receive the right care in the right place and at the right time, delivered by kind, caring people that you can trust.*

- *We will make the most of our money by reducing waste, testing new ways of working that improve outcomes and funding the things we know will work.*

- *We will forge strong partnerships with people and organisations, in the City and across the region, and put health and wellbeing at the heart of the plans for developing Manchester's future as a thriving city.*

Over the course of the various engagement activities there was a lot of discussion about what our values should be as an organisation. Again, it was agreed that simplicity was key and avoidance of jargon or corporate language. When all the various feedback was analysed the three values which came out most strongly were: Positive, Collaborative and Fair

These will drive how MHCC functions. Appendix one gives more detail and can be clearly mapped to Our Manchester values and behaviours.

7 Commissioning strategy

7.1 The Commissioning strategy will set out how MHCC will achieve its mission, vision and values articulated in the section above. It will describe the overall ambition and outcomes to be achieved over the next 5-10 years. The population challenges in terms of both health and social care need are addressed within the strategy, although in the spirit of 'Our Manchester', the strategy will be framed in the context of building on the assets we have in neighbourhoods and across the City to drive improvement.

7.2 As the health and care system changes, it is vital that within the commissioning strategy, we set out the approach to commissioning that MHCC will pursue. The critical difference being that the organisation will move away from operational commissioning and become increasingly strategic in its role. As a strategic commissioner MHCC will have a wider system influence and leadership role beyond health and care, recognising the interdependency between wellbeing and wider social issues including, for example, employment, housing, and criminal justice.

Strategic commissioning	**Operational commissioning**
Commissioning systems not services	Commissioning health and care services
Leadership at all geographical levels	Neighbourhood focus, engaging with local people and practitioners to ensure local needs are understood and met
Setting outcome measures for the population of Manchester and defining	Focus on achieving outcome measure-clear 'logic' of metric at service level to

the broad models of care required from providers	high level outcomes
Assuring the quality and safety if service provisions, directly commissioned and through the supply chain.	Service and pathway redesign
Ensuring financial and performance targets are met – system wide	Functional support to contracting, business intelligence and finance
Fulfilling statutory functions and duties	Commissioning of individual or small scale packages of care and associated market development
Strategic market management	Oversee and manage medicines optimisation across the system
Innovation in commissioning including new contracting and payment systems	
Support asset based approach and co-production through commissioning	
Alignment with broader public services	

7.3 Moving to a strategic and system leadership approach to commissioning is a significant change and will be introduced over time, supported by an organisational development plan, referenced within the strategy.

The strategy will set out the strategic aims of the MHCC; these are currently being developed, but will reflect the need to:

- Improve health population outcomes
- Develop a thriving city, reducing dependency
- Achieve a sustainable system
- Deliver equitable, high quality care and patient experience.

The commissioning priorities will be expressed as priority outcomes for the system. These are being developed over the next two months, building on existing work (e.g. the LCO prospectus), and incorporating the opportunity that a more strategic approach will offer.

7.4 In summary the strategy will set out what MHCC will aspire to achieve and the approach it will take as a strategic commissioner to do this. The impact of this change in approach will be wider than the health and care system, and will drive improvement to achieve the strategic aims outlined above.

8. Governance

8.1 Governance model

From the outset, the ambition in setting up MHCC has been to create a single commissioning function, between a merged CCG and Manchester City Council, which will be able to create an organisational arrangement which is integrated and lean and is able to make decisions on the fullest scope of CCG and MCC's commissioning responsibilities as possible.

8.2 **MCC delegation of functions**

MCC can delegate those functions that it is allowed to do so by virtue of the National Health Service Act 2006 ('the NHS Act'), the Care Act 2014 ('the Care Act') and Regulations.

NHS Act 2006

8.3 Under the NHS Act local authorities and NHS bodies can enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised.

8.4 The powers permit the formation of a fund (pooled budget) made up of contributions by both parties "out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body or bodies and prescribed health-related functions of the authority or authorities" and the exercise of prescribed functions by each party.

8.5 These powers give rise to the three Health Act "flexibilities", namely:

- Pooled budgets.
- Lead commissioning.
- Integrated provision

8.6 Regulations set out the rules governing health and social care partnership. They specify what functions can and cannot be delegated. Delegable functions include:

- Social services and community care.
- Sports and leisure.
- Housing.
- Mental health.
- Residential care services for people with learning difficulties.
- Youth services.
- Numerous responsibilities under the Children Act 1989.
- Functions under the Education Acts.
- Deprivation of liberty functions under the Mental Capacity Act 2005
- Provision of healthy start vitamins.
- Numerous other functions, including those relating to waste collection and disposal, environmental health services, and highways and passenger transport functions

Care Act 2014

8.7 Under the Care Act most adult social care functions can be delegated although some are not capable of delegation and must remain with the council.

8.8 The duties and functions of the City Council as exercised by the DASS are set out in the Constitution. In addition to the specific obligations of the DASS the Care Act has brought together a wider set of duties than previously set out in legislation. Whereas previously the core Council obligations were to meet assessed, eligible need the Care Act widened or re-defined the core duties as:

- Prevention
- Promotion of wellbeing
- Co-operation
- Assessment (both those in need of services plus their carers)
- Provision
- Market shaping
- Safeguarding

8.9 Under the Care Act local authorities are generally able to delegate all of their Care Act functions with a few exceptions.

8.10 Section 79 of the Care Act lists those exceptions and expressly does not allow the Council to delegate the following Council's functions:

- A duty on the Council to exercise its functions under the Care Act "with a view to ensuring the integration of care and support provision with health provision and health-related provision".
- A duty on the Council to co-operate generally with "each of its relevant partners" and to co-operate "in specific cases".
- The Council's "power to charge for meeting needs under sections 18 to 20 of the Care Act".
- A duty on the Council in relation to Safeguarding adults at risk of abuse and neglect, which includes the duty to "make enquiries" where the Council has "reason to suspect" that an adult "(a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it".
- The duty of the Council to establish a "Safeguarding Adults Board"

8.11 Care and Support Statutory Guidance clarifies section 79 of the Care Act and provides guidance on its interpretation and implementation.

8.12 The effect of the legislation and the statutory guidance supporting it is that:

- Integration and cooperation duties cannot be delegated. Local authorities must cooperate and integrate with local partners. Delegating these functions would not be compatible with meeting their duties to work together with other agencies.
- Certain safeguarding functions may be delegated under s.75 partnership arrangements save for the duty to establish a Safeguarding Adults Board (SAB). Since the local authority must be one of the members of the SAB,

and it must take the lead role in adult safeguarding, it may not delegate this function to another party

- The power to charge under the Care Act under section 14 of the Care Act cannot be delegated as local policies relating to what can and cannot be charged for must remain a decision of the local authority. However, it may commission or arrange for other parties to carry out related activities and the Council can enter into partnership arrangements whereby a health body is able to exercise the Council's function of making a charge for the provision of adult social care services provided pursuant to sections 18 to 20 of the Care Act).

8.13 It is clear that ultimate responsibility for delegated functions will still rest with the local authority. Where delegation is permitted, its primary effect is to enable the delegated body to perform the function on behalf of the public authority. Therefore, the actions of the delegated body are treated as actions of the public authority. The essence of delegation is that the public authority retains responsibility for the actions of the delegated body i.e. any acts /omissions by the delegated body will be treated as done / omitted to be done by the local authority.

8.14 Individual wellbeing should always be central to any decision to delegate a function and local authorities should not delegate its functions simply to gain efficiency where this is to the detriment of the wellbeing of people using care and support.

8.15 In order to meet the Council's legal obligations and to ensure that the single commissioning function meets its strategic objectives it is proposed that all adult social care and public health functions that can be lawfully delegated to the single Manchester CCG are delegated. It should be noted that the DASS and Director of Public Health roles will remain within and accountable to the Council whilst also having accountability to the CCG Accountable Officer

Public Health functions

8.16 Since 1 April 2013 local authorities have been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse. The Secretary of State continues to have overall responsibility for improving health – with national public health functions delegated to Public Health England.

8.17 Under s.2B(1) of the NHS Act: "Each local authority must take such steps as it considers appropriate for improving the health of the people in its area". Examples of the steps which may be taken include:

- providing information and advice;
- providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way);

- providing services or facilities for the prevention, diagnosis or treatment of illness;
- providing financial incentives to encourage individuals to adopt healthier lifestyles;
- providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;
- providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;
- making available the services of any person or any facilities.

8.18 Further, every local authority is required to provide or make arrangements for the provision of:

- health checks to eligible people in its area;
- health visitor services.
- sexual health services;
- public health advice to local CCGs;
- information and advice to other public bodies in its area (e.g. the police) to promote the preparation of health protection arrangements or participation in such arrangements by those bodies.

8.19 Other local authority functions include a duty to provide for the medical inspection and medical treatment of pupils attending maintained schools and the power to provide similar services to pupils attending other schools and the weighing and measuring of junior pupils.

Directors of Public Health

8.20 The Council is required to appoint a Director for Public Health who has responsibility for ensuring that the Council's public health duties are complied with.

Delegation of Public Health Functions

8.21 Partnership Regulations set out those health related functions of a local authority that can be subject to s.75 partnership arrangements. Regulation 5 lists the health related functions of a local authority which include:

- the functions of local authorities under or by virtue of sections 2B NHS Act; or
- s. 6C(1) of the NHS Act; or
- Schedule 1 to, the NHS Act

Board arrangements

8.22 The City Council can only delegate its functions to the CCG but it cannot be a member of the CCG or its Governing Body. In light of this, it has therefore been agreed to pursue an organisational governance model whereby the CCG

delivers its statutory functions, duties and delegated functions through further delegation and authorisation to:

- **A MHCC 'Board'** - a committee of Manchester CCG that discharges the vast majority of CCG functions and is authorised to carry out the functions that are delegated to it from the CCG and the functions delegated to the CCG from the City Council. This is considered the most legally suitable mechanism to achieve the best governance structure. Whilst the legal host of the function will be Manchester CCG this will be a partnership of equals with Manchester City Council. The City Council will be represented on the Board by the DASS, and 2 Executive members. The Board will be supported to discharge its functions through a number of committees which will also include City Council representation, as follows:

    - Finance and Contracting Committee
    - Quality and Performance Committee
    - Clinical Committee
    - Joint Executive Committee
    - Governance Committee
    - Patient and Public Advisory Group.

8.23 The Board will be established in such a way that it can also receive delegated functions from other bodies such as NHS England with the intention being that the fully delegated commissioning arrangements for primary medical services are managed through the Board. In the event that this is not agreed a Primary Care Committee will be established and will meet 'in common' with the Board.

8.24 The CCG Governing Body will be responsibility for the specific CCG statutory functions required through legislation and agreeing partnership agreements.

8.25 The City Council Executive and DASS will remain responsible for the Council's statutory functions.

<u>Partnership agreement with Manchester City Council</u>

8.26 The details of the Partnership agreement between the CCG and Manchester City Council will be described within a co-signed Partnership agreement which will detail the 'rules' of the partnership including:

- General principles
- Partnership flexibilities
- Functions within the scope of the agreement
- Commissioning arrangements
- Establishment of a pooled fund
- Pooled fund management
- Financial contributions
- Non-financial contributions
- Risk share arrangements, overspends and underspends
- Liabilities, insurance and indemnity
- Standards and conduct of services

- Conflicts of interest
- Governance
- Terms of review
- Termination and default.

8.27 The Agreement will detail those functions to be delegated as set out above. Work to finalise this agreement will continue through February with Legal Services and the CCG's legal advisors.

8.28 Constitutional arrangements

The constitution of the newly formed CCG will be drafted to align with the partnership agreement, the delegations and overall governance of the CCG set out above, including the delegation of primary care function from NHS England. Manchester City Council's constitution will be amended to reflect any changes in the delegations of its statutory functions.

9. Human Resources and organisational development

9.1 CCG Governing Body

Members of the CCG Governing Body are as follows.

- Chair
- Lay member for governance (vice-chair)
- Lay member for governance
- Lay member for patient and public engagement
- Secondary Care Doctor
- Nurse
- Chief Officer
- Chief Finance Officer

Each member of the Governing Body is also a member of the Board. It should be noted that the City Council cannot be a member of or sit on a CCG governing body.

9.2 The Board

The MHCC Board will fulfil the functions as set out in section 8.22. This will be the pre-eminent decision making group of MHCC. Its membership will be as follows:

- Chair
- GP Board member
- GP Board member
- GP Board member
- Lay member for governance
- Lay member for governance

- Lay member for patient and public involvement
- Executive Councillor as nominated by Manchester City Council
- Executive Councillor as nominated by Manchester City Council
- Manchester City Council DASS
- Secondary Care Doctor
- Board Nurse
- Chief Accountable Officer
- Chief Finance Officer

Joint Executive Team members will be in attendance and other senior officers as appropriate.

9.3 **Joint Executive Team**

The Joint Executive Team structure has been developed as a result of engaging in discussions with a range of stakeholders. The proposed structure has the potential to radically shape the way the work is undertaken in Manchester. The team needs to be different from previous and current structures to reflect the nature of reform and transformation in the City.

Key design principles:

- The team needs to be a blended team across health and social care
- The team needs to work with a high degree of cross-directorate working
- The team needs to reflect innovation and signal accelerated change
- The team form needs to be radical and brave
- The team needs to be small in number and flexible
- The skill set of the team needs to be appropriate and the best possible for the task in hand, which may require new skill combinations
- The team will need to deliver upon finance, strategy, transformation and reform, innovation, improvement and quality.

The proposal is to recruit six executive director roles, which would report directly to the Chief Accountable Officer. The six direct report posts will have corporate responsibility across the health and social care agenda, but will have lead areas of responsibility. The team will work closely as one unit to ensure integration of expertise and provide business continuity. The posts will have a focus upon system leadership.

The posts are:

- Chief Finance Officer
- Medical Director
- Director of Strategic Commissioning (this role will also carry the statutory functions of the Director of Adult Social Care)
- Director of Planning and Operations
- Director of Nursing
- Director of Population Health and Wellbeing (this role will also carry the statutory functions of the Director of Public Health)

MHCC will begin formal operations from April 2017 and will develop during the year. It is anticipated that the development of the LCO and MHCC will see a shift in operational functions to the LCO. As a result MHCC Executive Directors' portfolios will develop and be reviewed.. There is a firm intention to undertake all necessary processes so the Governing Body, Board and Joint Executive Team can begin operations effectively from April 2017.

10. Finance

10.1. The intention to expand the pooled fund substantially from 2017/18 is considered a key enabler to fully integrating health and social care. This is because a joint pool is more likely to encourage system-wide financial decisions, with a joint focus upon closing the funding gap and provides the mechanism for funding to flow around the whole health and social care system.

10.2. A Section 75 agreement is the mechanism used to establish a pooled fund. Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service functions. The Section 75 agreement forms the governance framework and includes decision making responsibilities, reporting arrangements, dispute resolution and finance rules including permitted expenditure and risk sharing.

10.3 The overall Integrated Commissioning Budget (ICB) for the MHCC partnership will indicatively be made of the following funds:

(i) Those budgets that can be pooled under S75 (pooled budgets);

(ii) Those budgets that legally cannot be pooled under the S75 arrangements (aligned budgets); and

(iii) Other budgets which are not pooled (in collaboration budgets).

<u>Manchester City Council</u>

10.4 The Executive's 2017-20 budget proposals are detailed elsewhere on the agenda. The budget proposals outline a core level of funding, or 'social care expenditure limit' which the Council would look to contribute to the health and social care ICB, which is set out in the table below (Public Health excludes approximately £15m of Children's Public Health within other Directorate cash limits).

	2017/18 £m	2018/19 £m	2019/20 £m
Base Budget	**157.69**	**156.63**	**154.81**
Apportionment of pay and non pay inflation	2.52	4.50	6.49
National Living Wage costs for commissioned services	4.26	8.52	12.77
Demographic pressures	10.26	12.91	15.57
Sub Total Additional Funding	17.04	25.93	34.83
Sub Total Contribution	**174.73**	**182.56**	**189.64**
Savings Target met from Local	-5.00	-8.00	-12.00
Add Additional Social Care Pressures	-4.68	-4.75	-4.82
Total Savings Requirement	-9.68	-12.75	-16.82
Total Pooled Budget Contribution	**165.05**	**169.81**	**172.82**
Net Increase to Contribution	**7.36**	**13.18**	**18.01**
Year on Year change		**5.82**	**4.83**

10.5 The Council's indicative adult social care ICB contribution would increase from £165.05m 2017/18 to £172.82m in 2019/20. The intention is to maximise the pooled budget component, subject to the following:

(i) There are certain local authority functions which cannot be pooled and they are:
- Section 14 of the Care Act 2014 (power to charge)
- Section 17 of the Care Act 2014 (assessment of financial resources)
- Section 69 of the Care Act 2014 (recovery of charges, interest etc.)
- Regulations under section 2(3) of the Care Act 2014 (charging for preventing needs)
- Section 6 of the Local Authority Social Services Act 1970 (appointment of a DASS)
- Section 3 of the Adoption and Children Act 2002 (maintenance of adoption service)
- Sections 114 of the Mental Health Act 1983 (AMHP approval)
- Section 115 of the Mental Health Act 1983 (power of entry

(ii) The Strategic Director consider the following services should be deemed out of scope or phased for future years:

- Adult Safeguarding and Quality Assurance as these Council's statutory functions cannot be delegated

(iii) Agreement on the integration of budgets for Children's Services.

10.6. The final Council pooled budget contribution will be set using the table above but adjusted once work to complete the analysis of budgets which cannot be pooled (to be Aligned budgets) and other choices not to or to phase the pooling (to be In Collaboration budgets until pooled) is completed.

Manchester Clinical Commissioning Groups (CCGs)

10.7. CCG resources allocations, including those allocations to support primary care delegated functions, were agreed by NHS England in December 2015. These allocations provided detail of agreed funding for CCGs for 2016/17-2018/19 and indicative funding for 2019/20 and 2020/21. In setting allocations NHSE utilised the nationally agreed formula to ensure reflection of health needs at CCG level. Financial plans for revised single commissioning arrangements will be developed on the basis that budgets set will reflect national allocation policy at a CCG level with the need to underpin strategy objectives and VFM.

10.8. The newly formed CCG will inherit the allocations from the three legacy organisations. These are shown in the table below:

		2017/18				2018/19			
		NMCCG	SMCCG	CMCCG	**Total**	NMCCG	SMCCG	CMCCG	**Total**
		£m	£m	£m	**£m**	£m	£m	£m	**£m**
Recurrent	CCG core	288	239	260	**787**	294	244	266	**804**
	Primary care	32.3	23.8	31.3	**87.5**	33.7	24.8	32.5	**91**
	Running costs	4.12	3.65	4.47	**12.2**	4.12	3.66	4.46	**12.2**
	Total	324	267	296	**887**	332	272	303	**907**
Non Recurrent	Draw down	3.04	0	0	**3.04**	0	0	0	**0**
	HRG4+	1.01	0.09	0.59	**1.7**	1.03	0	0.6	**1.72**
	IR	1.26	-0.1	0.82	**2.02**	1.28	0	0.83	**2.05**
	Total	5.32	0.03	1.41	**6.76**	2.32	0.03	1.43	**3.77**
	Surplus cfwd	3.03	2.41	2.63	**8.06**	3.03	2.43	2.66	**8.12**
	TOTAL	**332**	**269**	**300**	**902**	**337**	**275**	**307**	**919**

NHS Manchester CCG will have a total allocation of £902 million in 2017/18 and £919m in 2018/19. Financial plans have been prepared for North, Central and South Manchester CCGs and were submitted to NHSE in December.

10.9 The final health contribution to the pooled budget will also be determined taking into account:

(i) The budgets which cannot be pooled under current legislative restrictions; and

(ii) Legal advice in relation to primary care commissioning (PCC) due to restrictions surrounding double delegation of budgets from NHSE.

10.10 From 1st of April 2017, it is expected that the following will be in place:

- The merger of three CCGs into one legal organisation, bringing together allocations, financial systems and budgetary control;
- An ICB with Manchester City Council covering the majority of health and social care expenditure with the element formally pooled maximised;
- Joint financial reporting, showing the total commissioning financial position, i.e. the whole ICB; and
- The development of a joint financial framework.

10.11. Further work will take place during 2017/18 to fully integrate health and social care financial systems and staff, to undertake due diligence on opening budgets and to develop a more sophisticated approach to risk and benefit shares. This will be necessary for the effective operation of a fully integrated pooled budget that enables resources to be more flexibly deployed to meet priorities and to support the development of the Investment Agreement required to underpin the GM Transformation Fund investment.

11 Requirements set out by CCGs in supporting the direction of travel

CCG Boards identified a number of key issues which they considered important in establishment of new commissioning arrangements. The response to these has been set out in the sections above. These are referenced below to demonstrate that plans that have taken note of these issues.

- The importance of clinical leadership is agreed across the system. The establishment of MHCC has:
  - Set out a new vision for clinical leadership
  - Established governance which ensures clinical leadership is 'wired' in the operations of the organisation including:
    - The clinical committee which creates a direct line between Board and member practice
    - Clinical membership of the Board, Committees and other working groups.
- In becoming a larger organisation, across a wider geographical footprint, it is important that there is a strong connection to neighbourhoods. Again, the governance and roles outlined above will ensure this, including:
  - Named GP Board members will have a specific responsibility to link with a number of defined neighbourhoods
  - The Clinical Committee will include clinical representation from each neighbourhood
  - The Patient and Public Advisory Group will include representation from each neighbourhood

- There will be an ongoing programme of community engagement, overseen by the PPAG and Lay representative for Patient and Public Involvement.

- It was important that North Manchester's increased allocation, due to historic underfunding in that area, was not lost. The three Manchester CCG Boards have agreed that an investment budget will be established to support investment in improvement in the North Manchester area in 2017/18.

12 Implementation milestones

The following section outlines the priority work in developing MHCC and also sets out MHCC's key priorities for the next eighteen months.

13 MHCC Development

Key actions for the next three months are:

- Mission vision and values
  - Agree and communicate

- Governance
  - Memberships' approval of merger
  - NHSE authorisation of NHS Manchester CCG
  - Establishment of partnership agreement with Manchester City Council
  - Schedule and plan Board and Committee meetings

- HR & OD
  - Appointment of Governing Body, Board and Executive Team
  - Development of integrated staffing structure

- Finance
  - Establish financial systems for Manchester CCG
  - Agree pooled budget arrangements for 2017/18

- Logistics
  - Short term office and IT solutions
  - Develop medium term plan for estates and IT

14 MHCC Forward Plan

Programme	Jan-Mar '17	Apr-Sep '17	Oct '17 - Mar '18
Commissioning	Establishment of MHCC through CCG merger and partnership with MCC. Strategy in place. Our Manchester projects established	Fully operational, workplan for full financial integration across health and social care agreed	Agreed plan for Children's commissioning integration

LCO	Issue of provider PIN, commission new care models, social care market shaping plan, nursing & residential action plan	Provider selection complete. Alliance agreement for 2017/18	Contract agreed for April '18 start
Single hospital service	Identification of benefits, progress with CMA, plan for NMGH	UHSM & CMFT merge, plan for NMGH in place	Timetable for NMGH inclusion agreed
Transformation	GMTF income and expenditure agreed, overall benefits of locality plan agreed. LCO funding for new care models	Delivering early services, especially in the LCO	Transformation programmes aligned to LCO provider
Mental health	Successful arrival of new provider - 4 agreed priorities	Delivering services effectively, integration plan to LCO in place	
Finance	Agree budget and savings plan for 2017/18	Delivery of financial plan	Agree budget and savings plan for 2018/19
Quality and performance	Key priorities e.g. DToC, NMGH	Delivery of Quality & Performance objectives	Delivery of Quality & Performance objectives

15 **Risks and issues**

In the November CCG Board papers a summary of key risks of establishing MHCC and also of not doing so were provided. This risk assessment is included in the table below with a current status for risks against establishment.

Risk as at Nov '16	**Current position**	**Mitigations**
Cultural and business practice differences between the four partner organisations.	Significant progress has been made with both culture and business practice. The OD programme has been very strong.	Further OD work as set out above. In addition a stocktake of systems and processes is being undertaken to support development of a unified operating model
The timeframe for implementation is challenging.	All critical timescales have been met to date. The remaining milestones are also significantly challenging.	A project team is now in place and workstreams are well resourced.
The implementation timescale is reliant upon NHS England approval processes.	NHS England have approved the merger subject to CCG Board and member approvals.	Strong proposition to CCG Boards. Intense engagement with GP memberships.

Legal and regulatory barriers might be an impediment to the ideal governance arrangements	A suitable governance arrangement has been identified which will allow MHCC to work effectively. Drawing up of the appropriate agreements and seeking approvals is still required	Working with legal teams of MCC and CCGs and liaison with senior leadership to ensure arrangements are satisfactory.
The opportunity cost in terms of workforce	There is still significant time commitment from CCG/MCC staff for MHCC development. However, this will start to reduce from April. Efficiencies in new ways of working are expected to offset this in the short and longer term.	Additional appointments supporting MHCC development.
The time to implement a pooled budget and associated risks	Development of a roadmap towards full financial integration over a two year period.	Work progressing between finance teams.

Risk assessment of MHCC development.

For information the risks set out in the November paper, of not establishing MHCC were.

- Continued sub-optimal working leading to City workstreams with unclear leadership, governance and decision making
- Unacceptable levels of stress within the workforce and increased staff turnover due to stress and uncertainty
- An incompatibility of commissioning arrangements with the external environment e.g. (GM Partnership and provider configuration)
- The financial and performance implications of not progressing transformation programmes at sufficient pace due to sub-optimal working arrangements.

16. **Recommendations**

As above

Appendix 1

We will be:	This means:	So we will: (Examples below for illustrative purposes)
Positive	We are proud of Manchester	Work with partners to deliver the city's Our Manchester strategy
	We work hard to deliver for local people	Commission to promote social value
	We do what we say we will	Deliver 100% of our operational plan each year
	We are proactive, creative and ambitious	Try new things
	We act quickly	Reduce bureaucracy and speed up decision making
	We recognise the strengths of individuals and communities	We support and develop community assets through our commissioning work
Collaborative	We listen to, and act on, what people tell us	Evidence how local people's view have impacted on our work
	We will be open and honest	Hold Board meetings in public and publish as much as we can
	We are active partners to work with	Play our part in delivering Manchester's priorities
	We will work on a neighbourhood basis	Our neighbourhoods will influence our decision making
	We value our employees	Create healthy, reflective workplaces where we innovate and learn together
	We will influence regionally and nationally	Play an active role in GMHSCP and share our good practice
	We will be clinically/professionally led	Have clinicians and professionals throughout our organisational structure shaping and informing decision making
	We will work with all communities of place and identity	We will constantly monitor and evaluate Manchester's rapidly evolving population and reach out to all communities to ensure their needs are reflected in the service we commission
Fair	We address health inequalities	Invest more in areas with poor outcomes currently
	We will make unbiased	Our decisions will be based on evidence

	decisions	and data
	We will engage and empower our workforce	Our workforce practices, policies and development processes will shape our values
	We recognise and value diversity and inclusion	Act on the views and experience of different communities
	We will develop equitable high quality services across Manchester	Swiftly address examples of poor quality care

Appendix 2 Duties of the DASS and Adult social care functions

1. DASS

The local authority shall take steps to ensure that the post holder is given the necessary authority, is enabled/given the necessary resources to provide professional leadership (including delivering workforce planning in social care and deliver the cultural change necessary to implement person-centred services and to promote partnership working, and such other responsibilities as the local authority determines.

The local authority shall ensure that the DASS is made accountable for the delivery of local authority social services functions listed in Schedule 1 of the Local Authority Social Services Act 1970 (as amended), other than those for which the Director of Children's services is responsible.

Local authorities shall ensure that the DASS is directly accountable to the Chief Executive of the local authority and comparable in terms of seniority, with the Director of Children's Services.

2. The statutory role of the DASS

The DASS's key leadership role is to deliver the local authority's part in:

- Improving preventative services and delivering earlier intervention
- Managing the necessary cultural change to give people greater choice and control over services
- Tackling inequalities and improving access to services
- Increasing support for people with the highest levels of need

There are seven key aspects to be included in the DASS's remit:

(i) Accountability for assessing local needs and ensuring availability and delivery of a full range of adult social services
(ii) Professional leadership, including workforce planning
(iii) Leading the implementation of standards
(iv) Managing cultural change
(v) Promoting local access and ownership and driving partnership working
(vi) Delivering an integrated whole systems approach to supporting communities
(vii) Promoting social inclusion and wellbeing

3. Adult social care functions

3.1 The following adult social care are functions specified in Schedule 1 to the Local Authority Social Services Act 1970:

3.1.1 Functions under section 49 of the National Assistance Act 1948 (Defraying expenses of local authority officer applying for appointment as deputy for certain patients);

3.1.2 Functions under section 3 of the Disabled Persons (Employment) Act 1958 (Provision of facilities for enabling disabled persons to be employed or work under special conditions);

3.1.3 Functions under section 8 of the Mental Health Act 1959 (Welfare and accommodation of mentally disordered persons);

3.1.4 Functions under section 5(1)(b) of the Health Visiting and Social Work (Training) Act 1962 as extended by section 45(9) of the Health Services and Public Health Act 1968 (Research into matters relating to local authority welfare services);

3.1.5 Functions under section 1 of the Chronically Sick and Disabled Persons Act 1970 (Obtaining information as to need for, and publishing information as to existence of, certain welfare services; providing information about certain welfare services);

3.1.6 Functions under section 2 of the Chronically Sick and Disabled Persons Act 1970 (Provision of certain welfare services);

3.1.7 Functions under section 2A of the Chronically Sick and Disabled Persons Act 1970 (Welfare services: transition for children to adult care and support in England);

3.1.8 Functions under sections 6 and 7B of of the Chronically Sick and Disabled Persons Act 1970 (Appointment of [director of adult social services or director of social services, etc; provision and conduct of complaints procedure)

3.1.9 Functions under section 18 of the Chronically Sick and Disabled Persons Act 1970 (Provision of certain information required by Secretary of State);

3.1.10 Functions under Schedule 5 to the Supplementary Benefits Act 1976 (Provisions and maintenance of resettlement units for persons without a settled way of living);

3.1.11 Functions under Parts II, III and IV of the Mental Health Act 1983 (Welfare of the mentally disordered; guardianship of persons suffering from mental disorder including such persons removed to England and Wales from Scotland or Northern Ireland; exercise of functions of nearest relative of person so suffering);

3.1.12 Functions under Parts II, III and IV of the Mental Health Act 1983 - welfare of the mentally disordered; guardianship of persons suffering from mental disorder including such persons removed to England and Wales from Scotland or Northern Ireland; exercise of functions of nearest relative of person so suffering

3.1.13 Functions under sections 66, 67 and 69(1) of the Mental Health Act 1983 (Exercise of functions of nearest relative in relation to applications and references to the First-tier Tribunal);

3.1.14 Functions under section 116 of the Mental Health Act 1983 (Welfare of certain hospital patients);

3.1.15 Functions under section 117 of the Mental Health Act 1983 (After-care of detained patient);

3.1.16 Functions under section 117A of the Mental Health Act 1983 (Functions under regulations about provision of preferred accommodation under section 117);

3.1.17 Functions under section 130 of the Mental Health Act 1983 (Prosecutions);

3.1.18 Functions under section 130A of the Mental Health Act 1983 (Making arrangements to enable independent mental health advocates to be available to help qualifying patients);

3.1.19 Functions under section 46(2) and (5) of the Public Health (Control of Disease) Act 1984 (Burial or cremation of person dying in accommodation provided under Part III of the National Assistance Act 1948, and recovery of expenses from his estate);

3.1.20 Functions under section 213(1)(b) of the Housing Act 1996 (Co-operation in relation to homeless persons and persons threatened with homelessness);

3.1.20 Functions under sections 1 to 4, 5(5), 7 and 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986 (Representation and assessment of disabled persons);

3.1.21 Functions under section 46 of the National Health Service and Community Care Act 1990 (Preparation of plans for community care services);

3.1.22 Functions under section 47 of the National Health Service and Community Care Act 1990 (Assessment of needs for community care services);

3.1.23 Functions under section 1 of the Carers (Recognition and Services) Act 1995 (Assessment of ability of carers to provide care);

3.1.24 Functions under the Community Care (Direct Payments) Act 1996 (Functions in connection with the making of payments to persons in respect of their securing the provision of community care services);

3.1.24 Functions under the Health and Social Care Act 2001 (Making of direct payments to person in respect of his securing provision of community care services or services to carers);

3.1.25 Functions under Part I of the Community Care (Delayed Discharges etc.) Act 2003;

3.1.26 Functions under section 39 of the Mental Capacity Act 2005 (Instructing independent mental capacity advocate before providing accommodation for person lacking capacity);

3.1.27 Functions under section 39A of the Mental Capacity Act 2005 (Instructing independent mental capacity advocate when giving an urgent authorisation, or making a request for a standard authorisation, under Schedule A1 to the Act);

3.1.28 Functions under section 39C of the Mental Capacity Act 2005 (Instructing independent mental capacity advocate when no representative for relevant person under Part 10 of Schedule A1 to the Act);

3.1.29 Functions under section 39D of the Mental Capacity Act 2005 (Instructing independent mental capacity advocate when representative for relevant person under Part 10 of Schedule A1 to the Act is not being paid);

3.1.30 Functions under section 49 of the Mental Capacity Act 2005 (Reports in proceedings);

3.1.31 Functions under Schedule A1 of the Mental Capacity Act 2005 (Any functions);

3.1.32 Functions under Part 1 of the Care Act 2014, except sections 14, 17, 69, 78, and regulations made under section 2(3) (see further at paragraphs 1.41 and 1.42 below) so far as that Part and regulations under it give functions to local authorities in England (General responsibilities in relation to care and support services; Assessing and meeting needs for care and support, and carers' needs; Direct payments, deferred payment agreements and loans; Continuity of care and ordinary residence; Safeguarding adults; Provider failure; Children in transition to adult care and support; Independent advocacy support; Recovery of Charges; Appeals against local authority decisions; Discharge of hospital patients; Registers; Delegation of functions);

3.1.33 Functions under section 14 of the Care Act 2014 (function of making a charge for meeting needs) and section 17 of the Care Act (function of carrying out a financial assessment in relation to the making of the charge) in respect of meeting needs for care and support under section 18 or 19 of the Care Act 2014;

3.1.34 Functions under regulations made under section 2(3) of the Care Act 2014 (function of making a charge for the provision, or arranging the provision, of services, facilities or resources or taking other steps under section 2(1) of the Care Act 2014).

3.1.35 The arrangements in place for determining the services for which a user may be charged and informing users about such charges in respect of meeting the needs for care and support under section 18 and 19 of the Care Act, and in respect of providing or arranging for the provision of services, facilities or resources or taking other steps under section 2(1) of the Care Act 2014 or making a charge, arrangement or taking of steps under regulations under section 2(3) of that Act are set out in the Council's Charging Policy for Homecare and other non residential social services.