Is Manchester Greater?

A New Analysis of NHS Integration

BY KARL WILLIAMS

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Executive Summary

In developed countries around the world, health and care systems are coming under intensifying pressure from ageing populations. On top of that, they now face the aftermath of the coronavirus. In England, the NHS is confronting a record backlog of more than five million people awaiting treatment, while operating with a workforce worn down by the biggest health crisis in generations.

In response to the crisis, the Government has brought forward the Health and Care Bill, whose stated purpose is to build on the work done during the pandemic to accelerate collaboration and integration across health and social care. In truth, as is widely recognised, the proposals are largely based on those put forward by NHS England in the NHS Long Term Plan, published in January 2019.

‘Already, the NHS in England has been subdivided into 42 Integrated Care Systems (ICSs), of which 13 are at a more advanced stage’

The Bill reflects the conventional wisdom that the solution to the pressures faced by the NHS (and indeed other healthcare systems) is ‘integrated care’. The accent here is on greater collaboration both within health services (between GPs and consultants, for example) and between health services and third parties such as local authorities. There will, for instance, be a new legal ‘duty to collaborate’.

Already, the NHS in England has been subdivided into 42 Integrated Care Systems (ICSs), of which 13 are at a more advanced stage. The Bill will put these on a statutory basis, and make them the central bodies through which the NHS is managed. The aim is to shift incentives so that individual patients get a joined-up care pathway, and there is more of a focus on prevention rather than cure. Accompanying this, there will be a shift in financial incentives away from payment per procedure and towards rewarding better care outcomes more broadly.

While it draws on previous reforms such as the Better Care Fund, established in 2013 to incentivise health and social care providers to work more closely together, this change represents a distinct break with the decades-long trend towards seeing greater choice and competition as the best way to increase NHS efficiency. For example, the new Bill rolls back the requirement for competitive tendering of many NHS services.

In contrast to the most recent top-down reorganisation under Andrew Lansley, the bulk of the proposals in the Health and Care Bill originate with NHS England itself, and the shift towards the ICS model of greater collaboration has been broadly welcomed by the sector – not least because the ICSs will replace Lansley’s Clinical Commissioning Groups (CCGs) as the holders of the purse strings within the system. Yet given the disruption caused by the Lansley reforms, it is vitally important that we do not repeat

the mistakes of the past – especially given the strain the NHS is already under due to the pandemic.

And the alarming truth is that, as with the Lansley reforms, this seismic reform of how the NHS works has had surprisingly little scrutiny. To put it bluntly, everyone is in such fervent agreement that the ICS model of integration and collaboration is the future of the NHS that hardly anyone appears to have looked properly at whether this approach works in practice. The National Audit Office (NAO) noted in 2017 that: 'The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients. The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration.' That is still fundamentally the case.

This paper seeks to fill that gap, by examining the evidence for integration where it has been tried so far – to see whether integration is working, and what kinds of integration are working best.

In doing so, we have evaluated performance of local health systems against three criteria: how the area has performed against the national average; how local trends have shifted post-integration, either positively or negatively; and how the integrated service has performed against the explicit targets that were set for it, where they exist. We have then used this blended metric to assess whether performance in a given area has improved, deteriorated or remained the same. (For obvious reasons, we have taken the start of the pandemic, in March 2020, as our cut-off point in analysing the data.)

'This paper seeks to fill the gap identified by the NAO, by examining the evidence for integration where it has been tried so far – to see whether integration is working, and what kinds of integration are working best'

Our primary case study is Greater Manchester. This was the first region in England to integrate its care systems, and is therefore the place where the data is richest. It is also widely recognised as the kind of place where such a system should work best: a densely populated, highly integrated conurbation with a strong regional identity, devolved political leadership and a collaborative etc. Its path to integrated status was also smoothed by the establishment of a £450m 'transformation fund', the equivalent of 7.5% of the region's £6 billion annual health and social care budget.

Our secondary case study is the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP). Unlike Greater Manchester, which is a 'devolved' institution, WYHHCP is under the supervision of NHS England. As a 'second wave' integrated care system, launching only in 2018, there is less progress data available. However, the WYHHCP is not only more typical of what the ICS model will look like nationwide, but is viewed by NHS bosses as the best available example of the integrated model in action.

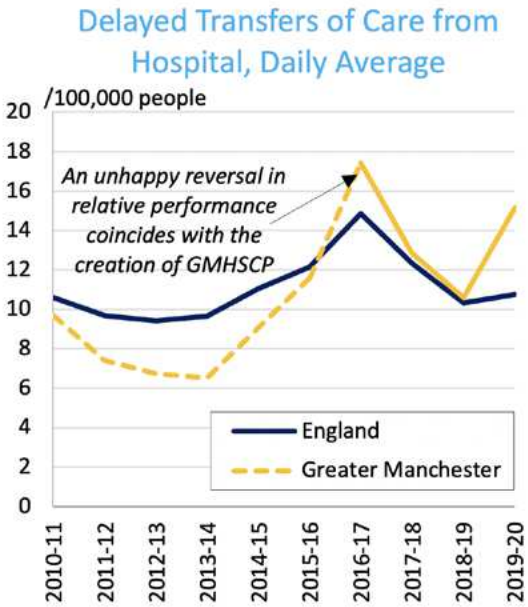
Finally, we will highlight some findings from all of the 13 ICSs (or proto-ICSs) currently in operation – most significantly Delayed Transfers of Care (DtoCs), i.e. the frequency with which patients are kept waiting to move out of hospital and into care. This is generally recognised as the key indicator of whether health and social care systems are properly joined up, and a major driver of the NHS's capacity problems. We then offer our concluding recommendations.

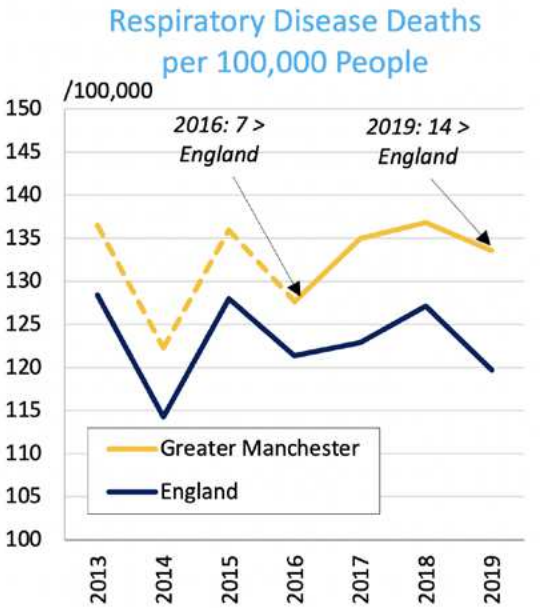
Greater Manchester

Outcomes in the Greater Manchester Health and Social Care Partnership

Indicator	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
DtoC and Bed-Days					Y	
Attendances at A&E		Y				
Emergency Admissions			Y			
Unplanned ACSC Admissions			Y			
Emergency Readmissions			Y			
SHMI				Y		
Cancer Survival Rates			Y			
Cancer Mortality				Y		
CVD Mortality	Y					
Respiratory Disease Mort.					Y	
Neonatal Outcomes					Y	
Mental Health Bed-Days				Y		
Alcohol-Specific Admissions		Y				
Life Expectancy at 75			Y			
NHS FTE Workforce					Y	
TOTAL	1	2	5	3	4	0

- With the notable exceptions of cardiovascular mortality and alcohol-related admissions, health and social care outcomes in the Greater Manchester Health and Social Care Partnership (GMHSCP) are **generally significantly worse** than would have been expected based on pre-2016 trends in the area, national performance across England, and the GMHSCP's own stated objectives.
    - Across **many** of the care indicators analysed, outcomes in Greater Manchester deteriorated after the establishment of the GMHSCP, relative to the pre-GMHSCP period.
    - Across **most** of the care indicators analysed, outcomes in Greater Manchester deteriorated relative to England following the establishment of the GMHSCP.
    - As of March 2020, the GMHSCP was **generally failing** to meet its own quantified targets as set out in the five-year plan published in December 2015.
- Notable and alarming outcomes include:
    - A 65% rise in delayed transfers of care after the GMHSCP was established
    - 5,700 more emergency readmissions compared to the pre-GMHSCP trend
    - 320 more deaths associated with hospitalisation under the GMHSCP
    - 220 more respiratory disease deaths in 2019 than if the region had paralleled national trends
    - 940 more cancer deaths in 2019 than implied by the GMHSCP's five-year plan





- There was also a significant decline in productivity. Between 2016 and 2019, the regional full-time equivalent (FTE) workforce per 100,000 population increased by 8.7%, compared to a 4.7% rise nationally. However, the share of the workforce with clinical qualifications fell from 55% to 52% between 2016 and 2020, compared to a fall from 54% to 53% across England. There was a 23% increase in senior managers, and the support and infrastructure workforces expanded by 33% and 30% respectively.

- This weak performance came in spite of the upfront £450m transformation fund. If repeated nationwide, this would represent a £11 billion funding increase for the NHS and social care, almost the equivalent of the entire NHS budget increase in 2021/22. If such funding had not been available, it is possible that the performance of the GMHSCP would have been even worse.

West Yorkshire

Outcomes in the West Yorkshire and Harrogate Health and Care Partnership

Indicator	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
DtoC and Bed-Days	Y					
Attendances at A&E		Y				
Emergency Admissions		Y				
Unplanned ACSC Admissions				Y		
Emergency Readmissions					Y	
SHMI			Y			
Cancer Survival Rates			Y			
Cancer Mortality			Y			
CVD Mortality			Y			
Respiratory Disease Mort.			Y			
Neonatal Outcomes						Y
Mental Health Bed-Days					Y	
Alcohol-Specific Admissions					Y	
Life Expectancy at 75			Y			
NHS FTE Workforce					Y	
TOTAL	1	2	6	1	4	1

- The data for the WYHHCP is more limited than for Greater Manchester, given it was only formally set up in 2018. Yet it is possible to make some preliminary conclusions.

- On balance, performance has been slightly better than in Manchester – perhaps reflecting the impact of greater supervision from NHS England. However, the picture is one of limited change at best, with some areas of improvement counterbalanced by deterioration across other metrics.

- The WYHHCP has been one of the better ICS regions for delayed transfers of care. But rates of emergency readmissions have soared, overtaking the national average. This may suggest that patients are being transferred from care too hastily in some cases.

- Again, there is also the problem of falling productivity, albeit less sharply than in Greater Manchester. The regional NHS FTE workforce increased by 6.5% – again higher than the national average. However, this was again driven mainly by an expansion in non-clinically qualified personnel. A proportion of the total regional NHS FTE workforce, clinically qualified staff fell from 52% to 50%. The number of NHS managerial staff, meanwhile, increased by 20%.

- On balance, as shown in the table below, things look a bit better in the WYHHCP than in the GMHSCP. But in neither case – although it is still early days – has there been the expected improvement in outcomes that has been the justification for the ICS approach to health and care integration.

	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
Greater Manchester	1	2	5	3	4	0
West Yorkshire	1	2	6	1	4	1

England

Average Outcomes across the 13 more integrated ICS Regions

Indicator	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
DtoC				Y		
Attendances at A&E		Y				
Emergency Readmissions			Y			
Alcohol-Specific Admissions			Y			
Respiratory Disease Mort.			Y			
TOTAL	0	1	3	1	0	0

Thus far, 13 regions in England have started operating under the ICS model, either via devolution or through the implementation of Sustainability and Transformation Partnerships (STPs). While there is substantial variation in terms of how exactly they operate, and when the ICSs or equivalent began operating, we have chosen to contrast the four years before and after 2016 as a broad comparator. In particular, while some ICSs only formally began operation in 2018, they were chosen for the pilot programmes because these were the areas in which integration was already most advanced.

Because of this variation, and the limited time some of these ICSs have had to take effect, we consider the data in this section indicative rather than conclusive, when compared to the more granular analysis above. Nevertheless, the emerging evidence is either mixed or not encouraging.

Delayed Transfers of Care (DtoC)

green = well below England trend, light green = below trend, amber = above trend, red = well above trend

STP/ISC Region	Change in DtoC, 2016-20 avg. vs 2012-16 avg.	First Wave: Devolved	First Wave: NHS	Second Wave
Gloucestershire	111%			Y
Frimley	95%		Y	
Greater Manchester	65%	Y		
South Yorkshire & Bassetlaw	50%		Y	
Lancashire & South Cumbria	24%		Y	
North East & North Cumbria	19%			Y
Suffolk & North East Essex	17%			Y
England	14%			
England, excluding wave 1 + 2 ICSs	9%			
Surrey Heartlands	7%	Y		
Dorset	6%		Y	
Bedfordshire, Luton & Milton Keynes	1%		Y	
West Yorkshire	0%			Y
Buckinghamshire, Oxfordshire & Berkshire West	-2%		Y	
Nottingham & Nottinghamshire	-7%		Y	
STP/ICS Average	30%			
STP/ICS Weighted Average	24%			

- Perhaps the most significant statistic here is delayed transfers of care (DtoCs), given that improving patient flow and reducing pressure on acute wards is at the core of the ICS rationale.

- On average, DtoCs across England as a whole were 14% higher in 2016-2020 than in 2012-2016. However, in in STP/ICS areas, the increase was 24% (when weighted for population). In other words, across the 13 early movers, delayed transfers of care (DtoC) increased by 70% more than the national average, resulting in over 80,000 extra hospital bed-days across a four-year period.

- However, there was significant variation, with the difference ranging from -7% to 111%.

- In terms of A&E attendance, ICS regions outperformed the national trend, with attendances at A&E growing by 3.7 percentage points less than for England as a whole, comparing the averages for each of the two periods either side of April 2016. Again, there is a fair bit of variation in outcomes.

- On emergency readmissions, there is no real difference between the national and ICS averages.

- We examined the admission rate for alcohol-specific conditions to see whether the ICS model had had any early impact on population health. Generally, outcomes in STP/ICS regions have been weaker than average. However, the key thing again is the variation in results. Surrey Heartlands and Greater Manchester are both devolved first wave ICSs, yet are at the opposite ends of the alcohol admissions spectrum. (It is worth flagging however that reduction in alcohol consumption was not one of the specific targets set by Greater Manchester at the start of the GMHSCP – this came along later, in 2019 – so it is hard to tell what has produced the notable fall.)

- Respiratory disease mortality is one of the key focuses identified in the NHS Long Term Plan. Again, on average, integrated regions slightly underperformed the national trend. But again, there was plenty of variation, with Greater Manchester being an under-performer this time.

Overall, there is no obvious correlation between DtoC outcomes and the nature of the ICS – whether predominantly urban or rural, located in the North or South, with a small or large, or young or old, population, or devolved or not, or combining few or many local authorities.

‘Outcomes for patients and populations under the ICS model have been at best mixed and at worst outright negative, both on a regional and national level’

In several areas, in particular DtoCs, there is also a significant asymmetry in outcomes: the bad results are much further from the average than are the good ones. This suggests that there may be more downside risk than upside potential to the reforms.

Against this, there is strong anecdotal and in some cases statistical evidence that specific initiatives within different ICSs – often at the Integrated Care Partnership (ICP) or Primary Care Network (PCN) sub-levels – do appear to be contributing to improvements in processes and outcomes. Examples include the Dorsetshire Care Record (DCR); strengthened PCNs in the Bedfordshire, Luton and Milton Keynes (BLMK) ISC; and hospital efficiency drives in the South Yorkshire and Bassetlaw (SYB) ICS.

Conclusions and recommendations

In spite of the significant amounts of time, energy and money that have gone into creating new structures and processes, outcomes for patients and populations under the ICS model have been at best mixed and at worst outright negative, both on a regional and national level. In our two primary case studies, they are linked to weaker clinical outcomes and significant bureaucratic bloat. However, the model of devolution followed in West Yorkshire does appear to have been more effective (or perhaps less ineffective) than in Greater Manchester.

We should stress that the evidence is still only preliminary. In the consensus view, it should take 10-15 years for an ICS to bed in and positive results to become widely evident. But what can be said for certain is that the data that is available does

not justify the speed and scale of the change that is envisaged. And given the extraordinary impact that this latest top-down transformation of the NHS will have, the burden of proof must be on supporters of the ICS model.

It may be argued that the poor performance of the early ICSs, and the inconsistency in performance between them, reflects temporary disruption caused by the implementation of the reforms. But the data from Greater Manchester indicates that the problems may be more deeply rooted. There is a risk that, by putting ICSs on a statutory footing, the Health and Care Bill will create a new, parallel structure of formal healthcare bureaucracy sandwiched between the NHS and local government. The result, in a worst case scenario, is duplication, confusion, a general lack of accountability – and worse outcomes for patients.

'There is a risk that, by putting ICSs on a statutory footing, the Health and Care Bill will create a new, parallel structure of formal healthcare bureaucracy sandwiched between the NHS and local government'

The Government's determination to tackle the long-term problems facing health and care provision is to be welcomed. Policies implemented in the next few years could have implications for generations, not just in terms of the health and wellbeing of an ageing population, but also in terms of the fiscal sustainability of wider social policy.

While we recognise that there is a widespread consensus within the health and care sector that greater integration and collaboration are necessary, it is important to take the time to get this process right – rather than intensifying the current pressures on the NHS through costly and disruptive reforms.

We therefore propose that the Government should focus on joining up the existing system, and fostering and replicating the useful local collaboration that is already taking place, rather than pressing ahead with a full-scale top-down reorganisation. In the newer ICSs, this means having ICS boards concentrate on managing the Better Care Fund (BCF), coordinating patient care pathways and flows through the system while building on the lessons of the pandemic. This approach recognises that integration is a matter of local collaboration and trust, developed over time through persistent working relationships. It cannot be willed into being by bureaucratic fiat.

Meanwhile, the more established ICSs should be left to run until c.2026, creating a deeper evidence base for assessing the ICS model.

We therefore propose that the Government should:

1) **Drop from the Health and Care Bill legislation to put ICSs on a statutory footing.** The evidence to date suggests that there is no clear link between ICSs and improved outcomes. If the reorganisation goes ahead, we need to ensure that formal ICS bodies generate enhanced collaboration, rather than proving a source of lasting confusion and conflict.

2) **Task the 29 newer ICSs with overseeing regional BCF budgets rather than investing them with new and expanded powers and responsibilities.** These ICSs should focus on filling in the gaps and joining up the existing system, strengthening relationships that have already developed organically around the BCF. It is notable that more

informal collaboration in Greater Manchester around the BCF before the GMHSCP was associated with better results than seen under the GMHSCP. A focus on the BCF would also help to orient ICSs towards primary and community care solutions, reducing the risk of entrenching the dominance of hospitals and acute care pathways.

3) **Encourage each ICS to explore the further development of standardised local referral and care pathways, thus streamlining patient flows between different care settings.** Standardisation should also free up resources for multi-disciplinary teams to collaborate on personalised solutions for complex cases involving multiple morbidities. In other parts of the world such as Canterbury, New Zealand, this approach to vertical healthcare integration has a good record of reducing friction between community, primary and secondary care settings. Some of the early-mover ICSs have followed Canterbury's lead on this front already. All ICSs will have to be careful, however, that their pathways do not just funnel more people into the hospital system.

4) **Allow the 13 more advanced ICS pilot schemes to run their courses until around 2026.** In the consensus view, ICSs should take around 10-15 years to really bed in. NHS England has set out four phases for ICS development: 'emerging', 'developing', 'mature' and 'thriving'. None have reached 'thriving' yet, and most would probably not want to be described as 'mature'. These 13 test-beds should now be used to see if the consensus view on integration is actually correct, evidence to date notwithstanding. If there is no clear improvement in ICS outcomes relative to England over the next five years, the case against the ICS model of integration will be fairly conclusive. On the other hand, if outcomes data shows significant improvement, then the 29 newer ICSs can accelerate down this path of integration, using best practices tested and refined by the pioneers. A firmer evidence base would also help in obtaining 'buy-in' from health professionals.

5) **Compel the ICSs and NHS England to collect and publish more data on health outcomes. Use the data to create a consolidated ICS database.** NHSX should implement an 'ICS Accountability Dashboard', initially covering at least the original 13 ICS pilots. This could begin through drawing on existing NHS Digital datasets and would be a natural outgrowth of the 'NHS System Oversight Framework' now under development. It would allow for easy but detailed and meaningful comparisons between ICSs on a broad range of outcomes. This would be useful for policymakers but would also enable citizens to hold their ICS leaderships to account and to push back against poor outcomes and inefficiencies.

6) **Use aggregate outcomes data to drive competition between ICSs, rewarding innovation towards achieving quality results and thus incentivising ICSs to emulate best practices developed in other ICSs.** ICSs that moved up an indexed league table relative to other ICSs could be eligible for additional grants from a dedicated funding pot. In contrast to the 'Integration index' outlined in the 'Integration and Innovation' White Paper, this would be based around outcomes, rather than processes and perceptions. It would help to tip system designers towards focusing on patients and population health outcomes, rather than becoming overly preoccupied either with managing public perceptions or with structures and processes for their own sake. There would also be the potential for some ICS managers to engage in bolder experiments, such as embracing external providers or outsourcing testing and diagnosis from hospitals to dedicated units, creating best practice that can be adopted elsewhere.

List of Abbreviations

ACSC	Ambulatory care-sensitive condition
ASCOF	Adult Social Care Outcomes Framework
BLMK ISC	Bedfordshire, Luton and Milton Keynes Integrated Care System
CCG	Clinical Commissioning Group
CCG OIS	Clinical Commissioning Group Outcomes Indicator Set
CQC	Care Quality Commission
DH	Department of Health
DHCS	Department of Health and Social Care
DtoC	Delayed transfer(s) of care
FTE	Full-time equivalent
GMCA	Greater Manchester Combined Authority
GMHSCP	Greater Manchester Health and Social Care Partnership
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GVA	Gross value added
HEE	Health Education England
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICSD	Integrated Care System for Devon
JCB	Joint Commissioning Board
LCO	Local Care Organisation
MHRA	Medicines and Healthcare products Regulatory Authority
NAO	National Audit Office
NHSE	NHS England
NHSI	NHS Improvement
NHS OF	NHS Outcomes Framework
ONS	Office for National Statistics
PCN	Primary Care Network
SMHI	Summary Hospital-level Mortality Indicator
STP	Sustainability Transformation Partnership
SYB ICS	South Yorkshire and Bassetlaw Integrated Care System
WYHHCP	West Yorkshire and Harrogate Health and Care Partnership

1. Healthcare Integration: The Future of the NHS?

Caring for an ageing population

Integrated Care Systems such as the Greater Manchester Health and Social Care Partnership represent an attempt to address the structural, long-term health challenges associated with an ageing population.

When the NHS was founded in 1948, average life expectancy at birth was 66 and 70 years for men and women respectively.[1] About 11% of the population was aged 65 or over.[2] Relatively few people lived long enough to suffer from age-related injuries or chronic illnesses. Those who did develop such conditions – cancers, lung disease, dementia, arthritis – tended not to live for as long as sufferers do today. The NHS was therefore geared towards episodic treatment of acute illnesses or injuries, rather than long-term therapy for chronic ailments.

> **'When the NHS was founded in 1948, average life expectancy at birth was 66 and 70 years for men and women respectively'**

The demographic situation today is very different. Life expectancy has trended upwards for most of the last 70 years and now stands at around 79 years for men and 83 for women. Over-65s make up 18% of the population. Indeed, 8% of the population is now aged 75 or over (compared to just 4% c.1948).

But while average lifespans have lengthened, the frailties and infirmities of old age have not gone away. The gap between average life expectancy and average healthy life expectancy has widened to 16 years for men and 20 for women.[3] More people are living for longer, but they are doing so while afflicted with (often multiple) chronic conditions.

Demographic change is thus giving rise to growing demand for treatment for complex and long-term conditions. At the same time, people with multiple pre-existing morbidities are more likely to succumb to acute illnesses. This is a major factor in the recurrent NHS winter crises, which have at times seen elective operations suspended due to the pressure on clinical resources, most notably beds – that basic unit of secondary care capacity.

Indeed, while healthcare needs have evolved considerably since 1948, the fundamentals of healthcare provision have not. Acute illnesses are the underlying cause of a significantly smaller share of the total demand on healthcare services –

1 ONS, 2016 based *England and Wales period life expectancies, 1948 to 2016* (June 2018).

2 ONS, *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2017* (June 2018).

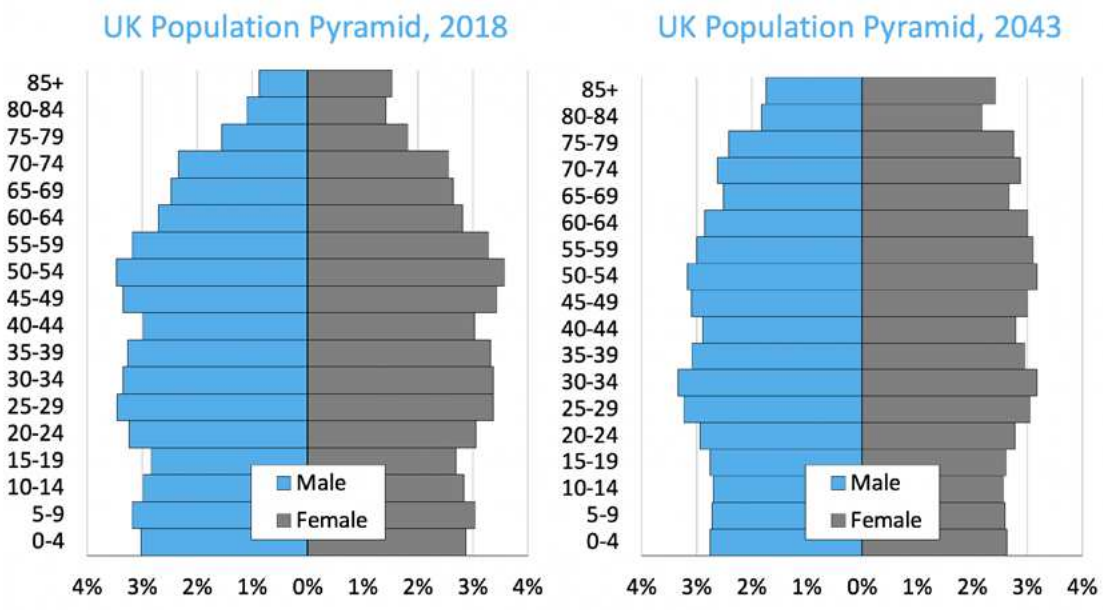
3 ONS, *Life expectancy at birth and selected older ages* (March 2020).

yet highly expensive hospital treatment continues to predominate over other forms of healthcare, including preventative health interventions and care in homes or community settings.

Partly this reflects the perennial preference for hospital services from users at the point of admission into the healthcare system. But it also reflects problems at the point of discharge. In the 10 years prior to Covid, almost 1.74m Delayed Transfers of Care (DtoC) from hospitals were recorded, often involving chronically ill patients who could be better supported in home or community care settings.[4] Quite apart from the unnecessary suffering this can cause to patients and their families, DtoCs (more colloquially known as 'bed-blockers') are a source of significant friction within the NHS, as reduced bed availability means more delayed emergency operations and fewer elective surgeries.

An ageing population with complex healthcare needs is also a source of growing financial pressure on the taxpayer. Pre-Covid, total UK government healthcare expenditure stood at around 7.5% of GDP, triple what it was at the inception of the NHS. In 2019-20, the Department for Health and Social Care (DHSC) accounted for almost 17% of government expenditure – five times what was spent on defence, for example.

An ageing population means more people living for longer, with more chronic conditions requiring expensive medical intervention and support. Barring a series of major scientific/medical breakthroughs, there seems little reason to expect things to improve.[5] Demographic projections point towards a 60% increase in the number of people aged 75+ by 2040, while by 2035, the proportion of people aged 65+ with four or more diseases is expected to double.[6] The humanitarian and fiscal implications are huge.



4 Data basis annual datasets from NHS Digital, '2C(1): Delayed transfers of care from hospital, per 100,000', *Measures from the Adult Social Care Outcomes Framework (2013-2020).*

5 Population pyramid data basis: ONS, *National population projections: 2018-based* (October 2019).

6 DHSC, *Integration and Innovation: working together to improve health and social care for all* (February 2021), p.12.

In other words, while the Government's new Health and Care Bill has been presented as a response to the Covid crisis – which has added very significantly to the pressures facing the health service – it is in fact a response to much longer-term trends and demands. The proposals might be framed as a way to 'build back better after Covid',[7] but the central provisions of the Bill represent the latest stage in a journey towards more integrated care that goes back at least to the 'NHS Five Year Forward View' of October 2014, if not to the Wanless Review of 2002 (see Annex I: Integrated Care Policy Milestones).

What is integrated care?

In general terms, the Health and Care Bill reflects the view that 'integrated care' is the best approach to the long-term problems facing healthcare services in developed countries such as England. There are different types and forms of integrated care, but at its core, it is about joining up different elements of health and care provision around individual patients and/or specific geographies. This can entail, for example:

'Attempts at integrating care in places such as Canterbury in New Zealand, Alzira in Spain, Jönköping in Sweden and by Kaiser Permanente in California have been shaped by very different debates, resources and challenges to those of the NHS'

- Greater collaboration within health services, for example between GPs and hospital consultants, so that care is not fragmented across different institutional settings.
- More planning and coordination between health services and clinicians on the one hand, and local authorities and social carers on the other, to enhance patient flow through the system.
- Prioritising earlier interventions to prevent illnesses developing to the point where patients turn up at A&E.
- Targeting wider determinants of health (nutrition, smoking, alcohol, air quality, housing) at the level of population health, thereby alleviating pressure on clinical resources in the longer term.
- Better accounting for the links between mental and physiological wellbeing, including via the use of 'social prescribing'.

However, integrated care is a contested concept, having taken on quite different meanings in different contexts.[8] Attempts at integrating care in places such as Canterbury in New Zealand, Alzira in Spain, Jönköping in Sweden and by Kaiser Permanente in California have been shaped by very different debates, resources and challenges to those of the NHS.

In England, however, the roots of current policy go back two decades, though the agenda really came to the fore in about 2014. A more in-depth account can be found in Annex I, but the potted history is as follows:

7 DHSC, *Integration and Innovation*, p.3. Covid is directly referenced 76 times, an average of once per page.

8 P. Dawda, 'Integrated healthcare: past, present and future', *Integrated Healthcare Journal 1* (2019), pp.1-3.

- About 20 years ago, policymakers began to give much more serious thought to the long-term healthcare implications of an ageing population. The landmark report was the Wanless Review of 2002. The Marmot Review (2010) also brought into focus social determinants of ill health.[9]

- The first tentative steps towards integrating care were taken against this backdrop, with the launch of 'integrated care pilots' at 16 sites across England in 2009. The Department of Health (DfH) published an evaluation in 2012, finding essentially no evidence of improved outcomes.

- Further steps down the road to integrated care were not taken at this point. Instead, the Health and Social Care Act 2012 (i.e. the Lansley reforms) focused on the nature of commissioning within the NHS, handing the purse strings to GPs who would then purchase care from hospitals and other parts of the system on behalf of their patients.

- In 2013, Chancellor George Osborne announced what became the Better Care Fund (BCF), which was intended to facilitate greater cooperation between local authorities and the NHS on adult social care via pooled budgets and joint planning. This was reinforced in the Care Act 2014.

- In 2014, Simon Stevens became the CEO of the NHS in England. He presided over the publication of the 'NHS Five Year Forward View' that October.[10] This marked the start of concerted efforts to integrate health and social care in England.

- Over the next 18 months, this report led to the creation of 50 'vanguard sites' under the New Care Models Programme, as well as 44 Sustainability and Transformation Partnerships (STPs) covering the whole of England.

- This period also saw the devolution of health and social care in Greater Manchester, with the Greater Manchester Health and Social Care Partnership (GMHSCP) being formally established in April 2016 and becoming the country's most advanced test bed for the integration of care at scale. 'Greater Manchester now has a unique opportunity for innovation and improvement in health and wellbeing,' said Stevens. 'The eyes of the country will now be on what this new partnership can deliver.'[11]

- The GMHSCP became part of the first wave of Integrated Care Systems (ICSs), in spirit if not in title, alongside the devolved Surrey region and eight other ICSs under the auspices of NHS England. Another four STPs evolved into ICSs before the end of 2018 – a second wave.

- The ICS concept was then fleshed out and formalised in 'The NHS Long Term Plan' (January 2019) and supporting documentation.[12] The 44 STPs in England were gradually rejigged and consolidated into 42 ICSs, all of which were at least nominally in place by April 2021.[13]

9 D. Wanless, *Securing Our Future Health* (April 2002); M. Marmot, *Fair Society, Healthy Lives* (February 2010).

10 NHS England, *NHS Five Year Forward View* (October 2014).

11 S. Stevens, as reported in 'Greater Manchester £6bn NHS budget devolution begins in April', *BBC News* (27 February 2015). Link

12 NHS England, The NHS Long Term Plan (January 2019); NHS England, *Designing integrated care systems (ICSs) in England (June 2019); NHS England, Integrating care: Next steps to building strong and effective integrated care systems across England* (November 2020).

13 Several tweaks to boundaries were announced in July 2022, and the door has also been left open for further adjustments in the future. However, the essential outlines of the 42 ICS regions are now in place. See: E. Argar, Integrated Care Systems, *Statement made on 22 July 2021*.

- In September 2019, NHS England formally recommended that the ICS concept should be adopted in an NHS Bill, alongside a suite of other recommendations. This formed the basis of the Department for Health and Social Care (DHSC) White Paper on 'Integration and Innovation' in February 2021, which in turn became the basis of the Health and Care Bill, published in July 2021 and due to go before Parliament in the autumn.[14]

This summary shows two important things. First, that the various practical experiments carried out since 2014 – especially in Greater Manchester – provide the only real evidence for evaluating the proposed reforms in the Health and Care Bill. Second, that through this process, integrated care in England has gradually become synonymous with the ICS concept, eclipsing the more voluntary, gradualist approach embodied by the Better Care Fund. Indeed, if the Health and Care Bill were passed into law in its current form, ICSs would become the only permissible framework for integration at scale.

But what would the new system look like?

The cultivation of STPs and ICSs happened in the cracks left between existing laws. The new Bill is intended to give legislative underpinning to some practices that have already developed, while enabling further integration through the ICS model by creating new, formalised management structures sat between the NHS and local authorities.

The White Paper that the Bill is based on contained 32 sets of proposals, grouped under four main themes:[15]

1. Working together and supporting integration

2. Stripping out needless bureaucracy

3. Enhancing public confidence and accountability

4. Additional proposals to support social care, public health, and quality and safety

The proposals under themes 2-4 are mainly intended to facilitate the achievement of theme 1. And the most consequential recommendation under that theme is that ICSs should be put on a statutory footing.

What does the ICS model of integrated care entail?

ICSs have been defined as 'partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population'.[16] As of April 2021, every part of England is at least nominally covered by one of 42 ICSs (see Annex III for the full list). Each of these 'systems' is also further

14 See House of Commons, *Health and Care Bill, Government Bill, Originated in the House of Commons, Session 2021-22* [https://bills.parliament.uk/bills/3022].

15 DHSC, *Integration and Innovation*, p.12. See also Annex II: The Government's Proposals. For a helpful overview of the White Paper in its entirety, see: The King's Fund, H. McKenna, *The health and social care White Paper explained* (9 March 2021). Link

16 The King's Fund, A. Charles, *Integrated care systems explained: making sense of systems, places and neighbourhoods* (April 2020).

subdivided, first into 'places' or Integrated Care Partnerships (ICPs), which in turn contain multiple 'neighbourhoods' covered by Primary Care Networks (PCNs).[17]

Geographical Level	Name	Typical Number	Typical Population
System	Integrated Care System (ICS)	1 per region	500,000 – 3,000,000
Place	Integrated Care Partnership (ICP)	2-10 per ISC	250,000 – 500,000
Neighbourhood	Primary Care Network (PCN)	5-10 per ICP	30,000 – 50,000

The system-place-neighbourhood pyramid is intended to provide the scaffolding for the horizontal and vertical integration of health and social care, both within the NHS and between NHS bodies and other organisations. As well as enabling more joined-up care and a more strategic approach to population health, this layering is expected to facilitate specialisation and economies of scale.

The thinking behind the Health and Care Bill reinforces this taxonomy. At the neighbourhood level, PCNs are already fairly well established, having been established in one form or another in many regions before the title was coined in the NHS Long Term Plan.[18] 'Integration and Innovation' also acknowledges a 'primacy of place' principle in making integrated care work, giving great latitude to decentralised planning at this level.[19]

However, the reforms are far more prescriptive regarding the top level of ICS organisations. Each ICS is to have a dual governing structure, comprising a statutory **Integrated Care Board (ICB)** (called an ICS NHS Body in the 'Integration and Innovation' White Paper) and a statutory **Integrated Care Partnership (ICP)** (called an ICS Health and Care Partnership in the White Paper, and not to be confused with the 'neighbourhood' level of the ICS). This will apply, it seems, not just to the newer, less developed ICSs, but also to older, more embedded systems such as Greater Manchester.

In effect, a new tier of geographically delineated healthcare bureaucracy is proposed, sitting between and partly impinging on both the NHS (including the seven NHS England regional organisations) and local government.

The **Integrated Care Board** is to function as the ICS's executive, overseeing strategic planning, resource allocation (including capital spending) and the day-to-day running of the ICS. In this capacity, it will take on the commissioning functions of Andrew Lansley's Clinical Commissioning Groups (CCGs) – which will be abolished – and some of those of NHS England.

The ICB will be overseen by a unitary board consisting of (at the very least) a chair and a chief executive, with room also for representatives from NHS trusts, general practices, local authorities and other organisations as deemed appropriate in each ICS. The chief executive will be the Accounting Officer for the NHS money allocated to the ICS. It is expected that the ICB will drive integration and joined-up planning within the NHS.

17 For example, in the Greater Manchester, beneath the GMHSCP system level, there are ten Local Care Organisations or LCOs (Greater Manchester's version of ICPs) roughly coterminous with the ten borough authorities. Beneath each of these LCOs, there are varying numbers of PCNs. The Trafford LCO, for instance, overlays five PCNs: Sale, Altrincham Health Alliance, South Trafford, Trafford West and North Trafford.

18 For an overview of PCNs, see: The Kings Fund, B. Baird & J. Beech, *Primary care networks explained* (20 November 2020). Link

19 DHSC, *Integration and Innovation,* pp.20, 67.

The Integrated Care Partnership, meanwhile, would be more akin to an advisory board, with a much broader range of representatives than the ICB. Example organisations given in the White Paper include: Health and Wellbeing Boards, partner organisations (like Healthwatch, voluntary sector organisations and social care providers), and organisations with wider interests in local priorities relevant to population health (such as housing providers, fire brigades and schools).

> **'Legislation will allow ICSs and NHS providers to form a range of 'joint committees' to discuss the commissioning and provision of care, thereby removing barriers erected by the Health and Social Care Act 2012'**

The chief function of the Health and Care Partnership will be to promote collaboration between the NHS and other bodies, by developing a plan to address the health, social care and public health needs of the area. The ICB and local authorities would be required 'to have regard' to this plan.[20] The ICP is thus envisaged as a sort of joint committee or forum for coordinating priorities and actions.

Other provisions under the rubric of 'working together and supporting integration' are intended to facilitate integration and collaborative planning:

- A 'duty to collaborate' will be imposed, with legislation applying to NHS organisations and local authorities, and a provision for the Secretary of State to issue guidance in particular instances.

- ICSs, NHS England and NHS Trusts and Foundations Trusts will all be required to 'have regards to' the 'Triple Aim' of 'better health and wellbeing for everyone', 'better quality of health services for all individuals' and 'sustainable use of NHS resources'.[21] Explicit alignment around a common set of overarching objectives is intended to facilitate cooperation.

- The DHSC will retain a reserve power over capital spending by NHS Foundation Trusts, nominally to forestall capital outlay that goes against the spirit of collaboration and that might cause ICSs to breach their legally defined capital spending limits.

- Legislation will allow ICSs and NHS providers to form a range of 'joint committees' to discuss the commissioning and provision of care, thereby removing barriers erected by the Health and Social Care Act 2012. This is intended to amplify the ICB provisions for integration within the NHS, diffusing the principle throughout the system-place-neighbourhood pyramid.

- Collaborative commissioning will be facilitated through new mechanisms. Notably, NHS England will be able to combine its direct commissioning functions (e.g. for treatment of rare diseases) across multiple ICSs for the benefit of their combined populations. In certain instances, ICSs will also be able to collaborate with each other directly, across commissioning and other functions. However, the NHS tariff (which sets a price per procedure) is being retained, albeit with modifications to allow for local flexibility.

20 DHSC, *Integration and Innovation,* p.71.

21 DHSC, *Integration and Innovation,* p.34; NHS England, *The NHS Long Term Plan,* p.113.

- Guidelines will be issued to facilitate joint appointments across different organisations in order to 'help to reduce management coasts and engender a culture of collective responsibility across organisations'.[22]

- Data-sharing across health and adult social care organisations is to be facilitated through a forthcoming Data Strategy for Health and Care, which may entail primary legislation.[23]

- Despite the general tendency of the reforms being to erode competition within the NHS, patient choice is meant to be preserved and reinforced, with ICSs expected to be drivers of more patient-centric approaches to care.

These reforms self-evidently amount to a radical change in the fundamentals of health and care delivery in England, breaking with the paradigm created by the National Health Service and Community Care Act 1990, which marked the beginning of the NHS internal market, created NHS trusts and transferred responsibility for community care from the Department of Social Security to local authorities.

'These reforms self-evidently amount to a radical change in the fundamentals of health and care delivery in England'

According to the prevailing orthodoxy, this radical change should lead to better out-of-hospital care, reduced pressure on emergency services and a greater focus on population health, together yielding productivity gains in the NHS and improved health outcomes generally.

However, the focus on the ICS model has also limited the debate on other, possibly more efficient, forms of integration and approaches to joining up health and care. And more than a few people working in the NHS, social care or local government quietly (or not so quietly) dissent from the consensus around the top-down ICS approach. For example, in February 2017, the National Audit Office (NAO) published the results of its investigation into integrating care in England. One of its key findings is worth quoting at length:

'The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients. The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration. International examples of successful integration provide valuable learning but their success takes place in a context of different statutory, cultural and environments.'[24]

This state of affairs has not fundamentally changed.

22 DHSC, *Integration and Innovation*, p.36.

23 The preliminary version of this strategy was published as: DHSC, *Data saves lives: reshaping health and social care with data (draft)* (June 2021).

24 NAO, *Health and social care integration* (February 2017), p.7.

Fortunately, however, the debate over integrated care does not need to remain merely theoretical. As noted above, the ICS model emerged from a process of experimentation with integrated care approaches, including STPs. And 13 of these – most notably in Greater Manchester – moved down the pathway towards integrated care at pace, evolving into ICSs before the end of 2018.

> **'If the ICS model as it now stands is an effective approach to health and social care integration, it should now be possible to demonstrate this, or at least establish a convincing hypothesis, through the 'robust evidence base' that was previously missing'**

These regional experiments have produced several years of pre-Covid data on health outcomes, which can be used in preliminary but meaningful analysis of outcomes under ICSs to date. In other words, if the ICS model as it now stands is an effective approach to health and social care integration, it should now be possible to demonstrate this, or at least establish a convincing hypothesis, through the 'robust evidence base' that was previously missing. The purpose of this paper is to investigate whether that is the case.

2. Case Study: Greater Manchester

There are three overarching reasons for focusing on Greater Manchester as a source of detailed regional data for integrated care:

1) It is further down the road of health and care integration than any other region in England, so the data reflects the impact of more extensive and deeper integrated care reform.

2) Greater Manchester has significantly influenced the wider debate on integrated care in England, feeding back via various routes into the 'Integration and Innovation' White Paper.

3) There are a number of factors – material, cultural and demographic – that make Manchester an ideal test bed for integrated care. If the ICS approach cannot be made to work here, then the implications for the wider ICS reform agenda are significant.

Overview

The Greater Manchester Health and Care Partnership (GMHSCP) is responsible for the health and care of 2.8m people, accounting for about 4.8% of England's population. It came about through the fusion of the integrated care agenda (being pushed by NHS England) with the Coalition Government's devolution agenda, as well as Manchester's existing public sector reform agenda.

The formal devolution of powers and responsibilities to Greater Manchester began in November 2014 with the signing of what would be the first of six devolution deals. The centrepiece was the creation of an elected mayoralty to head up the Greater Manchester Combined Authority (GMCA), which had itself been in existence since April 2011. Devolution of responsibility for health and care came with the second devolution deal, the MoU for which was signed in February 2015.

'The Greater Manchester Health and Care Partnership (GMHSCP) is responsible for the health and care of 2.8m people, accounting for about 4.8% of England's population'

At the signing of the MoU, Simon Stevens – who had been Chief Executive of NHS England since April 2014 – lauded 'a path to the greatest integration and devolution of care funding since the creation of the NHS', adding that 'Greater Manchester now has a unique opportunity for innovation and improvement in health and wellbeing. The eyes of the country will now be on what this new partnership can deliver.'[25] Indeed, in the

25 S. Stevens, as reported in 'Greater Manchester £6bn NHS budget devolution begins in April', *BBC News* (27 February 2015). Link

years since, healthcare researchers and policy analysts covering England's healthcare system have engaged closely with developments in the region.

Much of the year following the MoU was spent on planning and preparing for the launch of the GMHSCP Ten plans were drawn up by the local authorities and NHS organisations in each of Greater Manchester's boroughs. These then fed into the initial five-year system plan for the GMHSCP published by the GMCA in December 2015, 'Taking Charge of our Health and Social Care in Greater Manchester: The Plan'.[26] This outlined the aspirations and target health outcomes of GMHSCP reforms. The final draft of 'The Plan' was version 11.3, which gives some indication of the time and energy that went into the process.

The health and care devolution deal actually came into effect from April 1, 2016, with the GMHSCP taking direct control over the region's £6bn health and social care budget and assuming responsibility for health and social care across the region's 10 metropolitan boroughs: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside and Glossop, Trafford and Wigan.[27] Each has become roughly coterminous with a CCG (Manchester's three CCGs were amalgamated in April 2017).[28] The boroughs function as the geographical footprint for the place level of system-place-neighbourhood organisation, though they are termed Local Care Organisations (LCOs) rather than ICPs. At the lower level of the pyramid, forerunners to PCNs were already in place across Greater Manchester by April 2016, but these networks have been further developed since 2016.

At the top level, administration and strategic planning is overseen by a Health and Care Board as the GMHSCP's executive body, comprising senior clinicians, health professionals and representatives of local government.

Aside from 'The Plan' of December 2015 and later strategic evaluations, a number of system plans on specific themes or strands of integration have been published,

26 GMCA, Taking Charge of our Health and Social Care in Greater Manchester: *The Plan, Final Draft v11.3* (December 2015).

27 Although in July 2021 it was announced that Glossop (but not Tameside) was to be transferred to the Derbyshire ICS.

28 A list of the public sector organisations making up the GMHSCP (as of June 2021) can be found in Annex II.

including digital, workforce, estates, population health, specific diseases (such as cancer), maternity, disabilities and commissioning. The Health and Care Board has sought to elicit a high degree of engagement from across the system, including via open meetings (held online in the pandemic). Meanwhile, commissioning of specialist or other system-wide services is overseen by the Greater Manchester Joint Commissioning Board (JCB), made up of representatives from each of the region's 10 CCGs. The JCB commissions over £800m of activity previously commissioned directly by NHS England.

In short, it is easy to discern in the architecture of the GMHSCP a rough first draft of the dual structure of Integrated Care Board and Integrated Care Partnership now being proposed in the Health and Care Bill. The ICB would in effect be taking on the work of the JCB and the execution functions of the Health and Care Board, while the ICP would assume the strategic planning and system engagement functions of the Health and Care Board. The system-place-neighbourhood principle for the vertical and horizontal integration of health and care across in Greater Manchester is also now firmly embedded in the ICS model. This should be unsurprising, given that much of what has been tried in Greater Manchester has gone on to inform reforms that are to be applied nationally.

However, in overseeing health and care integration in Greater Manchester, the GMHSCP has benefited from a number of advantages relative to other parts of England:

1) **Geography and infrastructure.** If the ICS model is going to work well anywhere in England, one would expect it to be somewhere like the densely populated (2,200 people/km^2) conurbation of Greater Manchester. In terms of connectivity, it has a dense road network, five central rail stations and tram/bus networks overseen by Transport for Greater Manchester. The region is dense enough to facilitate meaningful specialisation of healthcare resources, while travelling across a borough (i.e. a 'place' or LCO) or from the outer edges of the system into the centre for specialist treatment should be easier than in many parts of the country. Broadband coverage is also good, meaning that infrastructure barriers to digitally integrated healthcare, e.g. remote multi-specialist video consultations, are low, especially relative to rural regions. The table below shows Greater Manchester's relatively strong starting position, in terms of population density, staffing and budgets, compared to the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP), the extremely rural Integrated Care System for Devon (ICSD) and an average of the 42 STP/ISCs.[29]

	Area	Population	Population Density	Per Capita Budget	Trans. Funding	Places	No. NHS Trusts	NHS Staff (2016)
GMHSCP	1,280 km^2	2.8 million	2,200/km^2	£2,140	£450m	10	13	2,250/ 100,000
WYHHCP	3,630 km^2	2.6 million	740/km^2	£2,040	-	6	13	2,150/ 100,000
ICSD	6,700 km^2	1.2 million	180/km^2	£1,830	-	3	6	1,880/ 100,000
STP/ICS Avg.	2,800 km^2	1.4 million	490/km^2	£1,950	-	4	7	1,880/ 100,000

29 Devon did not become an ICS until April 2021 but 2016 NHS staff figures have been used for comparative purposes. The same applies to West Yorkshire and Harrogate, which became an ICS in May 2018. STP/ICS averages are non-weighted best estimates. Deriving precise figures is complicated by the reconfigurations, amalgamations and consolidations through which STPs/ICSs have gone. For more information, see Annex III: Integrated Care Systems in England.

2) **Political culture.** In part, the GMHSCP has its roots in the broader local government and public sector reform agenda in Greater Manchester, not to mention its strong regional identity – the spirit of 'Devo Manc'. Local public servants at all levels already had a track record of cooperation and joint initiatives years before the GMHSCP came into being. As the King's Fund has said, 'Greater Manchester stands out because its work on health and social care is embedded within a broadly based and long-established public sector partnership led by local authorities.'[30] Building a culture of collaboration is generally seen as necessary to the ICS approach. Greater Manchester started with strong foundations.

3) **Transformation funding.** In order to get this flagship region for integrated health and care up and running smoothly, the GMHSCP was granted a one-off 'transformation fund' of £450m, agreed with the national government and NHS England. While less than the GMCA and the GMHSCP were angling for, it still equated to a chunky 7.5% of the region's annual health and social care budget. The importance of this money in planning for a smooth transition was explicitly acknowledging the five-year plan for the GMHSCP: 'Central to the delivery of the Plan is our Transformation Fund. This money, from NHS England, will allow us to keep our services safe for people while we develop the new ways of working.'[31] No other STP or ISC has been granted comparable funding.

4) **Economic growth.** Greater Manchester does contain areas of deprivation (largely reflecting the region's industrial history, including deindustrialisation in more recent decades). This was a part of the rationale for the additional cash. But the region has seen higher annual gross value added (GVA) growth per capita than the rest of England during the STP/ICS period: 3.8% versus 3.0%. The region's relative economic strength was well known going into the reforms: as the GMCA noted in 'The Plan' of December 2015, 'Manchester has the fastest growing economy in the country'.[32] Assuming some degree of association between wealth and health, underlying economic trends have thus been moving in a helpful direction for health and care in Greater Manchester, or at least more so than in the country as a whole.

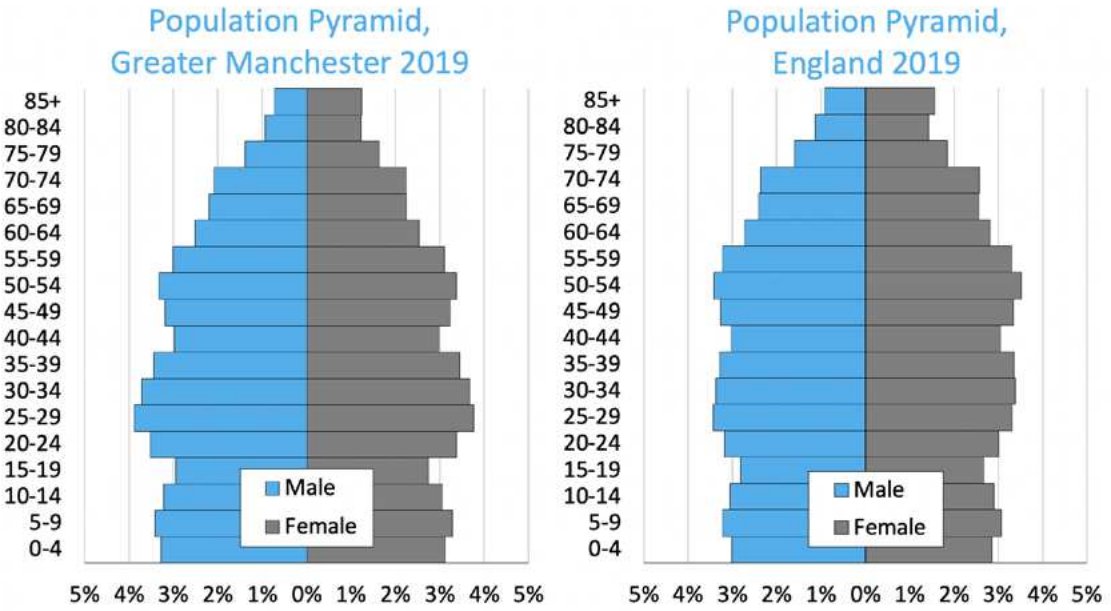
5) **Demographics and population health.** Before the creation of the GMHSCP, Greater Manchester lagged behind national trends for many health indicators such as life expectancy and survival rates for various diseases. But starting from lower baselines meant that the region had scope for greater gains in health outcomes. Indeed, bringing health outcomes in the region into line with national trends was a major ambition articulated in 'The Plan', which identified some of the relatively low-hanging fruit. Greater Manchester also has significantly a younger demographic profile than the average across England, so should face less short-term pressure on health and care resources from the mere fact of ageing. Moreover, as the table above shows, at the time of the GMHSCP's launch, the region benefited from a higher ratio of NHS workers (FTE basis) to population, at 2,252/100,000 versus 1,857/100,000 across England.[33]

30 The King's Fund, C. Ham, *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England* (20 February 2018).

31 GMCA, *Taking Charge of our Health and Social Care in Greater Manchester: The Plan, Summary* (December 2015), p.8.

32 GMCA, *The Plan,* p.2.

33 Data basis: NHS Digital, *NHS Workforce statistics*.



In short, between the foundation of the GMHSCP in April 2016 and the arrival of the pandemic in early 2020, highly favourable conditions for testing the ICS approach obtained in Greater Manchester – conditions that ought to have been conducive to the demonstrable improvements in health outcomes needed to justify the ICS reforms more widely.

Indicators

In using health outcomes data to assess the performance of the GMHSCP, a holistic approach – very much in the spirit of the reforms – is called for. It is not any particular ward, hospital, GP surgery, care home, Trust, PCN or even LCO that is under evaluation but rather what the reforms add up to across the system, which after all is the ultimate principle of the ICS model.

Accordingly, we have used three main criteria to assess the data from the GMHSCP:

a) Outcomes under the GMHSCP compared to the pre-GMHSCP period in Greater Manchester, taking into account not just indicator values, but also whether pre-existing trends have held steady, accelerated, decelerated or reversed.

b) Outcomes under the GMHSCP relative to the national average, again taking into account not just indicator values but also trends, looking at relative trajectories and whether outcomes in Greater Manchester and England as a whole have run parallel, diverged or converged.

c) How the GMHSCP has performed in relation to the explicit, quantified targets that were set by the GMCA in the five-year plan for the GMHSCP published in December 2015, 'Taking Charge of our Health and Social Care in Greater Manchester: The Plan'.

At present, very few data series are published according to ICSs. We therefore used a range of sources to compile the featured indicators analysed below, most notably the Clinical Commissioning Group Outcomes Indicator Set (CCG OIS) and the Adult Social

Care Outcomes Framework (ASCOF) data available through NHS Digital. Population and most mortality data is from the Office for National Statistics (ONS).

Some of these data series were concerned with CCGs, while others were done by local authority areas. Where raw data was provided, we have derived appropriate weighted series for the Greater Manchester region. In the couple of instances where data series represent unweighted averages due to source limitations, this is indicated.

If all the available data series had been analysed in depth, this report would be many times larger than it actually is. Instead, a representative range of indicators have been carefully selected, bearing in mind the following criteria:

- **Data coverage and quality**. Is there sufficient data for both the 2016-20 period and at least a similar period of time before 2016, so that meaningful comparisons can be made across time?

- **Relevance to ICS activities**. Is this particular metric within the ICS's gift to affect? For instance, commissioning of tertiary healthcare for rare diseases is generally carried out by NHS England, so survival rates for specific rare cancers are not going to be as relevant for evaluating ICS outcomes.

- **Relevance to integrated care**. Does the indicator look at an outcomes related to the pressures on the health system that integrated care is supposed to relieve, or where knock-on effects might reasonably be expected? (DtoC is the obvious example here.)

- **Relevance to Greater Manchester**. Were specific targets set for the GMHSCP, reflecting local conditions and priorities?

On that last point, some of the goals set by the GMCA for the GMHSCP were fairly general or related to processes rather than outcomes, for example:

- The ambition 'to see the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people in the towns and cities of Greater Manchester'

- A strong emphasis on population health and preventing illness

- Developing LCOs so that people can receive support in their local community, with 'hospitals only needed for specialist care'

- Developing a Greater Manchester Mental Health Strategy
- Forming a Greater Manchester Cancer Strategy and Vanguard pilot, based around the Christie NHS Foundation Trust

However, others were much more specific and measurable. In particular, by 2021, the aim was for:[34]

- 1,300 fewer people dying of cancer per annum
- 600 fewer people dying from cardiovascular disease per annum
- 580 fewer people dying from respiratory disease per annum
- 270 more babies being over 2,500g at birth per annum
- 3,250 more children emotionally and socially ready for the start of school aged 5
- 2,750 fewer people suffering serious falls per annum

Of course, most data series for 2020-21 have not been published yet. And even if they had been, the pandemic has made rendered previous targets meaningless – especially in areas such as respiratory disease mortality.

However, purely from a data perspective, the pandemic has had less of an impact than might be supposed. The first lockdown came into effect on March 23, 2020. Given that most NHS data is published according to the fiscal year, we have reliable data for four out of the five years. And where data is published according to the calendar year, that still leaves the years from 2016 to 2019 to use.

‘By 2021, the aim was for 1,300 fewer people dying of cancer per annum, 600 fewer people dying from cardiovascular disease, and 580 fewer from respiratory disease’

In other words, it is still possible to hold up the GMHSCP against its own quantified targets: assuming linear progress (an assumption that is admittedly open to criticism), the GMHSCP should have been around 80% of the way towards meeting its five-year goals in 2019/20, or 60% in 2019 where the data uses the calendar year. Furthermore, it is worth noting that the GMHSCP published its own stock-take in March 2020, ‘Taking Charge is working in Greater Manchester’ – a claim which, as we shall see, is open to question.[35]

In the following section, we shall examine a range of key performance indicators, including the most important of those directly or indirectly set out by the GMHSCP itself.

34 GMCA, *The Plan*, p.3.

35 GMHSCP, *Taking Charge is working in Greater Manchester* (March 2020), p.32.

Delayed Transfers of Care

- **DtoCs became around 65% more common in Greater Manchester following the establishment of the GMHSCP.**

- **After the GMHSCP was created, Greater Manchester underperformed the England DtoC average by about 16%; previously it overperformed by 20% – a significant reversal.**

- **Over 136,000 more DtoCs from hospitals occurred from April 2016 to March 2020 than would have been the case if Greater Manchester had conformed to the national trend.**

In the four years prior to the establishment of the GMHSCP, delayed transfers of care (DtoCs) per 100,000 of the adult population in Greater Manchester averaged 8.5 per day. In the four years from the foundation of the GMHSCP, this metric averaged 14.0, i.e. an increase of almost 65%. This includes a dramatic spike in DtoC in 2016-17, which could be attributed to the dislocations of the transformation.

> **'In the four years prior to the establishment of the GMHSCP, delayed transfers of care (DtoCs) per 100,000 of the adult population in Greater Manchester averaged 8.5 per day'**

That being said, the DtoC rate was rising in the two years before the GMHSCP was established, and more importantly, was doing so across England. Yet in the 2012-16 period, DtoC across England averaged 10.6, and in 2016-20, 12.1 – a much more modest rise of 14%, versus the 65% seen in Greater Manchester.

In fact, whereas before health and social care devolution, Greater Manchester consistently outperformed England on DtoC, since then it has consistently underperformed against the national average. In 2012-16, the DtoC rate in Greater Manchester was 20% lower than the average for England; since the GMHSCP came into being, it has been 16% higher.

If DtoCs in Greater Manchester had increased in line with the more limited national increase, then the DtoC indicator for the GMHSCP would have averaged about 9.7, i.e. 31% lower than was in fact the case. In raw terms, this equates to over 136,000 additional delayed transfers of care from hospitals in Greater Manchester over the 2016-20 period than would have been the case if the regional DtoC rate had risen in line with the national trend.

Digging a little deeper, it would seem patients 'awaiting completion of assessment' by relevant clinicians and/or care specialists (at hospitals and/or in care settings) has been a major factor in rising DtoC under the GMHSCP.[36] Indeed, the 2019-20 period saw a 188% y-o-y increase in DtoCs for this reason.[37]

The GMHSCP's self-assessment on DtoC could perhaps be described as selective. It notes that 'good progress' was made 'on reducing delayed transfers of care in 2017'.[38]

36 The methodology and definitions underlining these DtoC metrics can be found in DHSC, *The Adult Social Care Outcomes Framework 2018/19: Handbook of Definitions* (March 2018), pp.54-57.

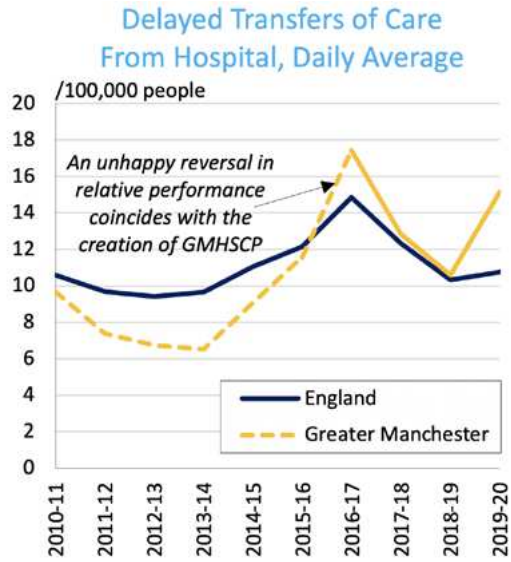
37 Derived from NHS England, *Delayed transfer of care improvement tool* (February 2021).

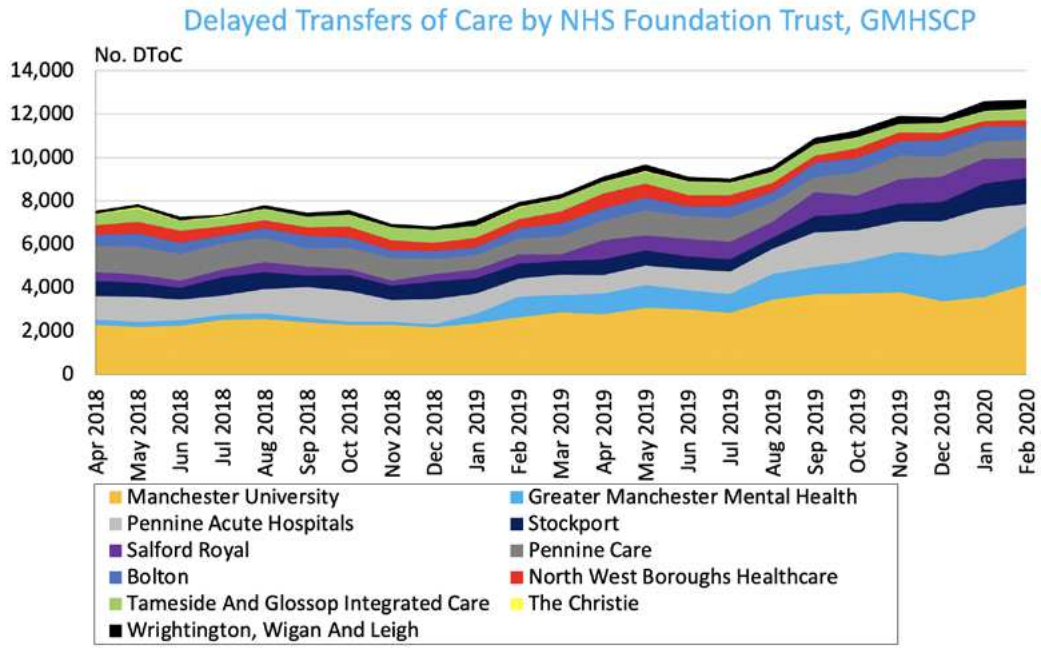
38 GMHSCP, *Taking Charge is working*, p.32.

But as our DtoC graph shows, the prior period, 2016-17, saw a sharp rise; subsequent progress might be thought to represent something of a return to the mean.

The GMHSCP attributes this less than stellar outcome to 'local variation on performance […] with those areas that have more advanced integrated social care and discharge teams doing better'.[39] Looking at the DtoC data for individual NHS trusts, much of the increase does indeed seem to be localised to the Manchester University NHS Foundation Trust and the Greater Manchester Mental Health NHS Foundation Trust. But an upward trend is also in evidence for the Pennine Acute Hospitals NHS Trust, the Stockport NHS Foundation Trust and the Salford Royal NHS Foundation Trust – so five out of 11 trusts that consistently submit DtoC data.

Whatever the causation, it is unarguable that in the four years after health and social care in Greater Manchester came under the auspices of an integrated healthcare system, the DtoC situation in the combined authority has significantly deteriorated, and done so at a notably faster rate than in England as a whole.





39 GMHSCP, *Taking Charge is working*, p.32.

Bed Occupancy

- **Hospital care capacity in the GMCA has come under increased pressure, with bed-days in 2019/20 some 2.6% higher than in 2015/16, whereas bed-days in England as a whole fell by 1.3%.**

- **When adjusted for population growth, Greater Manchester has seen a slight fall in bed-days over the 2016-20 period – but at only 1/6th the rate of England as a whole.**

- **If bed-days had followed a similar trajectory in Greater Manchester as in England, over 81,000 fewer bed days would have been recorded in 2019/20 than was in fact the case.**

A bed is one of the basic units of secondary care capacity. Overall bed utilisation in a given area can be measured using the concept of bed-days: three beds occupied for two days, for instance, would equate to six bed-days.[40]

> **'In the year beginning April 2016, bed-days increased by 5.8% y-o-y, rising from 2.33m in 2015/16 to over 2.46m'**

Given the rise in delayed transfers of care from hospital beds in Greater Manchester following the creation of the GMHSCP, it is not surprising that bed-days should have risen in the area too.

In the year beginning April 2016, bed-days increased by 5.8% y-o-y, rising from 2.33m in 2015/16 to over 2.46m.[41] Moreover, bed-days, which are highly seasonal, were up year-on-year in each quarter of 2016/17.

These sharp increases are quite possibly due to the disruption of the GMHSCP transition period, given that in England as a whole, bed-days rose by just 0.4%. In subsequent years, bed-days moved back down towards previous levels. However, by 2019/20 they were still 2.6% (56,000) higher than in 2015/16, due to a combination of more patients and lengthier average stays.

On the face of it, Greater Manchester therefore compares poorly against the national trend: bed-days across England in 2019/20 were down by 1.3% on 2015/16. On the other hand, the daily average number of beds in hospitals had declined by 2.3% (3,015 beds) nationally over this period, and hence bed occupancy actually averaged 88% in 2019/20, as against 87.1% in 2015/16. There was therefore a slightly more intensive usage of existing stock in 2019/20, which could be interpreted either as greater efficiency in the use of resources, or as greater pressure on resources. In comparison, bed occupancy in Greater Manchester averaged 88.2% in 2019/20, up from 86.7% in 2015/16 – a steeper rise than seen nationally. The picture is complicated, but with bed-days in the area having risen, unlike in England, this looks more like intensified pressure than more efficient use of resources.

40 More precisely, a bed-day is defined as: a day during which a person is confined to a bed and in which the patient stays overnight, and where that bed is under the care of a consultant. It excludes day cases – patients admitted for a medical procedure in the day and released before the evening.

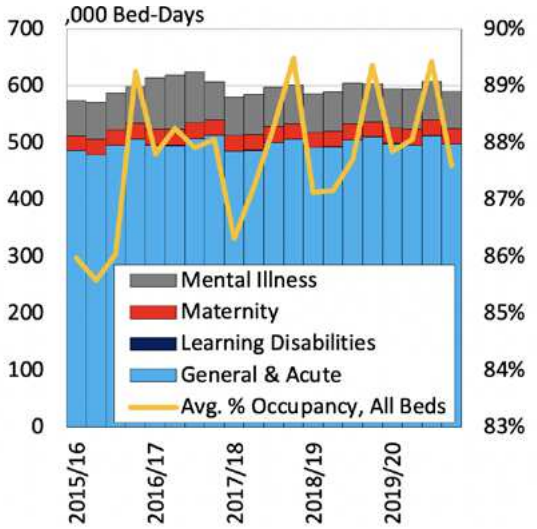
41 Data basis: NHS England, *Bed Availability and Occupancy Data.*

The comparison between Greater Manchester and England here can be further refined by adjusting for population growth.[42] The record of the GMHSCP looks better in this light, with per capita bed-days 0.6% lower in 2019/20 than in 2015/16. Yet per capita bed-days across England fell by over six times as much (3.9%) over the same period.

If bed-day/capita trends had followed a similar downwards trend in Greater Manchester as in England as a whole, the area would have seen over 81,000 fewer bed-days in 2019/20 than was actually the case. Bed occupancy would therefore have fallen to around 85%, assuming no further reduction in the number of available beds.

In summary, the creation of the GMHSCP seems not to have led to any noticeable improvement in bed-days or bed occupancy rates in Greater Manchester relative to national levels – in fact, if anything, the reverse has happened.

Greater Manchester Bed-Days
by Category, per Quarter



42 Data basis ONS mid-year population estimates: ONS, *Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland* (June 2020).

Emergency Admissions to Hospital

- **Total emergency admissions in Greater Manchester have trended upwards more or less in line with national figures, increasing by 13% from 2016 to 2019, to reach 391,000 in 2019.**

- **Direct admissions to emergency care increased by a relatively limited 1% from 2016 to 2019 in Greater Manchester, which could point towards timelier and more efficient community care.**

- **There is an apparent decline in unplanned hospitalisations for chronic ambulatory care-sensitive conditions (ACSCs), but this may be a statistical artefact.**

Given the GMHSCP's emphasis on preventative interventions and population health, a general reduction in emergency admissions to hospitals might be expected (at least relative to England as a whole), for example from serious falls or chronic ambulatory care-sensitive conditions (ACSCs). Fewer such emergency admissions would help to obviate capacity problems arising from DtoCs.

> **'From 2016 to 2019, total emergency admissions in the region increased by over 43,000'**

However, in terms of emergency hospital admissions, the track record in Greater Manchester since 2016 has been mixed. Total emergency admissions include those via attendance at A&E departments,[43] as well as 'direct' admissions of patients by GPs or consultants to ambulatory clinics, bypassing A&E.

From 2016 to 2019, total emergency admissions in the region increased by over 43,000 to stand at 391,000, representing an average annual growth rate of 4.0%.[44] This rate was essentially in line with the trend across England during the same period.

As such, Greater Manchester's share of national total emergency admissions held more or less steady at around 6% across the period. Taking into account population growth from 2016 to 2019 (1.8% in England, 2.0% in the GMCA) does not do much to change the overall picture either.

It is notable, though, that most of the increase in emergency admissions to hospitals in Greater Manchester over 2016-19 resulted from A&E rather than direct admissions, with the former increasing by 16% over the period and the latter by a little less than 1%. As such, the proportion of A&E admissions rose from 78% in 2016 to 81% in 2019. In England as a whole, the increase in the share of A&E admission was more limited, rising from 74% to 75%, as A&E admission increased by 15% and direct admission by 6%.

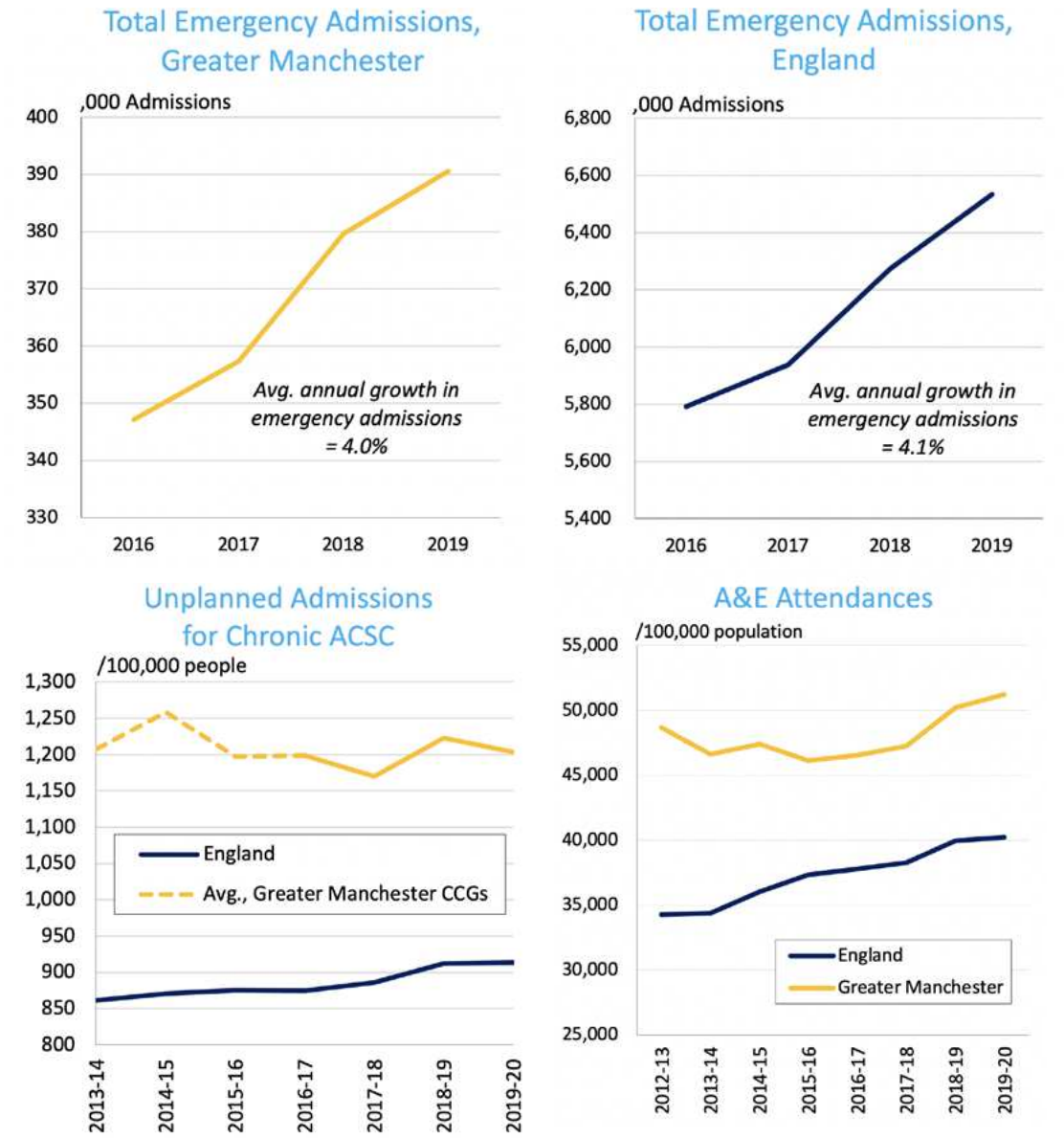
So on the one hand, it could be that clinicians under the GMHSCP have been less effective at admitting patients to emergency care directly, with more patients finding their way in via A&E departments. On the other, it could be that timelier and more efficient community or outpatient care in Greater Manchester has been reducing direct admissions to emergency care, with the sharper rise in A&E admissions explained by other factors.

43 A&E in this context means all types of A&E provision including Type 1, Type 2, Type 3, Type 4 department and Urgent Care Centres that average more than 200 attendances per month. See: NHS England, A&E Attendances and Emergency Admissions Monthly Return Definitions (July 2019), p.3.

44 Data basis: NHS England, A&E Attendances and Emergency Admissions.

There is some evidence that points towards the second explanation. Unplanned admissions for chronic ACSCs in Greater Manchester have been slightly lower on average since the GMHSCP was established, whereas admissions have trended upwards in England.[45] Indeed, in the three years prior to the creation of the GMHSCP, unplanned ACSC admissions in the region averaged 1,221 per 100,000 registered patients; in the four years after, they averaged 1,199 – a 1.8% decrease. The comparable figures for England are 869 and 897, representing a 3.2% increase. This narrowed the disparity between Greater Manchester and England from 37% higher to 32% higher.

Yet is also worth noting that chronic ASCS admissions in the two years after the creation of the GMHSC were low in historical terms, with the numbers then trending back upwards. It could easily be the case that the comparison between the before and after periods is distorted by normal statistical variation – the peak in 2014/15, and the trough in 2017/18. It is notable that the trend line for England as a whole – with a much larger sample size – is much smoother. On balance though, it seems that this indicator held more or less steady under the GMHSCP.



45 Data basis NHS Digital, 'Indicator 2.6 Unplanned hospitalisation for chronic ambulatory care sensitive conditions', CCG OIS. The data as provided is age- and sex-standardised across England. The derived Greater Manchester figures used here reflect an average calculated at the CCG level, rather than a properly weighted average for the GMHSCP as a whole, given data limitations.

Emergency Readmissions to Hospital within 30 Days

- **The incidence of emergency readmissions in Greater Manchester has risen since 2016/17, though at a slower rate than nationally, with the region seeming to outperform on this indicator.**

- **However, the rate of growth in readmissions was already smaller than the national average before the GMHSCP came into being.**

- **In fact, the rate of growth in readmissions accelerated from 2016; at previous growth rates, there would have been 5,700 fewer emergency readmissions in the 2016-20 period than was the case.**

A more holistic, less siloed approach to patient wellbeing is central to the integrated healthcare concept. In theory, if healthcare provision is focused around the patient rather than the clinical setting, there should be an enhanced level of monitoring and aftercare once patients have been discharged from hospitals, with local authorities and social carers liaising more closely with hospitals and clinical staff. The expected result would be fewer emergency readmissions of recently discharged patients, given that health lapses should more often be either forestalled or anticipated.

> **'In the three years before the establishment of the GMHSCP (the period for which there is available data), the rate of emergency readmissions within 30 days of discharge from hospital averaged 13.3%; in the subsequent four-year period, emergency readmissions averaged 13.7%, with a peak of 14% in 2018/19'**

In the three years before the establishment of the GMHSCP (the period for which there is available data), the rate of emergency readmissions within 30 days of discharge from hospital averaged 13.3%; in the subsequent four-year period, emergency readmissions averaged 13.7%, with a peak of 14% in 2018/19. However, as shown in the graph below, this rise was rather less steep than the national average, which rose from 12.9% to an average of 14% (with a peak of 14.4% in 2019/20).[46]

So relative to England, there been a fairly clear improvement in the performance of Greater Manchester, notwithstanding the fact that emergency readmissions have still become proportionally more common in the region.

On the other hand, it is not clear whether this is attributable to the GMHSCP reforms. The rate of emergency re-hospitalisations was already rising more slowly in Greater Manchester than nationally, with annual growth averaging growth just 0.2%, compared to 2.7% countrywide. In fact, growth in the rate of readmissions in the region accelerated after 2016, to an annual average of 0.9% (versus 2.2% nationally).

So although Greater Manchester performed noticeably better than the national average for readmissions subsequent to the creation of the GMHSCP, it is impossible

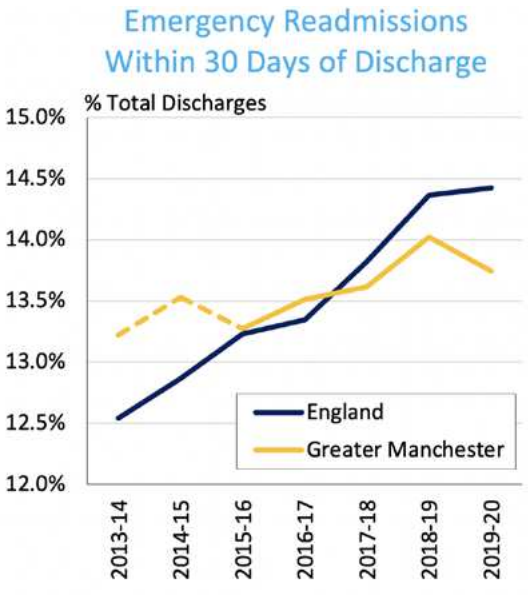
46 Data basis: NHS Digital, 'Indicator 3.2 Emergency readmissions within 30 days of discharge from hospital', *CCG OIS*. Note that very slightly different regional values emerge from emergency readmissions data in NHS Digital, *Compendium of Population Health Indicators*. This is because the former is based on CCGs, the latter on local authorities, which can cover slightly different areas.

to use this to justify the ICS reforms without further data and contextualisation. In fact, had the rate of emergency readmissions in Greater Manchester continued to grow at the same pace as before the reforms, there would have been over 5,700 fewer emergency readmissions in the 2016-20 period.

It is also worth considering the trajectory of emergency readmissions for the 75+ age cohort specifically, where rates tend to be much higher than average for obvious reasons. On the face of it, the most recent datapoints portray Greater Manchester in a favourable light, with the rate of emergency readmissions having dropped by 1.1 percentage points to 18% from 2017/18 to 2019/20, even as the national average rose by 0.2 percentage points to 18.6%.

However, while 18% might be the lowest point in the timeseries, it is only 0.2 percentage points lower than the pre-GMHSCP low. The recent trend looks like progress because it follows from a rapid increase in emergency readmissions in the two years immediately following the creation of the GMHSC.

In summary, following the establishment of the GMHSCP, Great Manchester saw a slower rise in emergency readmissions to hospital within 30 days of discharge than occurred at a national level. As a result, emergency readmissions became relatively more frequent in England than Greater Manchester. However, this would have been expected on the basis of pre-GMHSCP trends – which deteriorated following the establishment of the GMHSCP.



Deaths Associated with Hospitalisation

- **Since the establishment of the GMHSCP, annual deaths associated with hospitalisation have risen relative to the average across England.**
- **Had the region's relative performance averaged the same as in the 2013-16 period, there would have been 320 fewer deaths associated with hospitalisation than was in fact the case in 2016-20.**
- **There continues to be considerable variation in performance between NHS trusts within Greater Manchester, with some trusts doing 10% better and some 15% worse than the national average.**

The summary hospital-level mortality indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at an acute trust and the number that would be expected to die, given the characteristics of the patients treated there. Deaths are recorded under SHMI if they occur at hospital or anywhere outside of hospital within 30 days of discharge.[47]

> 'There were around 2% more deaths associated with hospitalisation per annum than would be expected, afterwards deaths averaged 3% higher per annum'

The SHMI is a high-level indicator that can be influenced by a wide and complicated range of factors and regional variations in the provision of health and social care, so a certain caution is needed in drawing conclusions from it in isolation.[48] That said, given the GMHSCP's overall objective of inducing 'the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people in the towns and cities of Greater Manchester'[49], some improvement on this front might reasonably be expected.

Sadly, as the graph shows, the SHMI for Greater Manchester was on average higher following the establishment of the GMHSCP. Whereas beforehand, there were around 2% more deaths associated with hospitalisation per annum than would be expected, afterwards deaths averaged 3% higher per annum.[50]

The SMHI rose sharply to 1.04 in 2016/17, perhaps reflecting disruption during the transition period. It then fell to a low of less than 1.01 in 2017/18; but this improvement was not sustained, and by 2019-20, the SHMI was almost back at 1.04. In contrast, in the years for which data is available before the GMHSCP was founded, the peak SMHI was less than 1.03.

The elevated SHMI values in the years following the establishment of the GMHSCP are not just empty abstractions: they represent 320 more deaths than would have been the case if SMHI had remained at pre-reform levels.

47 NHS Digital, 'About the Summary Hospital-level Mortality Indicator (SHMI)' [https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-shmi].

48 For some of the potential pitfalls in using SHMI, see for example: CHKS, *Insight Report: Six things to know about the Summary Hospital-level Mortality Indicator* (January 2015).

49 GMHSCP, 'Taking charge', p.1.

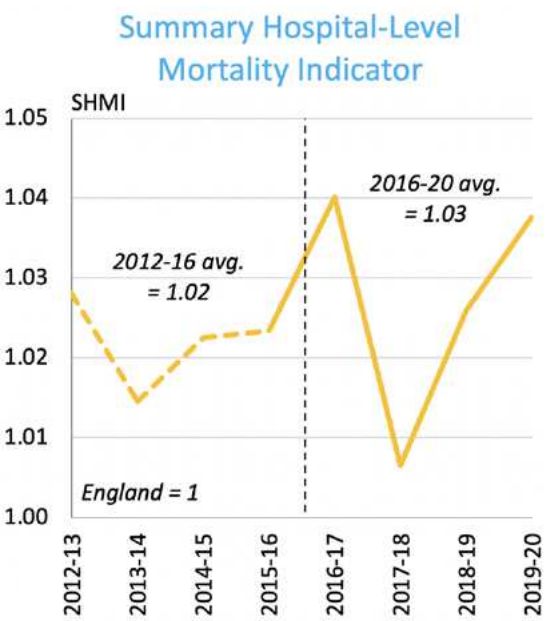
50 Data basis: NHS Digital, *Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation.* The regional SHMI is derived from combining the data for each relevant NHS trusts in Greater Manchester on observed and expected deaths, to produce a weighted regional SHMI value.

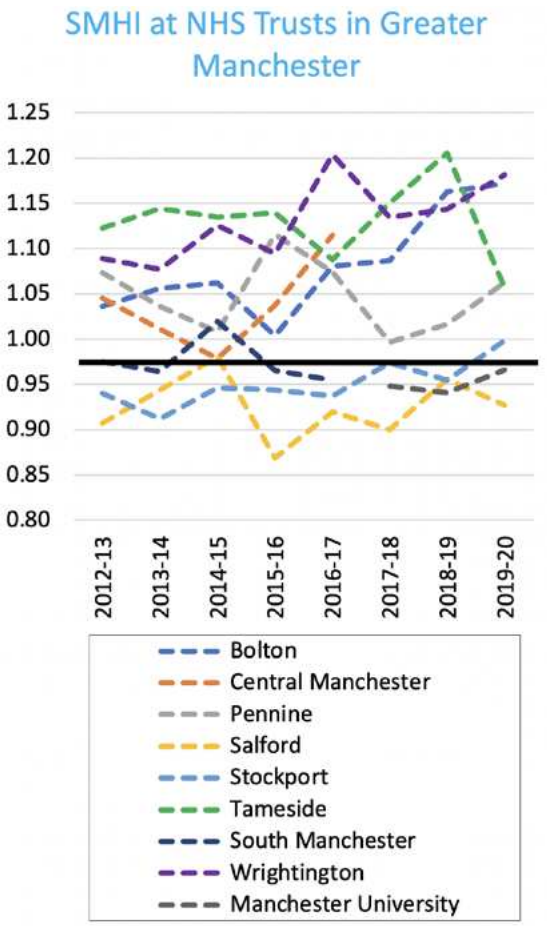
Of course, rising SHMI need not be a negative thing. It could be that more people who would previously have died at home as a result of undiagnosed conditions were being diagnosed, and hence admitted to hospital.

That being said, if the ICS approach is to be rolled out across England, it is worth first getting to the bottom of the increase in SMHI in Greater Manchester.

Furthermore, it is worth noting that differences in SHMI between trusts in Greater Manchester have persisted since the GMSHCP was created. Some trusts, such as Salford Royal Foundation NHS Trust, have consistently performed around 10% better than England as a whole. Others, like Wrightington, Wigan and Leigh NHS Foundation Trust, have been consistently 10-15% worse, and slightly more so since the GMHSCP came into being.

Integration within the NHS is a core part of the ICS concept. One element of this in Greater Manchester, for example, was the decision by the CCGs to 'move to four single services to provide acute general surgery in Manchester'.[51] But such initiatives do not seem to have led to any significant narrowing of the performance gaps between trusts in the region, and the associated healthcare inequalities.





51 GMHSCP, *Taking charge*, p.5.

Cancer Mortality

- **Based on the five-year plan for the GMHSCP, there should have been around 780 fewer cancer deaths in 2019 than 2016; in fact, there were 162 more.**
- **The standardised cancer mortality rate in Greater Manchester has continued to converge on the (lower) national figure, but this trend long predates the GMHSCP.**
- **One-year cancer survival rates in Greater Manchester have continued to converge on the (higher) national figures, but again, this trend long predates the GMHSCP.**

At the inception of the GMHSCP, the GMCA set a target of 1,300 fewer cancer deaths in Greater Manchester by 2021. Using 2016 mortality data as a baseline, this amounts to an ambitious 19% reduction in annual cancer deaths by the end of the five-year plan: 5,446 cancer deaths, down from 6,746.

Assuming a fairly linear progression towards the goal, then 780 fewer cancer deaths would be expected by 2019. In fact, after having fallen very slightly in 2017 and 2018, regional cancer deaths shot up in 2019 to stand at 6,908, representing an increase of 2.4% on 2016, to 942 above the implied target.[52]

There will obviously be an element of statistical noise in any such figures – something worth bearing in mind throughout this report. But even before 2019, the GMHSCP was nowhere near the trendline for hitting the 2021 target. This might explain why this metric is not specifically addressed in the March 2020 review of the five-year plan, which instead focuses on the subpar performance of Greater Manchester with regard to cancer waiting times.[53]

Although failing on its core cancer target, trends in cancer mortality in the area overseen by the GMHSCP can be seen in a more positive light, as per the second graph below.[54] Standardised for age and sex, cancer mortality fell by 5% over 2016-18 in Greater Manchester, from 298 to 283 per 100,000 person-years. In comparison, England saw a 4% decline over the same period.

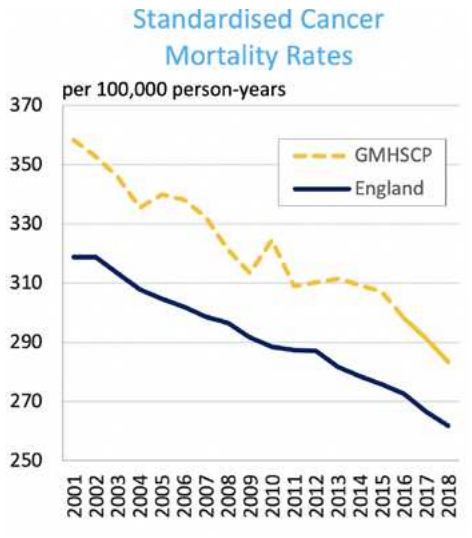
It is possible – probably even likely – that the release of 2019 data will show a reversal in this trend, given the sharp rise in cancer deaths that year. But cancer outcomes in Greater Manchester have certainly been converging towards the national average – a welcome development, given the region's history of lagging performance. By 2017, one-year survival rates for breast, lung and colorectal cancer in Greater Manchester were essentially on par with England for the first time on record.

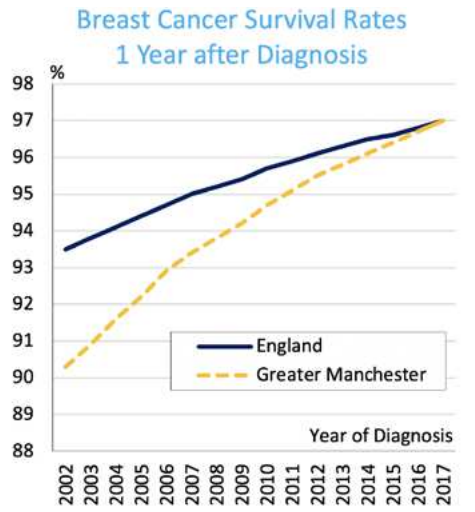
What is immediately obvious here, however, is that this convergence is the result of a long-term trend, playing out for over a decade before the GMHSCP even came into being. The same can be said for the general converge in terms of standardised cancer mortality rates – the gap between England and Greater Manchester was 39 person-years per 100,000 people back in 2001, and had already closed to 26 by 2016.

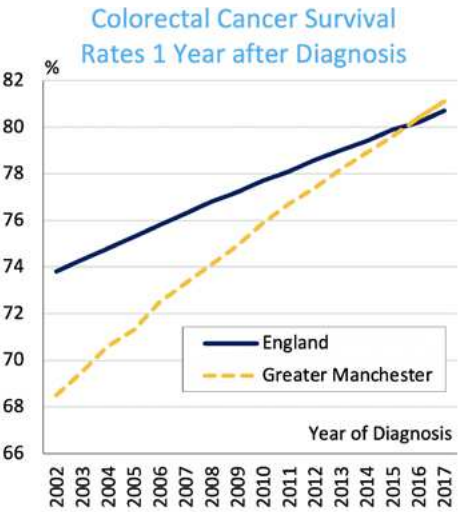
While the continued improvement in a number of cancer outcomes in Greater Manchester is obviously to be welcomed, more improvement – an acceleration of prior trends – might have been expected, given efforts being made as part of the five-

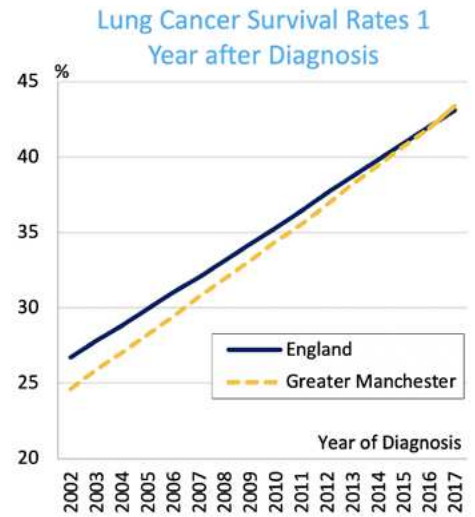
52 Population mortality data basis: ONS, *Mortality statistics – underlying cause, sex and age* (June 2020).
53 GMHSCP, 'Taking charge', p.33.
54 Data basis: PHE, 'Mortality', *Cancer Data*. Link

year plan. For example, the Greater Manchester Cancer Strategy and Vanguard pilot, centred around the Christie NHS Foundation Trust, was expected to have 'the potential to save hundreds of lives a year'.[55] As it is, the GMHSCP has been falling well short of the progress it needed to be making to hit the target of 1,300 fewer cancer deaths by 2021 – and while convergence with the national average is continuing, there is not yet any statistical evidence to suggest this is being accelerated by the GMHSCP reforms.









55 GMCA, *The Plan*, p.5.

Cardiovascular Disease Mortality

- **Good progress has been made towards reducing annual CVD deaths in Greater Manchester, which fell by 262 between 2016 and 2019.**

- **The long-term decline in CVD deaths in Greater Manchester seems to have accelerated since the creation of the GMHSCP, with deaths declining by 4.2% over 2016-19, versus 3.3% in 2013-16.**

- **In absolute and population-adjusted terms, Greater Manchester has outperformed England in reducing CVD deaths during the GMHSCP period.**

A core target in the five-year plan for health and social care devolution in Greater Manchester was 600 fewer people dying of cardiovascular disease (CVD) by 2021. This reflected and anticipated national aspirations. For instance, the NHS Long Term Plan of 2019 identifies CVD as a clinical priority and the 'single biggest area where the NHS can save lives over the next 10 years'.[56]

> **'There were 6,171 deaths from CVD in Greater Manchester in 2016. Using this as a baseline, the GMHSCP aim equates to a reduction of almost 10%'**

There were 6,171 deaths from CVD in Greater Manchester in 2016. Using this as a baseline, the GMHSCP aim equates to a reduction of almost 10%. Assuming relatively linear progress towards the goal, then a reduction of about 360 deaths would be expected by 2019, as shown by the first of the graphs below.

As with the GMHSCP's cancer deaths target, the actual trend has consistently lagged the target trend. CVD deaths in 2019 were 98 higher than target – though that does mean the GMHSCP was 73% of the way towards the implied target.[57]

Indeed, following a rise in 2017 – perhaps due to the disruption of the transformation – CVD deaths in the region trended downwards quite sharply. Moreover, while CVD deaths in Greater Manchester declined by 3.3% (211) in 2013-16, they fell by 4.2% (262) in 2016-19. So it appears as though the longer-term trend towards fewer CVD deaths in Greater Manchester accelerated under the GMHSCP.

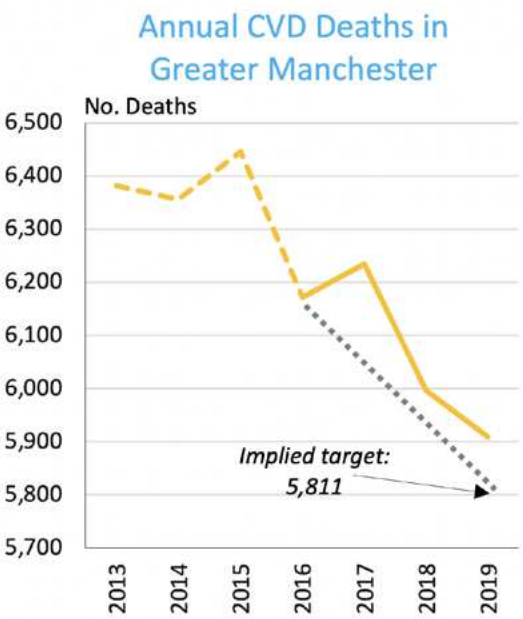
This is in contrast to the trend in England at large. While CVD deaths declined by 4.6% over the 2013-16 period in England, they fell by 3.2% over the 2016-19 period. Similar trends obtain when adjusting for population, as per the second graph, with CVD deaths declining more quickly in Greater Manchester than in England as a whole.[58] As such, Greater Manchester has pulled slightly further ahead of England on CVD deaths: in 2016, there were four more CVD deaths per 100,000 people across England than in Greater Manchester; in 2019, there were six more.

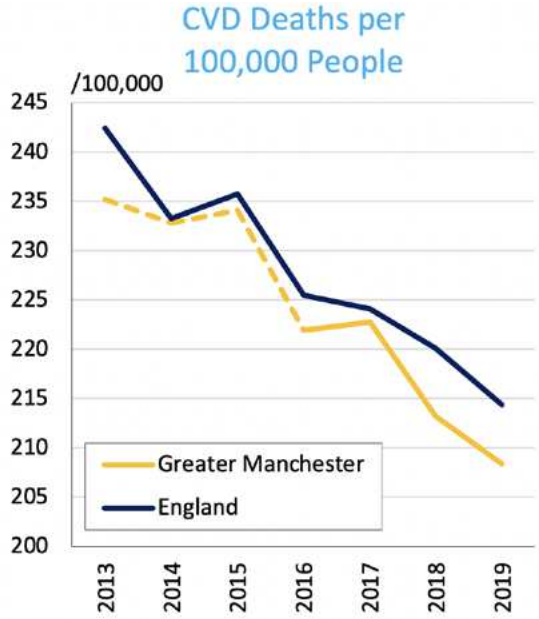
56 NHS England, *The NHS Long Term Plan,* p.62.

57 Population mortality data basis: ONS, *Mortality statistics – underlying cause, sex and age* (June 2020).

58 However, note that these timeseries are not age or sex standardised.

In summary, while the GMHSCP is not quite living up to its own targets for reducing CVD deaths, outcomes are certainly moving in the right direction. Greater Manchester also seems to have been outperforming the national trend.





Respiratory Disease Mortality

- **Annual respiratory disease deaths in Greater Manchester increased by 6.7% from 2016 to 2019, rather than falling as per the GMHSCP target.**

- **The gap between respiratory disease mortality rates in Greater Manchester and England as a whole doubled in size between 2016 and 2019.**

- **The widening gap represents an additional 217 respiratory disease deaths in 2019 compared to what would have occurred if the region had paralleled the national trend.**

One of the main objectives in the five-year plan for the GMHSCP was for 580 fewer people to be dying of respiratory disease by 2021. Striving to achieve this goal, it should be noted, could be expected to produce a range of beneficent side-effects, not least because respiratory diseases are a major factor in winter pressures on the NHS.[59]

> **'There were 3,549 respiratory disease deaths in Greater Manchester in 2016, so using this as a baseline, the five-year plan aimed at a 16% reduction in respiratory disease deaths, to just under 3,000 per annum'**

The target is also particularly relevant to Greater Manchester, as high levels of respiratory disease tend to be associated with areas of relative deprivation, which often have higher smoking incidence, exposure to higher levels of air pollution, poorer housing conditions and occupational hazards – or at least a legacy of such, from mining or heavy industry.

There were 3,549 respiratory disease deaths in Greater Manchester in 2016, so using this as a baseline, the five-year plan aimed at a 16% reduction in respiratory disease deaths, to just under 3,000 per annum. Assuming a fairly linear progression towards this goal, then around 3,200 respiratory disease deaths would be expected in 2019.[60]

However, after the GHMSCP came into being, respiratory disease deaths trended upwards. By 2019 they stood at 3,787, up by 6.7% on 2016.

Of course, as noted in the GMHSCP's March 2020 review, with some measures to reduce respiratory disease deaths, it could 'take time for the benefits to be demonstrated… because of the time it takes the body to recover from smoking, for example'.[61] So assuming a linear target trend line, with results becoming immediately evident, might be somewhat unfair.

That being said, in order to hit the 2021 target, there would need to be a decline in annual respiratory disease deaths of 818 – a 22% reduction over the course of two years. Such an outcome seems unlikely. By its own benchmark, the GMHSCP is falling short on this front.

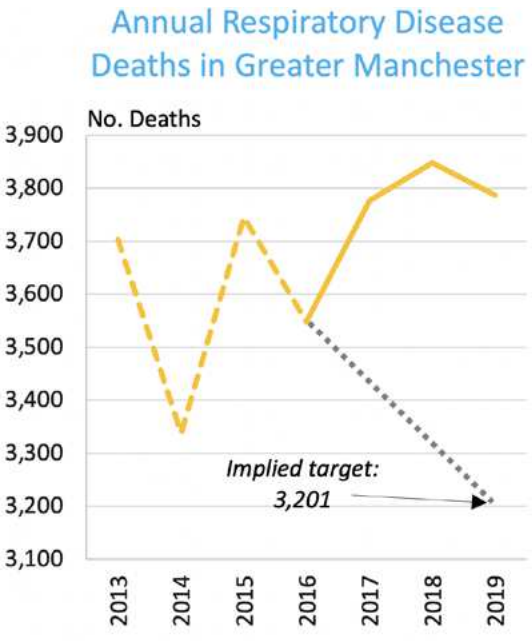
59 NHS England, *The NHS Long Term Plan*, p.66.

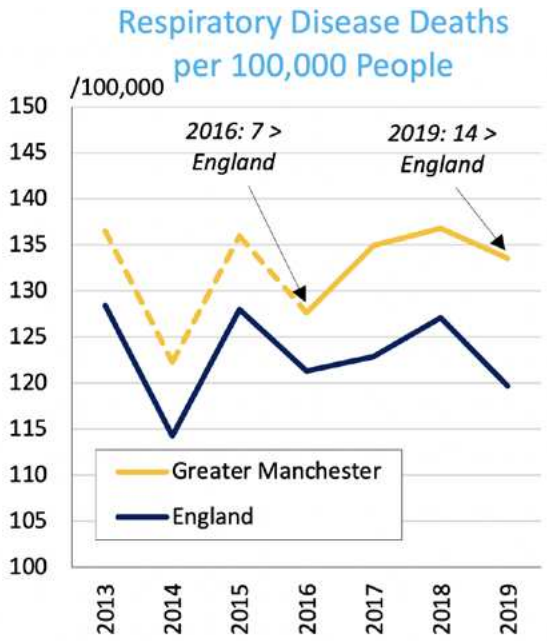
60 Population mortality data basis: ONS, *Mortality statistics – underlying cause, sex and age* (June 2020).

61 GMHSCP, *Taking charge,* p.13.

Comparisons to national trends in respiratory disease mortality are not flattering either. As shown by the second of the graphs, respiratory disease mortality in Greater Manchester has historically been much higher than in England as a whole. This largely reflects relative deprivation in parts of Greater Manchester, as noted above.

But following the creation of the GMHSCP, the performance differential between England and Greater Manchester widened further. In 2016, there were 128 respiratory disease deaths per 100,000 people in Greater Manchester, and 121 in England – so a difference of 7. In 2019, there were 134/100,000 in Greater Manchester but 120/100,000 in England – a doubling of the performance gap. If respiratory disease mortality in Greater Manchester had followed the national trend over this period, there would have been 217 fewer deaths from this cause in 2019 than was in fact the case.





Neonatal Outcomes

- **The proportion of full-term babies born underweight (<2,500g) in Greater Manchester increased from 3.0% in 2016 to 3.2% in 2018, at a faster rate and to a higher level than seen nationally. This was despite a target to reduce such births (which was abandoned midway through the period).**

- **In Greater Manchester, the proportion of stillbirths out of total births fell from 4.5 per 1,000 to 4.1 per 1,000 births from 2016 to 2018, more or less in line with the national trend.**

- **However, before the establishment of the GMHSCP, stillbirths in Greater Manchester had been declining at about three times the national rate – the decline subsequently slowed.**

A core target specified at the inception of the GMHSCP, in order to gauge progress on the preventative healthcare front, was for an extra 270 babies per annum to weigh at least 2,500g at birth by 2021. This was of course a somewhat woolly target, as it could be met simply through an uptick in birth rates. But interpreting it according to the spirit rather than the letter, and using 2016 as the baseline year, that would imply a reduction in annual underweight births of around 27% over five years, assuming the annual total number of births stayed about the same in each year; alternatively, it would mean the proportion of underweight births falling from 3.0% in 2016 to 2.1% in 2021.[62]

> **'Assuming roughly linear progress towards the 2021 goal, a reduction in underweight births of around 11% would be expected in 2018 versus to 2016; or alternatively, the proportion of underweight births would fall to circa 2.6-2.7%'**

This target was abandoned in the GMHSCP progress review of March 2020, on the basis that updated clinical guidance has led to more babies being delivered earlier in a planned way.[63] Yet this was slightly disingenuous, as data is readily available specifically for full term births. Such data is the basis of the first graph below.

Assuming roughly linear progress towards the 2021 goal, a reduction in underweight births of around 11% would be expected in 2018 versus to 2016; or alternatively, the proportion of underweight births would fall to circa 2.6-2.7%.

In fact, however, there was a 1% increase in underweight births, and the proportion of underweight births out of total births had risen slightly, from 3.0% to 3.2%. So going by the GMHSCP's original five-year plan, the ICS has fallen well short of its own goals for neonatal outcomes. It has also failed to close the gap with England, where the proportion of underweight births stood at 2.8% in 2016 and 2.9% in 2018.

An alternative approach to gauging progress in maternity support and preventative healthcare is through looking at figures for stillbirths. Indeed, this is the measure now preferred by the GMHSCP, and is the basis of the second graph below.[64]

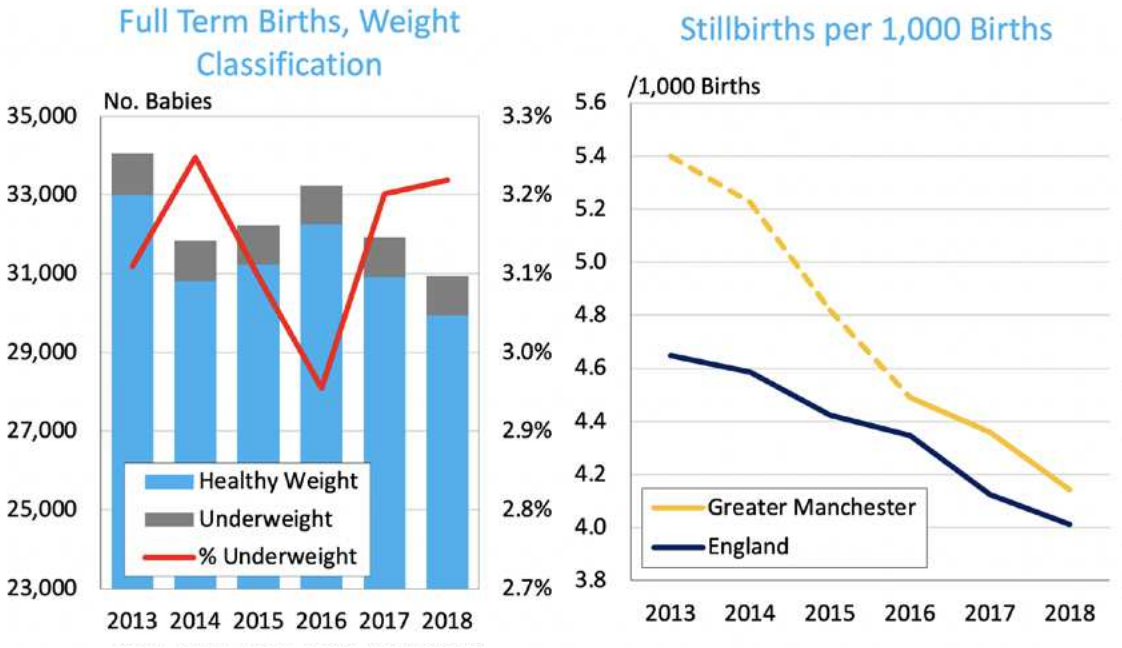
62 Data basis: NHS Digital, 'Indicator 1.26 Low birth weight full-term babies', *CCG OIS*.

63 GMHSCP, 'Taking charge', p.7.

64 Data basis: NHS Digital, 'Indicator 1.25 Neonatal mortality and stillbirths', *CCG OIS*.

In 2016, stillbirths per 1,000 total births stood at around 4.5 in Greater Manchester; in 2018, this had fallen to around 4.1, an improvement of 8%. In England, stillbirths/1,000 births also fell by 8% over this period, from 4.3 to 4.1. Stillbirth trends in Greater Manchester more or less aligned with national trends following the formation of the GMHSCP.

However, this contrasts with the preceding few years, when the gap between the region and England narrowed rapidly. Over the 2013-16 period, stillbirths per thousand births in Greater Manchester declined by around 17% – almost three times as quickly as the circa 6% decline in England. It seems to have been only after the establishment of the GMHSCP that the region ceased converging towards national rates of stillbirths.



Mental Health Outcomes

- **Patients admitted on mental health grounds accounted for over 593,000 bed-days in Greater Manchester in 2016/17, rising by 6.3% to 633,000 by 2019/20.**

- **Even adjusting for population growth, mental health bed-days in the region increased by 4.8% over the period, from 213 to 224 per 1,000 people, with a significant spike in 2018/19.**

- **In terms of freeing up secondary care capacity and reducing pressures on the NHS, the region has underperformed against England by a growing margin.**

As part of the GMHSCP reforms, a Greater Manchester Mental Health Strategy was implemented from April 2016, with an emphasis on prevention and early intervention through a more collaborative and patient-centred approach, under the umbrella of the Greater Manchester Mental Health NHS Foundation Trust (GMMH). This was partly in recognition of the fact that mental health is linked to various poor health outcomes, driving as much as 18% of long-term NHS spending.[65]

'Patients admitted on mental health grounds in Greater Manchester accounted for about 593,000 bed-days in 2016-17'

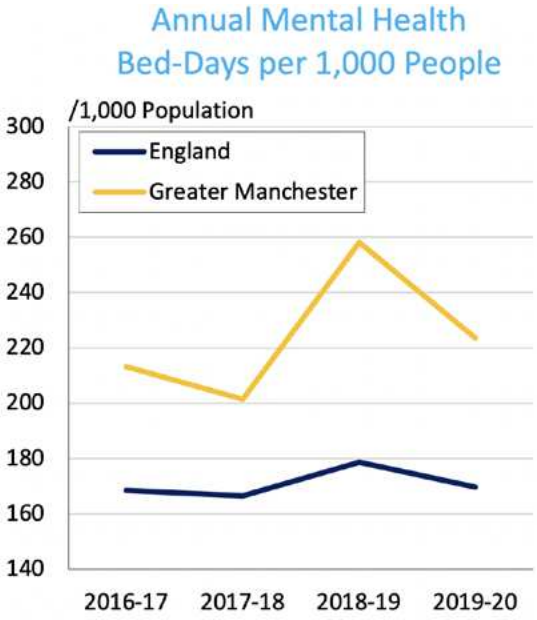
In terms of freeing up secondary care capacity (through earlier interventions or improvements in community care, for example), this strategy does not seem to have yielded much success. Patients admitted on mental health grounds in Greater Manchester accounted for about 593,000 bed-days in 2016-17.[66] After a slight fall in 2017/18, bed-days increased dramatically in 2018/19, and remained at a relatively elevated level in 2019/20, with 633,000 mental health bed-days representing an increase of 6.9% on 2016/17. This increase was proportionally much larger than that seen in England over the same period, when mental health bed-days increased by 2.5%.

Adjusting for differing population growth rates does not significantly alter the picture. The graph shows annual bed-days per 1,000 people in Greater Manchester and England. This metric stood at 213 in Greater Manchester in 2016/17 and 224 in 2019/20, so points to a more limited rise in bed-days than suggested by the raw figures, of 4.8%. However, in England this measure rose by a mere 0.7%. As such, while there were 45 more mental health bed-days per 1,000 people in Greater Manchester than in England in 2016/17, by 2019/20 there were 54 more – a 20% increase.

In summary, whatever else might have been achieved in terms of mental health outcomes in Greater Manchester, the GMHSCP reforms may have had a net negative effect on secondary care capacity in the region, both in absolute terms and relative to the national average benchmark. This rather goes against the underlying rationale for reform.

65 GMCA, *The Plan*, p19.

66 Data basis: NHS Digital, *Mental Health Bulletin*.


Annual Mental Health
Bed-Days per 1,000 People
/1,000 Population
300
280
260
240
220
200
180
160
140
England
Greater Manchester
2016-17
2017-18
2018-19
2019-20

Alcohol-Specific Hospital Admissions

- **The rate of alcohol-specific hospital admissions in Greater Manchester was 21% lower on average under the GMHSCP compared to the three years before healthcare devolution.**

- **However, half of that decrease in admissions occurred in the year immediately before the GMHSCP came into being, while after 2016-17, rates were relatively stable.**

- **That being said, the gap between Greater Manchester and England still closed by 25% over the 2016-20 period, from 50/100,000 to 40/100,000 registered patients.**

Although improving population health was a central goal of the GMHSCP from its inception, the five-year plan contained few quantified population health targets. Alcohol was only mentioned twice in the plan, both times in relation to vague aspirations.[67]

However, alcohol is still worth looking at because hospital statistics provide a useful (though not perfect) proxy for assessing reductions in alcohol abuse. Many other population health outcomes are much harder to assess, given the data available.

> **'On the surface, the GMHSCP seems to have presided over a major improvement in the rate of alcohol-specific admissions to hospital per 100,000 registered patients'**

On the surface, the GMHSCP seems to have presided over a major improvement in the rate of alcohol-specific admissions to hospital per 100,000 registered patients.[68] Admissions averaged 163/100,000 a year from April 2016 to March 2020, 21% lower than for the three years beforehand (data does not go back to before April 2013).

Yet it is not clear how much of the improvement can be attributed to measures taken by the GMHSCP. Already in 2015-16, the rate had fallen by 11% compared to the previous year, though it did then fall again by 14% year-on-year in 2016-17, under the GMHSCP. After that, it more or less stabilised, at least in comparison to these significant decreases, fluctuating around 165/100,000. It seems there was a pre-existing trend driving the reduction in admissions, one which ran out of steam or reached a natural terminus during the ICS period.

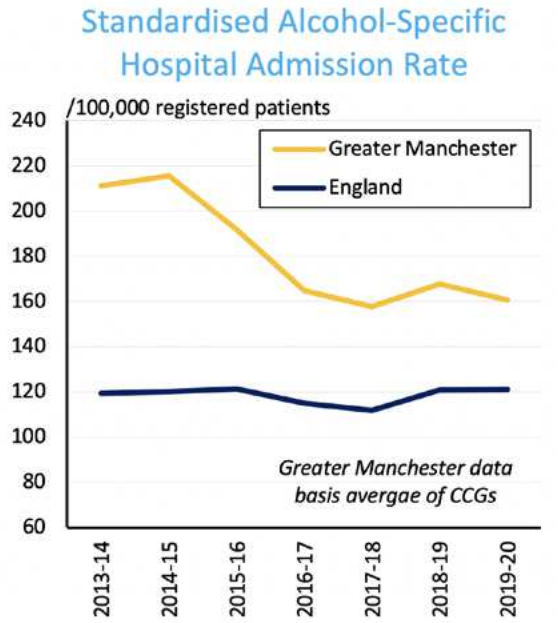
Nevertheless, admissions in Greater Manchester continued to converge on the lower national trendline under the GMHSCP. Whereas admissions to hospital for alcohol-specific conditions were 43% higher in Greater Manchester than in England on average in 2016-17, by 2019-20 the difference had fallen to 33%.

67 GMCA, *The Plan*, p.33.

68 Data basis: NHS Digital, 'Indicator 3.14 Alcohol-specific hospital admissions', *CCG OIS*.

Interestingly, the GMHSCP published and began to implement a much more detailed population health strategy from March 2019 – 'Transforming the Health of Our Population in Greater Manchester'.[69] It is notable that alcohol-specific hospital admissions fell by 4% following the introduction of the plan – a much smaller decrease than in 2015-16 or 2016-17, but still bucking the national trend that year, when admissions basically held steady. For several years prior, admissions had moved in the same direction in Greater Manchester as nationally.

On the whole then, while the GMHSCP is not the only factor (and probably not the greatest factor) in the falling rate of alcohol-specific hospital admissions in Greater Manchester, this metric has at least seen some improvement under the ICS, with signs that the region may be outperforming the national direction of travel, even if convergence looks to be some way off yet.



69 GMHSCP, *Transforming the Health of Our Population in Greater Manchester: Progress and Next Steps* (March 2019).

Life Expectancy at 75

- **Life expectancy at 75 increased by 3.7% for men and 1.8% for women in the years following the establishment of the GMHSCP, at twice the national rate.**

- **However, the resultant gaps in life expectancy between England and Greater Manchester were within the normal range of variation over the last 20 years.**

- **The data is therefore encouraging, but it is too early to claim conclusively that the GHMSCP reforms have had a significant impact on life expectancy.**

Life expectancy in Greater Manchester has historically lagged the national average. One of the general aims of healthcare devolution has therefore been to bring life expectancy up towards the national level. Given so many of the GMHSCP reforms have been directed at chronic age-related conditions, improvements in life expectancy could be expected to manifest most clearly in elderly cohorts, at least in the short term. Thus the graphs show the average number of additional years a man or woman aged 75 can be expected to live if they continue to live in the same place and the death rates in their area remain the same for the rest of their life.[70]

> **'Regional life expectancy at 75 was 10.7 years for men and 12.3 years for women in 2014-16; by 2017-19, life expectancies had risen to 11.1 and 12.5 years respectively'**

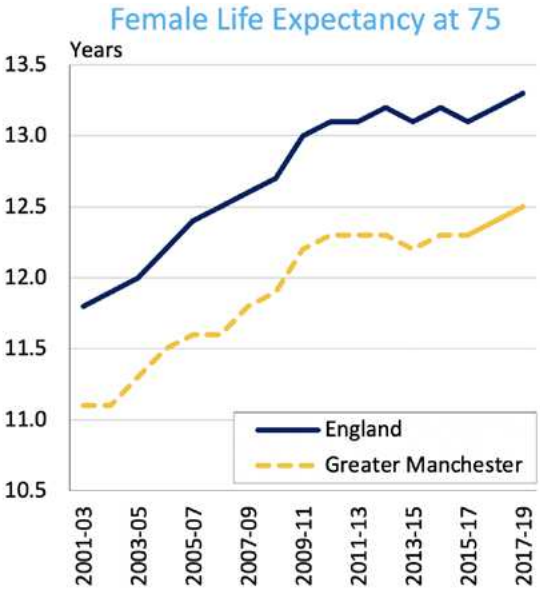
Regional life expectancy at 75 was 10.7 years for men and 12.3 years for women in 2014-16; by 2017-19, life expectancies had risen to 11.1 and 12.5 years respectively. These increases – 3.7% for men and 1.8% for women – are notable for having come after a long period of stagnation in life expectancy at 75, stretching back to around 2009-11.

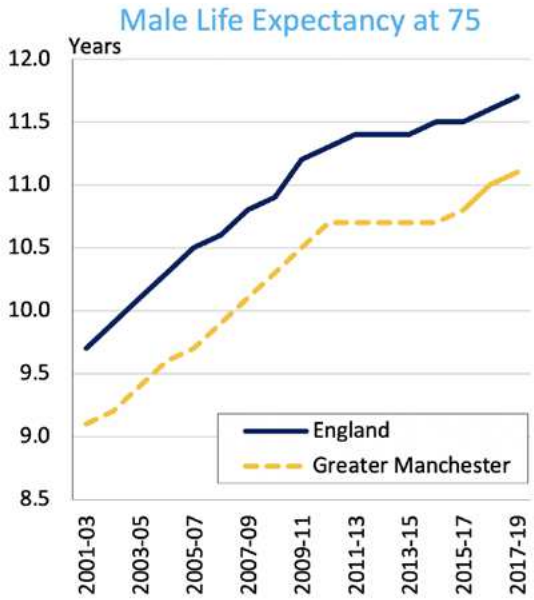
As the graphs make clear, the return to growth in life expectancy at 75 was not an isolated phenomenon, but rather tracked the national trend, as has generally been the case historically. That being said, the rate at which life expectancy at 75 increased after 2014-16 in Greater Manchester was double that of England as a whole (1.7% for men and 0.8% for women). Thus the gaps in life expectancy at 75 between England and Greater Manchester closed very slightly. It was 0.8 years for men and 0.9 years for women in 2014-16, but by 2017-19, 0.6 and 0.8 years for men and women respectively.

This is, on the face of it, encouraging news. However, it could easily be a statistical artefact. Across the 17 available data points, the gap between England and Greater Manchester stood at 0.6 for men in five instances, including the first datapoint, for 2001-03. Similarly, for women, the gap stood at 0.8 in 10 out of 17 instances – more than half the timeseries.

70 Data basis: NHS Digital, 'Indicator 1b Life Expectancy at 75', *NHS OF*.

So while it might be tempting to claim that the GMHSCP reforms have had an improvement on life expectancy at the margins, the evidence in favour of convergence to England levels is weak at best, and might be better described as inconclusive. Data for a longer period post-2016 is needed to substantiate the GMHSCP's claim in 2020 that 'for Greater Manchester the progress [on life expectancy] is greater than for England as a whole, closing the gap with the national rates'.[71] (Indeed, it is striking that the graphs they used do not go back beyond 2013, even though the data series is readily available to the turn of the century.)





71 GMHSCP, *Taking Charge is working*, p.14.

NHS Workforce

- **From mid-2016 to mid-2019, the NHS FTE workforce per 100,000 people in Greater Manchester increased by almost 9% (from 2,552 to 2,775), versus a 4.7% increase in England.**

- **However, this relative increase in healthcare inputs was not matched by an increase in health outcomes; in fact, the reverse is true.**

- **In part, this might be because over 60% of the growth in the region's NHS workforce was in support staff (including 23% more senior managers), rather than clinically qualified professionals.**

The ratio of NHS workers to total population has historically tended to be higher in Greater Manchester than England, poorer healthcare outcomes notwithstanding. This has continued and indeed grown more pronounced under the GMHSCP.

> **'In mid-2016, there were 2,552 NHS workers on a full-time equivalent basis (FTE) for every 100,000 people in Greater Manchester; in mid-2019, there were 2,775 – an increase of 8.7%'**

In mid-2016, there were 2,552 NHS workers on a full-time equivalent basis (FTE) for every 100,000 people in Greater Manchester; in mid-2019, there were 2,775 – an increase of 8.7%.[72] In comparison, the ratio of NHS FTE workers to population in England as a whole increased by a more restrained 4.7% over the same period. Thus by mid-2019 the ratio was 43% higher in Greater Manchester than in England, compared to 37% higher in mid-2016. (These figures exclude NHS employees at the NICE office in Manchester.)

Given these additional inputs, it would be reasonable to expect a general improvement in outcomes relative to England as a whole. But as the preceding analysis has shown, this is not the case across the majority of indictors, including DtoCs, bed occupancy and many causes of death. And most of the indicators where there was relative improvement after 2016 simply show a continuation of long-term trends.

In essence, while a key input – the NHS FTE workforce – increased in Greater Manchester relative to England as a whole, health outcomes actually declined in relative terms. Thus there was not only an absolute decline but also a relative decline in the productivity of the local NHS.

This seemingly paradoxical state of affairs can perhaps be explained, at least to some extent, by the changing composition of the NHS workforce in Greater Manchester. As the second graph shows, from March 2016 to March 2020, the proportion of Greater Manchester's NHS workforce with clinical qualifications fell by 3.1 percentage points, from 55.0% in to 51.9%.[73] Over the same period, the share in England fell by 1.0 percentage points, from 54.1% to 53.1%.

72 Data basis: NHS Digital, *NHS Workforce Statistics*, using the month of June for each year; and ONS, *Estimates of the population*, which provides mid-year population estimates.

73 Data basis: NHS Digital, *NHS Workforce Statistics*.

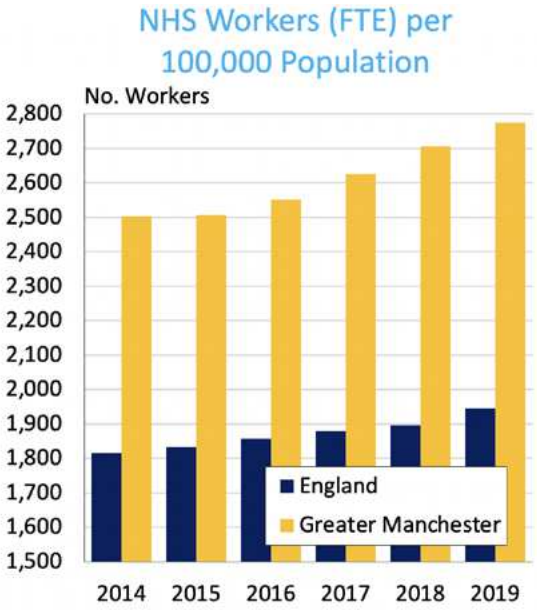
Although the number of professionally qualified clinical staff in Greater Manchester increased in absolute terms, there was a faster rise in non-clinical staff, in support roles (scientists, therapists, clerical staff) or in roles related to NHS infrastructure (such as IT systems and estates). For example, from March 2016 to March 2020, the number of senior managers (on an FTE basis) employed by the NHS in Greater Manchester increased by 23%, to stand at 782. Similarly, the workforce employed in 'central functions' increased by 25% to reach 12,243.

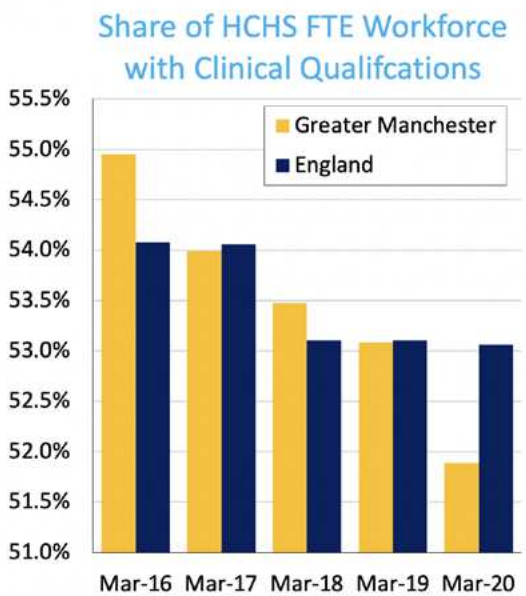
These increases also occurred in spite efforts to streamline services in the region, for instance the merger of the three CCGs for the city of Manchester into one. Indeed, the non-clinically qualified CCG FTE workforce in the region increased by 18% from March 2016 to March 2020.

In other words, the claim made in the GMCA's five-year plan for the GMHSCP that 'there are no extra bodies or layers of management but rather structures that allow the existing organisations to come together to work far more effectively and closely than before' is fine so far as it goes, but it does not give the whole picture.[74] More administrators in existing organisations is still more administrators.

In fact, 61% of the growth in the region's FTE NHS workforce in this period is accounted for by non-clinical roles. It thus seems that under the GMHSCP, there has been a fairly significant expansion in bureaucracy in the NHS in Greater Manchester, in absolute terms and relative to England.

It could be that many of the new support jobs were thought necessary to integration, for example by facilitating enhanced cooperation at the LCO and PCN levels, and between the NHS, local authorities and charitable organisations. But while a growing administrative burden might be justifiable if health outcomes are improving, it actually seems that bureaucratic expansion is coming at the expense of health outcomes.[75]





74 GMCA, *The Plan*, p.4.

75 An interesting question is whether there has also been a corresponding increase in bureaucracy at local authorities in Manchester, which would not show up in NHS workforce statistics.

Summary

- **Across many health and social care indicators, outcomes in Greater Manchester deteriorated after the establishment of the GMHSCP, relative to the pre-GMHSCP period.**

- **Across most health and social care indicators, outcomes in Greater Manchester deteriorated relative to England following the establishment of the GMHSCP.**

- **The establishment of the GMHSCP seems to have inaugurated a period of productivity decline in the NHS in Greater Manchester, with increased inputs yielding worse outcomes.**

Greater Manchester is the region where the ICS approach to integrating care is most deeply embedded. It is also a region with a number of factors – material, cultural and demographic – that should be highly conducive to making a success of integrating care. Yet as the preceding analysis shows, in the pre-pandemic period, health outcomes were not showing the significant improvements expected. In fact, health outcomes generally worsened, at least in relative terms, once the GMHSCP was established. The GMHSCP's March 2020 assessment of progress, 'Taking Charge is working in Greater Manchester', has a somewhat misleading title to say the least.

'Greater Manchester is the region where the ICS approach to integrating care is most deeply embedded'

The overall picture in Greater Manchester is summarized in the table below. The category into which indicators have been sorted are based on the three overarching criteria used to evaluate the GMHSCP's performance, which to recap, are:

(a) Comparing outcomes before and after April 2016.

(b) Comparing outcomes in Greater Manchester with national trends.

(c) Outcomes relative to the targets adopted by the GMHSCP at its inception (where relevant).

In interpreting and summarising the data for Greater Manchester, each of these criteria has been given equal weighting, and so as a general rule of thumb:

- Firm improvement = clearly better outcomes in respect of at least two of a, b and c, not offset by clearly worse outcomes under the third criterion.

- Some improvement = clearly better outcomes in respect of one of a, b or c; or slightly better outcomes across two of a, b or c, not offset by clearly worse outcomes in the third criterion.

- Steady = little discernible change in respect of a, b and c; or some improvement in one of a, b or c being offset or undermined out by some deterioration in another of a, b or c.

- Some deterioration = clearly worse outcomes in respect of one of a, b or c; or slightly worse outcomes across two of a, b or c, not offset by clearly better outcomes in the third criterion.

- Firm deterioration = clearly worse outcomes in respect of at least two of a, b and c, not offset by clearly better outcomes under the third criterion.

- Data unclear = potential outliers or other anomalies across any of a, b or c render any interpretation ambiguous.

Outcomes in the Greater Manchester Health and Social Care Partnership

Indicator	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
DtoC and Bed-Days					Y	
Attendances at A&E		Y				
Emergency Admissions			Y			
Unplanned ACSC Admissions			Y			
Emergency Readmissions			Y			
SHMI				Y		
Cancer Survival Rates			Y			
Cancer Mortality				Y		
CVD Mortality	Y					
Respiratory Disease Mort.					Y	
Neonatal Outcomes					Y	
Mental Health Bed-Days				Y		
Alcohol-Specific Admissions		Y				
Life Expectancy at 75			Y			
NHS FTE Workforce					Y	
TOTAL	1	2	5	3	4	0

So overall health and social care outcomes skew heavily towards a weaker performance relative to what might have been expected based on pre-reform trends, national comparisons and the objectives of the GMHSCP, with half of the indicators showing either some or firm deterioration.

Across many of the indicators, outcomes in Greater Manchester deteriorated after the establishment of the GMHSCP, relative to the pre-GMHSCP period. This did not always mean that trends were suddenly thrown into reverse or that there was a surge in deaths or delays. In some cases, rates of improvement significantly slowed or stalled from April 2016 onwards, as with reductions in stillbirths for example. Other trends accelerated after April 2016, for instance emergency readmissions.

These changes contributed to the deterioration of Greater Manchester relative to England from April 2016, a trend seen across most of the indicators examined. In the case of DtoC, England and Greater Manchester's relative position actually reversed, with Greater Manchester having consistently higher DtoC than England under the GMHSCP, in stark contrast to the previous norm. In other cases, existing gaps widened, converging trends stalled or England began to pull away, as for example in respiratory disease mortality rates.

Furthermore, on the measures that it was possible to examine, the GMHSCP was not even remotely on track for meeting its own quantified targets for 2021/21 as set out in 'The Plan' of December 2015. The notable exception to this was cardiovascular disease

deaths, which though still falling short of where it needed to be as of 2019, showed significant improvement relative to pre-GMHSCP regional trends and national data.

In general, however, the targets set in 'The Plan' have proved wildly ambitious. There was a clear failure of expectation management, to the point where the setting of such unrealistic goals begins to call into question the wisdom behind strategic planning at a regional level.

Workforce statistics also present an unflattering picture. By 2019, about 4.7% of Greater Manchester's working age population was employed directly by the NHS in hospital and community trusts and CCGs (compared to about 4% nationally). However, the share of the regional NHS workforce with clinical qualifications declined from 55% to 52% between 2016 and 2012, compared to a decline from 54% to 53% across England. The NHS support workforce (ranging from biomedical and genetic scientists to art and drama therapists to clerical and administrative staff) expanded by 33% from 2016 to 2020 (versus 14% nationally). The infrastructure workforce (everyone from managers to data analysts to plumbers and janitors) increased by 30% (again versus 14% nationally). And the number of senior managers increased by 23%, compared to a 17% increase nationally.

'There was a clear failure of expectation management, to the point where the setting of such unrealistic goals begins to call into question the wisdom behind strategic planning at a regional level'

There is good evidence, in other words, that a good chunk of the extra funding given to Manchester to make integration work got swallowed up by bureaucracy. For example, the Health and Care Board agreed upon a specific estates strategy in April 2017, which was then followed up in 2018.[76] This also articulated ambitions to rationalise and consolidate the NHS estate in the region as part of a general savings drive. And yet between 2016 and 2020, the NHS FTE headcount working on 'Hotel, property and estates' in the region increased by 35% to 3,473.

This all needs to be held in mind when considering 'Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives', the recently published review into health in the region carried out by Sir Michael Marmot at the behest of the GMHSCP.[77] The headline finding of the review is that the Covid mortality rate in Greater Manchester was 25% higher than in England as a whole, and that the rate within the region was 2.3x higher in the most deprived population decile compared to the least deprived decile. The region's high Covid mortality rate is ascribed by Marmot to 'austerity' over the preceding decade and to longstanding socioeconomic inequalities. The proposed solutions tend to revolve around 'increasing national funding allocations across Greater Manchester'.[78]

There are two obvious rejoinders to this prescription. Firstly, Greater Manchester benefited from a vibrant and dynamic economy in the 2010s, with economic growth outstripping the national average. Second, Manchester already received that £450 million in transformation funding – which did not appear to make a significant difference.

76 GMHSCP, *Greater Manchester Estate Strategy* (April 2017), p.4.

77 M. Marmot, *Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives* (July 2021).

78 Marmot, 'Build Back Fairer', p.10.

Indeed, it is arguable that things were heading in a better direction before the GMHSCP was created. This era still saw a significant degree of integration and collaboration, for instance around the BCF, but there was no top-heavy, formalised integration structure.

> **'Manchester already received that £450 million in transformation funding – which did not appear to make a significant difference'**

We have focused in this paper on Greater Manchester because the GMHSCP is the most longstanding attempt at healthcare integration in the country, and the one for which there is the most solid evidence. However, those within the healthcare system argue that it cannot be considered typical, because of Manchester's unique situation, such as its distinctive tradition of local government – even though it was this unique situation that was expected to make it a success.

We have therefore chosen to compare and contrast it with a more recent creation, the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP), which is not only overseen directly by NHS England but viewed in Whitehall as the closest thing to a template for the reforms' future path.

3. Case Study: West Yorkshire and Harrogate

If Greater Manchester exemplifies the devolved approach to the ICS model, then the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) exemplifies the non-devolved approach. The main difference lies in the initial planning and implementation period, with the non-devolved ICSs receiving more direct support from the System Transformation team at NHS England/Improvement.

'The main downside to looking at the WYHHCP is that as a second wave ICS (formal designation received May 2018), it is not quite as far down the road of integration as the GMHSCP, at least at an overall system level'

In theory, given that regional flexibility, local decision making and subsidiarity are inherent to the ICS concept, devolution status should not ipso facto make much difference to ICS healthcare outcomes in the long run, although it might be that more central NHS involvement in the early stages results in smoother transitions. (Something that may be reflected in the fact that WYHHCP suffered far less of a spike in DtoCs during the transition to the ICS model than the GMHSCP, or indeed the ICS population as a whole.)

The main downside to looking at the WYHHCP is that as a second wave ICS (formal designation received May 2018), it is not quite as far down the road of integration as the GMHSCP, at least at an overall system level. The health data therefore captures less about integration at scale than with Greater Manchester. But there is still much of use that we can learn.

Overview

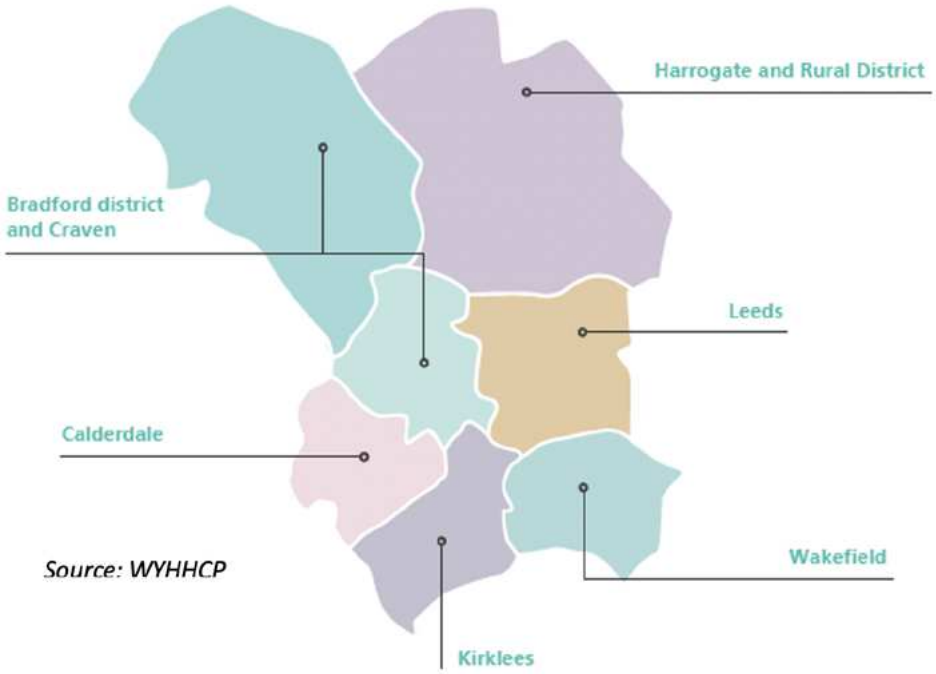
The WYHHCP is a large ICS covering an area of around 3,600km^2 and a population of 2.6 million. Although average population density is about 740 people/km^2, the region contains densely populated urban areas such as Bradford and Leeds as well as sparsely populated rural areas. As in Greater Manchester, there are some extremely deprived areas, where health indicators including life expectancy have long lagged national trends.

The ICS is divided into six ICPs: Bradford and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield. The region was covered by nine CCGs at the time it transitioned from STP to ICS status, though these have since been consolidated down to six, roughly coterminous with the ICP boundaries. The partnership is also made up of eight local councils and 13 NHS trusts or foundation trusts (see Annex V for the full list), as well as a number of other non-NHS and voluntary organisations.

At the top level, the structure of the WYHHCP is fairly similar to that of the GMHSCP, with planning and implementation coordinated by a System Leadership Executive, while strategic planning is assisted by a Partnership Board, made up of a broad range of senior representatives from within the ICS region, across the NHS, local government and other organisations.[79] Commissioning of services, meanwhile, is conducted by the Joint Committee of Clinical Commissioning Groups.

A distinctive feature of the WYHHCP is its rigorous approach to subsidiarity, with three tests used to determine whether something should be led by the wider system or by the more local places within it. The idea is to keep decision-making as local as possible, rather than accruing too much responsibility to the top-level components of the STP/ICS.

As noted above, the WYHHCP received ICS designation in May 2018, after it had reached sufficient integration milestones. However, it was actually ready to become an ICS six months earlier, but this was delayed due to political controversies around the idea of the ICS (or ACS at the time), which had been associated with privatisation of the NHS.[80]



The WYHHSCP did not at any point receive a block grant for system transformation in the same way as Greater Manchester and the GMHSCP. On the other hand, NHS trusts in West Yorkshire and Harrogate did succeed in attracting significant sums from the 'sustainability and transformation' funding announced in the 2015 Spending Review, perhaps more than flowed into any other single region. In this respect, the WYHHCP was a lot less disadvantaged compared to Greater Manchester than at first appears to be the case.

So while there are quite large differences in the geography and local conditions faced by the GMHSCP and the WYHHCP, there are enough similarities in structures, approaches and resources that both ICSs can be used to assess the integration agenda which underpins the Health and Care Bill.

79 See Annex V for more information.

80 See for example D. Campbell, 'How to keep older people out of hospital? Get the NHS and care services together', *The Guardian* (2 August 2017). Link

Indicators

The indicators used here to assess outcomes in the West Yorkshire and Harrogate are the same as those used for Greater Manchester, so as to enable a like for like comparison to be made. This means that while the method and sources are the same for the two regions, fewer of the indicators relate specifically to goals the WYHHCP set for itself.

Like the GMHSCP, the WYHCP started out with a five-year plan, albeit published in January 2019, once the partnership was already officially an ICS, rather than before the region was even an STP.[81] The plan identified 10 main goals:[82]

1) Reduce the life expectancy gap by 5% (six months of life for men and five for women) between people in the most and least deprived communities by 2024.

2) Achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population by 2024.

3) Address the health inequality gap for children living in households with the lowest incomes, including halting the trend in childhood obesity.

4) By 2024, increase early diagnosis rates for cancer, ensuring at least 1,000 more people will have the chance of curative treatment.

5) Reduce suicide by 10% across West Yorkshire and Harrogate by 2020/21 and achieve a 75% reduction in targeted areas by 2022.

6) Achieve at least a 10% reduction in anti-microbial resistant infections by 2024 by, for example, reducing antibiotic use by 15%.

7) Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.

8) Have a more diverse leadership that better reflects the broad range of talent in West Yorkshire and Harrogate, helping ensure that the poor experiences in the workplace that are particularly high for Black, Asian and Minority Ethnic (BAME) staff become a thing of the past.

9) Become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.

10) Strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and the region as a whole.

81 Like every region that has gone on to become an ICS, West Yorkshire and Harrogate did have a STP plan, drawn up in 2016. However, while there are some continuities in priority areas, the STP plan was superseded by the plan drawn up in response to region's subsequent develop into an ICS in 2018.

82 WYHHCP, *Better health and wellbeing for everyone: Our five year plan* (November 2019), pp.11-12.

A number of these goals are obviously pretty nebulous or divorced from health outcomes (reducing the carbon footprint of the West Yorkshire NHS is not going to reduce flooding-related injuries in Calderdale, unless the ICS can persuade China and India to follow its lead). And most of the measurable goals are for around 2024. So unlike for Greater Manchester, analysis of the indicators has to focus solely on:

(a) Comparing outcomes before and after April 2016.

(b) Comparing outcomes with national trends.

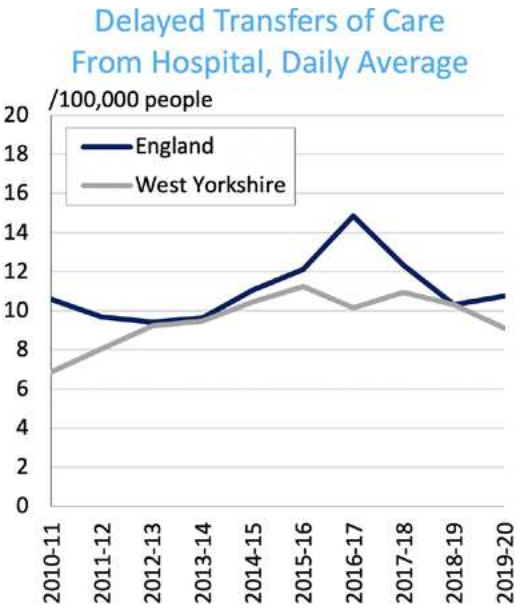
Otherwise, however, the treatment of the indicators below remains the same. Crucially, the baseline for these comparisons remains April 2016, when the STPs came into being. This means that data from when the WYHHCP was less integrated than Greater Manchester underpins parts of the analysis. It was still, however, much further down the pathway to integration than other parts of the NHS, so the comparison is valid, if imperfect.

Delayed Transfers of Care

- **On average, DtoCs in West Yorkshire and Harrogate were equally prevalent in 2016-20 as in the four years prior to the establishment of the STP.**

- **However, this obscures some underlying improvement: DtoCs trended steadily upwards until 2016, but after this point DtoCs stabilised and then began to fall under the ISC.**

- **Delayed transfers of care per 100,000 adult population were on average 16% lower in the West Yorkshire STP/ICS than in England as a whole across the 2016-20 period.**

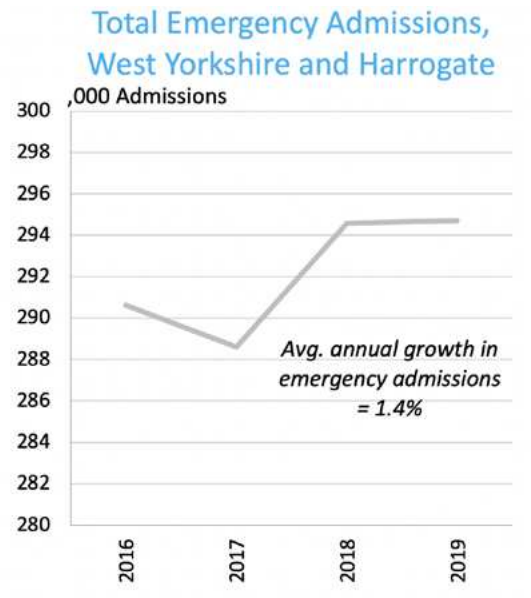


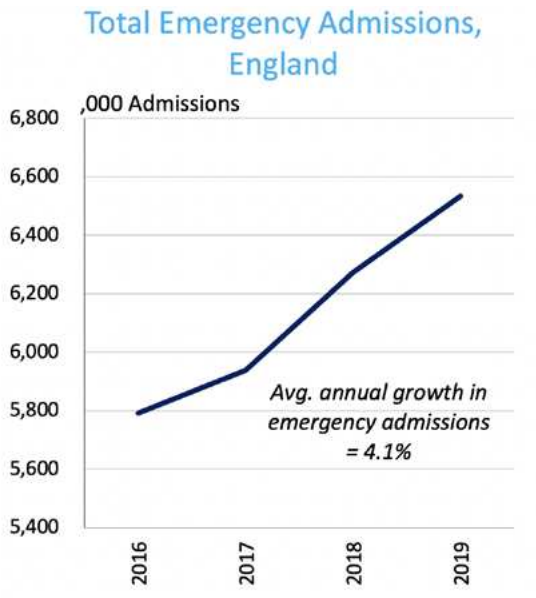
Emergency Admissions

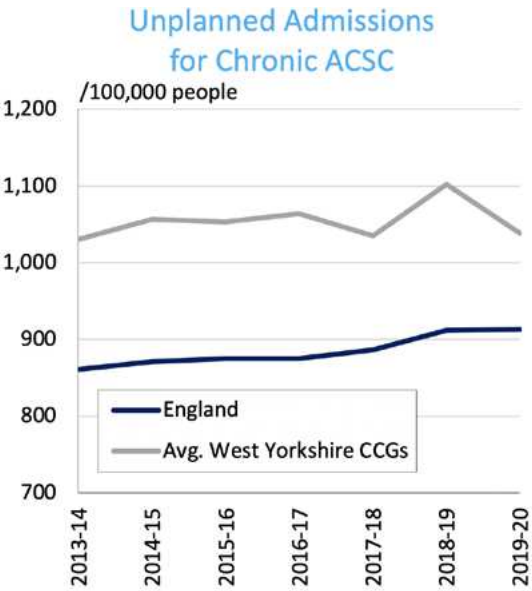
- **Growth in emergency admission to hospitals in West Yorkshire averaged 1.4% p.a. from 2016 to 2019, increasing at a much slower pace than nationally (or indeed in Greater Manchester).**

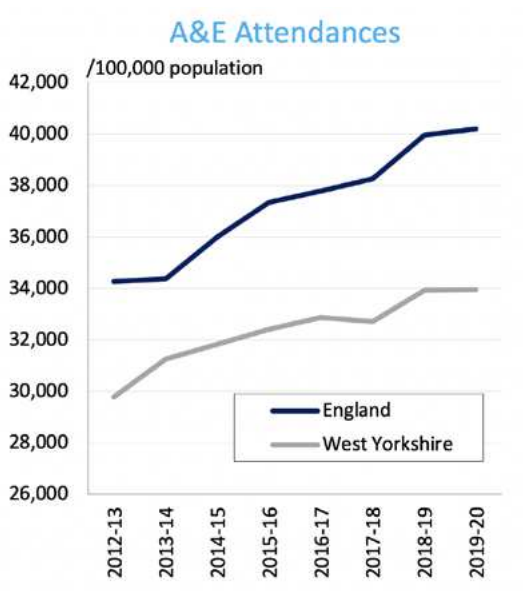
- **However, the transition from STP to ICS in 2018 coincided with a firm increase in admissions, which remained elevated in the subsequent year.**

- **During the year in which the WYHCP ICS came into being, 2018-19, unplanned chronic ACSC hospital admissions increased by over 6% – double the rate of increase seen nationally.**







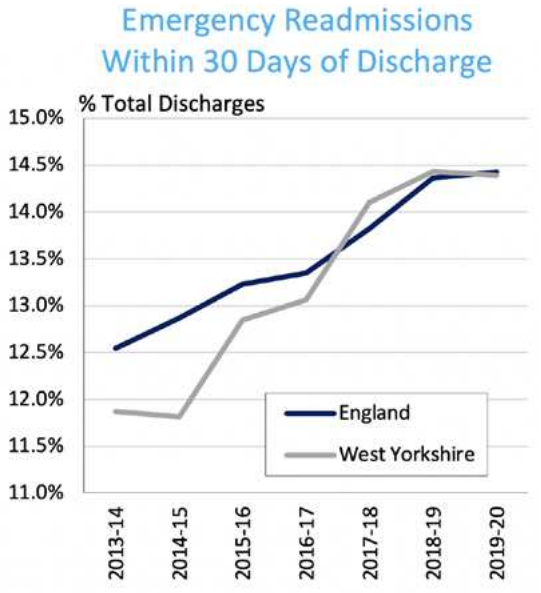


Emergency Readmissions

- **The rate of emergency readmissions in West Yorkshire climbed rapidly under the STP, rising by 1.4 percentage points to 14.4%, exceeding the rate of emergency readmissions nationally.**

- **This represents an acceleration of the pre-STP, trend, when the rate of readmission in West Yorkshire rose by 1.1 percentage points over four years.**

- **Data for 2019-20, after the WYHHCP ICS had been established, seems to point towards some improvement at the margins, though it is not clear whether this was the start of a new trend.**

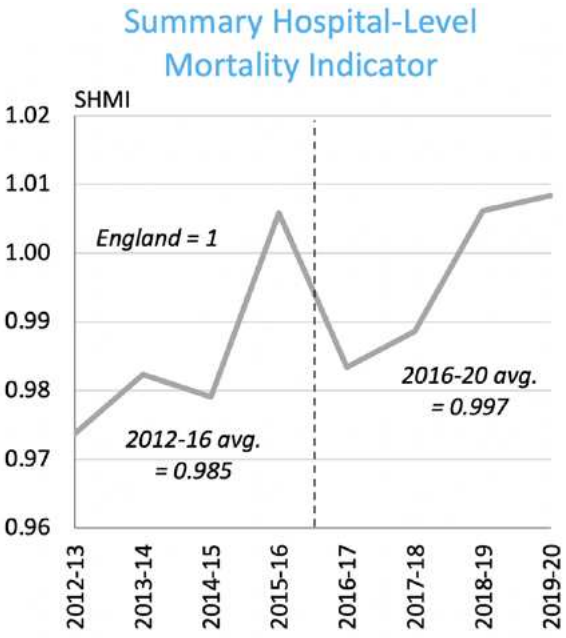


Deaths Associated with Hospitalisation

- **Mortality associated with hospitalisation in West Yorkshire was very slightly higher on average in 2016-20 compared with 2012-16, though the trend is clearly volatile.**

- **In 2019-20, mortality associated with hospitalisation in West Yorkshire stood at just under 1.01, its highest level in the years for which data is available.**

- **The development of the STP into an ICS coincides with a relatively rapid rise in the mortality rate, though as the increase in 2015-16 shows, this was not unprecedented in the region.**

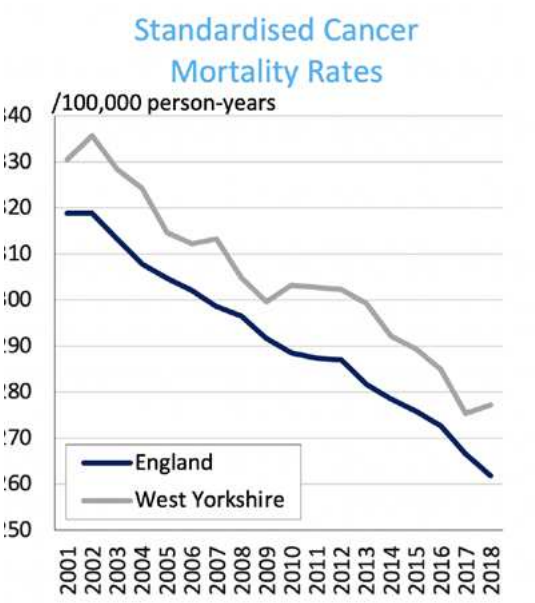


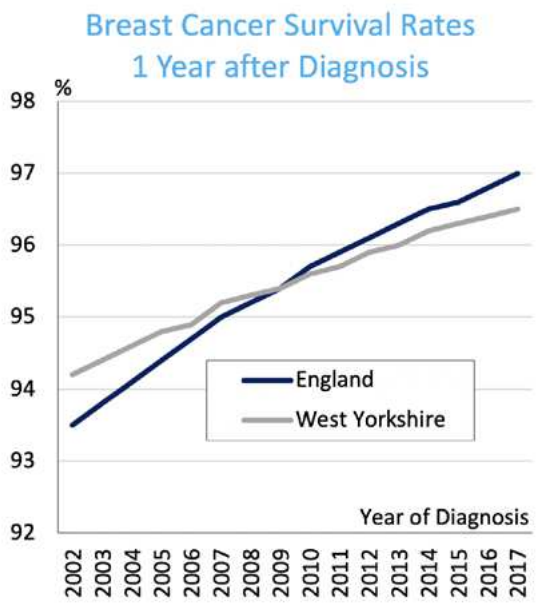
Cancer Deaths and Survival Rates

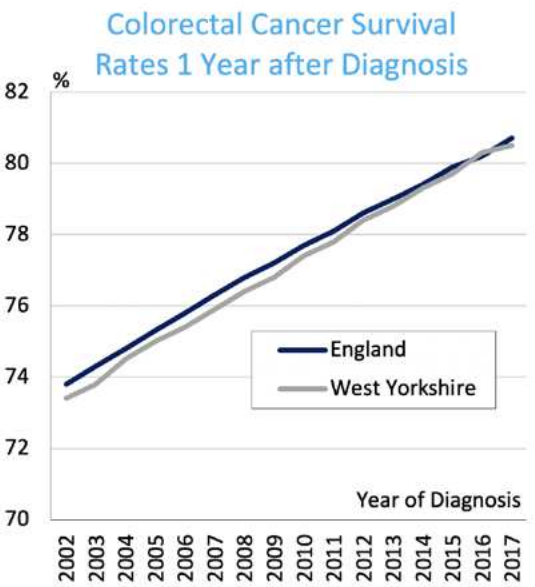
- **The long-term trend of falling standardised cancer mortality rates continued under the West Yorkshire and Harrogate STP, declining by an average of 1.3% p.a.**

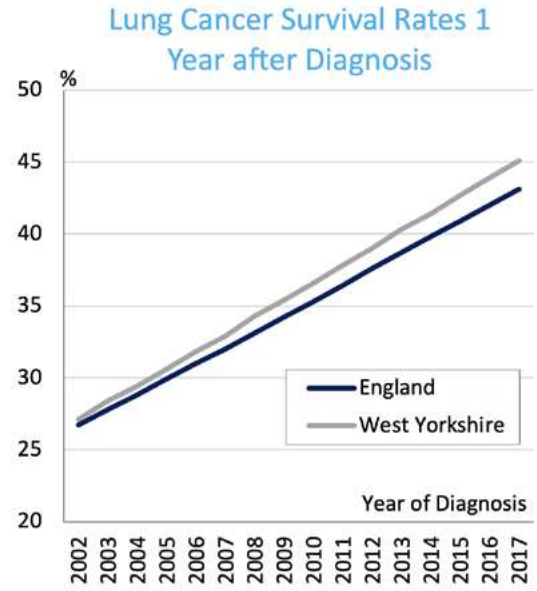
- **The gap between West Yorkshire and England in terms of cancer mortality rates did not close in any significant way from when the STP was set up.**

- **Cancer survival rate trends are more complicated in West Yorkshire than in Greater Manchester, with some cancers converging and some diverging from national trends over the long term.**



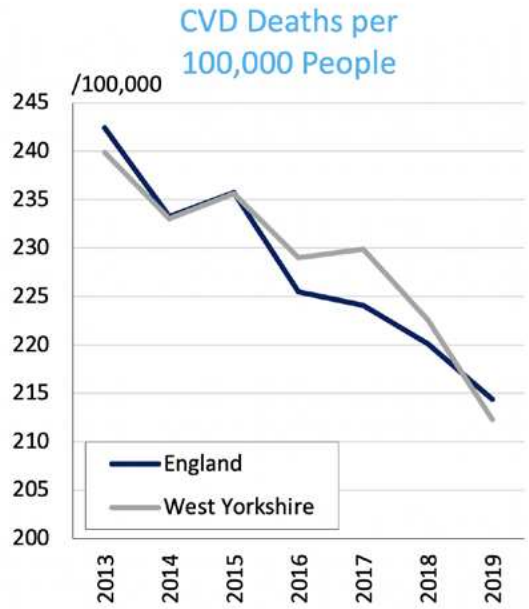






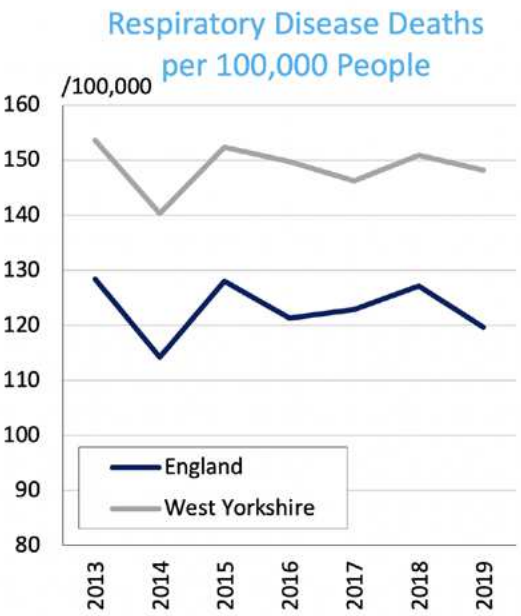
Cardiovascular Disease Deaths

- **Until the STP was established, regional CVD mortality trends were essentially in line with national trends, but after 2016 there was a notable divergence.**
- **If West Yorkshire and Harrogate had continued in line with the national trend after 2016, there would have been around 160 fewer CVD deaths recorded than was in fact the case.**
- **CVD deaths in West Yorkshire once again fell below the national trend in 2019, after the STP became an ICS, though it is too early to tell whether this was the start of a sustained trend.**



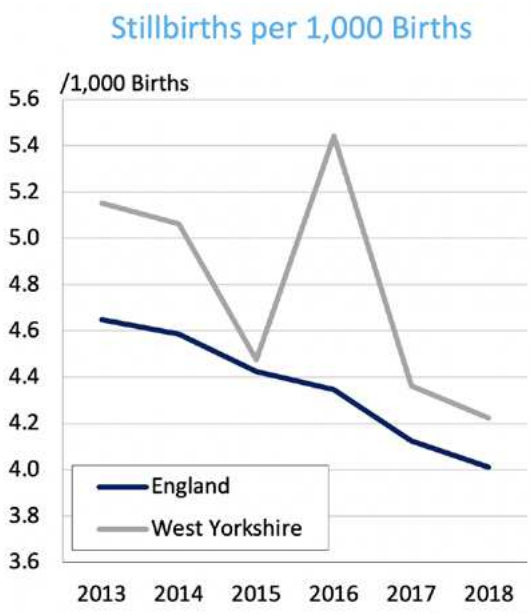
Respiratory Disease Deaths

- **On average, respiratory disease mortality was 0.4% lower in West Yorkshire in the three years from the establishment of the STP in 2016 compared to the three years beforehand.**
- **However, the gap between West Yorkshire and England only closed marginally in West Yorkshire's favor in 2017 and 2018, with the gap then opening up again in 2019.**
- **While there is no real evidence of improvement on this metric in the WYHHCP region, at least the sharp deterioration in outcomes seen under the GMHSCP was avoided.**



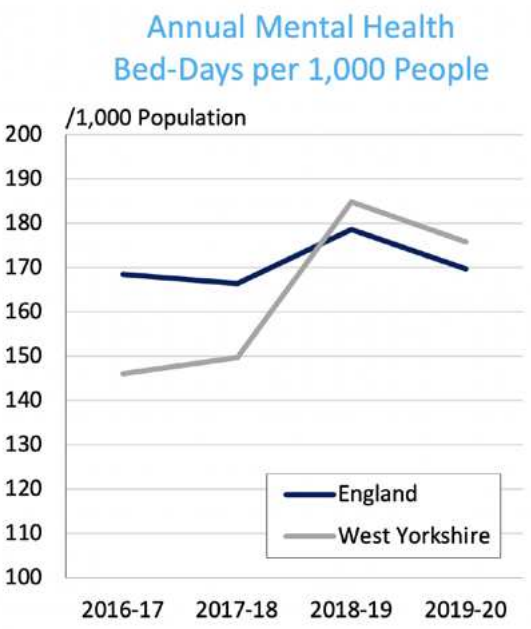
Neonatal Outcomes

- **Stillbirths in the West Yorkshire and Harrogate region have been trending downwards: there were 4.2 stillbirths per 1,000 births in the region in 2018, down from 5.2 per 1,000 in 2013.**
- **Overall, there seems to have been some convergence on the national trend, with the gap dropping from 0.5 to 0.2 stillbirths per 1,000 births between 2013 and 2018.**
- **However, the volatility of regional data for 2015-17 means the picture is more complicated than that – it would be premature to assert that there has been definite improvement.**



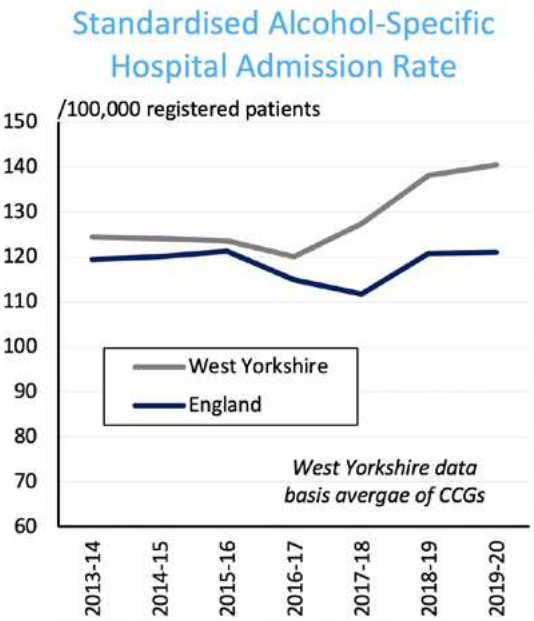
Mental Health Outcomes

- **Over the course of the 2016-20 period, mental health bed-days in the West Yorkshire and Harrogate region increased by 20%.**
- **As an STP, West Yorkshire recorded 12% fewer mental health bed-days per 100,000 people than England on average (2016-18); as an ICS, it recorded 4% more (2018-20).**
- **While it seems that mental health needs in the region were receiving more attention, this was not happening in the community but rather in clinical settings.**



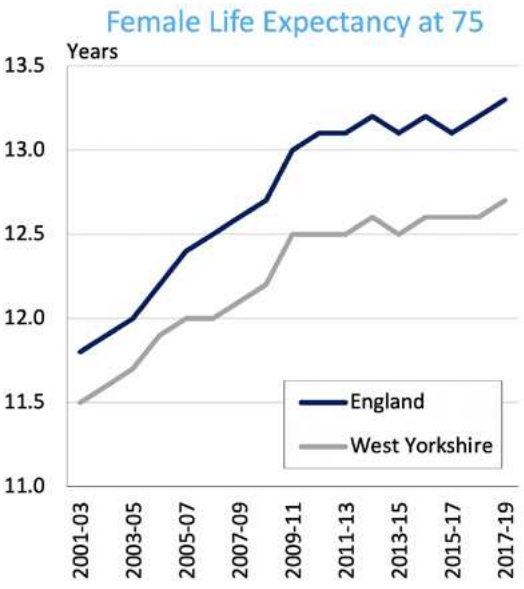
Alcohol-Specific Hospital Admissions

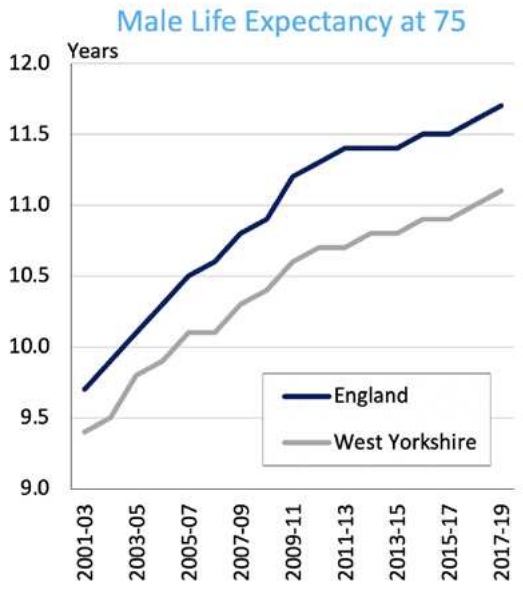
- **Before the establishment of the STP and the ICS, alcohol-specific hospital admissions in the region were stable, but over 2016-20, admissions increased by an average of 3.3% p.a.**
- **Alcohol-specific hospital admissions in West Yorkshire were 6% higher in 2016-20 than in 2013-2016, whereas nationally, admissions were down by 2.6% between the two periods.**
- **In 2016-17, there were 5 more admissions per 100,000 registered patients in West Yorkshire than in England, by 2019-20, there were 19 more, with a significant gap having opened up.**



Life Expectancy

- **Life expectancy at 75 increased by 1.8% for men in the years following the establishment of the West Yorkshire STP, roughly in line with the national rate**
- **Life expectancy at 75 increased by 0.4% for women in the years following the establishment of the West Yorkshire STP, compared to a 0.8% increase nationally.**
- **However, the resultant gap in life expectancy for women between England and West Yorkshire was within the normal range of variation over the last 20 years.**



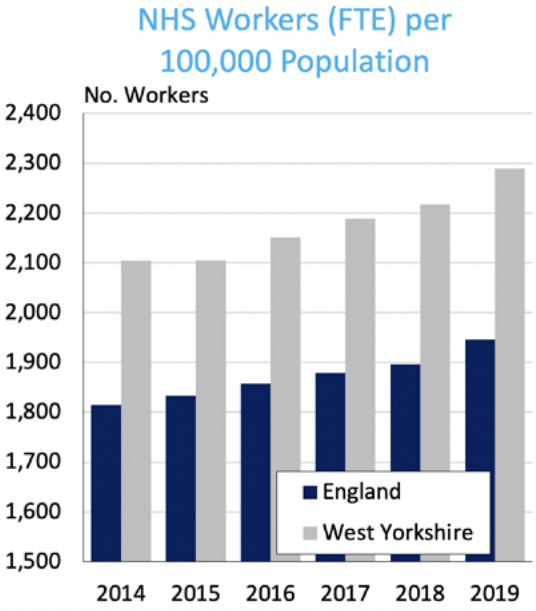


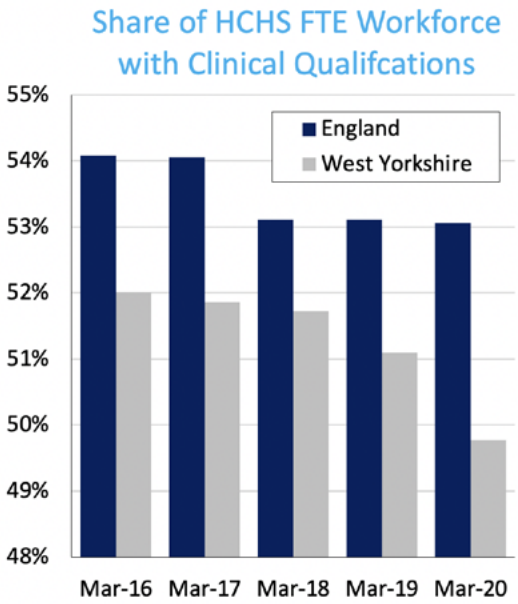
NHS Workforce

- **The NHS workforce in West Yorkshire and Harrogate increased by 6.5% under the STP and ICS to reach 2,290/100,000 population in the region. This rise was 40% greater than seen nationally.**

- **There was a 10% increase in senior managers from March 2016 to March 2020, while the support and infrastructure workforces grew by 16% and 19% respectively.**

- **The clinically qualified workforce grew up 6.5%, and so the proportion of clinically qualified workers declined from 52% when the STP was set up to under 50% under the WYHHCP.**





Summary

- **There was some improvement in indicators relevant to patient flow through the system, notably DtoC, although there was a worrying and perhaps related rise in emergency readmissions.**

- **Fewer indicators showed deterioration in outcomes compared to the GMHSCP, with more indicators holding steady, though clear improvement was likewise limited to just a few indicators.**

- **The establishment of the WYHHCP seems to have led to a degree of productivity decline, with greater inputs yielding no overall improvement in outcomes – even on an optimistic reading – in a region that has been cited as proving the effectiveness of the NHS England led approach.**

In compiling the WYHHCP summary table below, the same approach has been used as for the Greater Manchester table (see pp.56-7), though without any reference to specific goals set by the ICS itself.

Outcomes in the West Yorkshire and Harrogate Health and Care Partnership

Indicator	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
DtoC and Bed-Days	Y					
Attendances at A&E		Y				
Emergency Admissions		Y				
Unplanned ACSC Admissions				Y		
Emergency Readmissions					Y	
SHMI			Y			
Cancer Survival Rates			Y			
Cancer Mortality			Y			
CVD Mortality			Y			
Respiratory Disease Mort.			Y			
Neonatal Outcomes						Y
Mental Health Bed-Days					Y	
Alcohol-Specific Admissions					Y	
Life Expectancy at 75			Y			
NHS FTE Workforce					Y	
TOTAL	1	2	6	1	4	1

As the table above shows, using the same set of indicators produces a picture of limited change, with some areas of improvement counterbalanced by deterioration across other metrics.

Take DtoC for instance. DtoC in England in the 2016-20 period averaged 14% higher than in the 2012-16 period. In the West Yorkshire and Harrogate region, there was no significant difference in average DtoC between the two periods, with a slight rise after the STP was established cancelled out by a slight decline later, under the WYHHCP. The metric has also remained below national levels, unlike in Greater Manchester under the GMHSCP.

So it could be that the creation of the WYHHCP forestalled the sorts of increases seen elsewhere – which would be extremely welcome news.

Yet there are pitfalls in relying on DtoC to drive care outcomes, including a risk of patients being discharged prematurely in order to hit targets.[83] These patients are more likely to be readmitted into emergency care within short order. And there was a notable growth in emergency readmissions to hospital within 30 days of discharge within West Yorkshire: the rate rose from 12.8% in 2015-16 to 14.4% in 2019-20, and was worse than for England as a whole in both of 2017-18 and 2018-19.

It is impossible to say whether these two metrics are connected in this instance. But it is certainly the case that while regional DtoC data looks promising on its own terms, questions remain about the overall processes around health and care integration in West Yorkshire. And ICSs do need to be judged on their own terms: holistically.

83 See for example J. Bunn, 'No way home: The unintended consequences of DToC targets', *Local Government Chronicle* (20 June 2019). Link

In other areas, mortality indicators generally remained stable either side of the move towards integration, with pre-existing trends mostly continuing. The decline in cardiovascular mortality did stall for a couple of years (in contrast to Greater Manchester), though the trend seems to have resumed by 2019, when it fell to slightly below the national average.

Yet while outcomes appear to have been more or less steady, funding and staffing increased, meaning that there was a degree of productivity decline, although less sharp than in Greater Manchester. The NHS FTE workforce increased by 6.5% from 2016 to 2019, but again this was mainly driven by an expansion in non-clinically qualified personnel. The clinically qualified proportion of the workforce fell from 52% to 50%. The number of non-clinical NHS managerial staff, meanwhile, increased by 20% over the period. This supports the earlier hypothesis that the ICS approach can result in greater bureaucratic complexity, rather than less as is its stated aim.

Off the record conversations we held with some healthcare practitioners found them worried that the ICS approach would lead to an increase in bureaucracy and backroom functions, rather than improved outcomes. The data from West Yorkshire – as with the data from Greater Manchester – shows that these worries may not be misplaced.

	Firm Improvement	Some Improvement	Steady	Some Deterioration	Firm Deterioration	Data Unclear
Greater Manchester	1	2	5	3	4	0
West Yorkshire	1	2	6	1	4	1

On balance, as shown in the table above, things look a bit better in the WYHHCP than in the GMHSCP, with less deterioration in outcomes and more 'steady as she goes'. However, across most domains West Yorkshire has not advanced as far down the path of integration as Greater Manchester. And in neither case has there yet been the clear improvement in outcomes that was the justification for health and care integration.

4. Comparing ICSs across England

The introduction of the ICS model is not intended as a single 'Big Bang' reform. Rather, ICSs have been introduced within the gaps left by existing legislation, and at various speeds in various different places.

Indeed, the creation of an ICS is – formally speaking – an evolutionary process. The 'integrated care system maturity matrix' is designed for assessing regions as they progress from STPs to ICSs and continue to develop thereafter.[84] This matrix consists of multiple domains of integration (such as leadership, system architecture and track record of delivery) and four phases of system progression: 'emergent', 'developing', 'mature' and 'thriving'. A region is formally given the title of ICS once it is at the mature phase. Some proponents of the ICS model hold that it will take 10-15 years for ICSs to reach the thriving phase, with clear improvements in health outcomes only really becoming readily apparent by this point.

'The 'integrated care system maturity matrix' is designed for assessing regions as they progress from STPs to ICSs and continue to develop thereafter'

What this means, as referred to above, is that is impossible to pick a single point at which each of the 13 regions in England have started operating under the ICS model – either via devolution or through the implementation of Sustainability and Transformation Partnerships (STPs) – or moved from being non-integrated to integrated. Nonetheless, it also means that while many ICSs only formally began operation in 2018, these were the areas in which integration was already most advanced. In other words, applying the same analytical framework as with Greater Manchester, of comparing the four years before and after 2016, will not provide a perfect 'before and after' snapshot of the effects of integration, but should certainly capture any overall impact it has had on the quality of care, either positive or negative.

Accordingly, we consider the data in this section indicative rather than conclusive, when compared to the more granular analysis above. Nevertheless, the emerging evidence is either mixed or not encouraging – and in particular suggests that ICS status has not prevented wildly divergent performance between different regions and on different criteria.

84 NHS England, *Designing integrated care systems*, pp.9-11.

Delayed Transfers of Care (DtoC)

green = well below England trend, light green = below trend, amber = above trend, red = well above trend

STP/ISC Region	Change in DtoC, 2016-20 avg. vs 2012-16 avg.	First Wave: Devolved	First Wave: NHS	Second Wave
Gloucestershire	111%			Y
Frimley [a]	95%		Y	
Greater Manchester	65%	Y		
South Yorkshire & Bassetlaw [b]	50%		Y	
Lancashire & South Cumbria	24%		Y	
North East & North Cumbria	19%			Y
Suffolk & North East Essex [c]	17%			Y
England	14%			
England, excluding wave 1 + 2 ICSs	9%			
Surrey Heartlands	7%	Y		
Dorset	6%		Y	
Bedfordshire, Luton & Milton Keynes	1%		Y	
West Yorkshire	0%			Y
Buckinghamshire, Oxfordshire & Berkshire West [d]	-2%		Y	
Nottingham & Nottinghamshire [e]	-7%		Y	
STP/ICS Average	30%			
STP/ICS Weighted Average	24%			

Data basis: ASCOF, Indicator 2C(1), December 2020. Data is provided according to local authority area. (a) A complex ICS partially overlapping several local authorities; data excludes the Surrey parts of the ICS (covered here in Surrey Heartlands instead). (b) Excludes Bassetlaw data, as Bassetlaw sits within the Nottinghamshire authority. (c) Note that the ICS does not cover all of Suffolk; also excludes East Essex. (d) The BOB STP was divided into two ICSs, Berkshire West and Buckinghamshire, which were subsequently recombined with Oxfordshire. (e) Includes Bassetlaw data, whereas Bassetlaw is in fact in the South Yorkshire & Bassetlaw ISC.

In the NHS England definition, a delayed transfer of care (DtoC) occurs when an adult patient is ready to go home and is still occupying a bed.[85] A patient can end up 'bed-blocking' due to a number of problems, including awaiting a package in a care home, awaiting further non-acute NHS care, patient or family choice and so on.[86]

Importantly, DtoC does not include delays in transferring patients between wards or different hospitals for acute treatment. Instead, it attempts to measure what is going on at the interface between health and social care, acting a proxy for whether clinicians and carers are talking to each other, whether hospitals and local authorities are engaged in joint planning, whether transfers between care settings are smooth and so on. DtoC thus attempts to measure a major source of inefficiency and poor health outcomes in the health and care sectors. It gets to the heart of the rationale for health and care integration.

The DtoC data underpinning table above is taken from Adult Social Care Outcomes Framework (ASCOF), published by NHS Digital. In this format, data is broken down by local authority area. It is worth noting that there has been some debate over how consistent DtoC data collection has been between different trusts and areas, and that the basis of the timeseries changed slightly in 2017/18. However, DtoC remains a common measure used by NHS decision-makers and remains the best metric there

85 NHS England, *Monthly Delayed Transfers of Care Situation Report: Principle, Definition, Guidance* (November 2018), p.3.

86 For the full list, see: NHS England, *Monthly Delayed Transfers of Care Situation Report: Principle, Definition, Guidance*, p.8.

is for evaluating whether the different parts of the health and care system are working well together.

Alarmingly, the table shows that on average, delayed transfers of care in STP/ICS areas increased by 70% more than in England as a whole (24% vs 14%, weighted for the size of the patient population) when comparing the four years before and after the STPs were established. This in itself is troubling. Perhaps more troubling, however, is the huge range of outcomes, from a startling 111% increase in the Gloucestershire to a rather more welcome 7% decrease in Nottingham and Nottinghamshire.

Noticeably (and as is the case for most of the other metrics we will examine in this section), there is no obvious correlation between DtoC outcomes and the macro features of the ICSs: urban or rural; located in the north or the south; with a small or large, or young or old, population; devolved or not; or with few or many local authorities. Explanations for the wide inter-regional variation are therefore more likely to rest with organisations, processes and human decisions, rather than what might be termed environmental or exogenous factors.[87]

There is also an asymmetry evident in DtoC outcomes. More of the ICSs saw a greater increase in DtoCs than the national average than saw less. But also, the poor results are much further from the national average than the relatively good results. This suggests that there may be more downside risk than upside potential to the ICS process, or that the transition period can be alarmingly disruptive if not properly handled. (We will obviously know whether more about whether these increases are temporary or permanent as the pilot schemes continue.)

A&E Attendances

STP/ISC Region	Change in A&E attendances, 2016-20 avg. vs 2012-16 avg.	First Wave: Devolved	First Wave: NHS	Second Wave
Dorset	23.3%		Y	
Nottingham & Nottinghamshire	18.1%		Y	
Bedford, Luton & Milton Keynes	16.4%		Y	
England, excluding wave 1 + 2 ICSs	15.3%			
Suffolk & North East Essex	14.9%			Y
Buck., Ox. & Berk. West	13.6%		Y	
England	13.4%			
Surrey Heartlands	10.1%	Y		
Gloucestershire	10.0%			Y
South Yorkshire & Bassetlaw	9.6%		Y	
West Yorkshire	9.0%			Y
Greater Manchester	6.6%	Y		
Frimley	6.4%		Y	
North East & North Cumbria	6.2%			Y
Lancashire & South Cumbria	1.0%		Y	
STP/ICS Average	11.5%			
STP/ICS Weighted Average	9.7%			

Data basis: NHS Digital, 'Table 1: Number of A&E attendances by gender in each provider, 2016-17', *Hospital Episode Statistics for England, Accident and Emergency (A&E) statistics.* STP/ICS attendances figures derived from aggregating data for relevant NHS Trusts and Foundations Trusts.

87 Compare the conclusions reached in N. Goodwin, 'Improving Integrated Care: Can Implementation Science Unlock the 'Black Box' of Complexities?', *International Journal of Integrated Care 19* (2019), pp.1-3.

The remaining measures in this section attempt to capture the indirect effects of integration. Under a properly integrated system, according to the objectives set out in the NHS Long Term Plan, there should be fewer A&E admissions, because more problems will be caught earlier due to the greater focus on preventative healthcare; fewer emergency readmissions after leaving hospital, because there will be better and more joined-up care pathways for patients upon discharge; and better population health.

Obviously, it would be wrong to expect an immediate transformation. But the pattern here, again, is of mixed progress and continuing regional variation.

In terms of A&E attendance, for example, ICS regions outperformed the national trend, with attendances at growing by 3.7 percentage points less than for the rest of England, comparing the averages for each of the two periods either side of April 2016. This is welcome news. However, again there were very substantial differences between the best and worst performers, with no obvious demographic pattern to explain them.

Emergency Readmissions to Hospital within 30 Days

STP/ISC Region	Percentage point difference, 2016-20 avg. vs 2013-16 avg.	First Wave: Devolved	First Wave: NHS	Second Wave
Buck., Ox. & Berk. West	2.7		Y	
West Yorkshire	1.8			Y
Dorset	1.6		Y	
Surrey Heartlands	1.5	Y		
Frimley	1.3		Y	
Suffolk & North East Essex	1.2			Y
Nottingham & Nottinghamshire	1.2		Y	
Bedford, Luton & Milton Keynes	1.1		Y	
North East & North Cumbria	1.1			Y
England	1.1			
England, excluding wave 1 + 2 ICSs	1.1			
Gloucestershire	0.9			Y
South Yorkshire & Bassetlaw	0.7		Y	
Lancashire & South Cumbria	0.4		Y	
Greater Manchester	0.4	Y		
STP/ICS Average	1.2			
STP/ICS Weighted Average	1.1			

Data basis: NHS Digital, 'Indicator 3.2 – Emergency readmissions within 30 days of discharge from hospital', *CCG OIS.* STP/ICS emergency readmissions figures derived from underlying CCG data (taking into account CCG mergers over the 2013-20 period where appropriate).

On emergency readmissions, there was no real difference between the national and ICS averages. As with DtoCs, however, the worst performer was much further from the average than the best.

Admission Rate for Alcohol-Specific Conditions

STP/ISC Region	Change in alcohol admissions 2016-20 avg. vs 2013-16 avg.	First Wave: Devolved	First Wave: NHS	Second Wave
Surrey Heartlands	43%	Y		
Gloucestershire	17%			Y
Buck., Ox. & Berk. West	12%		Y	
North East & North Cumbria	11%			Y
West Yorkshire	6.0%			Y
Dorset	4.3%		Y	
Suffolk & North East Essex	4.2%			Y
Frimley	1.0%		Y	
South Yorkshire & Bassetlaw	-1.6%		Y	
England	-2.6%			
England, excluding wave 1 + 2 ICS CCGs	-3.8%			
Bedford, Luton & Milton Keynes	-4.5%		Y	
Nottingham & Nottinghamshire	-9.8%		Y	
Lancashire & South Cumbria	-19%		Y	
Greater Manchester	-21%	Y		
STP/ICS Average	-0.8%			
STP/ICS CCG Average	-2.2%			

Data basis: NHS Digital, 'Indicator 3.14 – Directly age and sex standardised admission rate for alcohol-specific conditions, per 100,000 registered patients, 95% confidence intervals', CCG OIS. Note that STP/ICS alcohol-specific admissions derived from CCG level data (taking into account CCG mergers over the 2013-20 period where appropriate) and therefore do not represent weighted averages.

We have included the admission rate for alcohol-specific conditions to see whether the ICS model has had any early impact on population health. Here, outcomes in STP/ICS regions have generally been weaker than average. However, the key thing again is the variation in results. Surrey Heartlands and Greater Manchester are both devolved first wave ICSs, yet are at the opposite ends of the alcohol admissions spectrum. (It is worth flagging however that reduction in alcohol consumption was not one of the specific targets set by Greater Manchester at the start of the GMHSCP – this came along later, in 2019 – so it is hard to tell what has produced the notable fall.)

Respiratory Disease Deaths

STP/ISC Region	Change in mortality rate, 2013-16 avg. vs 2017-19 avg.	First Wave: Devolved	First Wave: NHS	Second Wave
Lancashire & South Cumbria	7.0%		Y	
Dorset	5.1%		Y	
Greater Manchester	3.5%	Y		
Suffolk & North East Essex	2.0%			Y
North East & North Cumbria	0.4%			Y
Bedford, Luton & Milton Keynes	0.4%		Y	
England	0.3%			
England, excluding wave 1 + 2 ICSs	0.0%			
Buck., Ox. & Berk. West	-0.1%		Y	
West Yorkshire	-0.4%			Y
South Yorkshire & Bassetlaw	-0.9%		Y	
Frimley	-1.2%		Y	
Nottingham & Nottinghamshire	-1.8%		Y	
Surrey Heartlands	-4.3%	Y		
Gloucestershire	-5.8%			Y
STP/ICS Average	0.7%			
STP/ICS Weighted Average	0.4%			

Data basis: ONS, *Mortality statistics – underlying cause, sex and age* (July 2020). Data provided according to local authority areas. See DtoC table for notes on local authorities and STP/ICS footprints.

Respiratory disease mortality is one of the key focuses identified in the NHS Long Term Plan. Again, on average, integrated regions slightly underperformed the national trend. But again, there was plenty of variation, with Greater Manchester being an underperformer this time. (This data obviously fails to include the impact of the Covid outbreak, which saw respiratory deaths surge nationwide.)

To reiterate, the evidence above does not suggest that the ICS model has been a disaster. But it definitely shows that it is not a panacea: in particular ICS status appears far less significant in determining healthcare outcomes than other factors, including how well or how badly the trusts in question are managed.

That said, there is strong anecdotal and in some cases statistical evidence that specific initiatives within different ICSs – often at the Integrated Care Partnership (ICP) or Primary Care Network (PCN) sub-levels – do appear to be contributing to improvements in processes and outcomes.[88] Examples include the Dorsetshire Care Record; strengthened PCNs in Bedfordshire, Luton and Milton Keynes; and hospital efficiency drives in the South Yorkshire and Bassetlaw.

88 For cases studies, see: NHS England, Case Studies. Link

5. Conclusion and Recommendations

Some proponents of the ICS model hold that it will take 10-15 years for ICSs to reach the 'thriving' phase, with clear improvements in health outcomes only really becoming readily apparent by this point. They argue that it is unrealistic to expect linear progress in health outcomes, and indeed that it might even be reasonable to expect temporary reversals as the new system beds in. Instead, a future inflection point will be reached, in which population health measures and new integrated processes supported by a culture of collaboration leads to a dramatic improvement in outcomes.

'National and regional data for both Greater Manchester and West Yorkshire show that at best, the ICS model of integrated health and care does not yield significant, consistent or reliable improvements in outcomes, notwithstanding the time, energy and money that goes into these massive reorganisations'

But this is, essentially, faith-based medicine. Given the evidence presented in this paper – especially about Greater Manchester, the region where healthcare integration is most advanced – it is clear that the evidence gap identified by the National Audit Office back in 2017 has not been filled. No evidence at scale can be adduced in favour of the plan to formalise the ICS approach across the country. Putting ICSs on a statutory basis would be a leap in the dark, taken in spite of poor national and regional data, in the face of the pressures from Covid, in the belief that things will improve in the future. The NHS has been down this road before.

National and regional data for both Greater Manchester and West Yorkshire show that at best, the ICS model of integrated health and care does not yield significant, consistent or reliable improvements in outcomes, notwithstanding the time, energy and money that goes into these massive reorganisations. And at worst, the data points towards significant deterioration, with more Delayed Transfers of Care, stalling progress on key mortality indicators and widening inequalities versus national average trends.

Given the very substantial variations in performance across the metrics we have examined, there is no reason to think that putting ICSs on a statutory footing, as per the Health and Care Bill, would fundamentally change this picture.

It could be argued that poor and wildly inconsistent DtoC results reflect temporary disruptions caused by the implementation of STP and ICS reforms. But the data from Greater Manchester – and to a lesser extent West Yorkshire – strongly indicates that problems with the ICS model are more deeply rooted.

Given the complexity of systems such as Greater Manchester, with its system-level structures, 10 local authorities, 10 CCGS, 10 LCOs, 13 trusts, hundreds of sites and tens of thousands of workers trying to collaborate to serve a population of 2.8m, pinning down precise causes of specific weaker outcomes is not something that can be done with high-level data alone.

However, the workforce data – more managers and support staff, fewer clinicians – does seem to point towards a general weakness in the ICS model: it creates new committee structures and other layers of health bureaucracy, tangling up NHS trusts, local authorities and any other groups getting involved, and complicating the administration of health and care.

It follows that one very plausible interpretation of the health and workforce data is that new structures – as with bureaucracies everywhere – tend to direct efforts towards processes and structures rather than results, slowing decision-making and obscuring accountability. This leads to worse outcomes for patients as time, focus and resources are diverted away from clinical and care settings.

From this perspective, analysis of the data from the first two waves of ICSs suggests seven main flaws in the current approach:

1) **Bureaucratic structures and processes risk being prioritised over health outcomes.** This is reflected in the centrality of the dual ICS Body-Partnership structure to the proposed reforms: a top-heavy management structure is being hardwired into the system. For all the platitudes about bureaucracy-busting in 'Integration and Innovation', it is all too easy to see how the ICS-ICP-PCN structure, replete with joint committees and joint appointments, could ossify into something neither responsive nor collaborative, dominated by processes rather than results. There is also a risk that it dilutes the power of strong NHS leaders to drive through change, given the switch to more of a committee structure.

2) **ICS accountability mechanisms are poorly defined and likely to lead to confusion, conflict and crises of legitimacy.** NHS and local government responsibilities and employees are to be joined together in formalised management structures. But while elected officials are democratically accountable to their local electorates, NHS staff are accountable to the chain of management running up to NHS England. There is clearly scope for the politicisation of commissioning and other issues.

   Indeed, aside from the frictions that may arise from a new healthcare bureaucracy sandwiched between the NHS and local authorities, it is unclear how relationships between the Integrated Care Boards and the Integrated Care Partnerships will work in practice.[89] Given that both groups could legitimately claim to be speaking for the needs of the population and patients, conflicts of opinion may well emerge. Moreover, in a system of diffused accountability where people are supposed to hold themselves accountable to each other, and where there are many overlapping bureaucratic layers to both planning and implementation, holding any one individual or organisation accountable for poor performance is going to be complicated. Responsibilities are already often bounced back and forth between CCGs and NHS Trusts. Adding new hierarchies to the list is not going to help.

89 A similar point is made in: The Kings Fund, H. McKenna, *The health and social care White Paper explained.*

3) **The new ICS structures could actually cement the dominance of secondary care within the healthcare system.** There will always be strong consumer demand for hospitals, giving hospital chiefs strong claims on resources. At present, this is tempered in various ways. GPs are strongly represented on CCGs, for example. But CCGs are to be abolished. The NHS ICS Body in particular looks at risk of becoming a platform through which systems are shaped around hospital needs rather than vice versa. This is almost the opposite of what the ICSs are supposed to achieve.

4) **While the purchaser/provider split in the NHS is being kept in theory, in practice it looks likely to be greatly diluted.** The Health and Social Care Act 2012 undoubtedly has its shortcomings but the new statutory ICS approach is likely to reintroduce or reinforce the classic public sector procurement problems Andrew Lansley set out to solve: lack of oversight, emergence of monopolies, poor value for money and so on. For example, rather than GPs holding commissioning power on behalf of patients, NHS Trusts that provide healthcare services will have representatives in the ICS organisations planning what services need to be commissioned. Explicit commitments to preserving 'the division between funding decisions and provisions of care' and patient choice are, when viewed in the broader context of the reforms, fudges. They are also likely to lead to further confusion and inefficiencies.

5) **Incentives for collaboration are nebulous and fragile, while bureaucratic structures and rules do not in themselves constitute a culture of collaboration.** Incentives to collaborate across organisational boundaries are hard to design and implement. ICSs have sought to cultivate a culture of collaboration in which healthcare workers (and others) take the big picture view and feel invested in the ICS, as opposed to just their place of work and immediate colleagues. This depends on individuals being motivated by an unusually high degree of benevolence rather than self-interest. Most healthcare workers are of course caring, kind and benevolent people. But that benevolence is directed primarily towards the patients in their care. The successes that established ICS have achieved have come from years of careful planning and work to obtain buy-in from clinicians. In a sense, formalising the ICS structures is an attempt to substitute formal rules and structures for a culture of collaboration.

6) **Contradictory impulses towards decentralisation and centralisation could generate tension and conflict.** On the one hand, ICSs are supposed to be based around local geographies, with the flexibility to adapt health and care priorities to local needs and conditions. On the other hand, the Health and Care Bill would give the Secretary of State enhanced powers to intervene directly in local decisions, for example to compel organisations to work together, to forestall capital spending, or to prevent the closure of politically sensitive services. This top-down approach arises partly from the sense of a need to maintain a national health service, but creates the potential for flashpoints between individual ICSs and the centre, especially if the Secretary of State were to come under pressure from local MPs.

7) **Even semi-effective implementation of the ICS reforms in their current form is likely to be costly.** The GMHSCP received a one-off sum of £450m (equating to 7.5% of the region's annual health and social care budget) to help in its transformation into an ICS – a transformation that was far from smooth. If each of the 29 ICSs established since the first two ICS waves were to receive similar funding, the Government would need to find about £7 billion. Even in West Yorkshire, which appears to have managed the transition more smoothly, there was additional

funding made available, though not on the same scale. It is clear that considerable amounts would need to be provided in transition funding to implement statutory ICSs across England.

An alternative approach

The Government's determination to tackle the long-term problems facing health and care provision is to be welcomed. But it is important to take the time to get things right, rather than intensifying the current pressures on the NHS through costly and disruptive reforms that are not supported by national or regional data.

The data we have examined in this paper is far from complete. But it is clear that a focus on the grand architectonics of the ICS model risks obscuring important changes, for good or ill, at a more local level. The key question, in other words, is not whether ICSs are good or bad – although the data presented here suggests it is hard to make a compelling case for the former scenario – but why some ICSs do so much better than others.

As mentioned above, there is good evidence that specific initiatives within different ICSs are contributing to improvements in processes and outcomes. These include the Dorsetshire Care Record; strengthened PCNs in Bedfordshire, Luton and Milton Keynes; and hospital efficiency drives in the South Yorkshire and Bassetlaw.

Yet most of these initiatives had their origins in the 50 vanguard sites launched in 2015 to experiment with specific strands of integrated care (see Annex I: Integrated Care Policy Milestones). These predated STPs, let alone ICSs, and did not rely on massive regional reorganisations.

In other words, integration can deliver better outcomes. But the emerging evidence is that this is better done on a bottom-up than a top-down basis. And it is very clear that far more evidence is needed before we commit the NHS as a whole to this untested new model, in particular as the evidence we have assembled here simply does not justify it. A rethink is needed about what form integration should take under the new ICS designation.

Given this imperative, we propose that the Government should:

1) **Drop from the Health and Care Bill legislation to put ICSs on a statutory footing.** The evidence to date suggests that there is no clear link between integration and improved outcomes; the region of the country, Greater Manchester, where the integration of care is furthest advanced is also the one where the health outcomes have been the most clearly negative. But across the 13 pilot areas, the significant rise of Delayed Transfers of Care is a huge warning sign. Before charging on down this road, we need much better evidence that the ICS model is the right one to adopt.

2) **Allow the 13 ICS pilot schemes to run their courses until around 2026, rather than sowing confusion by overturning existing approaches to integration in the immediate aftermath of Covid.** In the consensus view, ICSs should take around 10-15 years to really bed in. NHS England has set out four phases for ICS development: 'emerging', 'developing', 'mature' and 'thriving'. None have reached 'thriving' yet, and most would probably not want to be described as 'mature', given clinical outcomes to date. But these 13 test-beds can still be used to see if the consensus view is actually correct, evidence to date notwithstanding. Five years is not long to wait for evidence when it is the future of the entire NHS at stake. If (as seems likely) there is

no clear improvement in ICS outcomes relative to England over the next five years, the case against the ICS model of integration will be fairly conclusive. If outcomes data for the 13 ICSs unexpectedly show significant improvement, then the newer 29 ICSs can accelerate down this path of integration, using best practices tested and refined by the pioneers. A firmer evidence base would also help in obtaining 'buy-in' from health professionals – a vital factor, if the changes to create a culture of collaboration are to be effected successfully.

3) **Task the 29 newer ICSs with overseeing regional Better Care Fund budgets rather than investing them with new and expanded powers and responsibilities.** Alongside the existing pilot schemes, we should investigate whether alternative approaches to integration offer better solutions. It is notable that the more informal collaboration in Greater Manchester before the creation of the Greater Manchester Health and Social Care Partnership, driven and enabled by the Better Care Fund, appears to have been associated with better results than seen under the GMHSCP. A focus on the BCF would also help to orient ICSs towards primary and community care solutions, reducing the risk of entrenching the dominance of hospitals and acute care pathways.

4) **Encourage each ICS to explore the further development of standardised local referral and care pathways, thus streamlining patient flows between different care settings.** Standardisation should also free up resources for multi-disciplinary teams to collaborate on personalised solutions for complex cases involving multiple morbidities. In other parts of the world such as Canterbury, New Zealand, this approach to vertical healthcare integration has an encouraging track record in reducing friction between community, primary and secondary care settings. Some of the early-mover ICSs have followed Canterbury's lead on this front already. All ICSs will have to be careful, however, that their pathways do not just funnel more people into the hospital system.

5). **Compel the ICSs and NHS England to collect and publish more data on health outcomes and to create a consolidated ICS database.** NHSX should implement an 'ICS Accountability Dashboard', initially covering at least the original 13 ICS pilots. This could begin through drawing on existing NHS Digital datasets and would be a natural outgrowth of the 'NHS System Oversight Framework' now under development. It would allow for easy but detailed and meaningful comparisons between ICSs on a broad range of outcomes. This would be useful for policymakers but would also enable citizens to hold their ICS leaderships to account and to push back against poor outcomes and inefficiencies.

6) **Use aggregate outcomes data to drive competition between ICSs, rewarding innovation that achieves better results and so incentivising ICSs to emulate best practices developed in other ICSs.** Rather than removing competition from the NHS, we should use it to spur trusts on. Once appropriate databases and tools are in place, we will be much better placed to evaluate what is really working within the NHS – which may turn out to be the ICS model, or may turn out to be something more voluntary and collaborative, or may even involve moving activity out of hospitals and diversifying providers. One suggestion would be for regions that move up an indexed league table relative to others to receive additional grants from a dedicated funding pot. In contrast to the 'Integration index' outlined in the 'Integration and Innovation' White Paper, this would be based around outcomes, rather than processes and perceptions. It would push managers to focus on patients and population health, rather than structures and processes – a clear danger with the reforms as currently envisaged.

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Annex I: Integrated Care Policy Milestones

June 1990	**National Health Service and Community Care Act 1990** receives Royal Assent, setting the direction of travel for the NHS up until the inflection point of 2014, when policy shifted to integration of health and care. The Act, which came into force from April 1991, split provisioning and commissioning of healthcare, created NHS trusts and marked the beginning of the internal market. It also transferred responsibility for community care from the Department of Social Security to local authorities (though implementation was delayed until 1993).
June 1999	The Health Act 1999 receives Royal Assent. It contains provisions to facilitate greater integration of health and social care, including allowing the setting up of pooled budgets. However, implementation of these provisions is patchy.
April 2002	**The Wanless Review, 'Securing Our Future Health'**, is published. The report examines the long-term trends related to the future of healthcare provision, foregrounding the problem of an ageing population and highlighting 'bed blocking' at acute services due to under capacity in social care settings.
April 2003	The Community Care (Delayed Discharges) Act 2003 receives Royal Assent. It requires local authorities to pay healthcare providers if the local authority was responsible for the delayed discharge of an NHS patient.
July 2006	National Health Service Act 2006 receives Royal Assent. It mostly consolidates existing pieces of legislation, including that related to the integration of health and social care such as pooled budgets.
October 2007	The **Local Government and Public Involvement in Health Act 2007** receives Royal Assent, introducing a requirement for local authorities and primary care trusts (PCTs) to prepare joint strategic needs assessments covering the health and social care needs of their populations. This represents an early move towards place-based integrated care.
July 2008	The **Health and Social Care Act 2008** establishes the Care Quality Commission (CQC) as an independent regulator for health and adult social care services in England, consolidating several previously separate bodies.

January 2009	Department of Health publishes **'The NHS Constitution for England'**, which enshrines the right to informed choice for patients, thereby advancing the idea of patient-centric care.
April 2009	Launch of **Integrated Care Pilots** to explore different aspects of integrated care at 16 different sites across England, following on from the 'High Quality Care for All' report of 2008. An evaluation of these schemes is published in March 2012.
February 2010	**The Marmot Review, 'Fair Society, Healthy Lives'**, is published. The report focuses on health inequalities and the social determinants of ill-health. Its policy recommendations fall under six main headings: giving every child the best start in life; enabling all people to maximise their capabilities and have control over their lives; creating fair employment and good work; ensuring a healthy standard of living for all; creating and developing sustainable places and communities; and ill health prevention.
July 2010	The **'Equity and Excellence: Liberating the NHS'** White Paper is published, preparing the way for the 2012 reforms. The integration of services between health and social care is one of a number of themes in the paper.
November 2010	**'A Vision for Adult Social Care: Capable Communities and Active Citizens'** is published, articulating the need for holistic and joined-up provision of care and promoting the idea of personalised budgets, as well as noting the need for a greater focus on prevention.
May 2011	**The Law Commission** report on adult social care is published, recommending extensive reforms and consolidation of legislation governing adult social care. Many of the recommendations will be taken up in the Care Act 2014.
July 2011	**The Dilnot Report** is published. The report finds that adult social care needs substantial reform and requires more funding. It recommends that rising costs be met through a mixture of individual and state funding, and that a cap on lifetime costs of care in the region of £50,000 be applied.
March 2012	**'National Evaluation of DH Integrated Care Pilots'** is published, concluding that while staff believed the pilots had led to process improvements that had or would yield improvements to care, there was no clear evidence of improvement in patient outcomes. There was evidence of net cost savings, mainly for acute care providers. The **Health and Care Act 201**2 receives Royal Assent after a difficult and highly contested passage through Parliament. Its provisions are to come into force from April 2013. These include: the establishment of CCGs and the abolition of primary care trusts (PCTs); the establishment of Healthwatch England to act as an independent consumer champion for health and social care service; and the creation of Health and Wellbeing Boards (HWBs) at local authorities, charged with promoting

	greater integration and partnership between NHS, public healthand local government organisations. The Act also upholds a clear purchaser/provider split in the supply of NHS health services and seeks to increase patient choice and the role of competition in the NHS.
April 2013	The Health and Care Act 2012 comes into force, establishing 211 CCGs, HWBs and NHS England (replacing the NHS Commissioning Board).
May 2013	**'Integrated Care and Support: Our Shared Commitment'**, a statement of intent jointly authored by the DH, NHS, LGA, CQC, NICE and others, is published. It leads to planning for 'integrated care pioneers', the first of which were formed in November 2013. Ultimately, however, this programme would be eclipsed by the Better Care Fund and the new vanguard sites of the New Care Models Programme
June 2013	Chancellor George Osborne announces the Integration Transformation Fund – renamed the **Better Care Fund (BCF)** in July 2014 – with an initial budget of £3.8bn, designed to promote integrated care by bringing together CCGs, local authorities and Health and Wellbeing Boards around pooled budgets to jointly plan the provision of health and care. The core idea is to reduce pressures on hospitals by facilitating transfers of care. By 2019/20, mandatory minimum BCF budgets across England totalled £6.4bn, provided by CCGs, local authorities and direct grants from the DHSC and MHCLG.
October 2013	The Competition Commission (the forerunner of the CMA) blocks the merger of the Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in Dorset. This event comes to be seen as indicative of problems in advancing integrated care under the regime created by the Health and Care Act 2012 and prior legislation.
November 2013	The government selects the first 14 local areas to become integrated care pioneers, following on from the announcement of May 2013.
April 2014	Simon Stevens takes up the position of Chief Executive of NHS England.
May 2014	The **Care Act (2014)** receives Royal Assent. The Act places a statutory duty of wellbeing on local authorities and charges them with promoting integration of social care with health services when undertaking their social services functions – effectively giving statutory backing to the aims of the BCF. A cap on the lifetime costs of care is set to come into effect from April 2016, but this is postponed.
July 2014	The Integration Transformation Fund becomes the BCF and conditions relating to the performance element of the fund are revised by the Government, as plans submitted by HWBs in April 2014 did not contain the expected cost savings. New plans were to be submitted in September 2014.

October 2014	NHS England's **'NHS Five Year Forward View'** is published, giving major impetus to the integrated care agenda. At this stage, the focus is on joining up services and breaking down barriers within the NHS and across health and social care using six new care models outlined in the report – the New Care Models Programme that will go on to underpin the vanguard projects launched in 2015. Prevention, public health and health inequalities are also identified as priority issues feeding into the integrated care agenda. The importance of more investment in primary and community rather than acute care is highlighted too, along with a predicted annual funding gap of £30bn.
November 2014	The National Audit Office (NAO) publishes its assessment of the BCF to date, concluding that while it represented an innovative approach, the early preparations and planning have been largely ineffective.
	The Dalton Review, 'Examining New Options and Opportunities for Providers of NHS Care', identifies a number of new organisational models with the potential to help providers respond to the challenges f aced by the NHS. It is broadly in line with the thinking of the 'NHS Five Year Forward View'.
	Devo Manc: the devolution process in Greater Manchester begins with the Government and the GMCA signing the first of six devolution deals setting out the range of policy areas to be transferred to the control of the GMCA.
January 2015	A second wave of integrated care pioneers covering a further 11 local areas is announced.
	Organisations and partnerships are invited to apply to become 'vanguard' sites for the New Care Models Programme set out in the NHS Five Year Forward View. Eventually, 50 vanguard sites will be chosen to experiment with five aspects of integrated care: integrated primary and acute health systems (PACs); enhanced health in care homes; multi-specialty community providers (MCPs); urgent and emergency care vanguards; and acute care collaborations.
February 2015	**Devo Manc:** Government, NHS and local government leaders sign the Greater Manchester Health and Social Care Devolution MoU, in preparation for putting the region's £6bn health and social care budget under GMCA control.
March 2015	The first 29 vanguard sites are announced: 14 for multi-speciality community providers, 9 for integrated primary and acute health systems and 6 for enhanced health in care homes.
July 2015	The next 8 vanguard sites are announced, for urgent and emergency care.

September 2015	The final 13 vanguard sites are announced, for acute care collaborations.
November 2015	A £10bn 'sustainability and transformation' fund is announced in the Spending Review. This funding is allocated to trusts that meet specific criteria.
December 2015	**'Taking Charge of our Health and Social Care in Greater Manchester: The Plan'** is signed off and published, setting out the aims of the GMHSCP for the next five years. NHS guidance is that other regions should begin drafting sustainability transformation plans where they have not already done so.
January 2016	The **Cities and Local Government Devolution Act 2016** receives Royal Assent. The Act facilitates the devolution of health and social care responsibilities to local and combined authorities, notably the GMCA.
March 2016	NHS England publishes 44 sustainability transformation plan 'footprints' in a first attempt at delineating the geographical basis for integrated care across England. Over the next few years, these boundaries are significantly adapted through experience and feedback, leading to the current 42 ICS regions.
April 2016	**The Greater Manchester Health and Social Care Partnership (GMHSCP) is formally established.** NHS Improvement (NHSI) is formed with the de facto merger of Monitor and the NHS Trust Development Authority (NHS TDA). NHS England's **'General Practice Forward View'** is published. It built on the Five Year Forward View of November 2014 but with a focus on primary care, seeking to redress the imbalance in resource allocation within the NHS after a decade of robust growth in acute care provision. It argues that, given an ageing population with complex multiple conditions, 'personal and population-oriented care' has to become the norm. Emphasis is therefore put on the integration of primary and community care. Ideas around networks or federations of practices will later be incorporated into the PCNs promoted in The NHS Long Term Plan of 2019.
February 2017	The **National Audit Office** publishes an evaluation of health and social care integration, including the implementation of the BCF. The report is scathing about integration to date, noting that outcomes have fallen well short of what was envisaged, and argues that thus far no compelling evidence has emerged in favour of health and care integration.
March 2017	**Plans for a Green Paper on the financing of adult social care are announced** in the Spring Budget.

	NHS England's 'Next Steps on the NHS Five Year Forward View' is published. This update on the October 2014 document begins referring to sustainability transformation plans as sustainability transformation partnerships (STPs); it also states that STPs could evolve to become Accountable Care Systems (ACS) – later renamed as ICSs.
June 2017	General Election. Conservative plans to reform adult social care provision, with no cap on lifetime care costs (contra the Dilnot Report) are branded a 'dementia tax'. These plans are generally seen as a significant contributing factor to the Conservatives losing their majority. Plans for a social care Green Paper are pushed back in July. **NHS England announces the first wave of ICSs:** eight regions (in addition to the two devolved regions, Greater Manchester and Surrey Heartlands) are to be allowed to evolve their STPs into fully-fledged ACSs (later ICSs). These are: Frimley Health; South Yorkshire & Bassetlaw; Nottinghamshire; Blackpool & Fylde Coast; Luton, Milton Keynes and Bedfordshire; Berkshire West; and Buckinghamshire. The first 10 ICSs cover around 12.3m people.
November 2017	MoU signed on London Health and Social Care Devolution, with London to be split into five separate devolved systems. This builds on the London Health and Care Collaboration Agreement of December 2015. NHS England CEO Simon Stevens calls for a £20-30bn rise in the NHS budget at the NHS Providers Conference.
January 2018	The Department of Health (DH) is renamed the Department of Health and Social Care (DHSC), signaling the general direction of travel for health and care reform.
February 2018	Accountable Care Systems (ACSs) are rebranded as Integrated Care Systems (ICSs), with the ICS nomenclature also being applied to the existing devolved systems. ACSs had become associated with privatisation and hence were politically toxic. At the end of the 2017/18 winter crisis, Simon Stevens describes February as probably the 'most pressurised month the NHS had seen in its 70-year history'.
March 2018	**Informal integration of NHSE and NHSI announced**, to take effect from September 2018. This will entail integration of both national programmes/activities and regional teams, with the existing arrangements being consolidated into seven regional teams. ICS structures will exist in parallel to these structures.
May 2018	**The second wave of ICSs.** A further four areas are selected to evolve their STPs into fully-fledged ICSs: Gloucester, North East & North Cumbria, Suffolk & East Essex, and West Yorkshire & Harrogate. These cover around 7.5m people.

June 2018	**NHS at 70 funding settlement:** Theresa May announces a five-year funding settlement that will increase NHS England's budget by £20.5bn per year in 2018/19 prices by 2023/24. This increase was for day-to-day spending and did not cover other elements of the DHSC's budget, such as capital expenditure and adult social care.
August 2018	Commencement of a consultation on Integrated Care Providers – initially known as Accountable Care Organisations – that runs until October 26. These are to be new types of provider organisation focused on population-based integrated health and social care delivery.
September 2018	'Prevention is Better than Cure: Our Vision to Help You Live Well For Longer' is published by the DHSC, articulating ambitions to reduce inequalities in life expectancy and improve healthy life expectancy by at least five years by 2035.
October 2018	Autumn Budget: the Chancellor confirms a new five-year financial settlement for the NHS announced in June. Additional short-term funding of £650m is also announced for adult social care.
January 2019	NHS England publishes **'The NHS Long Term Plan'**. Building on the Five Year Forward View, it set out plans to 'accelerate the redesign of patient care to future-proof the NHS', making use of the long-term funding settlement agreed with the May government. It fleshes out the ICS concept and proposed that every area in England should be served by an ICS by April 2021. STPs and ICSs are instructed to prepare five-year implementation plans relating to the ambitions set out in the Plan. Primary care networks (PCNs) are also strongly promoted.
February 2019	NHSE and NHSI launch a consultation on implementing the long-term plan. It runs until April 25. This process informs the legislative recommendations published by NHSE and NHSI in September 2019.
March 219	NHS England publishes **'Breaking Down Barriers to Better Health and Care'**.
June 2019	NHS England publishes **'Designing Integrated Care Systems in England'**, setting out the principles for designing and assessing ICSs, including the maturity matrix for evaluating ICSs across nine domains according to four developmental phases. The House of Commons Health and Social Care Committee publishes a report on the NHS reform ideas.
September 2019	NHSE and NHI jointly publish **'The NHS's Recommendations to Government and Parliament for an NHS Bill'**, based on the consultation carried out earlier in the year. Many of the proposals make it into the DHSC White Paper of February 2021, via the additional report of November 2020.

March 2020	GMHSCP publish **'Taking Charge is Working in Greater Manchester'**, looking at progress towards the goals set out in the five-year plan finalised in December 2015.
	WHO declares Covid-19 pandemic. England enters into first lockdown.
May 2020	Another four ICSs, covering 6.5m people, are announced.
November 2020	NHS England publishes **'Integrating Care: Next steps to Building Strong and Effective Integrated Care Systems across England'**. Building on previous documents, this describes how ICSs could be further developed, with particular refence to legislative changes.
December 2020	A further 11 ICSs, covering 14m people, are announced, bringing the national total up to 29.
February 2021	The Department of Health and Social Care publishes a White Paper, **'Integration and Innovation: Working Together to Improve Health and Social Care for All'**. This takes on board many of the ideas for legislation advocated by NHE England and NHS Improvement in their report of November 2020. A total of 32 sets of proposals are outlined. The Health and Care Bill envisaged in the report is subsequently announced in the Queen's Speech.
April 2021	The final 13 ICSs covering 16m people are announced, bringing the national total up to 42.
May 2021	Plans for a Health and Care Bill are announced in the Queen's Speech.
July 2021	**The Health and Care Bill is introduced to Parliament**.

Annex II: 'Integration and Innovation' in Outline

The DHSC's White Paper of February 2021, 'Integration and Innovation: Working Together to Improve Health and Social Care for All', is structured around four main themes and 32 sets of reforms.

(I) Working together and supporting integration

1. Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Patient Choice
9. Data Sharing

(II) Reducing bureaucracy

1. Competition
2. Arranging healthcare services
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

(III) Enhancing public confidence and accountability

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions

(IV) Additional proposals

Social care

1. Assurance
2. Data
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

Public Health

6. Public Health power of direction
7. Obesity
8. Fluoridation

Safety and Quality

9. Health and Services Safety Investigations Body (HSSIB)
10. Professional Regulation
11. Medical Examiners
12. MHRA new national (UK wide) medicines registries
13. Hospital food standards
14. Reciprocal healthcare agreements with Rest of World countries

Annex III: Integrated Care Systems in England

Integrated Care System	Acronym	Date Designated*	% Pop. Covered
Bath and North East Somerset, Swindon and Wiltshire Partnership	BSWP	Dec-20	1.6%
Bedfordshire, Luton and Milton Keynes ICS	BLMK ICS	Jun-17	1.4%
Birmingham and Solihull	-	Dec-20	2.2%
Bristol, North Somerset and South Gloucestershire	BNSSG	Dec-20	1.7%
Buckinghamshire, Oxfordshire and Berkshire West ICS	BOB ICS	Jun-17	3.1%
Cambridgeshire and Peterborough STP	-	Apr-21	1.7%
Cheshire and Merseyside Health and Care Partnership	CMHCP	Apr-21	4.3%
Cornwall and the Isles of Scilly Health and Care Partnership	CIOS	Dec-20	1.0%
Coventry and Warwickshire Health and Care Partnership	-	Apr-21	1.7%
Frimley Health and Care	-	Jun-17	1.1%
Greater Manchester Health and Social Care Partnership	GMHSCP	Apr-16	4.8%
Hampshire and the Isle of Wight Health and Care	HIOWHC	Dec-20	3.1%
Healthier Lancashire and South Cumbria	-	Jun-17	3.1%
Herefordshire and Worcestershire	-	Apr-21	1.4%
Hertfordshire and West Essex	HWE ICS	May-20	2.7%
Humber, Coast and Vale Health and Care Partnership	-	May-20	2.9%
Integrated Care System for Devon	ICSD	Apr-21	2.0%
Joined Up Care Derbyshire	-	Dec-20	1.7%
Kent and Medway ICS	-	Apr-21	3.2%
Leicester, Leicestershire and Rutland ICS	LLR	Apr-21	1.9%
Lincolnshire NHS	-	Apr-21	1.3%
Mid and South Essex	-	Apr-21	2.0%
Norfolk and Waveney Health and Care Partnership	-	Dec-20	1.9%
North East and North Cumbria ICS	NENC ICS	May-18	5.5%
North East London Health and Care Partnership	NEL HCP	Dec-20	3.7%
North London Partners in Health and Care	NCL	Dec-20	2.6%
North West London Health and Care Partnership	-	Dec-20	4.1%
Northamptonshire ICS	-	Apr-21	2.6%
Nottingham and Nottinghamshire Health and Care	-	Jun-17	1.7%
One Gloucestershire	-	May-18	1.0%
Our Dorset	-	Jun-17	1.4%
Our Healthier South East London	-	Jun-19	3.4%
Shropshire and Telford and Wrekin	STW ICS	Apr-21	0.9%
Somerset ICS	-	Dec-20	1.0%
South West London Health and Care Partnership	SWLHCP	May-20	2.4%
South Yorkshire and Bassetlaw ICS	SYB ICS	Jun-17	2.6%
Staffordshire and Stoke on Trent	-	Apr-21	2.0%
Suffolk and North East Essex	-	May-18	1.7%
Surrey Heartlands Health and Care Partnership	-	Apr-18	1.9%
Sussex and East Surrey	-	May-20	3.1%
The Black Country and West Birmingham	BCBW	Apr-21	2.5%
West Yorkshire and Harrogate Health and Care Partnership	WYHHCP	May-18	4.6%

*Dates are broadly indicative of when an STP was designated an ICS (or equivalent, such as the earlier ACS designation). In some cases, the actual official launch of the ICS in an organisational and clinical sense was some months after the designation was announced. Note also that processes of amalgamation reduced the original 44 STP regions down to 42 ICS regions. Where ICS regions have been consolidated, the earliest ICS designation date has been used.

While these ICS regions are accurate as at the time of writing, further reorganisation of ICS boundaries should now be expected, given the DHSC Statement by Edward Argar MP, Minister of State for Health, on 22 July 2021: https://questions-statements.parliament.uk/written-statements/detail/2021-07-22/hcws248.

Annex IV: GMHSCP Constituent Organisations

Local Authorities x 10
Bolton Metropolitan Borough Council
Bury Metropolitan Borough Council
Manchester City Council
Oldham Metropolitan Borough Council
Rochdale Metropolitan Borough Council
Salford City Council
Stockport Metropolitan Borough Council
Tameside Metropolitan Borough Council
Trafford Metropolitan Borough Council
Wigan Metropolitan Borough Council

Clinical Commissioning Groups x 10
Bolton Clinical Commissioning Group
Bury Clinical Commissioning Group
Heywood, Middleton and Rochdale Clinical Commissioning Group
Manchester Health & Care Commissioning
Oldham Clinical Commissioning Group
Salford Clinical Commissioning Group
Stockport Clinical Commissioning Group
Tameside and Glossop Clinical Commissioning Group
Trafford Clinical Commissioning Group
Wigan Clinical Commissioning Group

NHS Trusts and Foundation Trusts x 13
Bolton Hospital NHS Foundation Trust
Bridgewater Community Healthcare NHS Trust
Greater Manchester Mental Health NHS Foundation Trust
Manchester University NHS Foundation Trust
North West Ambulance Service NHS Foundation Trust
North West Boroughs Healthcare NHS Foundation Trust
Pennine Acute Hospitals NHS Trust
Pennine Care NHS Foundation Trust
Salford Royal NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside Hospital NHS Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust

Source: https://www.gmhsc.org.uk/about-devolution/the-partnership/ [accessed 29 June 2021]. The list provided by NHS England contains more entries because of errors/ duplications. Due to mergers, the official GMHSCP list also comprises four fewer organisations than were reported to have signed the initial MoU in February 2015.

Annex V: WYHHCP Constituent Organisations

Local Authorities x 8
City of Bradford Metropolitan District Council
Calderdale Council
Craven District Council
Harrogate Borough Council
Kirklees Council
Leeds City Council
North Yorkshire County Council
Wakefield Council

Clinical Commissioning Groups x 6
NHS Bradford District and Craven Clinical Commissioning Group
NHS Calderdale Clinical Commissioning Group
NHS Kirklees Clinical Commissioning Group
NHS Leeds Clinical Commissioning Group
NHS North Yorkshire Clinical Commissioning Group
NHS Wakefield Clinical Commissioning Group

NHS Trusts and Foundation Trusts x 13
Airedale NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Leeds Community Healthcare NHS Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Locala Community Partnerships
The Mid-Yorkshire Hospitals NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Tees Esk and Wear Valleys NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Source: https://www.wyhpartnership.co.uk/about/our-partners [accessed 20 May 2021]. Note that that due to mergers, the number of CCGs has fallen from nine to six since the formation of the ICS.

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