Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Consider
Item No	7a	**Confidential / Freedom of Information Status**	No
Title	Update on GM ICS Transition		
Presented By	Geoff Little, Chief Executive Bury Council & Accountable Officer NHS Bury CCG		
Author	Will Blandamer, Executive Director Strategic Commissioning, Bury CCG and Bury Council		
Clinical Lead			
Council Lead			

Executive Summary
The arrangements for the operation of the GM ICS from April 2022 (subject to legislation) are progressing and Bury representatives are fully participating in their development, through the GM provider collaborative, the GM Joint Commissioning Board, the GM Partnership Executive board, and other relevant forums. This paper summarises a number of the key strands.
Recommendations
It is recommended that the Strategic Commissioning Board note the content of the report.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being	Yes	☐	No	☐	N/A	☒

Implications						
requested?						
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	Yes					
How do proposals align with Locality Plan?	As set out in report.					
How do proposals align with the Commissioning Strategy?	As set out in report.					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.		
Bury CCG Governing Body	26/05/2021	
Bury Locality System Board	20/05/2021	

Bury Health, Care and Well Being Partnership.

White Paper Transition Arrangements

Update on GM ICS Transition

Paper for;

- **Bury Locality System Board - 20th May**
- **Bury CCG Governing Body – 26th May**
- **Bury Strategic Commissioning Board – 7th June.**

Will Blandamer – Executive Director Strategic Commissioning – Bury CCG and Bury Council.

Background

The arrangements for the operation of the GM ICS from April 2022 (subject to legislation) are progressing and Bury representatives are fully participating in their development, through the GM provider collaborative, the GM Joint Commissioning Board, the GM Partnership Executive board, and other relevant forums.

This paper summarises a number of the key strands.

1. GM ICS operating model

1.1 GM Workshops and the Mike Farrar Report

A series of 4 workshops have been held over recent weeks involving representatives from all localities and all parts of the GM Health and Care Partnership. The workshops were chaired by Mike Farrar – former chief Executive of NHS North West. The report from the workshops is attached as Appendix 1.

There are some important principles to recognised in the report. This includes the following

1. Design principles and the 6 proposed areas of focus are good. The emphasis on preventative care and the contribution of primary care is particularly helpful. The 'stock' and 'flow' description of the different contributions of GM-wide provider collaboratives and localities in addressing planned care recovery and reform, though how these two work together in a positive way will be critical. It is good to see the report call-out the need to address unwarranted clinical variation.

2. The emphasis in building on the current spatial architecture (neighbourhoods, place, GM) is extremely helpful, as is the recognition of the need to plan and deliver services at different spatial levels. It is particularly helpful to see the emphasis on strengthening arrangements at a neighbourhood level.

3. The report emphasises the importance of provider collaboratives within each place, including acute providers, and the need to end the purchaser/provider split, which is consistent with our view.

4. The finance section is potentially open to different interpretations. Although no-one is going to disagree about a "blended approach", the flow of funding between GM and localities is still not clear though. The proposed commitment to "recognise and maintain, as a minimum, current arrangements where such money has been pooled with localities on a s75 arrangement" and the associated proposition to maintain levels of expenditure in community services is welcomed.

However, it is recognised that there are still some fundamental issues to address if the shadow arrangements by September 2021 are to be established and this will require continued dialogue. In particular there the report does not conclude key issues such as

- The governance and accountability arrangements at a GM level and how ensure place is reflected in GM level decision-making
- How the funding flows will work between the GM and locality system
- Formal programme governance arrangements and decision-making arrangements to establish the ICS, ensures timely and inclusive decision-making, with a transition timetable that enables effective shadow arrangements and the transition of the CCG staff and functions into the new arrangements

In addition, the report is not sufficiently strong on the necessity for clinical leadership (rather than just advice) at the level of both GM and particularly in the locality arrangements.

1.2 Next Steps to a GM operating model

In response to these issues and others, a brief report highlighting the steps to be taken to address some of the outstanding issue across the GM Health and Care Partnership has been produced and this is attached as Appendix 2. Key issues remain on matters of financial flow, decision making at spatial levels, the locality approach, the provider collaborative, the GM governance arrangements, and the Organisational Development Support Required.

Bury locality representatives have also articulated the need for further clarity on the future funding arrangements for current CCG clinical leadership and have escalated the query to the North West ICS transition group.

2. Workforce Communication

The following documentation has been developed by the GM ICS workforce transition group:

1) HR Transition principles
2) Employment Stability Principles
3) Equality Approach
4) Frequently Asked Questions
5) GM ICS update.

These documents are attached as Appendices. Items 4 and 5 have been circulated to all CCG and OCO staff in Bury, and a further all OCO/CCG staff briefing is being held on 3rd June by the Accountable Officer.

Greater Manchester - More than an ICS.....

Proposals for a new operating model for the GM health and care system

1. Context

This report was commissioned by the Greater Manchester Health and Social Care Partnership. Its' purpose is to advise the GM Partnership Board on the development of a new operating model* for the GM system. **The report is a part of the ongoing process for ultimately determining the model and reflects the outcomes of a major engagement exercise over recent weeks with key stakeholders and system leaders**. It also builds on a number of pieces of work that have been previously carried out or are currently in train. Finally, it sets out a number of next steps and suggested additional pieces of work.

1.1 Drivers of Change

There are four main drivers for why the GM health and care system wants and needs a new operating model

- whilst GM has made progress against its aim to improve the health and well being of its population, it has not been able to make as much progress as it wished to see against its four priorities of reducing health inequalities, meeting national constitutional standards, accelerating innovation and creating a financially sustainable health and care system

- Covid-19 has had a major impact in terms of the health of the mental, physical, social and economic health of the population. This has deepened the problems that the GM is facing in terms of poorer underlying health, longer waits, vulnerability in the social care sector, and increases in mental health problems especially amongst young people,

- Equally however Covid -19 has also driven a number of very positive new ways of working in particular: strong collective leadership by NHS and care providers; a greater emphasis on collaboration between health and care organisations; a different more engaged relationship between GM citizens and GM services; an acceleration of the digitisation of service delivery; and a strengthened sense amongst health and care leaders of a common purpose and constructive collective leadership behaviours

- The Government has signalled through a white paper its intention to establish statutory integrated health and care systems (ICS) which will require changes to the current system architecture. These will impact on GM, even with its devolution deal, and whilst there is a promise of permissiveness in terms of the means of implementation, there are likely to be a number of legal expectations on how the system operates and a stronger national direction over its priorities

1.2 Methodology

In order to develop a new model, there has been a rapid process of co design with health and care leaders across the system. This allowed the sharing of their analysis and wishes based on their experience to date of both successful and less successful progress. The report has been therefore been informed by

- a series of 4 design workshops involving over 150 health and care leaders from the GM system including political, managerial, clinical & professional, and community leaders

- a selected series of semi structured interviews with key opinion leaders in the system

*An 'operating model' is defined many times in the literature but as a general rule its definition centres on *'the process of how, by using people, processes and technology, the organisation delivers value described by its strategy'*

- previous work commissioned by the GMHSCP in addition to work from a number of organisations across GM to inform a revised operating model that described the spatial levels for organising the planning and delivery of care (GMSCP, CF 2021) and the evolution of commissioning (Deloitte 2017/18); and the model of spatial service organisation - West Yorkshire and Harrogate ICS (set out in the appendices)

1.3 The challenge of designing a new operating model - feedback from the process

Throughout the process of engagement, a number of challenges for GM leaders have emerged In proposing a new model. these largely centred on -

- lack of clarity of the GM priorities or expected outcomes going forward, in particular the balance between achieving national standards and priorities versus locally determined priorities and expected outcomes (without clarity it is hard to design an operating model to deliver them)

- differing views on what aspects of the model need to be fixed - for some this is technical and a matter of determining spatial distribution of service planning, for some it is about financial flows and accountability, whilst for others it is about behaviours and culture (in practice a new model needs to address and align all of these aspects)

- a recognition of the different starting points across the GM localities and whilst most leaders favour variability, there is a challenge to getting an operating model that recognises and enshrines these variations but also enhances a common sense of purpose

- a spectrum of views about the need to change aspects of the way GM works now - where for some their current locality model either works well or is believed simply to need more time to achieve its benefits, but there are others who wish to see a more fundamental reshaping of the operating model to enable faster transformation

- a presence of some deep seated mindsets within the leadership that reflects years of organisational thinking rather than system thinking and creates mistrust of sectors or organisations and accentuates a desire to build in restraints or control mechanisms

- a reduced level of confidence in the effectiveness of operating programmes at GM level since devolution driven by the perceived failure of some collective programmes to deliver the promised added value. This is often exacerbated by a mindset that views 'the level above' in the structure to be hierarchical rather than a sum of its component parts. (In practice GM is the ten localities, and the ten localities are their constituent neighbourhoods etc)

- inevitably there is a risk of a new operating model creating complexity which leaders wish to avoid, but they also recognise that undertaking functions such as priority setting, planning, and service delivery jointly does require reshaping or adding to the bureaucracy especially if joint decision making is to be transparent and subject to good governance rules (as the proverb says - *if you want to go fast - go alone; if you want to go far - go together*)

1.4 Design Principles

Throughout the process of engagement, there has been a large range of design principles shared with GM leaders, many of which stem from the original design principles for the current operating model (see appendices). Most of these are deemed relevant but there are a subset of principles supported by health and care leaders that have emerged as the major principles, for the new model to embrace.

- the new operating model must **be bold in enabling transformation** recognising that GM has much still to do on its journey; COVID has worsened the problems; some of GM's work has yet to bear fruit; GM is determined to tackle inequalities; GM has not been able to deliver consistently on national standards and this may threaten autonomy in the future model; GM residents still experience unwarranted variation in standards and processes of care including access standards

- the new operating model (including funding flows and accountability) must facilitate the **alignment of incentives** for each organisation and partnership to achieve the locality and GM priorities with **a greater emphasis at each level on reducing health inequalities**

- the new operating model requires **shared priority setting** that balances national and GM; and GM and locality priorities; **shared planning** between neighbourhood, locality and GM levels; **shared 'stewardship' of resources** at whatever level and whichever 'organisational bank' they sit; and **shared accountability** for delivering the key standards and priorities

- new forms of accountability that ends the purchaser provider split and **require care providers to be an integral part of shared leadership arrangements** at all levels

2.0 Proposed Approach - how the new operating model for GM will accelerate delivery of its overarching aim and accelerate the achievement of its priorities

2.1 What needs to be and will be different?

Taking the drivers, the challenges and the design principles emanating from the engagement into account, there is an emerging operating model that crucially builds on the existing system but places much greater emphasis on 6 major programmes of activity and focus -

1) maintaining physical, social and mental well being

- through the use of wider local authority and private sector expenditure (eg housing, jobs, retail, transport, education, police, leisure etc) to deliver the fundamental basics of health and well being - a home, a job and a family/social support system. This should pay particular attention to supporting children young people and families in their early years of life.

- through the NHS and care system building stronger links into the work of the Combined Authority and business community: alignment with the Mayoral programmes and drawing on the Marmot city region work,

- through the strengthening of the role that health and care organisations play as anchor institutions in particular, running a dedicated and shared programme to capitalise on the opportunities of creating employment/apprenticeships (with a heavy accent on D&I policies), local sourced procurement, and leadership of the sector's sustainable energy plans for example,

- each locality, working with its neighbourhoods, building and delivering a plan for community engagement and development through community groups, VCSE, patient groups, carer support

etc. This would align also with the opportunity to invest in community pharmacy, and PCN social prescribing programmes

- allocating resources differentially to individual neighbourhoods to recognise need and designing more accessible services that are culturally sensitive, targeted to reduce health and life inequality and work hand in glove with local welfare, employment and housing services

2) Creating more consistent evidence based preventive and proactive primary care

- GM has some country leading services but has some of the worst life expectancy. This means there should be a much greater focus on primary and proactive care to support the earlier identification and better management of chronic disease.

- The operating model must capitalise on the development of PCNs and structured working at the neighbourhood level. Through these structures there is now a clear opportunity to improve the service offer at this level by investing in programmes to reduce unwarranted variation, develop models of shared care with citizens, extend the use of personal health and care budgeting, train and educate carers, use digital and new forms of remote health and care monitoring

- Using the data (and investing in joined up data systems and software) to identify and stratify risk within the patient population on a real time basis in order to prevent deterioration of patients, hospital admissions and loss of independent living

3) Greater integration of the community based reablement, residential, rehabiliative, palliative and social care services (working to eliminate the traditional divide between hospital and out of hospital services)

- the development of provider alliances within localities can embrace the next stages on the journey to establish integrated community teams aligned to PCNs and neighbourhoods that can manage physical, mental and social health problems by offering holistic services

- using data sharing, streamline assessments, carer training and support, digital home monitoring, social care market management for example to deliver longer periods of independent living and speedier return to employment for GM citizens

4) Coordinating and improving the urgent and emergency care service response by mandating health and care providers to develop more coherent pathways of care and enabling patients to access the right level of care sooner

- using a clinically guided GM wide approach to develop the pathways between the local urgent care services such as GP OOH, 111, A&E and more specialist emergency care (such as for major trauma, HASUs)

- through empowering the Provider Collaborative (PFB) to play a greater role, working closely with the relevant locality/community based organisations and NWAS to organise and deliver a consistent approach to urgent care that ensures the appropriate levels of triage, treatment and transfer across urgent care and emergency sites

- using neighbourhoods and community groups to train more of the population in first aid

- through enabling the use of NWAS insights and data to predict and prevent acute and emergency episodes of care, whilst also targeting resources to known need demographically and geographically

5) Delivering more consistent planned care and delivering the planned care recovery programme

- through using the Provider Collaborative (PFB) to own the system wide planned care recovery programme, operating with a single PTL, as interpreted and delivered by their COO group, The Collaborative would work to access the ERF funding and directly addressing its criteria of targeting health inequalities, offering virtual outpatients, offering effective clinical validation, operating as a single system, and managing staff well being. This would help to deal with the *stock* of patients waiting for diagnosis and treatment

- through joint planning with localities and local provider alliances on managing the *flow* of new patients needing diagnosis and treatment. This might include access to specialist opinion sooner in the pathway, developing models for community diagnostics hubs and greater investment in primary care development

- through expanding a GIRFT or similar approach across GM to reduce unwarranted clinical variation and maximising existing bed and workforce capacity as a consequence. Using clinical networks to share learning and support training or colleagues where necessary.

- through joint service delivery between the constituent hospitals of the collaborative and local integrated community health and social care teams to facilitate discharge from hospital when clinically fit and using virtual wards and remote monitoring to accelerate acute care management and rehabilitation at home

6) Further developing GMS access to and delivery of world class specialised care and building a hugely capable innovation capability in HIM

- GM has a huge opportunity to develop its range and depth of specialised services to attract new investment and staff, in particular in light of the importance of the life sciences sector to a post Brexit UK.

- The work also of HIM is very impressive in comparison to other approaches within the NHS. This is a real asset for encouraging inward investments and partnerships but crucially for enabling the health and care system in GM to adopt leading edge technologies that will enhance the value of the GM pound and support improvements in outcomes for the GM population

- Work to create the first prototype virtual health and care system underpinned by integrated data flows, which would bring together the current range of best in class digitised point solutions into an end to end digitally delivered set of care pathways (from health and lifestyle apps, remote home monitoring, virtual out patients, remote diagnostics, virtual wards, flow management systems and assisted rehabilitation for example)

2.2 The architecture, spatial management and funding flows

2.2.1 General consensus on the architecture and spatial management

GM already has developed an architecture that set the pace for the national model of neighbourhoods, localities/places, provider collaboratives and an ICS (manifest in the HSCP and governance structures). This is well understood and leaders are clear that this architecture should remain the basis of the new operating model.

Equally there has been considerable work done on the spatial level at which service planning and delivery should be organised and undertaken (see appendix 2). In some specialities and conditions, such as mental health, these spatial levels have been taken to a more detailed and granular level with a clear explanation through the mental health THRIVE model for example as to how services and programmes could address the mental health challenge GM faces (appendix 3).

Philosophically this work also aligns with the adopted principle of leaders recognising what needs to be done once, what needs to be done 10 times consistently (ie in each locality) and what needs to be done 10 times on a bespoke basis

Again there is an agreement between leaders that these are evidence based models and should be adopted at the core of the operating model, These form the broad basis to underpin current planning assumptions but should now be taken and the spatial models crystallised with clinical input to gain assurance on the practicalities of managing clinical care pathways and locations to ensure that clinical co-dependencies are not overlooked and crucial services do not get fragmented or weakened as a consequence.

2.2.2 Specific comments on the consistency and detailed expectations of the architecture

There are however more specific thoughts on elements of the architecture and what expectations might be set on the commonality of developing the detailed arrangements

1) neighbourhoods need some form of management structure or group which aligns and builds on the PCN function (ideally PCNs and neighbourhoods would be geographically coterminous)

2) locality structures would feature a consistent locality model operating with -
   - A Locality Board (that can deliver accountability for decisions and budgets at place level) and includes LA political leaders/portfolio holders, and care providers (primary care, MH, social care and acute hospital care) as an integral element of the governance
   - A "place based lead" (accountable person to GM ICS for health and care)
   - An accountability agreement between partners in the locality and GM ICS
   - A mechanism for the priorities to be decided together in the locality and a process for determining consequent financial flows to providers or provider alliances
   - A system of clinical and professional advisory input
   - Provision of an appropriate organisational arrangement for employment of locality based ex CCG staff
   - An articulated relationship with their local Health and Well Being Board (the detail of which would be determined locally)

3) a means by which locally based providers work together in some locally determined form of alliance (but which 'typically' would be expected to include the acute services provider, mental health provider, primary care, neighbourhoods, VCSE, social care services). This alliance should be an integral element of the leadership group and engage fully in shared priority setting, shared planning and delivery of care, shared stewardship of the combined, pooled of aligned resources, and shared accountability for delivering the expected outcomes, They would also need to ensure that the group was informed on recognising the need for financial resilience in provider organisations whilst identifying clinical validated plans for improving the value of healthcare spending as part of any redistribution,

4) Provider Collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care as defined in the spatial model. The governance arrangements must enable the constituent organisations to hold/manage a shared budget and to address the associated shared risks and benefits. These must also support the shared learning and development of their constituent organisations.They would require additional resources and strengthened governance to underpin the Collaboratives' work if they are to manage key programmes of activity.

5) Capability at GM level to discharge the functions, governance and legal requirements of a statutory ICS (as constituted in the forthcoming legislation) whilst being consistent with the existing devolved GM structure and process. The engagement process referenced the need to address and agree the new governance structure at GM level but focused more thinking onto the operating model beneath this level and further work will need to be done on this once a new operating model has been agreed.

6) There will be management capability at GM level to discharge the ICS statutory functions, convene the constituent partners within GM as appropriate and agreed, organise and deliver GMS wide enabling functions and deliver the 'upwards, outwards and downwards' accountability for the agreed GM priorities and expected outcomes

7) A system of joint planning convened at GM level but with constituent localities and collaboratives fully engaged to identify the synergies and connections between allocated resources. This would support the ICS with calibrating allocations and ensure a seamless coherent deliver of programmes (eg connect the work on addressing both the stock and the flow of the planned care programme; join up cancer services delivery with cancer screening etc).

2.2.3 The funding flows of NHS money

There is much less consensus amongst leaders relating to the exact nature of the funding flows other than a very strong agreement that to get added value out of every pound we spend, to get best value out of any new money we have available, and to align any non-health and care spend with the collective pot, there needs to be shared stewardship of the money spent at each level irrespective of with which organisation it is banked.

This principle would apply between organisations in different sectors, between organisations within Collaboratives and between organisations engaged in enabling GM wide programmes.

At one level, this should mean that funding flows are immaterial however in practice there are underlying tensions and fears about the quantum of funding to each level, the alignment of primary care funding, the cohesion of the overall funding streams, the formula for differential allocation of resources against need in a plan to tackle inequalities, and in a few places mistrust of the hosting organisation acting in accordance with the principle.

Some leaders believe that the best and simplest way to allocate resources would be for all the money to go directly to Trusts who are bound by aligned incentive agreements to work collectively. Other leaders believe that the best and simplest way to allocate resources would be for all the money to go to localities with a commitment to pass through money to providers or provider alliances in a manner aimed at achieving local priorities whilst also recognising an agreed level of fixed and semi variable costs. There is also a desire to direct funding to GM wide provider collaboratives for specific programmes of work (in a manner currently operating for mental health specialised care).

Taking all of these issues into account the proposal would be for the operating model to

1) adopt a blended approach to funding flows of NHS money between direct allocation to Trusts, allocation to Collaboratives and to agreed NHS/LA arrangements in localities (and onwards through to local providers or provider alliances) with the exact calibration of quantum to be determined by the ICS NHS Board (as it becomes constituted within the new GM ICS governance structure)

2) recognise and maintain, as a minimum, current arrangements where such money has been pooled with localities on a s75 arrangement. This would also maintain the local level of expenditure from the CCG budgets for community services which would be considered and deployed as part of the Locality Boards stewardship.

3) maintain the current allocation of resources to the acute provider sector, especially in light of the huge backlog of patients waiting for diagnosis and treatment, but direct this through the PFB provider collaborative who would lead the delivery of integrated urgent care, manage the ‘stock’ element of a planned care recovery programme, address unwarranted variation and develop a specific anchor institution programme. This does not preclude providers agreeing through their locality boards to distribute any received resources into another area of the care pathway if they believe it could have a beneficial effect on the value of that resource (eg improving outcomes or managing demand)

4) allocate resources beyond the current level for specialised care to the two MH providers (acting as a specific Collaborative) to deliver the appropriate programmes of care as defined in the THRIVE model (see appendices). It would be important to ensure that any allocation of

resource to MH providers is aligned with other monies being spent in the locality in order to ensure that MH is an integral part of leadership boards or as an equal partner in any provider alliance groupings. This will enable them to work with other partners to deliver the benefits of holistic care and MH well being activity. In order to ensure the delivery of the LTP MH commitments, MH funding should meet the investment standards and given GM's history of underfunding against national benchmarks, with a strong steer to increase the levels of MH funding as a percentage of the total spend,

5) Locality leadership boards should allocate or delegate a shadow budget to each neighbourhood which could then be aligned by the neighbourhood management team with PCN and GMS funding.

6) The absolute quantum of primary care funding must be maintained as a minimum but there should be facility within the Locality Boards, (within which primary care would be an equal partner), to steer the specific activity and requirements placed on primary care practitioners by the locally determined primary care budgets (eg LES schemes etc - as opposed to nationally determined contractual requirements) in order to align these with the delivery of locally agreed neighbourhood objectives. If the neighbourhood is successful, in particular in managing demand and maintaining healthy communities, then there should be scope for additional investment and reward to create a virtual cycle of delivering improvement.

7) There should be an agreement on the establishment and funding for GM wide enabling programmes that would encompass functions such as Health Innovation Manchester, PCB GP Excellence programme, population health management, OD support, Information Management and technology, data and business intelligence, People and HR, estates (this is not an exhaustive list) and whether these are delivered by GMICS directly employed staff or Collaboratives, or by a lead organisation/locality on behalf of GM. Again the national guidance and spatial models indicate the programmes that should be organised on a GM basis but it is essential that these are tested against the principle of adding value and that constituent parties are confident of their delivery.

8) Allocation of money needs to be accompanied by deployment of staffing and the opportunity of reform means that there is a pool of people who could be effectively redeployed fo support the delivery of the new operating model. Once the model has been agreed there needs to be a clear programme to redeploy staff and budgets to the appropriate level or organisation in the GM system

3. Clinical Engagement

The reform of the system and the creation of a new operating model only makes sense if it is seen as enabling clinicians, professionals and practitioners to redesign care and to develop shared models of citizen engagement in health and care. There is a risk that the technocratic description of a new operating model will not signal the value or intent, and would be likely to pass most of our key staff by.

Therefore, it is essential that this work is

- aligned with the work of Tom Tasker on how to build clinical and professional engagement

- subject to a substantial communications and engagement exercise to explain the new opportunities and how GM is tending to accelerate its achievements of its aims and priorities

4) Establishing a new accountability process and culture

There is a real appetite amongst leaders to create a new process built on shared accountability, peer support and review, and performance improvement rather than old style performance management.

In order to achieve this, there will need to be a process through Locality and Collaborative Accountability Agreements for delivering the key GM, locality and programme objectives. The integrating care white paper signals the concept of earned autonomy but based on the consultation, the GM model might feature a greater focus on self assessment triggering support.

The crucial element is that locality boards providers of services (through alliances or collaboratives) are an integral element of the ICS and therefore accountability is to each other and not to a hierarchically positioned higher tier authority or agency. In parallel however, the ICS will need fo account to the NHS England Region for its achievements against national objectives and priorities and this requires collective ownership by all GM organisations also.

The GM operating model would feature

- a core principle of shared accountability (rather than a pure organisational focus), which could be manifest in Joint Committees, Committees in Common or aligned incentive contacts for example

- accountability agreements with NHS England with the potential of mirroring those in agreements with locality boards and provider collaboratives

- organisational contributions to the alliance or collective, governed appropriately and effectively as now by NED majority boards

- peer review and support

- escalation triggers in the event of failure to deliver within the agreement which would be agreed and reported with a view to securing help to recover

- light touch data reporting and monitoring against key priorities (sufficient however to allow the GM ICS to report upwards on key national priorities)

- an emphasis on continuous learning and development aligned to a people and talent management strategy

5) Establishing an OD programme

There is a very clear consensus that to make the new operating model work effectively will require a substantial programme of organisational development. This should work on establishing the capability and capacity to operate collaboratively as leaders and can focus its work on

- individual leaders including citizens as community leaders, GP and professional representatives

- groups such as joint committees, collaborative boards, PCNs, neighbourhood groups, locality boards and the GM board(s)

- individual boards

- system wide leadership groups that undertake key work programmes,

The OD programme would build on but enhance existing work and will require major investment

Leaders were clear that whatever the architecture it will be leadership behaviours and conduct, coupled with the ability of organisations to adjust their mindsets to a system orientation. The programme will include all four areas of managerial, clinical, political, non executive and professional leaders

6) Time frame for adoption and next steps

There is a widespread view that leaders want to see some momentum to adopt a new operating model as soon as possible. This would allow new locality and Provider Collaborative arrangements to be put into place or confirmed, if building on existing structures. There are however a number of areas of work in the operating model that haven't been addressed fully and need to be undertaken -

1) work on the precise nature of the GM ICS governance structure - how does the white paper impact on the current governance and how will the new structures discharge the national legally required functions? There is a need to do this work quickly in order to build confidence that the key roles of the ICS in particular, relating to priority setting and allocations are being discharged as a shared enterprise, with localities and providers an integral element of that

2) work to agree/confirm the GM enabling functions and their programme management

3) establishment of a wider task and finish group including clinical leaders to crystallise the spatial model using the technology of the THRIVE model to set out the planning levels for a number of key services such as the elements of the cancer and urgent care pathways

4) once the model is agreed there should be a dedicated programme management approach set up to ensure the model is implemented effectively and to the expected time frames

5) work on the detailed impact of the financial flows section of this paper to consider how best to create a simplified set of financial processes. This should be augmented by the use of financial modelling to allow leaders to understand and adjust for the consequences of sector and organisational investments, in particular to assess their impact and return in terms of value to the whole system.

Mike Farrar CBE, FRCGP, FRCP (April 2021)

Appendices

1) **GMHSCP spatial model**

2) **Carnall Farrar spatial model for planning and delivery**

3) **West Yorkshire ideological spatial model**

4) **GM design principles**

5) **Mental health THRIVE model**

Emerging spatial levels for integrated commissioning and provision

Local Planning & Decision	GM Planning & Decision for Local planning & delivery	Sub GM Planning & Decision	GM Planning & Decision
Community Services inc MH & LD Adult & Child Social Care Intermediate Care. Individual placements. Children's H&WB CAMHS. IAPT GMS, GP Extended & OOH's PCCA, Social Px.	Medicines oversight & optimisation Community mental health. G&A NEL's Maternity	?CYP ED services Mental health community services ?LD	MH Inpatients Intensive care. Cancer services GM Specialised commissioning Critical Care NHS111 NWAS G&A Electives Screening, IMMS ,

CRITIRIA

Local

Locality is the default location for the planning, design and delivery of services. This is matched by the related authority, resources and responsibility. Local decisions should take account of impacts in neighbouring geographies or at higher spatial levels.

Localities can individually determine whether to delegate to neighbourhood and/or collaborate with other localities at a sub-GM level.

Pathway designed to local need.

Local decisions should take account of impacts in neighbouring geographies or at higher spatial levels

GM / Sub GM Level

- National mandate
- Low volumes, little differentiation in service requirements between populations, significant cross boundary population flows
- Resilience of workforce, estate, equipment which cannot be achieved at a locality level.
- Integration opportunities with other GM led services
- Improved outcomes/experience or reduced clinical risks
- Value for money
- Downside risk is not greater than benefits

Ability to account for local variations

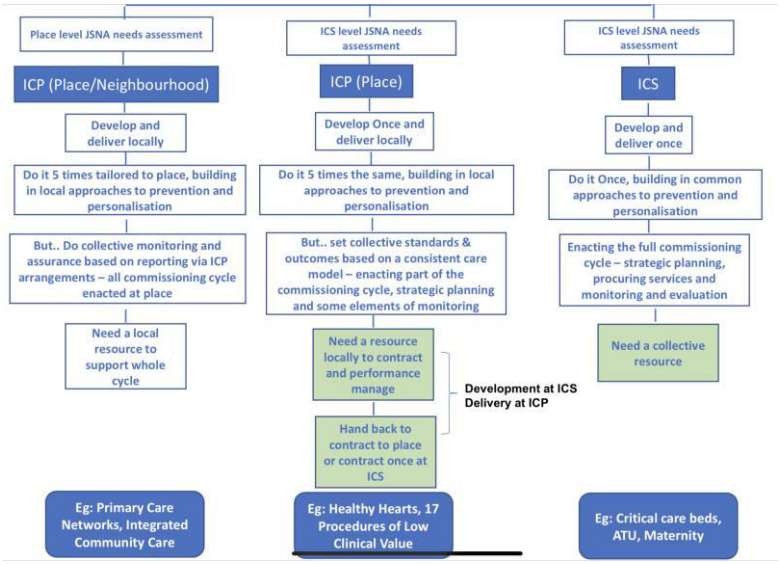
GM decisions should take account of impacts within Localities

We have also aligned on an emerging proposition for the optimal scope of services to be delivered by Local Delivery Collaboratives and GM Collaboratives (delivery)

Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality							
• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Maternity community • Paediatric Outpatients	• Ambulance Services - emergency • Patient Transport
• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• General & Acute planned care (adults) • All planned and urgent & emergency specialised services, including: Major Trauma, Critical Care, Paediatric Intensive Care, NICU Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	
GM ICS							

We have aligned on an emerging proposition for the optimal scope of services under the remit of the Locality and GM partnerships (planning)

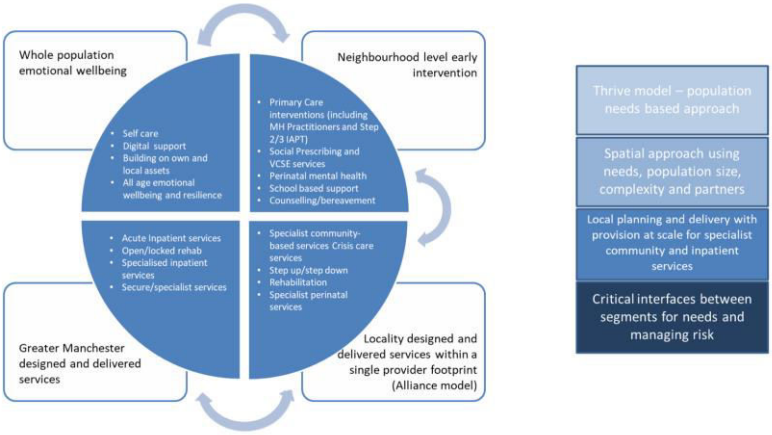
Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality							
• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Maternity community • Paediatric Outpatients	• Ambulance Services - emergency • Patient Transport
• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• General & Acute planned care (adults) • All planned and urgent & emergency specialised services, including: Major Trauma, Critical Care, Paediatric Intensive Care, NICU Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	
GM ICS							



A GREATER MANCHESTER APPROACH TO IMPLEMENTATION

- Change is **done with, not to**, people.
- We adopt **an asset-based approach** that recognises and builds on what individuals, families and our communities can achieve rather than focusing on what they lack.
- We encourage behaviour change in our communities that **builds independence** and supports residents to be in control.
- A **place-based approach** redefines services and puts people, families and communities at their heart
- Improving health requires **action on the social determinants** alongside the delivery of clinical care.
- Bringing those contributions together in **neighbourhoods with proactive primary care supported through PCNs**
- **Collaborating at scale** across Greater Manchester to deliver consistent standards of care.
- We expect to be **a place which innovates** and connecting our Universities, healthcare providers and industry base, through Health Innovation Manchester (HInM) to deliver at pace.
- Our entire system understands its **contribution to local economic potential** and the role individual organisations can make to growth and an inclusive economy.

Spatial level for design and delivery of all age mental health and emotional wellbeing services



GM – More than and ICS…. Next Steps

Following the presentation of the report from Mike Farrar to Partnership Executive Board on 30th April on the work undertaken to get us to the next stage in the development of an operating model for Greater Manchester (GM) and building on our first five years as a devolved system, the emerging programme plan has been updated and some of the more detailed work now required set out for agreement by the system.

There are areas of work that are well understood and progressing at pace – key elements of the People, Culture and Communications programme for example. Other aspects are only just getting off the ground or require further definition.

The recommendations in Mike Farrar's paper that need further clarification and development and need to take priority in resolution include:

- Finance
- Spatial Levels
- Locality approach
- Provider Collaborative
- GM Governance
- OD

Finance

FAC and FLG will take the lead in this work and will develop and recommend an approach to financial flows. Mike Farrar will work with both groups to develop final recommendations. It is acknowledged that the approach may need to evolve over the next two years, so although it needs to be ambitious, it is likely to be relatively simple initially as we move into system working.

Spatial Levels Analysis

As discussed at the workshops in April, agreeing where both planning and delivery of services will take place needs to be worked through in more detail. The model used by mental health which adopted the Thrive model will be used as the basis of the in-depth work which alongside spatial level, will need to set out how the agreed model will be delivered, by whom with what governance. The work will be co-ordinated by Mel McGuiness, Director of Commissioning from Bolton, and draw on provider, commissioner and primary care leaders to undertake the detailed work.

Alongside specific services, broader priorities will need to be looked at within a tight timescale. First priorities include:

- Urgent and emergency care
- Planned Care – both recovery and areas of concern eg breast services
- Mental Health

Locality Approach

Having agreed the key characteristics of locality working, each locality now needs to share their plans against the framework broadly articulated in Mike Farrar's paper.

- place-based leader – how will delegated responsibility be managed
- locality board – proposed role and form
- holding pooled budgets – who will act as 'banker'

- Relationship with GM ICS – how does the locality see accountability agreements working
- How will clinical and professional expertise be built into locality working and decision making

Provider Collaborative

Although GM is advanced in provider co-operation and working arrangements with Provider Federation Board bringing together acute and mental health trusts and linked to Local Care Organisations, the concept of a provider collaborative takes this model further. The GM Collaborative will require formal governance, the ability to manage a shared budget and take on formal accountability for delivery. PFB are working with Mike Farrar to develop their approach and will need to set this out as part of the GM Operating Model.

CCG Functions

If legislation is passed as intended, the 10 GM CCGs will cease at the end of March. All statutory accountabilities will need to be transferred to successor organisations and this technical piece of work needs to be undertaken consistently across all 10 organisations. Su Long is leading this work and will be running a workshop with key leads from across the CCGs, Shared Service and Partnership to get this underway.

GM Level Governance

The workshops helped take us further forward in agreeing a GM Operating model and ensured important engagement with stakeholders, but they did not come to any view on how we will work together at a GM level, the relationship between the ICS Team, Provider Collaborative, Combined Authority and other GM groups like Health Innovation Manchester and the VCSE. The supporting GM level governance (Partnership and ICS NHS Board) and relationship with localities needs to be worked through. Mike Farrar will be working with us to complete this work.

Organisational Development

A strong theme emerging from the workshops was the need to develop new ways of working, establishing a culture of trust and mutual support and strong engagement with stakeholders and the public.

Again, working with Mike Farrar and using the expertise we have in GM, we will develop a programme to support our move to shadow arrangements and final changes in April 21.

Timescales

GM will need submit set out our operating model and plan for implementation to the Region at the end of June. This will require focused activity to answer some of these more challenging questions.

By the 11th June we need to have a broad outline of the work completed allowing the second half of the month to bring all aspects together into one overall model and socialise with stakeholders.

Leads will need to develop a detailed timetable for each aspect of the work to pull into the programme plan.

Programme Oversight

The programme will run across the whole of 2021-22. As set out, the immediate focus will be on completing the work on the operating model with focus turning to implementation in the second half of the year when the Bill receives Royal Assent.

The programme plan will be developed further and support from the PMO team at the Partnership will provide the co-ordination of monitoring information and reporting required to ensure progress against the timetable.

A programme board will be established to oversee the work, chaired by the SRO.

Sarah Price, 13 May 2021