NEXT STEPS IN PROGRESSING THE LOCALITY APPROACH IN THE GM ICS

Context

1. Colleagues have raised concerns that the ICS transition programme presents itself as incredibly complex and is able to be tracked and understood by too few people. That is a risk to the model overall if it doesn't achieve the simplicity for colleagues to lead, shape and participate effectively.

2. The true headlines of the GM ICS transition can be simplified as improving the health and wellbeing of all the residents of Greater Manchester and achieving equity through our work to:
   - **Complete the journey to place based working** – refresh the locality plans; confirm the approach to local governance and place and neighbourhood based provider collaboration; provide clarity to locally deployed staff.
   - **Create a new model of GM collaboration** – achieve a mature system governance model built on districts and GM functions operating to confirmed common purpose; achieve empowered provider collaboration; improve our approach to delivery and the execution of standards; establish shared capacity to connect the system
   - **Enable the transformation** – developing the population health system; secure the methods to deliver innovation and digital and data transformation; support and develop our people and culture building an inclusive and equality based workforce; confirm the financial framework; and maximise the best use of public estate.

3. GM has spent 5 years travelling in this direction and the destination has not changed although we have learned lessons along the way and have challenged ourselves when we haven't made the progress we would have wished. It is critical to bring that learning and clarity to the model and to recognise that the development of that model is completing a journey in GM and not starting one. We can confirm how much of that journey has already been completed; how much is actually enabled by the Bill; how much remains to be done; what of that work must be completed before April 2022; and what, of that remaining work, should be the focus for the period beyond April 2022.

4. That doesn't mean no change of course. We retain our belief in place based working, delivery and connection in neighbourhoods, integrating public service and bringing resources together in the interests of residents we jointly serve. The ways we do that will develop. As CCGs go and those commissioning skills informing population health approaches will be more connected to providers, and PCNs, to social care and wider public services. Boundaries between providers will reduce as colleagues collaborate in neighbourhoods and localities and across GM. We will tackle unwarranted variation, but not through unnecessary and distant centralisation, but by concerted action driven by common purpose and the commitment to common standards.

5. This note suggests some tangible developmental steps aiming to bring greater clarity to the locality approach in particular. It was initiated through wider discussion with existing accountable place leads at Director and Chief Officer level. It recognises, however, the context of parallel discussions relating to the governance of the model, the spatial levels considerations and the development of the GM level model. To that end further discussion with colleagues through the Transition Programme Board, Primary Care Board, Provider

Federation Board and the LCO Chief Officers network will be essential in helping progress the actions suggested here so this note can developing into a way forward for the full ICS system as a whole.

Confirming what we have already agreed

6. We are clear on the architecture:

The Locality Model

locality structures would feature a consistent locality model operating with -

- **A neighbourhood approach** with integrated working, connecting to PCNs and to communities and the full range of local partners
- **A Locality Board** (that can deliver accountability for decisions and budgets at place level) and includes civic, clinical, care professional, provider and VCSE partners as an integral element of the governance
- A "**place based lead**" (accountable person to GM ICS for health and care)
- Appropriate **accountability agreements** between partners in the locality and clear **delegations** to enable place based delivery
- 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 care professional leadership** input
- Provision of an appropriate organisational arrangement for the **deployment of locality based ex CCG staff**
- An articulated **relationship with their local Health and Well Being Board**
- 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, general practice and wider primary care, community services, VCSE, social care providers). 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.

The GM Arrangements

GM collaboration would similarly confirm clear features including:

- **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.
- 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.

- 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
- 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).

7. The outputs of the work to date and the headlines from the spatial levels work appears to confirm that perhaps 80% of the actions and approach are clear and broadly agreed. This should be affirmed to allow us to apply early certainty on the scope of place based working, people deployment and headline funding flows. If we can isolate the 20% specific focus and attention can be given to it whilst mainstream developments are able to be progressed.

Taking a bottom up approach

8. In developing Taking Charge we took an early decision to develop Locality Plans and deliberately avoided seeking to overlay a GM blueprint. These plans were developed by health and local government working together in each of our ten districts and were the bedrock of GM Health and Care Strategy and of the devolution Memorandum of Understanding.
9. We have neighbourhood models, underpinned by local care organisations or other provider alliances and supported by integrated governance and pooled resources in all ten districts. They are developed to different degrees but they exist.
10. Each locality has been refreshing and updating its locality plans in the context their integration journey to date, learning from the pandemic and ambitions for the future. These represent key opportunities to inform the detail of the locality approach
11. **We should invite updated and refreshed locality plans from each locality and look to have them confirmed by the end of August. The brief for that task should be co-designed with local leads and should facilitate and inform alignment with GM recovery plans and longer term strategic planning objectives**. Those plans should confirm the operating model for each Place covering:
    - Their vision and objectives and approach to transforming the health of their residents
    - The organisation of integrated delivery through the local care organisation or provider alliance
    - How this operates at the neighbourhood level
    - How it will be governed through the local system Board
    - Their model of leadership and capability building in the triumvirate of political, clinical and provider leadership with officer support
    - The model of public engagement and participation
    - The approach to achieving equity and inclusion

- How it will lead in meeting the key challenges we have already recognised:
  - Creating and improving health – tackling the social determinants, addressing inequality, inspiring and supporting community action
  - Creating more consistent evidence based preventive and proactive primary care
  - Completing the integration of services and removing the historic barriers between primary, social, community, VCSE and secondary care services, across physical and mental health
  - Addressing variation in standards, access and quality of care

- How it will collaborate to support transformation across GM
  - Coordinating and improving the urgent and emergency care service response
  - Delivering more consistent planned care and delivering the planned care recovery programme
  - Further developing GM's access to and delivery of world class specialised care and building a hugely capable innovation capability in HIM
  - Development of its approach to equity and inclusion

12. It feels essential to have, right now, a clear and confirmed leadership constituency to drive the locality approach. For the process of transition that should relate to those with responsibility for:
    - The interim, immediate: who is responsible for the wind down of the CCG, transfer of CCG staff and functions
    - The interim, immediate: who is responsible for
        a. reporting the locality Transition arrangements and progress into GM
        b. being linked into the GM transition work via the GM ICS transition Board - and report back to the respective locality Transition Board.

Recognising dependencies whilst maximising clarity for localities and their teams

13. We should avoid being hamstrung by details which may still need to be clarified and act according to where broad certainty is already available. We should immediately utilise the significant areas of consensus already evident from the spatial levels work and apply that agreement to bring greater certainty to the scope of place based working. this is necessary in 2 key areas:
    - **People**
      - **We should confirm and communicate the expectation that CCG staff will transfer employment to the GM ICS and that the bulk of CCG staff (including those in joint roles with the Council and those in SLAs) will be deployed back to the locality**.
      - **We should recognise the 10 accountable leads for transition leads immediately and work with them on <u>all</u> aspects of the locality approach**.
      - **We should invite those locality leads to work with local provider partners and local authority partners to support deployment to appropriate place based roles.**
      - **For those colleagues supporting, or proposed to support GM functions the H&SCP and GMSS should work with PFB, PCB, GMCA and the LCO network to confirm shadow deployment arrangements from 1 October and begin to run the system in a way that we expect it to operate next year**
      - There will be some exceptions to that, although they will be the minority and will be identified in the spatial planning work. The exceptions will largely to be determined

by the work on 'spatial levels' currently being developed – where it is recognised that for a relatively small number of services and functions the correct spatial level for planning, and sometimes delivery, will be a GM wide footprint, either as part of the ICS itself or as part of the Provider Federation Board.

- Where staff are deployed back in the locality there is not intended to be any organisation change that moves us backwards from our integrated arrangements. We would broadly expect that where there are currently integrated functions between councils and CCGs and many would continue. And we would expect each locality to be developing the work of its integrated provider/LCO/place based provider collaborative – a characteristic of which is that it brings together providers from a range of organisations and they work together as if one team even where there employing organisation is different. Partners in localities will work together to secure alignment in the deployment of teams in line with their shared objectives in the locality plan
- Different localities in GM are developing slightly different models of provider collaboration – for example where lead provider organisations are taking on employment of what is currently CCG expertise. There is no expectation that these arrangements are in place from 1/4/22, although they may be in some places as determined within localities.
- For many current staff in CCGs across the conurbation, the work in building partnerships and transforming services will feel very similar on 1/4/22 to that of 31/3/21.

- **Resources**
  - We should confirm the headlines of the spatial levels work to confirm the NHS services to be planned and coordinated at place and support transparency on the spending made at place level.
  - The flow of money associated with the bulk of current resources associated with CCG staff costs should continue to flow into the purview of the locality board. The exceptions, again, will be identified in the spatial planning work
  - The locality board is where NHS partners and the local authority are meeting and together holding a large pooled budget for the district which as at least the size of the current section 75 agreement.
  - We would expect any variation from previous CCG budgets is by exception and able to be explained (for example because it is collectively agreed that it relates to functions and services delivered once across GM).

Summary of proposed actions

A. **We should confirm the expectation that CCG staff will transfer employment to the GM ICS and that the bulk of CCG staff will be deployed back to the locality. Where that is not the case we should confirm that quickly.**
B. **We should recognise the 10 locality leads for transition immediately, recognising the existing accountabilities for 2021-2022, and work with and through them on <u>all</u> aspects of the locality approach.**
C. **We should invite those locality leads to work with local provider partners and local authority partners to support deployment to appropriate place based roles.**
D. **For those colleagues supporting, or proposed to support GM functions the H&SCP and GMSS should work with PFB, PCB, GMCA and the LCO network to confirm shadow**

deployment arrangements from 1 October and begin to run the system in a way that we expect it to operate next year

E. **We should invite updated and refreshed locality plans from each locality and look to have them confirmed by the end of August. The brief for that task should be co-designed with local leads and should facilitate and inform alignment with GM recovery plans and longer term strategic planning objectives.**
F. **We set a timeline for shadow locality Boards to be in place by 1 October**
G. **We should confirm the headlines of the spatial levels work to confirm the services to be planned and coordinated at place and support transparency on the spending made at place level**

WARREN HEPPOLETTE

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