SUMMARY OF REPORT:

The paper provides an update on activities to inform the approach taken in Greater Manchester to the development of the ICS and a summary of the immediate next steps. It follows the presentation and paper provided to the Board in March which placed the ICS developments in the context of our work as a Partnership since 2016 and the work during summer and Autumn to consider our Future Direction as a Partnership. The paper summarises the output from recent workshops involving colleagues across the Partnership.

KEY MESSAGES:

The approach to developing the statutory Integrated Care System for Greater Manchester builds on the ways we have been working since the devolution agreement was signed with Government and NHS England in February 2015. The national documents intend to solidify and ensure we build on the integration and improved collaboration we, and others, have developed over the past five years.

For Greater Manchester therefore, the national proposals can be seen to represent a midpoint in a ten year journey towards integrated health and social care delivered through place based partnerships connected to neighbourhoods and communities and mature system wide collaboration building on decades of joint working.

It is important that we reflect this history in our approach to developing as an ICS and state those key beliefs that will inform the model we implement. At its last meeting the Board agreed the principles and approach to ICS development which built on our work over recent years and the activities over recent months to refresh that model in the light of our own review and the details of the NHSEI integrated care intentions and White Paper.
Since the previous meeting approximately 150 colleagues, spanning localities, organisations and sectors, engaged in a series of 4 workshops. The workshops sought to consider in depth the themes identified in the last update to this Board which were highlighted as central to ICS design:

- Ensuring the right functions and activities take place at the right spatial level (whether neighbourhood, place or pan-GM);
- Establishing appropriate mechanisms for resource allocations;
- Incorporating and supporting clinical and care professional leadership at all levels and across all activities; and
- Developing proposals for governance supporting the connections between neighbourhood, locality and GM working.

Progress was made in clarifying the approaches to GM and locality level functions and activities. Areas for further development and next steps were identified, including the approach to the allocation of funds and the nature of the GM ICS governance structure.

PURPOSE OF REPORT:

The report is intended to provide an update to the Board on ICS development activities since the last meeting and confirm the next steps.

RECOMMENDATIONS:

The Greater Manchester Health & Care Board is asked to consider the report and:

I. Support the design principles for the new operating model;

II. Discuss the proposal the 6 major programmes to help realise the ambitions for GM set out in section 2.2; and

III. Confirm the next steps set out in section 3.

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INTRODUCTION

1.0  INTRODUCTION

1.1. A series of engagement events took place in April to explore a number of different areas as part of the work to create an operating model for the Partnership’s future, taking account of the new statutory arrangements due to be set out in legislation in June.

1.2. The four areas, which we set out in the last briefing on 29 March were:

(i) **What spatial level to plan and decide services?**
    This will help develop proposals for which functions and services are best placed and developed at place or GM level

(ii) **How will NHS resources be allocated from 2022/23?**
    This will help ensure the continuation of place-based pooled budgets and support the development of our provider collaboratives

(iii) **Clinical and care professional leadership**
    This will inform proposals for the development and transition of clinical and care professional leadership

(iv) **Locality and GM working**
    To develop options on the way localities will work with the GM ICS in future, including working arrangements for the ICS Partnership Board and an NHS ICS Board

1.3. The sessions helped confirm our design principles and agree the key programmes to focus on going forward, to build on the existing GM approach, as well as the updated vision and objectives agreed by the Health and Care Board in March.

1.4. Feedback on those sessions and proposed next steps have been presented in a report to Partnership Executive Board, summarised below.

WORKSHOP OUTPUTS

2.0  WORKSHOP OUTPUTS

2.1. Design Principles

2.1.1. The principles of the Partnership and the way we work have been reaffirmed in the earlier stages of this process. However, a subset of design principles for the new model which build on our progress to date, but challenge us in relation to our continued development were proposed:

- 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 neighbourhood, 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

2.2. Confirming what needs to be different

2.2.1. 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:

- maintaining physical, social and mental well being

  ✓ Delivering 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. It will support alignment with the Mayoral programmes and draw on the Marmot city region and population health system work.

  ✓ It will build on assets and approaches developed over a number of years utilising partnerships with the Centre for Better Ageing to support Age Friendly ambitions; the Tripartite agreement with the Combined Authority and GM Housing Providers to support better homes, neighbourhoods and health; partnerships with Sport England through GM Moving and the ambitions to increase physical activity; and tackling worklessness and supporting good work through Working Well and the Good Employer Charter.

  ✓ Strengthening the role that health and care organisations play as anchor institutions. Capitalising 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.

- 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.

- **Creating more consistent evidence based preventive and proactive primary care**

- Improving healthy life expectancy through a much greater focus on primary and proactive care to support the earlier identification and better management of chronic disease.

- Capitalising on the development of the neighbourhood model and PCNs and structured working at the neighbourhood level. 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.

- **Greater integration of the community based reablement, residential, rehabilitative, palliative and social care services.**

- Building on 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.
Recognising and building on the Adult Social Care transformation progressed in recent years through models such as Living Well at Home.

- **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)
  
  - Empowering the Provider Collaboratives to play a greater role, working closely with the relevant locality/community based organisations across health & care and the VCSE 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
  
  - 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

- **Delivering more consistent planned care and delivering the planned care recovery programme**

  - Utilising Provider Collaboration to own the system wide planned care recovery programme. 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, primary care 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

  - Expanding a Getting It Right First Time (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

- **Further developing GMS access to and delivery of world class specialised care and building a hugely capable innovation capability in Health Innovation Manchester (HIM)**

✓ Developing GM’s 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.

✓ Utilising HIM as an 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).

2.3 Proposals for locality & GM structures

**GM structures**

- Provider Collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care. The governance arrangements need to enable the organisations to hold/manage a shared budget and to address the associated shared risks and benefits.

- Capability at GM level to discharge the functions, governance and legal requirements of a statutory Integrated Care System whilst being consistent with the existing devolved GM structure and process.

- Management capability at GM level to deliver GM-wide enabling functions and deliver the ‘upwards, outwards and downwards’ accountability for the agreed GM priorities and expected outcomes.

- A system of joint planning at GM level but with localities and collaboratives fully engaged to identify the connections between plans.
Locality structures

It is proposed that locality structures will feature a consistent model operating with:

- A Locality Board bringing together all the partners in the place across local government, NHS providers across primary, community, acute and mental health care, and the VCSE to drive integration and health benefit in neighbourhoods and across localities.
- An ICS ‘Local Lead’
- An accountability agreement between partners in the locality and GM ICS
- A mechanism for the priorities to be decided together in the locality
- A system of clinical and care professional advisory input
- An integrated neighbourhood delivery model joining up with wider public services and the VCSE.
- Appropriate structures to support local CCG staff continuing to work in the locality.
- An agreed relationship with the local Health and Wellbeing Board
- A means by which locally based providers work together in a locally determined form of Alliance. This alliance should be an integral element of the locality leadership group.

2.4 Areas Confirmed for Further Work

The workshops identified a set of tasks where either further work, or the conclusion of work already underway was relevant:

- The financial flows within the new model at both GM and locality level have been highlighted as an area for further development and this will be explored as a priority in the coming weeks.
- Outline the new GM ICS governance structure, considering how the Government’s White Paper impacts current governance.
- Build on the clinical and care professional engagement to date to enable clinicians, professionals and practitioners to redesign care and to develop shared models of public engagement as part of the new model.
- Ensure collaborative leadership is a key part of the new model, which will require a substantial programme of organisational development.

The approach to these is set out in the next steps below.
3.0 NEXT STEPS

3.1 Responding to the outputs from the workshops and the confirmation of the work 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.

3.2 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 areas that need further clarification and development and need to take priority in resolution include:

i. **Finance** – to develop and recommend an approach to financial flows covering:
   - Pooled budgets at locality level
   - Acute provider sector funding through the provider collaborative
   - Mental health funding
   - Neighbourhood budgets
   - Primary care funding

ii. **Spatial Levels** - The model used by mental health which adopted the Thrive framework will be used as the basis of the in-depth work to set out how the agreed model will be delivered, by whom with what governance. 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

iii. **Locality approach** - Having agreed the key characteristics of locality working, each locality now needs to share their plans against the framework broadly articulated through the workshops:
   - place-based lead – how will delegated responsibility be managed
   - locality board – proposed role and form
   - Place based provider collaborative/alliance or LCO
   - Joint management of the pooled budget and the role of the host partner
   - 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
iv. **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 the Primary Care Board, and the link 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. Providers are developing their approach and will need to set this out as part of the GM Operating Model.

The Spatial Levels work will inform and clarify the respective roles and overlaps between the GM collaboratives and place based provider collaboratives or alliances.

v. **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.

vi. **GM 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.

vii. **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. We will develop a programme to support our move to shadow arrangements and final changes in April 22.

viii. **Clinical and Care Professional Leadership** - The workshops recognised parallel work already in progress to develop proposals to ensure clinical and care professional leadership was an embedded feature at all levels of the ICS. The proposals developed through a representative network of clinical and care professionals are coming together and being tested through respective networks in May before coming through broader governance in June.

### 3.3 Timescales

GM will need to 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.

Agreement of the final model will need to be made by partners at the Health and Care Board. The Partnership Executive Board will receive reports on progress from the SRO and make final recommendations to the Health and Care Board.

3.4 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.

4.0 RECOMMENDATIONS

The Greater Manchester Health & Care Board is asked to consider the report and:

I. Support the design principles for the new operating model;

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