GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Shadow Joint Planning & Delivery Committee

Date: 22 December 2021

Subject: GM ICS – Implementing the Operating Model

Report of: Sarah Price, Interim Chief Officer on behalf of GMHSCP Core Leadership Group

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PURPOSE OF REPORT:

The Core Group were asked to work with Mike Farrar on making recommendations to JPDC on how to finalise some of the outstanding issues for implementing the GM operating model. The paper emerging from that work is attached.

Importantly, the paper recognises all the work done since the agreement of the operating model in July 2021 and then signals 5 areas (described as integrating processes) that have yet to be resolved. These cover -

- creating a simple narrative
- finalising governance and constitution
- financial flows
- assuring locality structures
- running costs and deployment of CCG/GMHSCP staff

There are detailed recommendations in each of these areas for JPDC to consider. However, it is very easy to get lost in the details and forget that GM is trying to create an ICS that ***transforms*** rather than simply ***manages*** the system (in doing so it will need to consider how it manages the likelihood of a strong expectation from NHS England that the ICS will be an effective system manager arguably first and foremost).

As a consequence, JPDC needs to consider these recommendations in the context of whether these final areas i*n addition* to those already agreed will deliver the transformation that GM committed to in the summer. So, the tests would be:

- Is JPDC confident that with these arrangements GM will now be able deliver the six transformation programmes set out in the operating model? i.e:

  ✓ have a systematic process for empowering citizens in communities and neighbourhoods

- ✓ will this enable localities and PCNs to reduce unwarranted clinical variation in primary care
- ✓ will this allow locality boards to create place based arrangements that integrate care for those citizens with greatest needs, reduce hospitalisation and help maintain them living independently
- ✓ will this empower providers to coordinate and improve the urgent care response (and meet national standards)
- ✓ will this empower providers to take responsibility for delivering the elective recovery programme within the finite resources available (and meet national standards)
- ✓ will this allow GM to fulfil its potential as a national centre for innovation and specialised care

- And do the arrangements create

  - ✓ the appropriate culture of joint NHS/LA working; clinical and care professional empowerment; joint working with VCSE and citizens
  - ✓ the ability to use existing health and care budgets to better effect and bend non health and care budgets to achieve a health and care dividend

REQUESTS OF JPDC:

The JPDC is asked to:

- Consider the proposals as described in the paper
- Approve the proposals as set out

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GM ICS - Implementing the Operating Model

Context

Constituent organisations in GM agreed an operating model and governance arrangements in summer 2021 with a view to their implementation by April 2022. GM is committed to implementing a model that is true to

- the **devolution agreement and intrinsic ambition** for improvements in the GM public's health and care
- the **national legislative requirements**
- the **agreed operating principles** (shared priority setting, shared planning, shared stewardship of resources, shared accountability), that also include **clarity and simplicity** of approach in order to enable neighbourhoods, localities, provider collaboratives and GM programmes to operate coherently with a shared mission and purpose. Crucially the implementation of the operating model needs to be focused on **system transformation** not simply a reinvention of system management

The purpose of this paper

- This paper **recognises and identifies the work that has been done since Summer** on building strong component elements of the model and also highlights a number of means by which these components are beginning to work together in a coherent and effective way.

- It provides further clarity on implementing the operating model and **we recommend actions on five integrating processes** that are essential for the GM system to capitalise on these components and deliver its aims and objectives -

1. Creating a simple narrative as to how this new system will work
2. Finalising ICB and ICP governance and priority setting
3. Agreeing Financial Flows and Responsibilities
4. Signing off Locality Leadership Arrangements
5. Agreeing Running Cost Allocations and deploying staff within the national HR framework

- **It recommends how the operating model should be initiated and delivered in the next twelve months** with the direction of travel clear for the 3-5 years.

What has been achieved since Summer 2021

Established Component Elements

A number of key components elements were agreed and developed throughout year since the operating model was signed off -

GM has agreed and now has strong platform of governance that is consistent with the ethos of partnership.

GM has created a clear expectation and framework within which the 10 localities have developed their approach to place based working. There is further work to be done on the balance of consistency and local variability of approach (see point 4 of the integrating functions)

GM has created the opportunity of intelligent deployment of resources by previously establishing, and now consolidating, country leading collaborative approaches in specialist, secondary, primary,

mental and physical health services through PFB and PCB, VCSE and neighbourhood working, with sector led, system wide development work on adult and children's social care

GM has built a platform for establishing strong neighbourhood working, with a formal GM wide Accord with the VCSE and national exemplars of working with citizens as assets in localities (eg Wigan)

GM has, at its disposal, country leading assets designed to accelerate innovation in Life Sciences, Digital and wider Technologies through MAHSC and Health Innovation Manchester that : facilitate and build on the strengths of GM academic institutions; create the potential for commercial partnerships; and provide the route for transforming services

GM has established a strong commitment to and platform for excellent HR management and OD as part of its work on individual and organisational transition.

Established Integrating Processes

GM has established an Integrated Partnership Board that sits centrally between the ICB and Local Authorities, the Combined Authority and the Mayor's Office

GM has established a single new Joint Planning and Delivery Committee that supports these structures to work in an integrated manner in practice (replacing a number of joint commissioning and GMGSCP structures)

GM and Localities are beginning to appoint leaders to the key posts within the structures at GM level (eg ICS/ICB Chair); Locality level (Place based leaders); Provider Collaboratives (Chairs and Managing Directors)

GM has established a core executive leadership group, bringing together the executive leaders of its component elements that represent all levels in the new system to enable joined up implementation of the new operating model

GM has completed an extensive exercise to identify the appropriate spatial level for planning and delivering integrated services (GM, multi locality, locality and neighbourhood/PCN(s))

Required Further Integrating Processes

Whilst progress has been made on building the component elements and beginning to put in place some integrating processes that will bind the components in a coherent operating model, there is more work needed. There are 5 areas that we believe need agreement to develop further -

1) ***Creating a simple narrative as to how this new system will work*** (see draft in the box below)

- All GM constituent organisations are committed to achieving better health, better standards of care, financial sustainability and reduced inequalities
- Our approach to do this requires us to receive and allocate NHS resources provided by the Government and align these with resources raised locally through our Local Authorities (including for non health and care spend)
- The new Integrated Care Board and Integrated Partnership Board will be responsible for considering the full range of these resources and setting a strategy and priorities for how these resources, when seen together, can be used to deliver it. This will be informed by the legitimate priorities set by national Government, the legitimate local priorities set by Local Government on behalf of GM residents, and the priorities set by the GM Mayor

- The new Joint Planning and Delivery Committee will be formally responsible, acting in support of the ICB, to ensure the delivery of this strategy and its impact on the GM overall objectives
- NHS Funding will flow from the ICB directly to NHS Trusts for locally agreed and GM wide programmes - the latter, having been advised by PFB who are taking on responsibility on behalf of GM ICS to coordinate and ensure the delivery of a programme of specialised services, elective care recovery, pathway transformation (eg MH and cancer), and coordination of urgent care
- NHS Funding will also flow from the ICB to the 10 GM localities where Locality Boards will have the ability to align or pool this with LA funding, prior to them a) setting the Locality priorities including the delivery of their contribution to the GM wide objectives, b) allocating the resources to their local provider collaborations/alliances, who will join up service delivery, and c) delegating responsibilities for how these resources will be overseen and stewarded at neighbourhood level with local communities and PCNs working together.
- This activity will be coordinated between localities and the ICB through the appointment of a single place based lead (who will have joint employment and accountability status with the ICB and with a LA or Trust)
- Finally, NHS funding will also flow to primary care practices and to PCNs in line with the national contract agreements. They will receive guaranteed funding levels, but will undertake to work through Locality Boards to align this spending with local and GM priorities and objectives. They also have flexibility to agree or maintain local incentive funding for achieving objectives. The ICB will be advised by PCB/GPB in this task and at local level by GP Boards working in support of Locality Boards,
- Some NHS and LA funding will be retained or deployed at GM level and spent by GM ICS, PFB or PCB. This will be largely associated with enabling functions such as system governance, data and digital, labour market and people, innovation support, performance improvement etc
- Wherever funding is held or banked within the system, every organisation is committed to the key principle of joint stewardship in order to help speed the processes of service transformation, productivity improvement and efficiency
- These processes will require a) joint planning and joint working at each level (in line with the operating principles) - overseen by the JPDC, b) informed allocation of resource (people and money) to enable each component part to deliver its contribution, c) bold, radical and collective leadership to tackle long standing issues such as health inequalities

2) Finalising ICB membership, delegation, constitution and relationship to priority setting process

Membership

Whereas there is flexibility in the ICS operating model and the ICP governance structure, the ICB structure itself needs to be consistent with the legislation including a number of specified mandatory elements. GM needs therefore to agree the membership, constitution, including delegations and the relationship with the ICP Board.

We recommend that the GM ICB begins simply by meeting the specified mandatory roles in terms of membership but this is reviewed in 6 months time to ensure that it is providing a governance approach capable of delivering on both national and GM objectives, operating model and culture

In relation to the membership of the ICP, we are aware that initial proposed membership arrangements have been subject to question (in particular the importance of securing clear

input from VCSE and from the voice of citizens) and so recommend a short review of those to be completed by the end of January 2022.

Chairing

The proposed chairing arrangements for the ICB and ICP (and the JPDC that serves them) have been considered in light of the need to have

- continuity of thought and direction
- confidence of the GM stakeholders
- the principles of good governance at their heart

This has led to a proposal that

a) Individual chairs for the ICB and the ICP with the JPDC being jointly chaired by the two Chairs
b) The ICB Chair is the vice chair of the ICP; and the ICP chair is in attendance at meetings of the ICB
c) The ICB is appointed through the national process set out by the NHS (as was the case); and the ICP Chair is the health and social care portfolio holder of the Combined Authority, and appointed by the Mayor

We recommend that this approach is now formally adopted within the GM ICS governance structure

Constitution and Governance Handbook

In terms of the Constitution that the ICS is required to establish, this will set out the core legal requirements but a Governance Handbook will sit along side this and will describe the component elements of the system that relate to GM's chosen operating model and process. This will provide a more comprehensive and understandable explanation of the ICS which would foster more transparency and openness to the GM public. It will also allow any changes that GM wishes to make to its approach to be enacted swiftly within the need for national recourse and permissions, as it 'learns by doing' in the coming period.

We recommend that the ICB constitution mirrors the national constitution with a commitment expressed in the Governance Handbook that it will operate in manner consistent with the GM operating model and principles, and will have full regards to the strategy and priority setting process of the ICP, and the role we have established for a JDPC, (which does not feature in the national model constitution).

We recommend that the ICB adopts a scheme of delegation allowing it to delegate budgets to localities and to providers on behalf of Collaboratives.

We recommend that the Governance Handbook should describe the crucial role of the JDPC as it holds responsibility for overseeing GM level activity and coordinating locality and multi locality working. It will also advise and oversee the option of establishing effective joint committees with localities, and with providers/provider collaboratives and be a driver and assurer of joint stewardship within the system and across GM functions.

The JDPCs role is crucial in ensuring coherence of the new model with its component elements and we recommend that it establishes a clear joint planning process that joins up the spatial levels and informs the allocation of resources (finance and staffing) across neighbourhoods, localities, collaboratives and GM enabling programmes)

We recommend that the Governance Handbook formally recognises the role of PFB, PCB, and the VSCE Accord in advising the ICB, ICP and JPDC on strategy, priorities, operational requirements, in line with their responsibilities to steer, coordinate and in some cases deliver key agreed programmes of work in support of their clinical strategies

We recommend that the Governance Handbook also formally identifies the commitment to create a clinically and care professionally driven and empowering culture as a key element of the GM system operating model.

Finally we recommend that the Governance Handbook sets out the basis upon which there will be a clear route for public engagement, through establishing precisely the GM commitment to open meetings and published minutes

3) Agreeing Financial Flows and Responsibilities

We are clear that it will be mission critical in order to achieve our shared objectives that we have aligned financial incentives

Ongoing work since the summer undertaken by the FAC supported by a core financial officers team on financial flows will be brought together with NHS Planning Guidance and work on spatial levels to recommend how flows will work. It is essential that this is finalised urgently and signed off it GM is to be able to pursue our objectives and make sure the next financial year (2022/23) is the starting point for the new approach we wish to take.

We recommend that JPDC oversee allocations into the system for the next financial year taking account of the priorities and strategy set by ICP and agreed ultimately by ICB. This will include them taking into account the work on spatial levels, balancing the need for simplicity with the key forward principle of joint stewardship to facilitate transformation

Looking at this in some detail, we need as a system to be very clear as to how the different funding streams in national and GM previous arrangements will flow in the new ICS from the ICB for the NHS and from LAs for locally raised revenue. So taking these in turn -

Simplicity

We recommend that money previously committed through the specialised commissioning route (ie funding for those highly <u>specialised tertiary services</u> that deliver extremely rare, complex or innovative treatments, concentrated largely at MUFT, Christie, MH Trusts and SRFT) are simply distributed directly to the relevant Trusts

We recommend that <u>money previously distributed through the NHS CCGs would be allocated by the ICB in two main streams</u>

a) Directly to Trusts as ***a single allocation to each for NHS work they do*** locally (in hospital and in community) and as informed through the programmes where PFB, in some cases working with partners, are leading the planning; and through discussion at the locality board (see joint stewardship principles). This will avoid a retrograde step of disintegrating budgets that have previously been integrated allocations for community, diagnostic and in hospital care, and which in many areas are also subject already to joint stewardship arrangement through s75 arrangements

b) To Localities, for money spent with non NHS Trusts (NB in Bolton for example, this sum may be around £150m of their previous allocation) which would be routed through a joint committee (ICB/LA) or lead provider option; money would then be allocated from there to individual care providers or via a lead provider. At this stage, using the role of Locality Leadership Boards, money available locally by LAs eg for social care or public health could be pooled via s75 or

aligned virtually to achieve a virtual place based budget. NHS Trusts and GPs/PCNs would also be expected to discuss the optimal utilisation of the money they had received directly from the ICB in this forum. This allows the simplicity of allocating and accounting to be married with the important ambition for service transformation

On the specific question of primary care core service funding we recommend this being allocated directly to practices and PCNs based on the national contract formula and conditions. But there is work in train with PCB working with local GP representatives to determine how money that was previously directed locally through co-commissioning routes (eg Local Enhanced Services) should be distributed into practices (NB it is also clear that NHSE are taking an active role in considering the next steps for these services, which they currently formally commission or co-commission) .

One option for example may be for this to be included in the locality allocation but with a view that the objectives associated with this local money are advised by the local GP Board and crucially with a ***minimum*** level of expenditure guaranteed to be spent through practices. Any agreement on the ***quantum*** within a minimum baseline however will need to take account of the current variation of local schemes across GM eg Salford's additional, non GMS, financial commitment to their quality scheme, where our understanding is that colleagues locally would clearly wish this to be protected and guaranteed.

There is a need to finalise and agree swiftly the route and level of *allocation* into the primary care sector. CFOs, and for primary care, PCB, should make clear recommendations for JDPC decision on this by the end of January. There is also an immediate need for JDPC to work in parallel with them on whether the GM system adopts a single model or allows variability depending on the preference of each locality.

This process should also propose, for agreement, funding for any programmes of work that need to be undertaken at GM level on behalf of the system. In this case, funding would need to flow predominantly from running cost budgets (see section below)

Joint stewardship

Whatever is ultimately agreed on any or all the allocation routes , ***the principle of joint stewardship is absolutely fundamental to the transformation of services .*** This, we know to be necessary to achieve our quadruple aim.

So we recommend that whatever arrangements are proposed and adopted for distribution of resources to fund previously NHSE/CCG/LA commissioned Health and Care services, there has to be the principle of joint stewardship applied to how the money is *deployed* and this should be built in as a condition of any allocation.

These conditions could be as follows -

1) money going directly to Trusts through the ICB directly must be 'brought to the table' to identify how that resource, when added to money sitting with other Trusts, organisations or sectors, can be used collectively to achieve maximum productivity, necessary cost saving and contribute most effectively to achieving the quadruple aim

2) Money going directly to Trusts for specialised care and those other hospital based programmes (eg elective care), that are subject to the shared planning and strategy set by Trusts through PFB, would be subject to joint stewardship through the PFB governance arrangements; and for wider services (eg urgent care, MH, cancer) through PFB working with partners under the specific governance process they establish to coordinate services

3) money going via locality joint committees, locally agreed lead providers or LA commissioned services would be required to adhere to the same principle as in 1) above (this allows for locally raised revenues for social care and public health programmes to be subject also to joint stewardship)

4) money for general practice should achieve the minimum guaranteed level (ie must meet previous levels of CCG based expenditure going into GMS services) and for core services go directly to the practices but should be 'brought to the table' for alignment and agreement about the requirements attached to any money out with global sum, QoF payments and DES payments (to ensure consistency with locally set priorities and objectives). There are a variety of local models in play in this regard, and local GP Board, where present, should propose the approach for any local alignment including protection of schemes that may add additional resources to the sector from non - GMS monies (eg local quality incentive schemes)

5) money for wider primary care practitioners should follow the same principle as for general practice with guaranteed sums and consistency with national agreements

Efficiency, Inequalities, and Review

We are conscious that there is likely to be pressure to generate efficiency across all budgets (including running costs - see next section). Allocations will need to balance technical efficiencies in each organisation with the need to secure allocative efficiencies by working more creatively. **We recommend that the finance community identify the level of efficiency required and JPDC commission a short piece of work to inform the distribution of the efficiency goals to be achieved in each organisation, Collaborative and Locality**

We recommend that all resources are allocated mindful of the GM objective to reduce health inequalities which may mean a gradual shifting of money to those individuals, communities and localities with greatest need.

We recommend that these arrangements would govern the starting point for the new system but, with the exception of maintaining the core principle of joint stewardship, be seen as the basis upon which longer term thinking on a more radical financial and service transformation strategy should be based, with this work starting in the new year.

4) ***Signing off Locality Leadership***

There is an important balance to strike between consistency of approach in each of the ten localities and the recognition that each has differing characteristics and history of joint working. The operating model set out some core expectations of having -

- 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" (jointly accountable person to localities and to GM ICS for health and care) - recognising this may be subject to further national policy
- 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
- An articulated relationship with their local Health and Well Being Board (the detail of which would be determined locally)

As we have a clear commitment to ensure the system is up and running to begin formally in April 2022, **we recommend that JPDC sets up a process where it has sight of the arrangements**

for each locality and the facility to run a process of check and challenge that would ensure all localities are fit for purpose. This would be appropriate given that each locality is represented on this Committee and can bring the advantage of peer review to the process, rather than this being a top down approach. (Should any locality require or ask for support, this would be arranged by the JDPC).

We recommend that this process is completed by the end of January 2022

On the specific point of the appointment of a place based lead we are aware of the need to make appointments to enable the ICB to function. As such **we recommend moving forward with a joint Locality/GM appointment process as per the current timeframe but making any appointments provisional subject to any emerging approaches associated with national guidance once clear.**

We believe that these appointments have a clear specific purpose of enabling the interaction between the ICB and the localities and so the principles of ***joint Locality and GM employment and accountability*** are fundamental to ensuring that the role of place based lead contributes effectively to the development of place based working and GM system wide working***. Successful appointments will allow for the effective delegation of budgets into place with appropriate accountability, when needed, back into the ICB***

Once appointed the place based lead would also be able to take responsibility for defining the locality posts that are needed within their defined running costs envelope

On the issue of staffing from the deployment of staff from CCGs we cover this in point 5 below.

5) Agreeing running cost allocations and redeploying staff (displaced by the abolition of CCGs) within the national HR framework

In order for the operating model to work, there must be a recognition that for a number of key functions there will be work to be undertaken that is over and above the single organisation operational and planning roles that are already in the system.

We believe that this must be resourced properly but equally ***we also know that to support our achievement of financial stability there is considerable scope for efficiency in the running cost envelope as we bring a large number of organisations together***. Clearly in the short term we must be cognisant of the employment commitment but over time we would wish to see running costs released to support more front line care and service delivery.

In order to treat staff fairly and the get the new system motoring, **we would recommend early decisions on the initial distribution of the running cost envelope to the component elements of the system, based on the work that the core CFO group is leading. (NB A separate paper is being worked up for JPDC along side this paper).**

In time we should ask each organisation individually and then working in concert, to make plans as to how safe and effective running cost reductions would be made to contribute over time to efficiencies and additional front line resources**.**

We recognise that this is tied intrinsically into people and posts and so needs intelligent thought and sensitive transparent and fair management. Any deployment of existing staff must be undertaken in line with the national HR framework and commitments given to staff through that route. This will mean maintenance of roles in transferring into the ICB in April but appropriate consultation with people on any changes down stream in the usual approved manner.

In order to start this process, **we are aware that the work being undertaken on behalf of the system by FAC needs to be considered urgently with agreement to follow swiftly. If that is**

not possible then we recommend that the default starting point for running cost allocations is the current distribution of budgets within the localities (based on previous CCG budgets) but that this is reduced proportionately to allocate running costs to provider collaboratives and GM programmes that JPDC agree should be maintained at this spatial level.

Any budgets agreed for provider collaboratives and GM programmes will need to differentiate between cash and staff (in the latter case, staff may be employed and paid for directly through the ICB but deployed, subject to due consultation, in support of the provider collaborative work).

As the new system is likely to have a more distributed leadership approach within the system, we believe there will be scope over time, and subject to consultation with staff, to reallocate resources held at GMHSCP into budgets held or steered by the component elements of the system.

We would also recommend that the GMICS applies its mind creatively to how it can attract inward investment (eg through life sciences and HIM commercial partnerships) and also in partnership with VCSE to create roles that enable differing employment and voluntary roles within the system as a means to improving social mobility for example.

Initiating the Operating Model and Arrangements

We believe that time is of the essence and we would like clear decisions to be made on our recommendations at the JDPC in December, wherever possible. This will allow for

- staff deployment and running cost budget assumptions to be finalised quickly in the new year
- Locality leadership boards to be agreed via the check and challenge process by the end of January and to begin operating in earnest
- Place based leads to be identified
- ICB and ICP to meet in shadow form
- the GMICS to plan for transformation and change in 2022/23 so that there is no loss of a further year due to organisational change
- the Constitution to be established (without decisions, this will not be possible within the expected timeframe).

We recognise that some of our recommendations are designed to get the new system up and running and these will need to be reviewed as the new system begins and then beds in.

We do not believe there will be a need for a fundamental overhaul of our arrangements but we recommend an informal review of the ICB and ICP membership arrangements early in 2022 with an operating model review undertaken in Summer, to make any adjustments necessary.

MF on behalf of the Core Leadership Group,

November 2021