PURPOSE OF REPORT:

This paper sets out our approach and findings towards understanding the development of LCOs. It describes the core model features that drive success, our learning to date and how we will continue to work together to increase the pace of change so that all residents in GM can benefit from these models of care.

This process has highlighted essential learning such as: the significance of integrated neighbourhood level working, a single leadership structure, clarity on permissions and accountabilities which, amongst others, are vital to successful delivery of new models of care.

The evaluation and learning from these reviews have been presented against the four key themes of an LCO. This will inform the work programme of the LCO Network for 18/19 and how we continue to support and move forward through revised ways of working.

RECOMMENDATIONS:

The GM Joint Health Scrutiny Committee is asked to:

- Note the contents of this report and support the way moving forward

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1.0 INTRODUCTION

1.1. In the first year of the Partnership’s existence we sought to capture the core features of each locality’s integrated care model. This process provided a narrative to describe the co-design of a GM Local Care Organisation (LCO) development framework which reflected each of those local ambitions and outlined the approach through which localities would be able to identify themselves against a set of core criteria and features of an LCO.

1.2. As we move swiftly from strategic intent to making our new models of care a reality, this process has proven to be an essential stage in our collective endeavour and understanding towards realising the potential we have set out to achieve.

1.3. It has been well rehearsed throughout our strategy documents that the ten LCO’s will form a vital connecting point for the delivery of ‘Taking Charge’ and as such are one of the key components of the system architecture for the delivery and implementation of the transformation.

1.4. As the ten Local Care Organisations have begun to come to life this year, we are beginning to see radical changes at neighbourhood level where localities are beginning to break down the barriers that prevent the integration of care around the needs of individuals. They are doing this by focussing on prevention and early intervention and building on the assets of individuals and their communities.

1.5. What has become strikingly clear through the LCO framework process is that this transformation in delivery is largely taking place at the neighbourhood level, serving populations of 30 to 50,000. As such, neighbourhood models (or hubs) are increasingly emerging as the main, clearly identifiable delivery unit for health and care reform and ultimately, the reform of wider public services.

1.6. Providing the overarching structure of contracting and co-ordination of these neighbourhood hubs, is the LCO assisted by a reformed, more integrated approach to commissioning.

1.7. At scale, Clinical Commissioning Groups (CCGs) and local authorities in Greater Manchester (GM) are now coming together to form Single Strategic Commissioning Functions (SCF’s) in all ten areas. These SCFs bring together health and care budgets at local level so that we move away from the silos that have previously impeded our ability to deliver genuine place-based commissioning.

1.8. This paper on LCO development, sets out our approach and findings towards understanding the development of Local Care Organisations, the core model features that drive success, our learning and how we will continue to work together to increase the pace of change so that all residents in GM can benefit from these models of care.
2.0 THE LCO DEVELOPMENT FRAMEWORK AND REVIEW PROCESS

2.1. The Development Framework

2.1.1. The LCO development framework was created with the GM LCO Network during the summer of 2017, and refined through engagement with the Provider Federation Board, the AGG, the GMCA Wider Leadership Team, the Primary Care Advisory Group, the Directors of Adult Social Care and other key GM groups. The aim being to provide a means by which localities could:

- Sense check where they are in developing their LCO against a number of core competencies that will drive outcomes and contribute to the delivery of Taking Charge. This will support localities in the translation of strategy into implementation;

- Articulate a clearer definition of the scope of an LCO in each place – to enable better alignment with the delivery of Theme 3 – in respect of activity flows to and from the acute sector;

- In the spirit of transparency, facilitate its own peer to peer learning, sharing and challenge within GM;

- Identify issues that lend themselves to being done once across GM;

- Define the scope of an LCO and operating models to facilitate other partners (PSR, Leisure, Housing, and Voluntary Sector) to align their delivery models with LCOs.

This is summarised below:

**Defining the purpose of a Development Framework**

<table>
<thead>
<tr>
<th>Peer to Peer opportunities</th>
<th>• Peer to peer learning, transparency, sharing and challenge within GM</th>
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<tbody>
<tr>
<td>Defining the scope of an LCO</td>
<td>• Alignment with theme 3, theme 1, enabling and cross cutting themes, including wider PSR work</td>
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<tr>
<td>Self Assessment</td>
<td>• To grip the maturity of an LCO in driving outcomes and delivering Taking Charge</td>
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<tr>
<td>GM Support &amp; Development</td>
<td>• Support to move from strategy into implementation. • Aligning enablers to the development e.g. workforce, estates etc</td>
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The LCO framework was constructed around the 4 core LCO themes agreed through SPBE in November 2016:

| Enable conditions to be managed at home and in the community. | -Radical reductions in demand  
-Extend beyond primary care at scale  
-Incorporate some acute specialists  
-Provide more accessible UC services in the community  
-Provide in reach services to other settings |
| Secure the contributions of the full range of public service partners to providing early help and prevention | -Connect H&C reform with supporting adults to connect to economic opportunity.  
-Connecting wider PBI and a full range of partners to max’ health benefit.  
-Incorporate housing provision |
| Support individuals & communities to take more control over their own health | -Utilising full capacity and assets of local community.  
-Empowering people and local communities voluntary sector input. |
| Take full responsibility for the management of the health & wellbeing of a defined population | -Robust governance and leadership.  
-List of registered patients for the population, serving a size “200,000  
-Expanded community based MDT’s  
-Risk stratification and electronic records  
-New type of capitated contract & budget. |

We added to these four themes, our intention to gain a deeper understanding of the capability to deliver, single leadership and management arrangements, together with the integrated governance in a place, which drives a culture for change and empowered staff through senior to neighbourhood level.

2.2. The LCO Peer Review Process

2.2.1. The framework underwent extensive engagement with all key Greater Manchester governance groups and with the LCO Network over a three month period during summer 2017. In response, to breathe life into an otherwise sterile template compilation process, the review and the framework were redesigned into a ‘conversation spine’, and included a team of peers to take part in a conversational review.

2.2.2. This greatly enhanced the learning opportunity with between 4 to 6 localities, and the VCSE sector, talking around the table together in each of the ten conversations.

2.2.3. Conversations lasted two hours and were firmly rooted within the context of development, support and learning. As such, localities were invited to be as transparent as possible in sharing their challenges, issues and opportunities. This was met with positivity and the fluidity of the reviews enabled good breadth and depth through key lines of enquiry.

2.2.4. The process of review for the 10 LCO’s commenced in December 2017 and concluded on 1st February 2018. The outputs from all 10 peer conversations were captured and summarised against the four core LCO themes into individual reports, each agreed by the locality. A complete set of final reports is attached in appendix 1.
The conversation spine:

### Peer to Peer – conversation spine

<table>
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<tr>
<th>Capability to deliver:</th>
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<tr>
<td>How mature are the LCO/SCF leadership arrangements</td>
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<td>• Is there a single leadership structure?</td>
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<td>• Is there clarity on roles, responsibilities and ownership?</td>
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<td>• Does the leadership meet regularly and have strong relationships?</td>
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### Maturity of LCO organisational development.

Is the culture & mind set within the developing LCO open to:

1) Devolved leadership
2) Managed risk taking
3) Learning & sharing
4) Engaging & collaborating with partners in the system
5) Working for a defined population, not an organisation
6) Embracing transformation change

### Governance

• Are decision making & accountability processes clear?
• Are corporate governance structures in place?
• What are the arrangements for integrated clinical governance between providers? What is the fit with place based hubs?
• What is the breadth of VCSE involvement in decision making, representation on key groups and involvement in operational delivery?

### In scope services and transformational programmes.

1. What transformational programmes will enable conditions to be managed at home & in community? What will be the key features in the LCO?

2. Describe the work underway to shift the balance to early help & prevention and how the full range of public service & VCSE partners contribute to it

3. How will the LCO support individuals & communities to take more control of their own health?

4. What developments are underway/planned for the LCO/SCF to take responsibility for the management of the health & well being of a defined population. What has gone well/issues/challenges...

### What services are in scope of the LCO this year and by 2021?

1. Example key features:
   • In primary and community care
   • Care homes
   • UAEC transformation
   • Mental health
   • Acute & specialised care

2. Example key features:
   • Population health programmes: early years, work & health etc.
   • Place based integration, integrated neighbourhood teams
   • Housing & health- supported housing, independent living.
   • Fire & Rescue – Safe & Well, home safety checks.

3. Example key features:
   • Asset based approaches & building community capacity
   • Social prescribing
   • Personal health budgets
   • Enhanced role for VCSE

4. Example key features:
   • Capitated budget agreed and in place
   • Risk stratification
   • Single commissioning function & governance structure
   • Population specific outcomes agreed
   • Public engagement plans resourced.
   • Enabling programmes: workforce; estates; IM&T
   • Data sharing agreements in place
   • Single shared support service arrangement in place

### Finance

Provider finance capability. Contracted services financially sustainable. Procurement and contract.

• Financial implications of the provider structure fully considered.
• Consideration given to: risk/gain share; VAT; financial assumptions & forecasts.
• Consideration given to competition & market engagement; procurement documentation; agreements between providers.
3.0 EVALUATION OF THE FINDINGS FROM THE PEER TO PEER CONVERSATIONS

3.1. Core findings

3.1.1. Through the development of LCOs, the delivery of the Public Service Reform (PSR) agenda and other programmes such as Person and Community-Centred Approaches (PCCA), we are both confirming and reinforcing that the principal route from strategy to implementation in GM will be via the neighbourhood of 30,000 to 50,000 population size.

3.1.2. The mobilisation and pace at which these new care models are established will be critical in achieving our ambition for a reduction in hospital utilisation which can embed quality in secondary care, and population health in theme 1 through radical activity shifts away from hospital on which our financial sustainability rests. We have backed these new and innovative care models with £275m investment of Transformation Fund money.

3.1.3. There are now clear examples across the conurbation of new locality delivery structures forming and being mobilised to manage populations at city, borough and neighbourhood level. We are seeing traction between health & social care and wider partners, between the VCSE, LCO and neighbourhoods and strong signals of primary care attachment.

3.1.4. Our collective understanding, therefore, of the core features of a fully effective LCO becomes not only necessary but vital.

3.1.5. This section sets out the defining features which have emerged from the conversations which are beginning to demonstrate success at local level, which are spreadable or scalable and describe best practice against the four core LCO themes.

3.2. Enable conditions to be managed at home and in the community

3.2.1. In order to enable transformed neighbourhood care which is capable of providing the focus, approach and capability to make reductions on demand for traditional health and care services, the creation of integrated neighbourhood teams/hubs are emerging as the main delivery unit.

3.2.2. Whilst some variation exists, all ten localities are establishing neighbourhood teams, proactively managing populations of between 30-50,000 structured around the GP registered lists. These units are of a size small enough to have a comprehensive understanding and connection to their communities, whilst being large enough to support functioning multi-disciplinary team working and MDT meetings. Critically, therefore, they are large enough to help colleagues support
each other to be resilient and meet local demands, and testing out new ways of working with a wider set of partners to address the causes of poor health.

3.2.3. Where these are working well there is a clear operating model which describes the composition and crucially, the co-location of the teams, for example:

- Community nursing
- Adult social care
- Occupational Therapy
- Mental health
- The Voluntary, Community and Social Enterprise Sector

3.2.4. Teams are supported with clear leadership at neighbourhood level provided most often by a lead GP or in some instance a triumvirate approach to include nursing, social care and therapies with clear lines of accountability and governance back into the wider LCO. Daily meetings, huddles and MDT meetings strengthen joint working and joint care planning where teams genuinely work together to address the whole person needs of their population rather than defaulting to cross referral.

3.2.5. These teams are delivering locally led transformation programmes which enable people to be managed at home and in the community. A number of core delivery features are being demonstrated, These include:

- **Urgent Primary Care** - Initiatives to provide more accessible and redesigned urgent care services such as 24/7 urgent primary care access. 24/7 urgent primary care is the collective term being used to describe a single primary care offer that covers A&E streaming, urgent treatment centres, GP out of hours and GP Additional Access and walk in centres. Essentially this will:
  - Provide urgent and out of hours primary care at scale
  - Integrate urgent primary care and other services
  - Simplify and rationalise access across all urgent and out of hours primary care

Urgent Treatment Centres will be integrated with existing services, co-located in either the community or with an acute trust, open a minimum 12 hours a day, seven days a week, and offer patients who do not need to go to a main hospital A&E department treatment by clinicians with access to blood tests, ECGs and X-rays.
• **High Impact Care** - Across localities there are significant ambitions of High Impact Care. This model sees GPs working alongside a wider team of social care, nursing and specialist colleagues. It provides a setting for hospital clinicians and teams to give specialist outreach including outpatients, pre and post interventional care with the benefit of co-location aiding communication. There is clearly a strong synergy with the development of the neighbourhood teams with this approach becoming the site of integration of specialist outreach and providing an interface to the generic community integrated teams.

For this model to be effective access to diagnostics is essential. This could be co-located with additional primary care access services and urgent primary care services. This new approach could see patients being taken to the high impact model diagnostic suite and returned home in a timely way. Ambulances would also have scope to convey patients to this clinical setting, where appropriate, for immediate care of a primary care nature.

The urgent care centre model with all its capabilities can be developed to see resources and at times, workforce, being shared with the high impact model clinic.

The high impact model clinics and urgent treatment centres combined could become a key enabler for the delivery of care closer to home and in the community for populations, as set out on our GM strategy.

• **Enhanced Care in Care Homes** - New models of care for nursing and care homes, such as Enhanced Care which brings together joined up primary, community and secondary, social care to residents of care and nursing homes, via a range of in reach services.

• **Supported Discharge** - Initiatives to expedite hospital discharge such as Home First, Discharge to Assess.

• **Admission Avoidance** - utilising digital technology and skype in different care settings to reduce admissions and A&E attendances alongside community crisis response teams and urgent treatment centres.

3.2.6 These integrated neighbourhood teams will increasingly be the route through which transforming community care is delivered and are flexible and ready to receive specialist outreach teams from hospital.

3.2.7 It is important to recognise the extent to which the LCOs are beginning to be the delivery point for pan-GM transformation programmes and agreements. This is evident in the extended primary care features described above. Over the coming year this will also extend to incorporate the community delivery of relevant aspects of the GM Mental Health Strategy. For example:
• delivery of the evidence-based iTHRIVE model throughout GM to support effective delivery of children and young people’s (CYP) services and the delivery of mental health and emotional support in educational settings

• access to physical health checks for people with severe and enduring mental illness which are integrated as part of the care they receive for their mental health

• Establishing 24/7 crisis care and community provision for children and young people

• increased access to psychological therapies, so that at least 25% of people (or 84,000 in GM) with common MH conditions access services each year. The majority of new services will be integrated with physical healthcare and it is intended that 168 new MH therapists are co-located in primary care

• Adult Community, Acute and Crisis Care providing timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary care, social care and other sectors.

3.3. **Secure the contributions of the full range of public service partners to provide early help and intervention**

3.3.1. We know maximum potential can be gained from establishing new care models when health and social care is connected into the wider system. When truly integrated neighbourhood teams are able to work together, to address not only traditional approaches to health but by also addressing the wider determinants of health and wellbeing.

3.3.2. This has been particularly strengthened where commissioners have built into their intentions for 2018/19 a focus for providers to connect their place based working with wider public sector reform e.g. schools, employment, leisure and housing to develop a truly integrated model working on early prevention and intervention. Thereby using the collective impact of public services to reduce demand, ensure financial sustainability and improve outcomes.

3.3.3. Examples of this connection between health and wider public services at neighbourhood level include:

• The GM Working Well Early Help programme – which is connecting to GP practices in neighbourhoods across the 10 localities;

• Linking the work of Local Home Improvement Agencies (HIAs) to neighbourhood delivery models;

• Connecting residents to leisure services via link worker roles in GP practices.
3.3.4. Whilst it is acknowledged that connection to the wider sector and public service reform work is at an early stage, there is a strong recognition of the opportunities that integrating at neighbourhood and borough level can present.

3.3.5. In support of this, at a GM level we are actively working to help develop health outreach teams in all localities, offering screening and health advice to those in hostels, refuges or no fixed abode in line with our best practice models where this is showing benefit in some of our districts.

3.3.6. We are proactively working with the housing sector to develop a Home Improvement Agency which can demonstrably improve outcomes related to falls, length of hospital stay, cold homes and environmental quality.

3.3.7. One example of wider integration benefiting people is through the ‘Warm Homes’ type initiatives. These have evaluated strongly in parts of GM where home energy improvements and advice to people at risk of fuel poverty have successfully taken people out of fuel poverty and their health and well-being has significantly improved.

3.3.8. Across GM our collective involvement with the VCSE sector is variable across the 10 localities. Where this is working well the VCSE are included at all levels in the new governance arrangements and are seen as an equal partner in local decision making, with support to organise their infrastructure to respond appropriately.

3.3.9. The role of the VCSE in reformed models of community care is well recognised, but where this is really showing added benefit the sector is supported in building additional capacity through enhanced, longer term strategic approaches to commissioning from the local authority and CCG, for example such as establishing community initiative funds.

3.3.10. This has enabled the sector to take a strategic lead for elements of the transformation within a locality, for example, in being a key partner in self-care programmes supported with longer term funding and investment.

3.3.11. In parallel to the GM LCO review process has been running the GM Strategic Self-Assessment for Reform through the GMCA. Over the past 6 months every locality in GM has been undertaking a strategic self-assessment for reform as a locality partnership.

3.3.12. A critical element of the Strategic Self-Assessment is the opportunity to understand across GM the extent to which there is a shared understanding or ‘currency’ for place, and a move towards consistent models of place based working across public service reform and Local Care Organisations.

3.3.13. The findings from these two processes will be jointly reviewed during March. This process should identify critical issues across the full public sector system and
provide an opportunity to develop a single shared narrative for GM around people and place in its entirety.

3.4. **Support individuals and communities to take more control over their health**

3.4.1. Through the emerging LCO’s and neighbourhood teams, many localities are developing a system wide approach to embed self-care approaches and empowers people to take more control over their health, through ‘self-care’ or ‘healthy communities’- type programmes.

3.4.2. The core focus of these programmes is built around person and community centred approaches (PCCA) towards prevention and population health. Where this is demonstrating a real difference localities have invested in capacity and capability to ensure asset and person centred approaches are embedded as a core principle across the system.

3.4.3. This is evidenced through the design of the new care model, involvement with the VCSE and the values and behaviours of leaders and training of staff. This approach ultimately shifts the culture to enable citizens to take more control of their health & wellbeing, by identifying their own strengths, reducing dependency on public services and increasing wellbeing.

3.4.4. We are increasingly seeing that informal access, or self-referral, into person and community-centred schemes or groups is just as important as formal access and connection to statutory health and care services. But, the systematic embedding of person and community-centred approaches into the health and care system requires a set of system connectors, such as social prescribing, personal budgets or other bridging roles (care navigators, health trainers, practice champions etc.) supported by a local directory of services and an enhanced role for voluntary and community groups in providing day to day support, help and connections for people.

3.4.5. We are seeing growth in the use of social prescribing models which are emerging as one alternative to using traditional statutory services. Social prescribing can provide a means to connect people into their communities, local assets and groups, integrating care and support which is ‘more than medicine’ whilst working alongside clinical care. Roles such as community navigators and health coaches are playing a vital role in bridging and connecting people to these neighbourhood services, working in partnership with the local VCSE sector providers and supported by community investment.

3.4.6. In localities where the thinking and implementation is more advanced there are strong examples where people are supported as equal partners in decisions about their care and treatment.
3.4.7. This includes supported self-care tailored to people’s level of knowledge based on an equal conversation between citizen and professional. It is strengths-based, around an individual’s personal goals, motivations, interests and assets, skills and confidence, and may include health coaching, self-management education and systematic access to peer support options; measured through tools such as the Patient Activation Measure (PAM).

3.4.8. This is built on and developed further in areas using, for example, personal health budgets and integrated personal budgets, enabling people who could benefit to take direct control of resources available for their health and care, providing an essential counterbalance to a ‘one-size-fits-all’ commissioning approach, with a greater choice of care and support options.

3.4.9. People can take a personal budget as a direct payment, have another organisation manage it on their behalf, or choose from existing commissioned services. This is a proven approach to securing co-ordinated, personal support for people with ongoing care and support needs, and is particularly suited to people with complex needs. All CCGs have committed to expanding their offer of personal health budgets, and as LCOs come together it makes sense to bring together personal budget delivery across health and social care so that local people have one coherent and accessible way to plan and manage their personal budgets.

3.5. **Take responsibility for the management of the health and wellbeing of a defined population**

3.5.1. The significant strength and benefit of connecting sectors, practitioners and communities in the 30-50,000 neighbourhoods, the true benefits of the LCO concept can only be fully realised if those neighbourhood teams exist within a comprehensive and proactive population health management model. That model provides the neighbourhood teams with connection, coherence and support as part of a comprehensive model of delivery. This year has seen the development of provider alliance arrangements coming to fruition across the majority the 10 LCO’s, with that intention now common to all. These arrangements bring providers of social care, mental health; secondary, community and primary care together to work under a legally binding alliance/partnership agreement.

3.5.2. The Provider Alliance is responsible for delivering population based outcomes within an agreed capitated budget with an agreed risk and gain share agreement in place. They will be expected to do this by utilising risk stratification and patient population segmentation to identify patients who will benefit most from intensive support. We are now seeing risk stratification models extend beyond their initial focus in hospital activity to wider public services. Some localities have developed neighbourhood level data profiles for teams to use along this to inform their daily
team huddles and enable multi agency teams to coordinate services and interventions around individuals and families.

3.5.3. Whilst neighbourhood profiles are in early stages of development, there are emerging examples in a couple of localities where these are being used to understand capacity, demand and inform delivery, underpinned with metrics identified that will drive improvement.

3.5.4. Where this is working well the neighbourhood team is able to own their contribution to local patterns of demand through delegation from the LCO with responsibility for their own budget. Whilst this is still early days, this resource following accountability for delivery drives transformation at neighbourhood level.

3.5.5. Provider Alliance arrangements, as a transitional stage to a single organisational vehicle, enable the locality to focus on building relationships, provide support through organisational development, engage with staff and develop a culture to support the transformation. The benefit of this approach in establishing a solid foundation provides a strong platform to enable a smoother transition towards a single contract and organisational form.

3.5.6. In preparation for this, and during the interim stage, successful alliance arrangements will ultimately go beyond co-location and partnership working to mimic a single organisation with single working arrangements and a single management structure. It will look and feel like a one organisation.

3.5.7. Best practice examples in GM bring providers together by entering into a legal Alliance Provider Agreement which includes the governance framework for decision making and the delivery of business cases in the transition period.

3.5.8. The Agreement sets out a collaborative and integrated way of working, underpinned by clear leadership, responsibilities and accountabilities. These are defined through the governance from the Alliance Provider Board at executive level - supported by an operational management team structure - through to structures at neighbourhood level with defined roles for the integrated neighbourhood leadership including for example, the job description and accountabilities of GP leads and neighbourhood team leaders.

3.5.9. As new models for community care are changing, a reformed, more integrated approach to commissioning is necessary.

3.5.10. Across all localities CCGs and Local authorities are coming together to form Single Strategic Commissioning Functions. The pace of change varies, but all are bringing together pooled budgets, joint commissioning arrangements and agreeing on the delegation of commissioning responsibilities during 2018.
Where this LCO theme is most advanced and works well is in those localities that have a clear and robust governance and decision making structures, with a single leadership/management team established across both the Single Commissioning Function and the LCO with an overarching Partnership Board function which enables providers and commissioners to work together in an integrated manner to deliver improved outcomes for their population.

3.6. **Key Learning**

3.6.1. Where we have seen the most rapid progress towards establishing a reformed health & care system in a locality, there have been some key checkpoints, decisions and subsequent action taken early on which have enabled significant progress to follow.

3.6.2. Rapid progress is most evident where localities have taken an action on the following core checkpoints towards defining the operating model for the LCO:

1. Agreeing and settling on their neighbourhood geographies between the local authority and local NHS
2. Agreeing their model for 30-50,000 populations - including permissions and accountabilities down to neighbourhood team level.
3. Defining the operating model for integrated neighbourhood teams (INTs) and working arrangements.
4. Connecting the INT’s into the wider LCO
5. Establishing a single leadership/management structure for the LCO and SCF with integrated provider and commissioner board functions.
6. Pooling of budgets (some range from ‘pooled’, ‘aligned’ to ‘in view’), and establishing integrated commissioning arrangements.
7. Translating the transformation into a number of core programmes.
8. Extending the integration into wider public services and the VCSE sector.
9. Early investment of time and resource into support programmes for organisational development for front line staff and teams to build relationships, trust and a deeper appreciation of roles as a key enabler towards culture shift and accelerating local progress.

3.6.3. The localities were these checkpoints have been delivered are the most advanced establishing their local care organisation and in taking responsibility for the management of the health and wellbeing of a defined population.
3.6.4. The outputs from the ten LCO conversations could be collated and a summary matrix of the stage of each locality developed. This option is undergoing a process of validation with the LCO Network.

3.7. Supplementary learning points

3.7.1. Different routes are being taken to achieve these changes. Some LCOs have focused on aligning structures and leadership – where there are new contracting arrangements, governance structures and alliances forming in some of the localities. Others have started by developing new delivery models, with plans for structural and governance arrangements to follow.

3.7.2. There is a strong recognition that the relational and behavioural aspects of transformation deserve as much, if not more attention, than technical and structural issues. Taking a structural route can seem relatively straightforward compared to the complex and often messy route to forming new relationships. Paying attention to the factors necessary for collaborative leadership – including the development of a shared vision, having frequent personal contact and surfacing and resolving conflict – is a critical piece of the puzzle.

3.7.3. There are clear benefits from the evidence of building a culture of cooperation with commissioning and with providers sat round the table together in pursuit of the same outcomes. Not doing anything ‘to’ but ‘with’.

3.7.4. As such, in beginning to determine local commissioning functions, conversations have been helped by focussing on outcomes and levels of delegation rather than a technical discussion to define between tactical v strategic -which often becomes unintentionally divisive.

3.7.5. Time and investment made into getting relationships and the culture right at all levels enables true integrated working. At a senior level, an aligned, shared vision built around a commitment to deliver improved population outcomes (focus on WHY not HOW); from the political, local authority and NHS leadership is essential when working together with the complexities of system transformation.

3.7.6. A single leadership for the LCO brought together into one place early on in the development has been seen as vital in driving progress and maintaining a hold on the vision.

3.7.7. Importantly as part of the leadership structure, strong clinical leadership has enabled previous barriers be overcome, especially in building relationships across primary and secondary care.

3.7.8. Strengthened integrated working amongst teams is enhanced through co location, workforce development and relationship building. Neighbourhood organisational
development programmes has been seen as a priority and has proven to be valuable in understanding roles, break down pre-existing silos and build trust - but engagement must be started early.

3.7.9. However, whilst LCO's are not yet entities or a single organisation, during the transition it is important that staff can identify with where they work, branding and identity is seen as important.

3.7.10. There are clear benefits in thinking beyond H&SC, and to the wider determinants of health, in designing integrated neighbourhood models together with the wider public service reform to get maximum benefit. This is strengthened where there is one operating model for place based working (at the 30-50,000 footprint) across H&SC and PSR under pinned by system behaviours supporting a one team approach.

3.7.11. Locality leadership must be prepared to take a certain amount of risk by giving permission, being brave and allowing innovation, supported by funding. If it works then there is an opportunity to scale and spread; if not it provides an opportunity to learn.

3.7.12. The role of the VCSE sector is pivotal in achieving the ambition of the local vision; they should be seen as equal partners. Recognition that the funding needs to shift with demand and the sector must be supported by adequate investment into building community capacity. How the sector is commissioned and the length of funding arrangements to grow a vibrant and robust sector should be being explored.

3.7.13. The use of case studies and patient stories to celebrate success can play a critical role in maintaining momentum and energy whilst the data catches up with the transformation. There are emerging examples from across GM where these stories are really demonstrating and bringing to life the impact of the transformation at a neighbourhood level on individual lives, some examples are illustrated in appendix 2.

3.7.14. Much of the strength in developing new models lie in the recognition that different changes require action at different levels. There is a focus on what should be done 'bottom up’ from within each locality, and what elements would benefit from a more ‘top down’ approach. The ‘top’ in this case being the Greater Manchester footprint, where some elements can be standardised to ensure consistency and allow economies of scale.

3.7.15. Also emerging is a third approach – middle out. Leaders from the LCOs can work together to learn from their peers, adopt and adapt each other’s models and take collective action when this is the best route forward. The LCO network offers a vehicle for building from the middle out, sharing and spreading learning from those developing models of care locally, nationally and internationally.
4.0 MOVING FORWARD AND WAYS OF WORKING

4.1. During 2017, the LCO Network has matured and developed to become the centre piece to the Transformation Theme 2 governance structures in that it aligns the ten locality transformation plans, public service reform, primary care, adult and children’s social care, Transformation Theme 1 and Transformation Theme 3 and draws in work from the GM cross cutting themes.

4.2. It has brought together senior leaders from across all ten localities and key partners to define, coordinate and drive the implementation of local care organisations by sharing best practice, identifying and learning from issues of commonality and take account of the regulatory landscape, with the development of the National Integrated Support and Assurance Process (ISAP) as localities move towards procuring new models of care.

The purpose of the LCO Network is illustrated below:

- **1.** Identify and address issues at a GM level which need a centralised investment or solution.
- **2.** Coalesce the interdependencies across GM transformation themes, public service reform and localities to ensure a single, streamlined approach is adopted across localities.
- **3.** Take account of the regulatory landscape, the development of the National Integrated Support and Assurance Process (ISAP) and how localities begin to procure new models of care.
- **4.** Support the GM ISAP Partnership in developing an evaluation framework in partnership with academic institutions.

4.3. This has culminated at the end of 2017 with the co design and evaluation of the LCO development framework through to a process of ten locality peer to peer conversations facilitated through the GM Health & Social Care Partnership.

4.4. The outputs from these reviews will set the work programme for 2018/19 for the LCO Network. Outputs range from work that can be taken forward at a locality level, at a sector level and at a Greater Manchester Level.

4.5. To facilitate this approach how we work together will need to flex across a number of levels within our health & care system.

This will be achieved, where appropriate by:
• Inviting localities to ‘buddy’ up where shared learning is beneficial at a local level.

• Establishing short term, focussed task groups with subject matter experts to rapidly progress common challenges such as outcome based commissioning, operating models for neighbourhood teams, approaches to risk stratification and connection back to neighbourhood level, data sharing agreements.

• Creating a shared resource library of best practice

• Identifying those challenges which can be addressed at a GM level through the Partnership team such as: the role of regulators, evaluation of transformation, issues relating to capital, estates and workforce, Taxation, VAT and procurement challenges.

• Creating an internal consultancy model of or pooled expertise and resource.

**4.6. The LCO Network work programme 2018/19**

<table>
<thead>
<tr>
<th>Key Themes</th>
<th>Work programme</th>
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<tbody>
<tr>
<td><strong>1. Functionality in the LCO</strong></td>
<td>Establishing Neighbourhoods: • Identity, assets, responsibilities &amp; leadership, extensive/enhanced/routine care, quantified contribution to achieving LCO objectives. • Defining operating model for integrated neighbourhood teams • Alignment to wider PSR • LCO outcomes framework, • Risk stratification, • Theme 2 and Theme 3 alignment (Right Care data). • Data, activity and Information governance.</td>
</tr>
<tr>
<td>Primary Care participation: • GP participation in contractual arrangements: Partial or full integration in Alliance / ACO contract; • Role and governance of the federation.</td>
<td></td>
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<tr>
<td>Contracting and organisational form: • Robust alliance agreements vs. contracting 19/20 • Strategic and tactical commissioning-implementing the commissioning review &amp; incentivisation work together, managing and confirming attributions, resource following delivery.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Leadership alignment</strong></td>
<td>• Aligned leadership at CEO/CO level that enables the model. • OD for the new organisation.</td>
</tr>
<tr>
<td><strong>3. Telling Stories</strong></td>
<td>• Using real life examples to illustrate and exemplify the model</td>
</tr>
<tr>
<td><strong>4. GM level specific</strong></td>
<td>• Regulation at place level • Estates and capital • Workforce and recruitment. • Challenge where progress is slower e.g. VCSE investment • Indemnity in neighbourhood teams/GP</td>
</tr>
</tbody>
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**5.0 RECOMMENDATIONS**

**5.1. The GM Joint Health Scrutiny Committee is asked to:**

Note the contents of this report and support the way moving forward.
**Appendix 1 : Examples of patient stories**

**Salford - Joan's Story; Living independently, at home**

Joan has several long term health conditions which contributed to her having frequent falls. After a number of falls and long stays in hospital, Joan was discharged to a care home, where she could be looked after safely. Joan was extremely unhappy in the care home because of a perceived loss of independence and cried constantly, insisting that she wished to return home, saying to the social worker “Don’t just look at my safety, look at my happiness. I want to go home.”

Joan insisted that she missed her independence and felt that her wellbeing and happiness were starting to decline. She insisted she wanted to spend her remaining years in her family home, the home she had lived in with her brothers, her family. “Living in your own home is part of being normal, being surrounded by your own things.”

Two social workers, a Community Occupational Therapist, a Mental Health Community Care Co-ordinator and the manager from the care home met with one of Joan’s family and an independent advocate representing Joan, to look at the options. During the meeting some of the professionals were very concerned about Joan’s safety and felt that she needed 24 hour care. Eventually they agreed to try and support Joan at home, because of just how important it is to her.

The social workers arranged a comprehensive package of care at home which would be closely monitored and regularly assessed by the GP and a Social Worker. They also checked Joan’s home for potential causes of falls and made some changes to help Joan manage the risk of falling. An occupational therapist supplied a hospital bed, specialist engineers installed electrical health monitoring equipment at her home, care agencies and district nurses all worked cooperatively together to maintain Joan's safety, dignity and general wellbeing at home.

Joan found it difficult at first saying, “My privacy has all gone and I was annoyed”, she found it difficult having strangers coming to the house so often “Not being in control of my own life that's what upset me. I want to be able to say I don't want you but I can't, I know that. I need to have carers so I had to accept it, I’m not daft.”

Now, Joan has a particularly good relationship with one carer in particular. Joan says, “It’s not bad now that we are organised.” Social Worker Abrefa said “Joan said I told you that I just wanted to go home. I then spoke to the care workers. They said that it was working fine. Joan was chatting to the workers, following their instructions and falling less.”

Eighteen months later and Joan is still at home being supported by her package of care and enjoying her independence and peace of mind. It’s been really important that the professionals have all worked closely together. The Social Worker and GP are based in the
same office, so able to pop in and deal with any problems that do occur. It has also worked out more cost efficient than if Joan had stayed in the care home.

**Oldham - John’s Story; Personal Health Budgets**

Until the age of 28 years John had led a very active sporting life and ran two local businesses. John was travelling in India and sustained a high level spinal cord injury and is now tetraplegic. Since his injury, John has maintained independent. John keeps himself extremely busy socially and is active in his voluntary community sector.

John is unable to perform physical activities due to the level of his injury and requires assistance from others to perform any physical activity, personal and social care needs, such as getting showered, dressed, moving and transferring, eating, drinking, meal preparation and taking medications.

John informed his Case Manager that he was interested in a Personal Health Budget (PHB). He was advised of the process step by step and kept informed at each stage. As John was unable to open letters via the post due to his disabilities, he preferred to communicate all correspondence via email. All letters and requests for further information were therefore made by email, telephone or face to face visits.

John completed his own support plan for the Personal Health Budget with support from the team, as he is the best person to describe his own needs and how these can be met. Once the support plan was submitted, it was considered by the CHC Review Panel and a meeting was held with John soon after and was advised that his Personal Health Budget had been agreed and that he could commence planning to recruit his PA team. To assist him with the above John decided to commission a ‘Broker’ from his indicative budget who helped him with the recruitment, training, and financial administration for his support/backup support team.

John is dependent upon the help of his personal assistants (PAs) to support all of his activities of living. He uses an electric wheelchair; a mobile hoist to move and transfer him and he has access to assistive technology to use his computer. John has a long term urinary catheter to help him manage his bladder and regularly experiences urinary tract infections.

Due to the nature of his disability and injuries John is at risk of experiencing episodes of Dysreflexia. It is important therefore that he receives daily bowel and bladder management from staff (PA) who have the relevant knowledge and skills and from PA’s who know John well.

Due to John’s immobility he is at high risk of developing pressure ulcers and requires regular and frequent pressure relief from his PA together with the use of pressure relieving equipment to assist and prevent the ulcers from occurring. John is also prone to chest infections and on occasions his PAs need to provide some basic chest physiotherapy to
loosen any secretions he has and assist him to cough. A chest infection can be extremely debilitating for John, restricting his activities and independence even further.

John’s longer term goals are to directly employ all of his staff team providing him with the choice of who enters his home. He aims to phase out the use of agencies and become responsible for the recruitment and training of his own personal assistants, who are reliable and consistent.

**HMR - Eddie’s Story; Integrated Neighbourhood Team's**

Eddie lost his left leg 12 months ago due to an infection after a knee operation. He also has multiple long term conditions and reported low activation scores. The Integrated Neighbourhood Team’s (INT) Wellbeing Champion worked with Eddie to develop his wellbeing plan which is part of the case management approach. The champion first met Eddie at the meet up group in Littleborough this followed him being part of the neighbourhood MDT ‘huddle’ conversation.

They had a lengthy chat and he expressed that he would love to give swimming ago but felt unable at attend a public swim. After some time the root cause was confidence and not knowing what to do with his false limb. We informed him about the accessible swimming session at Rochdale leisure centre; and explained that they have swimming teachers on hand to assist if required. Eddie was keen to give it ago and the champion accompanied him to his first swim. Eddie was introduced to staff.

At first he found the swimming difficult and manged three lengths, but really enjoyed swimming and was willing to continue. Fast forward ten weeks and Eddie is swimming twenty six lengths and is also attending two exercise classes per week. Eddie feels his fitness levels have increased and is feeling much happier and activated to care for himself. His clinical indicators of long term condition control also improved.

The redesigned integrated neighbourhood teams include a wellbeing champion and this offer is provided by link4life the borough arts, culture, sports and activity provider. The INT is delivered through a multi sector provider partnership. Both ITS and INT services are due to their partnership nature governed through a bespoke integrated governance between organisations framework.
Appendix 2: Locality Snapshot

**Bolton**
- 18/19 as a transition year for LCO including refining the model and implementing phase 1 arrangements in shadow form.
- Initial phase of LCO to include adult social care, acute, community and primary care with mental health in phase two.
- Strong emphasis on neighborhood working and integration.

**Bury**
- LCO Board in place.
- LCO-5 providers facilitating joint planning and transformation of services.
- Mutually binding contract in development and to be in place in April 18.
- Integrated Neighbourhood teams by April 19.

**Rochdale**
- LCO established – ONE Rochdale.
- Single integrated commissioning function in place.
- LCO Board established.
- Lead provider contract in place, which reflects demand management and ambitions as outlined in our Transformation Plan.
- LCO Chief Officer appointed and leadership/management arrangements in place.

**Wigan**
- Healthier Wigan Partnership Alliance Agreement in place, including core health providers & commissioners, Wigan Council and GPs.
- Healthier Wigan Partnership Programme defined.
- GPs and wider services alignment at 30,50,000 populations.
- Place-based health and care and public service model operating on a service delivery footprint.
- Integrated Community Services in place.
- Start Well Phase 2 design under consideration.
- Wigan GP Collaborative formed.

**Oldham**
- Shadow LCO and services in place – April 2018.
- Establishment of an Alliance contract.
- CCG aligns with LA (SCF).

**Tameside & Glossop**
- Creation of single place based budget for integrated strategic commissioning.
- Clinical and managerial leadership aligned to wider public sector and life course model.
- GP leaders driving neighbourhood development from within ICFT.
- 5 x neighbourhood teams co-located, operational and driving quality improvement/service transformation.
- Full rollout of social prescribing complete.
- Primary Care Access Service agreed post public consultation.

**Salford**
- Commissioning pooled budget, LCO and Salford Primary Care Together in place since 2016.
- Joint LCO and Salford Provider Board together with VCSE in place.
- Transformation programme implementing neighbourhood teams, improving primary care access, and supporting people at home and pathway redesign for adults during 2018/19.
- Integrated programme of work for children well established.

**Trafford**
- Mar: Local Care Alliance 7 originating providers to sign MoU, shadow form from Apr.
- CTRT 18/19:
  - Completion of Outcomes and Consultancy work leading to KPI baselining.
  - Operating model & Governance developed through live testing 4 LCO transformation pathways.
  - Define 4 neighbourhoods delivery models.

**Manchester**
- Manchester Local Care Organisation launched (01.04.18); Partnering Agreement in place.
- MLCO Target Operating Model developed.
- 12 GP Neighbourhood leads in post, 1819 priorities identified, wider INT to be operational in 18/19.
- TF-funded new care models mobilisation; benefit impact assessment underway.
- Plan for safe transition of year 1 services in place.
- Staff and partner engagement.

**Stockport**
- Provider Alliance Board and Alliance Agreement in place.
- Joint management structure in place.
- Neighbourhood leadership infrastructure in place.
- Procurement concluded with decision to remain in Alliance.
- Concluded a final public consultation successfully.