NHS
Bury
Clinical Commissioning Group

Meeting: Governing Body (Virtual Meeting)

Meeting Date	28 July 2021	**Action**	Consider
Item No.	6.0	**Confidential**	No
Title	Integrated Care System Update		
Presented By	Geoff Little, Chief Officer Will Blandamer, Executive Director of Strategic Commissioning		
Author			
Clinical Lead	-		

Executive Summary

The attached documents provide an update in respect of: -

- The Greater Manchester Transformation Programme;
- The locality;
- Recent Staff Briefing Note.

Recommendations

It is recommended that the Governing Body:

- Notes the current update.
- Raises any comments/questions on the latest ICS developments.

Links to CCG Strategic Objectives

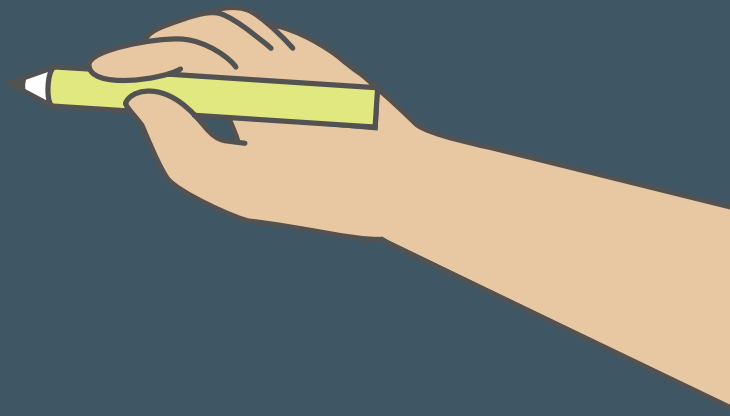
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF *N/A*	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐
The main risk associated with this paper relates to Conflicts of Interest, in terms of process, implementation and assurance. There are policies in place, however there is always a risk a declaration may not be captured. The process for seeking declarations at each meeting acts as a safeguard, however the CCG could be challenged on the robustness of arrangements.						

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Greater Manchester Health and Social Care Partnership

ICS TRANSITION STAFF BRIEFING JULY 2021 (1)



GMCA GREATER MANCHESTER COMBINED AUTHORITY

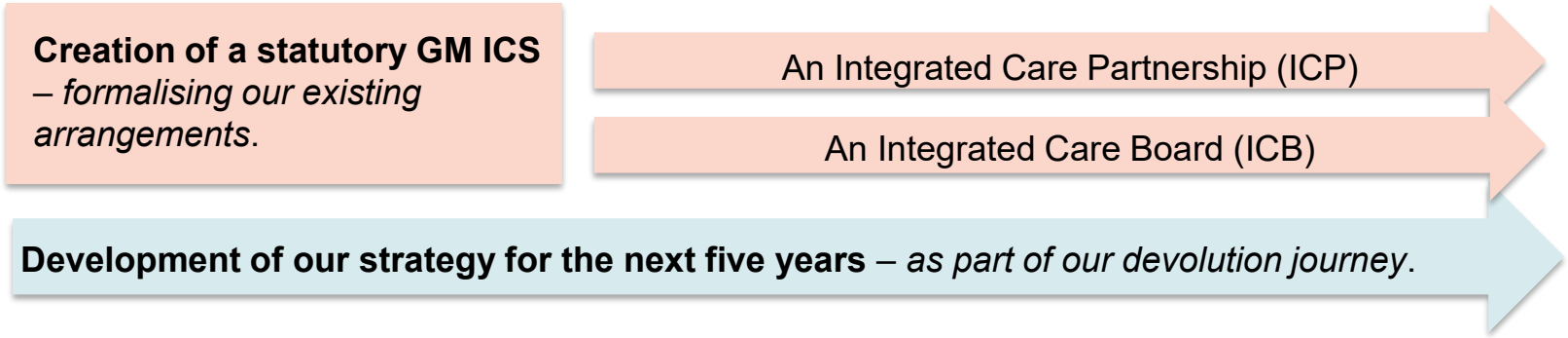
NHS in Greater Manchester

CREATING A STATUTORY INTEGRATED CARE SYSTEM

In February 2021 the Government's White Paper announced a number of new measures as part of a proposed Health and Care Bill, including the **creation of statutory Integrated Care Systems** (ICSs). **An Integrated Care System (ICS) describes a more joined up way of working across different organisations to meet health and care needs across an area.**

In Greater Manchester we have been working as an ICS for the last five years – with strong working partnerships between health and social care and the voluntary sector. The creation of a statutory Integrated Care Partnership (ICP), which will be a joint committee, and an Integrated Care Board (ICB) (previously referred to as the ICS NHS body/board) will **formalise the arrangements** we have in place.

At the same time, we're also developing our health and care strategy for the next five years (following on from 'Taking Charge'). This is happening alongside work to create a statutory ICS – and while they're linked, it is helpful to think of them as **two programmes of work**.



HOW WILL THIS LOOK IN GREATER MANCHESTER?

- The new statutory nature of an ICS will allow us to build on the ambitious and ground breaking ways we have been working over the last five years and continue to evolve to deliver even better health and care for the people of Greater Manchester.
- The GM ICS will operate on three levels:
  - **Neighbourhood**
  - **Locality**
  - **Greater Manchester**
- There will continue to be **team working** in neighbourhoods, localities or districts, and at GM level, just as there is now.
- It will mean continuing to **build upon and improve partnership working** across organisation boundaries; working together with VCSE colleagues and our communities to deliver a new five year vision and plan which we we're now starting to draft.

PROGRAMME OVERVIEW

This programme, the GM Statutory ICS Transition programme, the 'ICS Transition Programme', oversees the creation of the statutory ICS and has two phases:

(1) **Design phase** - to September 2021

(2) **Implementation phase** – September 2021- April 2022

And 14 workstreams -

Workstream	System lead
GM Operating Model	Sarah Price (GMHSCP
Establishing the GM ICS	Sarah Price (GMHSCP) and Eamonn Boylan (GMCA)
The locality approach	Geoff Little (Bury CCG)
CCG safe transition of functions	Su Long (Bolton CCG)
GM and locality spatial levels	Su Long (Bolton CCG)
Financial framework and funding flows	Steve Wilson (GMHSCP/GMCA and Ian Williamson (MHCC)
People and culture	Janet Wilkinson (GMHSCP) and Craig Harris (Wigan CCG)
GM Provider Collaboratives	Tracey Vell (GM Medical Executive/HInM) and Martyn Pritchard (Trafford CCG)
Place-based Provider Collaboratives	Karen James (T&G IC NHS FT), Geoff Little (Bury CCG) and Tracey Vell (GM Medical Executive/HInM)
Clinical and care professional leadership	Tom Tasker (GM Medical Executive/Salford CCG)
Population health	Joanne Roney (MCC) and Jane Pilkington (GMHSCP)
Developing the GM Strategic Plan	Warren Heppolette (GMHSCP)
Health innovation, data and digital	Ben Bridgewater (HInM)
Communications and engagement	Claire Norman (GMHSCP/GMCA) and Craig Harris (Wigan CCG)

LATEST UPDATES

The Greater Manchester Statutory ICS Transition Board, 'the ICS Transition Board' has been established to oversee the programme. It is made up of representatives from all 12 impacted organisations as well as NHS providers and local authorities. It had its first meeting in June and will meet on a fortnightly basis going forward.

Updates from the ICS Transition Board on 1 July 2021:

- Terms of reference for the ICS Transition Board are being finalised – and will be available for anyone who would like a copy. Sharmila Kar (MHCC) and Evelyn Asante-Mensah (Pennine Care NHST FT, and NW NHS BAME Assembly) will be joining the board to lead on equality, diversity and inclusion and ensure this is top of the agenda throughout the process
- Work is ongoing to define the relationship between the IC Partnership and IC Board to ensure all partners are clear and comfortable about roles and responsibilities.
- A piece of work on the critical path for each of the workstreams, and the overall programme, is to take place as a priority to make sure everything is captured..
- Agreed the name of the programme to support clear and consistent communications: Greater Manchester Statutory ICS Transition Programme.
- Agreed a staff communications protocol – to help ensure all staff have the same transition experience.
- Board recognised that this will be a difficult time for staff who are still managing Covid response and recovery – and emphasised the importance of a strong wellbeing offer (including our GM Wellbeing Toolkit) – with support from the programme's Wellbeing Guardian, Professor Sandeep Ranote (GM Medical Executive).
- Recruitment process underway for the Chair and subsequently the Chief Executive of the ICS NHS Body.

WHAT IS COMING UP?

Our People and Culture workstream are developing a detailed briefing pack to answer the employment related questions they are able to, including the development of transition principles and employment stability principles to try and answer more detailed questions. This will be issued later this month. Further updates will be provided as national guidance is issued.

There are still a lot of questions we don't have the answer to, but we're working hard to answer as many as possible.

We will continue to keep you updated on a regular basis, even if there's nothing new to report.

In the meantime:

- If you have any immediate questions, please do feed them up through your own management processes in your organisation
- Uncertainty can be stressful – **look after yourself and your team** using our Greater Manchester Wellbeing Toolkit

KEY DATES

June

- Publication of the Design framework

July

- First reading of the Health and Care Bill
- Publication of the national HR framework. This will help us understand how our team will move into the new organisation.

September

- Appointments to IC Board Chair and Chief Executive posts and confirm proposed governance arrangements for the new board.

December

- All ICS NHS Body board appointments made. This will form the leadership team for our new organisation.

December 2021 – March 2022

- Work will continue at pace to prepare for the creation of the new ICS NHS body and statutory GM Health and Care Board.

April 2022

- It is planned that staff will move into the new organisation from 1 April 2022. From April those staff that transfer will have a new employer – but there'll still be work to be done to develop our GM and locality functions. We expect colleagues to experience minimal changes on 1st April itself.

NEXT STEPS IN PROGRESSING THE LOCALITY APPROACH IN THE GM ICS

Context

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

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

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

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

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

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

Confirming what we have already agreed

6. We are clear on the architecture:

The Locality Model

locality structures would feature a consistent locality model operating with -

- **A neighbourhood approach** with integrated working, connecting to PCNs and to communities and the full range of local partners
- **A Locality Board** (that can deliver accountability for decisions and budgets at place level) and includes civic, clinical, care professional, provider and VCSE partners as an integral element of the governance
- A "**place based lead**" (accountable person to GM ICS for health and care)
- Appropriate **accountability agreements** between partners in the locality and clear **delegations** to enable place based delivery
- A mechanism for the **priorities to be decided together** in the locality and a process for determining consequent financial flows to providers or provider alliances
- A system of **clinical and care professional leadership** input
- Provision of an appropriate organisational arrangement for the **deployment of locality based ex CCG staff**
- An articulated **relationship with their local Health and Well Being Board**
- a means by which **locally based providers work together** in some locally determined form of alliance (but which 'typically' would be expected to include the acute services provider, mental health provider, general practice and wider primary care, community services, VCSE, social care providers). This alliance should be an integral element of the leadership group and engage fully in shared priority setting, shared planning and delivery of care, shared stewardship of the combined, pooled of aligned resources, and shared accountability for delivering the expected outcomes, They would also need to ensure that the group was informed on recognising the need for financial resilience in provider organisations whilst identifying clinical validated plans for improving the value of healthcare spending as part of any redistribution.

The GM Arrangements

GM collaboration would similarly confirm clear features including:

- **Provider Collaboratives** that operate across GM with formal governance to plan and deliver diagnostic and acute care as defined in the spatial model. The governance arrangements must enable the constituent organisations to hold/manage a shared budget and to address the associated shared risks and benefits. These must also support the shared learning and development of their constituent organisations. They would require additional resources and strengthened governance to underpin the Collaboratives' work if they are to manage key programmes of activity.
- Capability at GM level to discharge the **functions, governance and legal requirements of a statutory ICS** (as constituted in the forthcoming legislation) whilst being consistent

with the existing devolved GM structure and process. The engagement process referenced the need to address and agree the new governance structure at GM level but focused more thinking onto the operating model beneath this level and further work will need to be done on this once a new operating model has been agreed.

- There will be **management capability at GM level** to discharge the ICS statutory functions, convene the constituent partners within GM as appropriate and agreed, organise and deliver GMS wide enabling functions and deliver the 'upwards, outwards and downwards' accountability for the agreed GM priorities and expected outcomes
- A **system of joint planning convened at GM level but with constituent localities and collaboratives** fully engaged to identify the synergies and connections between allocated resources. This would support the ICS with calibrating allocations and ensure a seamless coherent deliver of programmes (eg connect the work on addressing both the stock and the flow of the planned care programme; join up cancer services delivery with cancer screening etc).

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

Taking a bottom up approach

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

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

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

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

Recognising dependencies whilst maximising clarity for localities and their teams

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

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

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

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

Summary of proposed actions

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

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

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

WARREN HEPPOLETTE

JULY 2021

Bury CCG/OCO Staff Briefing.

To be circulated in advance of the CCG/OCO staff briefing on 21st July at 10am

Will Blandamer – Executive Director

Exec Summary

1. The legislation around NHS re-organisation is progressing through parliament and is likely to be passed, to be affected from 1/4/22.

2. We expect all CCG staff will transfer employment to the Greater Manchester ICS from 1/4/22.

3. Greater Manchester guidance says "we expect minimal changes on 1st April itself"

4. We expect most CCG staff will continue to be deployed locally.

5. There is some work GM wide that may result in a small number of Bury CCG staff being deployed at a GM level. We do not have clarity on this currently but will keep everyone informed.

6. We have a good plan in Bury to continue to transform our system for Bury residents

7. We are building our new partnership arrangements now to operate in shadow form during this transition and be ready from 1/4/22.

8. The new arrangements allow us to continue to blur the lines between organisations and between commissioning and provision – and to work more and more as one system.

9. Because of our integrated management arrangements, we expect to provide continuity of management leadership through the transition and past 1/4/22.

10. Because we are developing a clinical and professional senate, we expect to provide continuity of clinical leadership.

11. There is still a lot to work out – we are awaiting the legislation, the national HR framework, and the finalisation of the GM operating model. We will keep you informed.

12. A GM wide staff briefing is due this week (w/c 19/7/21) and will be widely circulated.

13. We know the uncertainty is challenging, particularly when everyone is working so hard. Look after yourself and we will provide as much information as we can.

Briefing Paper

1. The 2nd reading of the health and care bill in the House of Commons was on 14/7/21 and it is likely to become legislation.

2. Subject to legislation the process to appoint the Chair of the GM ICS (Greater Manchester Integrated Care System) starts imminently and the national process to appoint the Chief Executive of the GM ICS will commence shortly afterwards with both intended to be complete by September. Other Senior Leadership posts will be appointed subsequently.

3. Further national employment guidance is due shortly. We expect the national guidance to confirm that all CCG staff will transfer employment to the ICS – for us that means CCG staff employer will be the Greater Manchester ICS. The GM ICS replaces the statutory role of all 10 CCGS in Greater Manchester.

4. Work is continuing across GM to develop the high-level operating model for the ICS. There are key themes/work programmes on for example, governance, financial flow, the role of provider collaboratives etc. Details of the GM wide transition work are attached.

5. The GM Staff briefing guidance of 8/7/21 confirmed that "It is planned that staff will move into the new organisation from 1 April 2022. From April those staff that transfer will have a new employer – but there'll still be work to be done to develop our GM and locality functions. We expect colleagues to experience minimal changes on 1st April itself."

6. For us in Bury we expect that all CCG staff will transfer employment to the GMICS and the bulk of staff (by which we mean the significant majority) will be deployed locally in Bury. This has been the position of the CCG leadership team at all points since the arrival of the White Paper and continues to be our expectation.

7. It is not however possible at this point to confirm <u>all</u> staff will be deployed in Bury – there are some services where there is work to consider whether local capacity in each of 10 places in GM should be aggregated to plan and deliver services once – for example in commissioning some surgical services or complex mental health services, or very specialist cancer services, or some aspects of individual funding review decisions. But we believe this will be a small minority of Bury CCG staff involved.

8. It is also true to recognise that the statutory functions of CCGs will be taken on by the GM ICS and may be considered best done once rather than 10 times therefore some staff will necessarily need to follow. Again, we believe this will be a small number of Bury CCG staff involved.

9. Further GM wide HR guidance is due this week (w/c 19/7/21)

10. The focus for us remains continuing our journey of transformation and partnership working in Bury.

11. In Bury we have refreshed our locality plan – our strategy for health, care and wellbeing. – endorsed by all Bury partners at our System Board and by political and clinical leadership at the Strategic Commissioning Board. This operates as our 'north star' during the uncertainty of transition, and it is attached for reference

12. In Bury we also continue to make progress on our transitioning to our new partnership system for health, care and wellbeing in Bury.

    - Terms of Reference in development for a new Locality Board – which will in the end replace the CCG Governing Body, the Strategic Commissioning Board, and the current System Board
    - The Integrated Delivery Collaborative Board – building out of the work of the LCO - is in place and beginning to be the focal point for the reporting of all transformation and assurance in the system
    - We are accelerating our work on building integrated neighbourhood team working
    - We have broad consensus on the proposition of a clinical and professional senate – operating as a borough wide network with a steering group potentially elected by the membership of the network
    - Developing proposal on single processes of system wide quality assurance, improvement, and safeguarding arrangements in way that can work as a 'golden thread' through all working.
    - Development of a single strategic finance group seeking to operate in a transparent and open book way as a system – recognising the value of the 'Bury pound'.
    - The work of enabling groups – on workforce development, estates, IM&T and so on – really beginning to focus as a system on their contribution to the transformation we describe
    - We have repositioned the role of the Health and Well Being Board to be a 'standing commission' on health inequalities.

13. A brief slide deck showing the inter-relationships between these structures and a brief update on progress (as reported to the Strategic Commissioning Board on Monday last) is attached.

14. Importantly we have some excellent examples of where we as a whole system are working together around particular priorities. This is where a transformation programme is being designed by the whole system and the best people and expertise is contributing to it regardless of employer or management reporting (e.g CCG, or Council, or what was the LCO, or providers, or the GP Federation) – in elective care, in urgent care, in end-of-life care and others. This is the future way of working envisaged in the white paper as a whole system not limited by organisational silos.

15. It is the belief of the CCG leadership team that the more confidence and certainty and clarity we can bring to the development of the local partnership arrangements the more likely it is that we are able to influence the shape of the final GM operating model. We are for example grateful to the leadership of the LCO in securing the transition of the LCO to a whole system model of integrated and collaborative delivery and would commend all colleagues to contribute to the development and operation of the integrated delivery board.

16. CCG Functions

17. In the Secondary Care Pillar
    - For CCG commissioning and transformation staff in the secondary care pillar we see most people employed by the ICS but deployed locally – managerially accountable locally and fully connected to the work of the Integrated Delivery Board and to neighbourhood team working in the spirit of whole system working. It is possible that the GM wide spatial levels work may require us to aggregate the whole or part of a smaller number of roles for services considered to be best planned and delivered GM wide. There is not as yet clarity on this.
    - The Children's Commissioning Team will continue to be employed and managerially accountable to locally within the integration context within the locality.

18. In the Community Commissioning Pillar
    - For primary care staff in the community commissioning pillar, we are already developing a more joined up partnership model of GP leadership, respecting the unique contribution of current CCG, GP Fed, PCNS, neighbourhood clinical directors and the LMC, that will operate as a single borough GP leadership voice. We are united in a belief that a strong boroughwide leadership voice of GPs is important and will allow a solid connection to emerging GM level structures such as the GM primary care board.

    - For medicines optimisation staff we believe the local focus of leadership and support and professional expertise is paramount and we would expect local accountability and continued connections to the GM wide medicines management arrangements. This constitutes no change in the current arrangements.

    - For mental health and learning disability commissioning staff within the pillar we know that mental health services form an important part of our transformation plans. We see most people employed by the ICS but deployed locally – managerially accountable locally and fully connected to the work of the Integrated Delivery Board. It is possible that the GM wide spatial levels work may require us to aggregate the whole or part of a smaller number of roles for services considered to be best planned and delivered GM wide. Like the secondary care pillar there is not clarity on this, but we will share it with you as soon as there is.

19. For the Nursing and Quality pillar we see the following:

    - The Quality improvement team is already working on building out of the existing CCG quality assurance processes into an integrated whole system quality assurance process – reporting directly to the locality board. We see the focus in strengthening the relationships with all partners and developing single processes through the IDCB. We will need as a system to manage quality assurance processes in the NHS in accordance with the reporting obligations described in an accountability agreement between the GM ICS Board and our locality board.
    - The CHC team are doing excellent work locally in difficult circumstances and we have recently strengthened capacity in the team. CHC team colleagues are working closely with the GM wide CHC network. We do not expect any change to the operation of this team, but it is possible over time (probably not from 1/4/22) that a GM ICS we will greater standardisation of process, and also may also achieve economies of scale in terms of commissioning to address gaps in market provision.
    - The CCG Safeguarding function already work closely with all safeguarding arrangements in the borough in NHS organisations and across the Bury Integrated Safeguarding Board. We see no change in the operation and local deployment of this team – and it is essential that we land safeguarding (and quality) arrangements safely throughout the transition, but again it is possible over time there will be some move to consolidate some functionality at a GM level.

20. For CCG staff in corporate functions such as finance, business intelligence, IM&T, and comms, and in corporate core we see no reason to move back from the models of integrated team working already in place between council and CCG. We would see further strengthening of the connections with NHS providers and indeed other providers, in the borough – working through the 'enabling groups' of the system as a whole. However again it is possible that as the GM ICS takes on CCG responsibility there may be some functions - particularly around statutory accountability - considered best done once, and a small number of staff may be affected. This work across GM has not yet reported.

21. For CCG clinical leadership staff there is a commitment that this invaluable expertise is within scope of the national employment commitment to CCG staff. We see the development of the clinical and professional senate providing the foundation stone from which mandated clinical leadership and clinical consensus can inform the operation of the system as a whole.

22. For managerial leadership, we will seek to provide certainty and continuity of managerial leadership of the health and care system partnership arrangements, subject to the availability of the GMICS funding to support the NHS element of these costs. For example;

    - The Chief Executive of the Council and Accountable Officer of the CCG (Geoff) is a joint appointment and a council employee - recognisable to all partners as

the ‘place-based lead’ for the health and care system during the transition and after 1/4/22.

- The Exec Director of Strategic Commissioning (Will) is a joint appointment and a council employee, and it is intended will continue from 1st April in a strategic health and care leadership role.
- The Exec director of finance for the CCG (Sam) is a joint appointment and will continue as the council s.151 officer and it is intended will be the key strategic finance lead for health and care for the borough in relation to the accountability agreement between the GM ICS and the locality.

23. The above represents the CCG leadership expectation of the future landing points for CCG staff and reflects the representations we are making into the developing operating model of the GM ICS. There are a number of general points to make.

    - As indicated, there is work progressing across GM on spatial levels and on statutory function. Bury CCG officers are connected to and informing these discussions and we will seek to keep staff potentially affected engaged.

    - The flow of funding from the GM ICS is not yet clarified. Essentially NHS funding will flow in 3 ways – to localities to be held alongside council funding as an integrated and capitated budget for the place, to the GM ICS itself for its own running costs including transferred CCG staff, and directly to providers at a GM level. While finalising this flow does not affect the commitment that all CCG staff will be employed by the ICS, the relative balance will determine in part the managerial deployment of the minority of current CCG staff not deployed locally. It is also true that the whole NHS system in GM faces significant financial challenge.

    - The accountability arrangements between the GM ICS and the locality board, governing the use of NHS spend in Bury is not yet finalised.

24. We should also recognise that although council staff and other NHS provider staff are not directly affected by these changes, non-CCG colleagues value the steps we have taken to integrated council and NHS working arrangements with the aim of improving outcomes for residents and may equally be concerned about any disruption to local working arrangements from the closedown of the CCG. It is hoped this paper provides some confidence.

25. We recognise this is an uncertain time for all CCG staff. We will endeavour to keep you informed, both from within Bury and also on the basis of GM wide and national HR guidance. Please speak to your manager, and Will will attend any and all staff meetings to update as required. In the meantime, support and advice on wellbeing is available for CCG staff through the normal routes – such as the Employee Assistance programme – Health Assured – details below

Employee Assistance Programme

A 24-hour helpline from Health Assured to support you through any of life's issues or problems.

Free 24-Hour Confidential Helpline

0800 030 5182

Online Health Portal: healthassuredeap.com,