# Bury Integrated Care Partnership

## Operating Model from 1/4/22.

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## Purpose of Document

In advance of the establishment of the GM ICS from 1/4/22, the Bury Health and Care System has moved to establish the new partnership arrangements in transition form. This document consolidates the progress to date and describes as far as possible how the system will operate in practice.

It is recognised that the arrangements may continue to develop and refine up until 1/4/22 in the light of national guidance and the GM wide operating model. We will also use the transition period December 2021 to March 2022 to test the arrangements described here with a series of scenarios – understanding how the system would work to address particular issues. This document will be updated as required.

It is also recognised that the arrangements may change and develop after 1/4/22 and again this document will be updated as required.

A strategy and operating model for health and care in the borough sits in the context of the ambitions of the Let's Do It 2030 Strategy for the Borough – securing sustainable economic growth and reducing the inequalities in life chances for many borough residents.

## Presentation

We are presenting this operating model in a way that meets three objectives.

- to provide confidence and assurance to key stakeholders, including the GM ICB and Bury Council – that we can effectively discharge the obligations of the locality board in relation to delegated authority.

- To describe to all partners in Bury the way the system will work in as clear and simple way as possible.

- To provide as much clarity as possible to staff affected by the changes, notably CCG staff.

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# Operating Model of the Bury Integrated Care Partnership System

## A. Background and Context

1) From the 1/4/22 – subject to legislation – the NHS is being reconfigured to work as part of Integrated Care Systems. The practical impact of this for Bury is the abolition of the CCG with its functions adopted by a single Integrated Care Board for Greater Manchester, and the creation of a number of other GM wide partnerships.

2) This is a high-level operating model for the **Bury Integrated Care Partnership** to be effective from 1/4/22. The term "Bury Integrated Care Partnership" describes the joint work of all partners in the health and care system to deliver the Bury Locality Plan – our strategy for health, care and wellbeing. The locality plan can be seen here.

3) The Locality Plan for Health and Care in Bury sits as one part of the Strategy for the Borough – Let's Do it 2030 - seeking to improve life outcomes for all residents in the borough. Let's Do It can be seen here

4) This document is an operating model for the way in which partners work together as a Bury Integrated Care Partnership, and refers to the partnership meeting arrangements, and the roles capacity and governance and running costs required to support the system.

5) The Bury Integrated Care Partnership is part of the wider Greater Manchester Integrated Care System, and we work closely with colleagues across Greater Manchester – including the GM Integrated Care Board, the GM Provider Federation Board, and the GM Primary Care Board – to both contribute to and benefit from the conurbation wide perspective.

6) In developing this locality operating model, we assume.
   - All CCG staff will TUPE to the GM ICS, and the bulk of staff will be redeployed in Bury. The expectation is that the number of posts that will not be locally redeployed back to Bury will be small.

   - We recognise that some CCG staff will be deployed at a GM level either directly in the GM ICB or via the GM provider Federation Board and other GM NHS partnerships. The posts in scope are yet to be determined.

   - We also recognise that most staff will continue to be deployed locally but the connections to GM wide working may be strengthened – connecting expertise across all parts of GM and the GM core.

   - We are further developing our integrated working arrangements in Bury e.g in terms of the work we have done in the last year to blend the expertise across what was the One Commissioning Organisation, and the Local Care Organisation, and in the way we have integrated business support functions between council and NHS – for example in finance, comms, business intelligence, IM&T.

## B. Locality Plan for Health and Care and the context of 'Let's Do It'.

7) Regardless of organisational change, the partners in Bury have recently adopted a refreshed Locality Plan. The Bury Locality plan describes our strategic ambition for the health and care system in Bury. It remains our 'north star' – to retain a focus on the outcomes we seek to achieve for residents of Bury during a period of transition. The Bury Locality Plan can be accessed at… In summary the agreed objectives are as follows

1) We will seek to **influence the factors that improve population health** and wellbeing and reduce health inequalities and foster inclusion
2) We will **support residents to be well, independent, and connected** to their communities and to be in control of the circumstances of their lives
3) We will support **residents to be in control of their health and well being**
4) We will **support people to take charge of their health and care and the way it is organised around them, and to live well at home**, as independently as possible
5) We will **support children to 'start well'** and to arrive at school ready to learn and achieve
6) We will ensure all residents **have access to integrated out of hospital services,** that promote independence, prevention of poor health, and early intervention
7) We will work through **5 neighbourhood teams** to create opportunities for front line staff to know each and work effectively together
8) We will secure **timely access to hospital services where required**
9) We will work to **reduce dependence of people on institutional care** – hospitals and care homes.
10) We will work to ensure **high quality responsive services** where people describe a good experience of their treatment

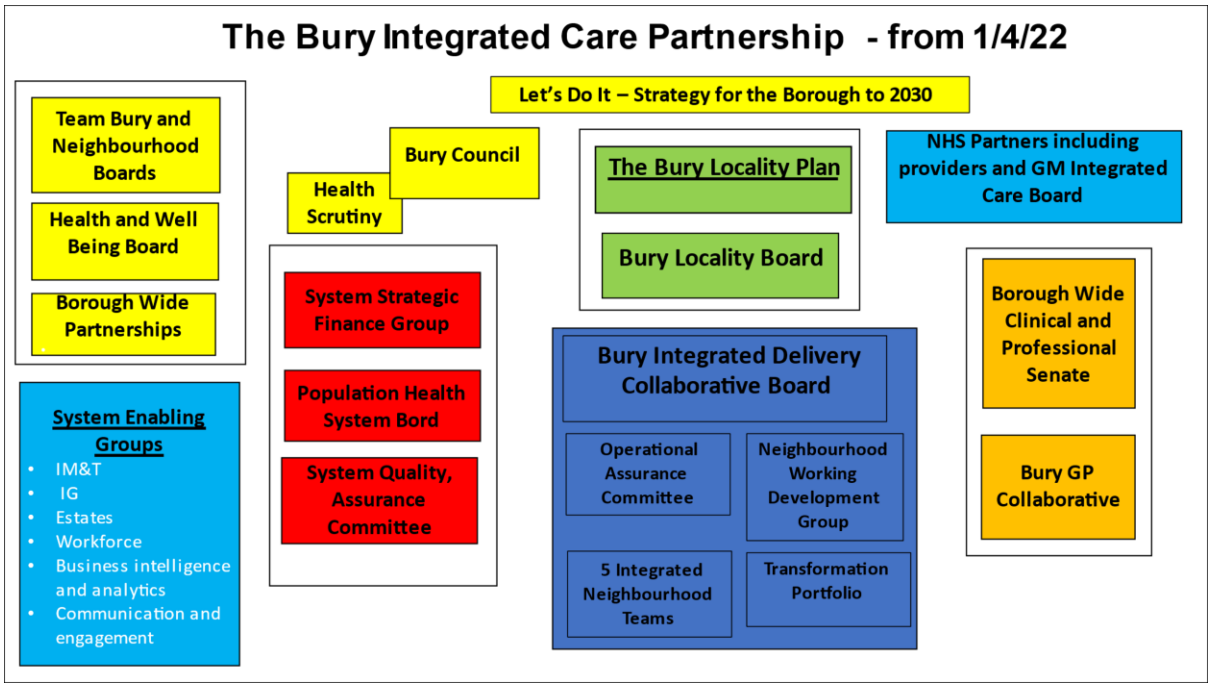
### 8) Let's Do It – The Bury Borough Strategy for 2030

The Let's Do It strategy is committed to securing access for all residents to sustainable economic growth, and to address the entrenched inequalities in the borough the limited life chances and outcomes for some residents and communities.

The Bury 2030 Strategy is for everyone who has a stake in our Borough's future: local people, community groups, organisations of every sort, whether public, private or voluntary. The strategy is a call to action for everyone in our Borough to get behind the change we all want to see and do all we can to make it happen. It is a commitment to a decade of reform; a bold ambition to tackle deprivation and improve growth through a programme of work that covers people; places; ideas; infrastructure and the business environment.

## C. Partnership System

9) Partners in Bury have from October 2022 established in transitional form the partnership arrangements we will have fully operational from 1/4/22. The diagram below describes this.




10) The component parts of our partnership model are as follows

**6.1 Locality Board**

- The partnership leadership of the Bury Integrated Care Partnership is through the Locality Board, made up of senior representatives from all relevant statutory organisations and other key partners. It will bring together political, clinical, managerial and professional leaders to help shape the strategy, prioritise and focus on integrated health and care for the Place. The Locality Board will include the Council, Primary Care Leadership, Northern Care Alliance, Pennine Care NHS FT, Manchester Foundation Trust, GP Federation on behalf of PCNs, the Greater Manchester ICB, the Bury VCFA, and Healthwatch. The Locality Board sets the shared strategy for the partnership and ensures triple aim outcome are improving, including overseeing the implementation of the planned budget for health and care in the borough (some of which may be formally pooled), ensuring services are high quality efficient and effective, and ensuring population health outcomes for our Borough are improving. The Board will set the direction for the way services are delivered as described in the Locality Plan. The terms of reference for the Locality Board can be **seen at...**

- To discharge its functions effectively the Locality Board should operate as formally a joint committee of the statutory partners – that is a joint committee of the boards of the NHS organisations who are party to it, including the GM Integrated Care Board, and as a committee with delegated authority from the Council. Operating as a formal joint committee will not only support delegated decision making in relation to any financial pooled budget, but will allow more nimble decisions of policy, strategy, and operational decisions. For the Locality Board to operate as a Joint Committee, each board of the

members will need to agree the necessary scheme of delegation from its own board to the Bury Locality Board.

- The Locality Board will have an accountability to all of its partners. In particular the Locality Board will together own the delivery of the MOU between the GMICB and the Bury Integrated Care Partnership for the delivery of GMICB priorities and commitments.

**6.2 Integrated Delivery Collaborative, and Board**

- The 'engine room' of the Bury Health, Care and Well Being system is the Integrated Delivery Collaborative'. This is the vehicle through which we are building relationships, structures and solutions between all the partners to drive improvement in the way we are working to improve triple aim outcomes for our Borough, and to deliver services and interventions in innovative ways. The IDC includes all partners to the Locality Board and several other key providers – e.g Persona (the Council owned social care delivery organisation), the Voluntary and Community Faith Sector Alliance and Bardoc. The Integrated Delivery Collaborative supports collaborative working at borough, neighbourhood and individual community level.

- We have undertaken significant organisational development work to determine the purpose, principles and values of the IDC. We have defined the purpose of Bury integrated delivery collaborative to be enabling health and care organisations and the voluntary sector in the borough to achieve more together than each individual organisation could do alone to provide more effective integrated services, to achieve better outcomes and experience for people, to improve cost control in health and care services and to have a greater impact on improving population health, reducing health inequalities and increasing inclusivity. Our scope includes all health and social care services for people of all ages. We recognise that for some services their optimum footprint may be greater than the borough of Bury. However, it is still essential these services are considered part of, and integrate with, the Bury system for the benefit of our local population.

- The vision of Bury IDC is

  - ✓ To create the right environment, right relationships and best conditions to deliver effective integrated care, closer to home

  - ✓ To work with all system partners to deliver the health and care system's ambitions for transformation so as better to achieve the triple aim (better care, better health, better value), address health inequalities and be inclusive.

  - ✓ To develop the platform to deliver effective integrated health and care at neighbourhood level in line with the locality plan and across the entire system.

  - **The principles of the IDC are as follows:**

  *People*

  - ✓ We will seek to develop and promote self-care and wellbeing
  - ✓ We will put neighbourhoods at the heart of our work with an emphasis on quality and safety.

- ✓ We will emphasise assets and strengths at every level: individual, family and community, encouraging and enabling people to take responsibility for their own health and wellbeing.
- ✓ We will seek out, value and learn from the lived experience of local people
- ✓ We value and will provide skilled leadership to our services and system which is representative of all aspects of our diverse community

*Relationships*

- ✓ We will prioritise develop and strengthen our relationships including by doing hard things together, such as working through conflict
- ✓ We will value creativity and innovation, including but not limited to digital innovation, which improves the personal, social and economic well-being of people in our borough
- ✓ We will always promote inclusivity, social justice and fairness and we will seek to add social value in everything we do
- ✓ We will be accountable in our actions to each other, to the wider system, and to the people of Bury
- ✓ We recognise, and seek always to learn more about, each other's pressures, environments, and statutory duties
- ✓ We will aim to align our work to our individual organisational priorities

*Decision-making and resources*

- ✓ We are committed to working within a jointly developed structure, with a shared purpose, and operating principles
- ✓ We will look to the IDC board as an authoritative body when, for example, there is challenge or ambiguity in our work
- ✓ We will seek to make the best use of our collective assets, to make best use of the public resources invested in the borough
- ✓ We will promote and advocate for the health and well-being of Bury people, and for the resources and access to services that people need, in our work with the Greater Manchester integrated care system

- Key tasks for the Integrated Delivery Collaborative include:
    a. To create the conditions for the delivery of high-quality integrated health and care services in each of 5 neighbourhood teams,
    b. To co-ordinate the delivery of the system wide transformation programmes – including for example urgent care, mental health, elective care, adult care transformation, learning disabilities
    c. to create the frameworks and partnership arrangements to deliver the expectations of the Locality Board as described.
    d. To assure the delivery of directly managed services

- To provide a focal point for all that we have established an Integrated Delivery Collaborative Board (IDCB), with senior representatives from all partners. The IDCB is independently chaired by Chris O'Gorman.

- The IDCB is alliance of partners and is bound together by a 'Mutually Binding Agreement' – a copy of which can be seen at ..

- There will be an MOU that describes the relationship between the Locality Board and the IDCB. The MOU describes particularly the adoption of the triple aim methodology – effectiveness, efficiency, and population health gain. A draft MOU between locality board and IDCB can be seen at:

- The national ICS guidance identifies three models that NHS providers have typically used to form collaboratives under existing legislation. The models are not mutually exclusive; they can be combined or work in parallel, and one may evolve into another. The models are described below:

| Model Type | Description |
|---|---|
| 1. Provider leadership board model | Chief executives or other directors from participating organisations come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners[1]. This model can make use of committees in common, where committees of each organisation meet at the same time in the same place and can take aligned decisions. |
| 2. Lead provider model | A single NHS trust or foundation trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required. Alongside the contract between the commissioner and NHS lead provider, the NHS lead provider enters into a partnership agreement with other collaborative members who contribute to the shared delivery of services. |
| **3.** Shared leadership model | Members share a defined leadership structure in which the same person or people lead each of the providers involved, with at least a joint chief executive. This model can be achieved by NHS trust or foundation trust boards appointing the same person or people to leadership posts. In the case of NHS trusts, this model can also be achieved by the board of one trust delegating certain responsibilities, consistent with the remit of the provider collaborative, to a committee which is made up of members of another trust's leadership team. Under either of the above approaches each provider's board remains separately accountable for the decisions it takes (even if aligned). Nevertheless, alignment of decision-making can be supported by using shared governance (such as committees in common). |

- In Bury our preferred model is Option 1 - In effect this would be described as a non-lead provider collaboration organised through a formal agreement and committee in common.

- The scope of services within the view of the Integrated Delivery Collaborative to transform and redesign to deliver improvements to improve triple aim outcomes for our population include:

  - all and any services required for the 'next step care' after a GP consultation; and
  - all care that can be provided in community settings, unless by exception – supported by specialists' opinion. Integration opportunities would therefore cover as a minimum:
  - the majority of support and services that are presently delivered in outpatients;
  - a significant array of diagnostics;
  - a range of ambulatory and same day emergency care (SDEC) pathways;
  - day case work;
  - the full range of community health services;
  - the full range of adults and children's care services; and
  - an extensive range of services provided from the voluntary sector.
  - The detail of the relative role of GM and Locality working is contained within the GM target operating model spatial planning levels of working and the detail can be seen

here. However, we expect to see the Locality Board and the IDCB as mechanism by which the inter-relationship between services, and the development of pathways – whether planned or delivered at a GM or local level – can be reconciled for the benefit of Bury residents.

**6.3 Neighbourhood Working**

- The default setting for integrated community health and care services in Bury is though joined up delivery across 5 integrated neighbourhood teams. These are:
    - Ramsbottom and Tottington
    - Bury
    - Radcliffe
    - Whitefield
    - Prestwich

- We have an operating model and development plan for integrated neighbourhood working in health and care and this can be seen at..

- The model of integrated neighbourhood team working in health and care operates at the same spatial levels as our community hubs - a focal point for community leadership and co-ordination in each of 4 places. In 2021 the community hubs have created opporuntiis for public services and volutary and community partners to come together with a shared understanding of each others role, the assets in those communities, and the residents and communities at risk of vulnerbaility.

- Increasingly wider public services are also working on the same spatial level - this includes GMP, Housing Providers, GMFRS, wide Council Services - with the understanding that prevention and early intervention across a range of public service can sustainabley improve outcomes. From a health and care perspective this work explicitiy recognises that the organisation of service delivery of health and care is actually a minority contributor to the health and well being of residents. More important is, for example, the quality of housing, the availability of quality work, the extent to which residents are connected to their communities, and whether a life is led free from harm and fear. This work is co-ordinated by the Bury Public Service Reform Board. A picture of the alignmenet of health and care INTS and the wider PSRR approach can be seen at....

- Primary care is at the heart of our model of integrated care. We have 4 Primary Care Networks working across the 5 neighbourhoods. The Primary Care Networks are supported in their development by the Bury GP Federation and work continues to explore how best to support the maturity and system leadership of the primary care networks, and the role of the GP Federation in doing so. The primary care team of the CCG/future ICB will work closely with the capacity of the GP Federation to support practices and PCNs.

**6.4 Triple Aim Assurance**

- The triple aim approach is well understood in health and care systems. It is a framework that describes an approach to optimising system performance through the simultaneous pursuit of three dimensions: improving the quality of healthcare, improving the he alth of the population, and achieving value and financial sustainability. Accordingly, the Bury Integrated Care Partnership will have a System Groups with dedicated leadership and capacity

reflective of whole system working, for each of the triple aim objective. These groups will be:

- **System Wide Quality and Assurance Group.**
  The role is to co-ordinate quality assurance arrangements on behalf of the system – connecting to uni-organisaitonal assurance processes. The Terms of Reference for the group can be seen at.

- **Strategic Finance Group**
  It will ensure oversight of the integrated fund in Bury – made up of pooled, aligned, in view funding, and also the delivery of financial risk and gainshare from system wide initiatives. It will also be a role of the FG to ensure that we can invest over the medium term into early intervention and prevention and move funding across agency boundaries at neighbourhood level. The terms of refence for the SFG is at

- **Population Health System Board**
  This strand is led by the statutory DPH Lesley Jones and supported by the capacity of the Bury Council Public Health team. The Health and Well Being Board operates as a standing commission on health inequalities, working with 'Team Bury', and a specific and operational population health board comprised of operational leadership from health and care and wider partners. The terms of reference for the HWBB and the population health board are at.

**6.5 Clinical and Professional Leadership**

- Bury has established a clinical and professional senate with the intention of ensuring clinical and wider professional (e.g social worker) leadership is significantly influencing, leading, guiding, and challenging the work of the wider partnership arrangements. It is also intended to create opportunities for strengthened clinical and professional leadership across different sectors and interfaces e.g primary care/secondary care, mental/physical health, health/care.

- A clinical senate board operates through mandated leadership and will coordinate the work of the wider clinical and professional senate. The terms of reference for the clinical and professional senate are at..

- In addition to the work of the GP Federation Bury will also seek to establish a GP Collaborative. This is a joint initiative between GP practices in Bury, the 4 Primary Care Networks, the GP Federation, and the Local Medical Committee. It is intended to support the voice of GP leadership particularly in the partnership arrangements, recognising the potential risk of the loss of the CCG as a GP membership organisation and as a key statutory authority in the borough. A draft terms of reference is at

**6.6 Enabling Groups**

- Bury Council and Bury CCG have in the last few years established a number of joint and integrated teams – a shared comms and engagement function, a shared Business Intelligence Unit, and joined up working in IM&T development. These functions will continue to build relationships with key partners to create and further mature system wide approaches where required.

- The Bury Health and Care System already has some existing system wide working groups – connected expertise from across council, NHS and other partners and these will be further developed.

- The Bury Integrated Care Partnership Groups are therefore the following:
    - Bury ICP Strategic Workforce Group
    - Bury ICP Strategic Estates Group
    - Bury ICP Business Intelligence Group
    - Bury ICP Comms and Engagement Group
    - Bury ICP IM&T Group

## D. Leadership System

11) Having described the role and function of the partnership arrangements to deliver our Bury Integrated Care Partnership, we need to consider the leadership architecture we need to manage and operate the system.

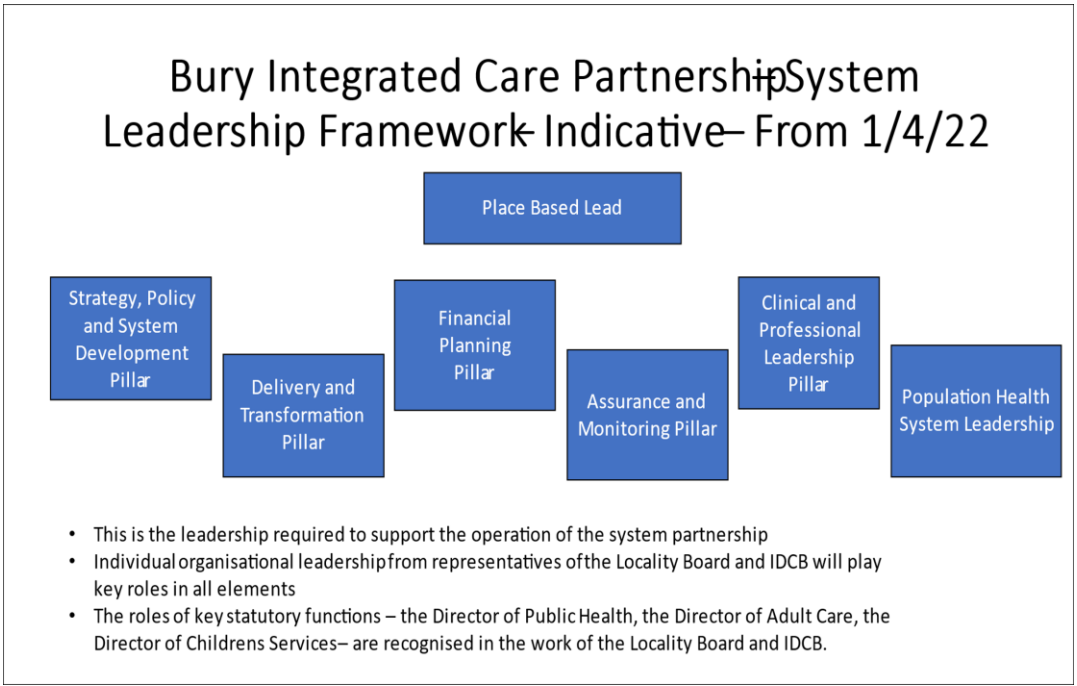
12) This is not about 'management structures' – because the system is complex with very many different organisations working together and with their own management arrangements. This is about the leadership arrangements of the partnership system.

13) The leadership architecture described below is indicative and is subject to wider consultation with all staff affected. Its is intended to represent a further step forward in the way all partners have worked together in the last 18 months – worrying less about who they work for, and rather focusing on the bringing the talents of all to the priorities of the system.

14) In particular the draft system leadership architecture draws heavily on the roles of current CCG staff who will transfer into the employment of the GM ICB, and of teams working across the Council and CCG as part of what is currently described as the one commissioning organisation, and of capacity and leadership of what is currently described at the Local Care Organisation. However, this is not about 'recreating' a CCG. It is about bringing the capacity and expertise of CCG staff, LCO staff, Council staff and colleagues from across provider organisations to support the whole partnership system be as effective as possible.

15) The following describes the pillars of work required to support the system partnership described.

16) We envisage there are 6 teams/pillars supporting the work of the place-based lead and the wider Bury Integrated Care Partnership.




17) The responsibilities of each pillar are described below.

| Pillars | Functions |
|---|---|
| **Strategy Planning and System Development** | • Strategy Development<br>• Business Planning<br>• Business Intelligence<br>• Organisational development<br>• Policy & Partnerships<br>• Ensuring enabling functions support system delivery<br>• Benchmarking |
| **Delivery and Transformation** | • Creating the conditions for system change enabling partners to work together to deliver improvements in triple aim outcomes for our population<br>• Managing the Business of the Bury Integrated Delivery Board<br>• System Reform – interventions to improve performance through system and process redesign.<br>• System Redesign – continuing pathway redesign development<br>• Creating conditions for neighbourhood team working<br>• Determining the requirements of enabling functions from a health and care perspective<br>• Workforce strategy |
| **Financial Planning** | • Financial Management – Financial Planning, Operational and Strategic Decision/Investment Support, Financial Monitoring<br>• Financial Reporting, Financial Control & Governance |
| **Assurance and Monitoring** | • Patient Experience<br>• Provider Quality Management<br>• Escalation and Resolution<br>• Clinical Quality Assurance<br>• Compliance Monitoring<br>• System Safeguarding (connected to Bury Integrated Care Partnership) |
| **Clinical and Professional Leadership** | • Convening Clinical and Professional Senate<br>• Clinical Development and Networks<br>• Connections to clinical networks on sub regional and GM footprint<br>• PCN Development<br>• Medicines Management – ongoing medicines management and prescribing support |
| **Population Health System Pillar** | • Ensuring a focus on health inequalities in all we do<br>• Reporting to Health and Well Being Board operating as a standing commission on health inequalities. |

18) The following are key considerations of leadership of each of the elements described above. It will be noted that the proposal remains subject to consultation.

**The Place Based Lead.**

- Each of the 10 Districts in GM will also identify a 'place-based lead'. The role of the place-based lead is to ensure the effective operation of the Bury Integrated Care Partnership with an accountability to both the GM ICB and the Council for the effective operation of the partnership.

- In Bury the partners have agreed that the place-based lead should be vested in the role of the individual currently the Accountable Officer of the CCG and the Chief Executive of the Council. We would expect that from 1/4/22 this person would have

a formal role/accountability to the GM ICB as well as a continuation of the role of the Chief Executive of the Council.

**Strategy Planning and System Development Pillar Lead**

- It is expected that this role is filled by the current Bury CCG/Bury Council Executive Director for Health and Care, and further that this role continues to be a joint appointment between the Council and the GM ICB. It is further expected that the staff currently formally reporting to the Executive Director will continue to report for reasons of managerial accountability but will of course work across all pillars.

**Transformation and Delivery Pillar Lead**

- It is expected this pillar lead role is filled by the current Chief Operating Officer of the LCO.

**The financial planning pillar lead**

- It is considered that the financial planning pillar lead is assumed to be the individual currently operating as the Section 151 Officer of the Council and the Director of Finance of the CCG. It is further expected that the post will continue to be operated as a joint appointment between the Council and GMICB. It is further expected that the current CCG finance team will report to the Joint Director of Finance as leaders of the Financial Planning Pillar

**Assurance and Quality Pillar**

- It is expected that this role is filled by the current Bury CCG Director of Nursing and Quality and that the staff in the current QA team and the Safeguarding and CHC staff will report to the lead of the Assurance and Quality Pillar.

**Clinical and Professional Lead**

- It is expected that the clinical and professional lead for the system leadership arrangements will be determined by the work of the Clinical and Professional Senate Board, and will in transition and beyond will be the current Chair of the Bury CCG.

**Population Health Pillar**

- It is expected that the population health pillar is led by the Director of Public Health and supported by the Council Public Health team.

19) There are three key statutory functions in the borough accountable to the Council that connect to all parts of the partnership arrangements described.
    a. The Director of Adult Services – this role is currently combined with the role of Director of Community Commissioning. There are no changes planned to the management scope of this role from 1/4/22. As now the role will work closely with all pillars described.
    b. The Director of Children's Services. Childrens services in health and care are in scope of the arrangements described above, and the Bury Children's Strategic Partnership will work to ensure the connection between the NHS service and the wider Children's partnership arrangements in the borough.
    c. The Director of Public Health will, as previously described, managing a team influencing across the borough from a population health system perspective, and particularly the work of the Health and Well Being Board

20) This structure also recognises where there are already integrated functions existing between the Council and the CCG, that we wish to build on and further develop. For Example

    a. The System Strategy pillar may have responsibility for Business Intelligence, the leadership would be provided from the existing CIO who leads the integrated NHS/Council BI function providing expertise and oversight to the team. The key task is ensuring the alignment of business and performance reporting to the system partnership arrangements, and ensuring performance and outcomes inform delivery and transformation priorities. There will be "a dotted line" to the Strategic Planning and System Development Pillar.

    b. The integrated Council/CCG Comms team will continue with the current management arrangements provided by the Council but will describe a "dotted line" to the Strategic Planning and System Development pillar.

21) That we recognise we are seeking to operate as a whole system – and that in addition to the formality of attendance at the locality board and the IDCB, there is a need for a relatively informal **system leadership group,** to be chaired by the Strategic Planning and System Development pillar lead. This brings in to the 'system management' sphere key senior operational leaders from a range of partners to work alongside the Pillar leadership described and the enabling group leads.

22) There is further work to be done to map the wider system governance of Oldham, GM and the Northeast Sector to avoid duplication. This has been partly described by work commissioned by the Northern Care Alliance and the 4 localities it serves – Bury, Oldham, Salford, and Rochdale – from Carnall Farrar and this is available at… A named "Alliance lead" has been appointed working across all 5 organisations.

## E) Running Costs

23) Partners in the Bury Health and Care System are committed to the capacity required to operate the Bury Integrated Care Partnership in way that secures the achievement of the objectives of the Locality Plan for residents of the borough.

24) Partners in Bury also recognise the national commitment that the implementation of the Integrated Care System arrangements is not in itself intended to be a cost saving measure, nor is intended to denude 'places' like Bury of the capacity to drive the scale of transformation required to deliver a clinically and financially sustainable system

25) Nevertheless, it is recognised that the Greater Manchester Integrated Care System is under significant financial pressure.

26) Our default setting is that the Bury Integrated Care Partnership needs the bulk of running costs and in scope programme management costs currently attributable to the Bury CCG. This is particularly true given the significant given that Bury is furthest from its target CCG funding than everywhere else in Greater Manchester, equivalent to £xm.

27) Bury CCG has one of the smallest headcounts of capacity, and the capacity is as below.

Overall CCG staffing structure

| Staff group | Total headcount |
|---|---|
| Admin and Business Support | 9 |
| Business Development | 2 |
| Business Informatics | 7 |
| CEO and Board | 5 |
| Chair and Non – Execs | 6 |
| Clinical Leads | 6 |
| Clinical Support | 8 |
| Safeguarding | 9 |

| Staff group | Total headcount |
|---|---|
| Commissioning | 9 |
| Communication and PR | 3 |
| Continuing Health care | 13 |
| Primary Care IT | 5 |
| Finance | 15 |
| Primary Care – Enhances services | 6 |
| Primary Care – Admin Projects | 8 |
| Meds Optimisation | 9 |

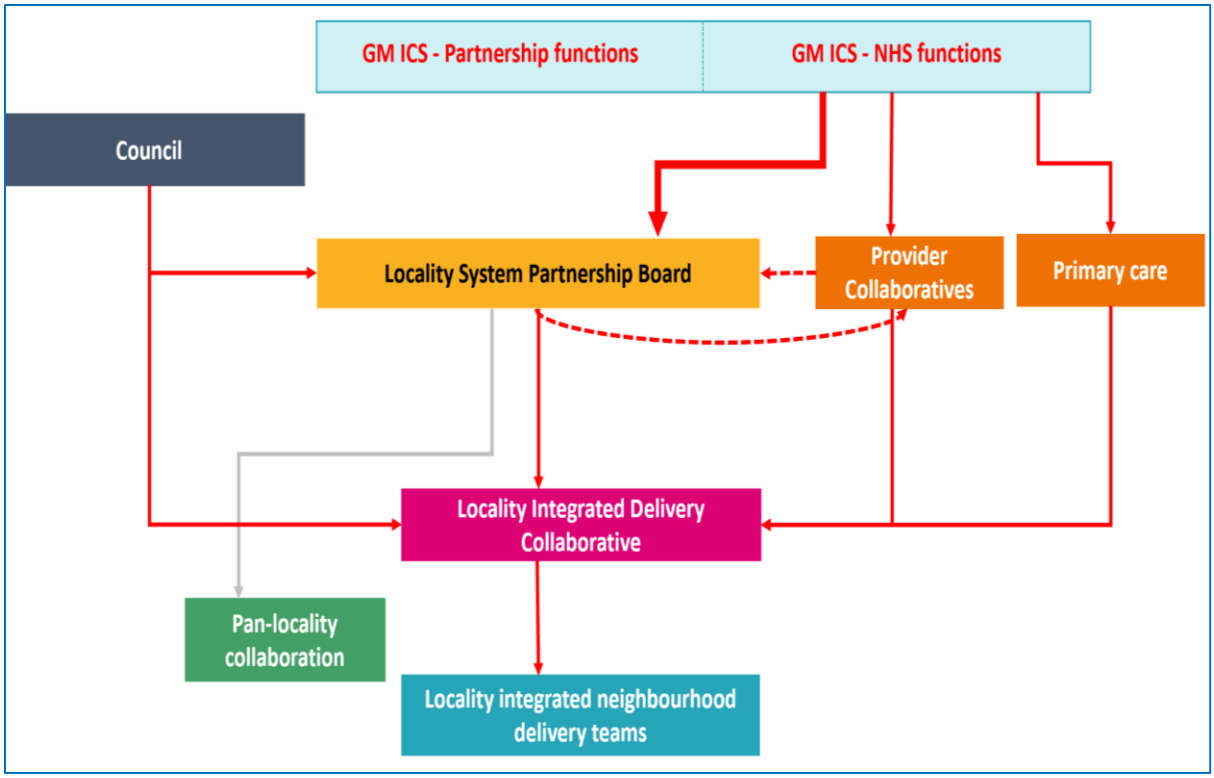
28) Further work is being done to develop the running costs proposition associated with this operating model.

## F) Funding and Financial Flow

29) We have done an initial assessment of the financial flows within the new GM ICS in tandem with the work going on across GM. Our assessment of options is as follows:

| Body | Financial flows |
|---|---|
| **GM ICS - NHS and Partners** | • Receives NHS budget allocation for the system<br>• Delegates funds to localities – these should be commensurate to the scope of the Locality System Partnership Board<br>• Provides some funding directly to provider collaboratives<br>• Provides some funding directly to primary care |
| **Council** | • Councils fund the Locality Board directly, contributing to the integrated fund for the locality<br>• Councils can fund the Locality Integrated Delivery Collaborative directly if they choose |
| **Locality System Partnership Board** | • Receives funding from the GM ICS Partnership Board / GM ICS NHS Board and the Council to create an integrated fund for the locality<br>• The integrated fund is used to fund the Locality Integrated Delivery Collaborative<br>• The Locality System Partnership Board can decide to 'passport' some of its funding to provider collaboratives<br>• The Locality System Partnership Board can decide to spend some of its budget on pan-locality initiatives |
| **Provider collaboratives** | • Receive funding from the GM ICS Partnership Board / GM ICS NHS Board<br>• The provider collaboratives have a responsibility to align budgets with localities and indeed will make up part of the relevant Locality System Partnership Board membership |
| **Primary care** | • Receives funding from the GM ICS Partnership Board / GM ICS NHS Board |
| **Locality Integrated Delivery Collaborative** | • Receives funding from the Locality System Partnership Board<br>• Provides funding for the locality integrated neighbourhood delivery teams |
| **Locality integrated neighbourhood delivery teams** | • Receive funding from the Locality Integrated Delivery Collaborative<br>• The ultimate aim is to work towards delegated funding at a neighbourhood level |
| **Pan-locality collaboration** | • May receive some funding from the Locality System Partnership Boards for pan-locality initiatives, but does not hold its own budget |

30) Our view is that significant NHS funding should be delegated from the GM ICB to the Locality System Partnership Board. But we also recognise significant funding flows from the GM ICB to directly to GM wide collaboratives, and in some circumstances to primary care. Again, regardless of funding flow we would expect the Locality Board to have the total health and care system funding for the borough in view, and a proportion of that may be pooled.

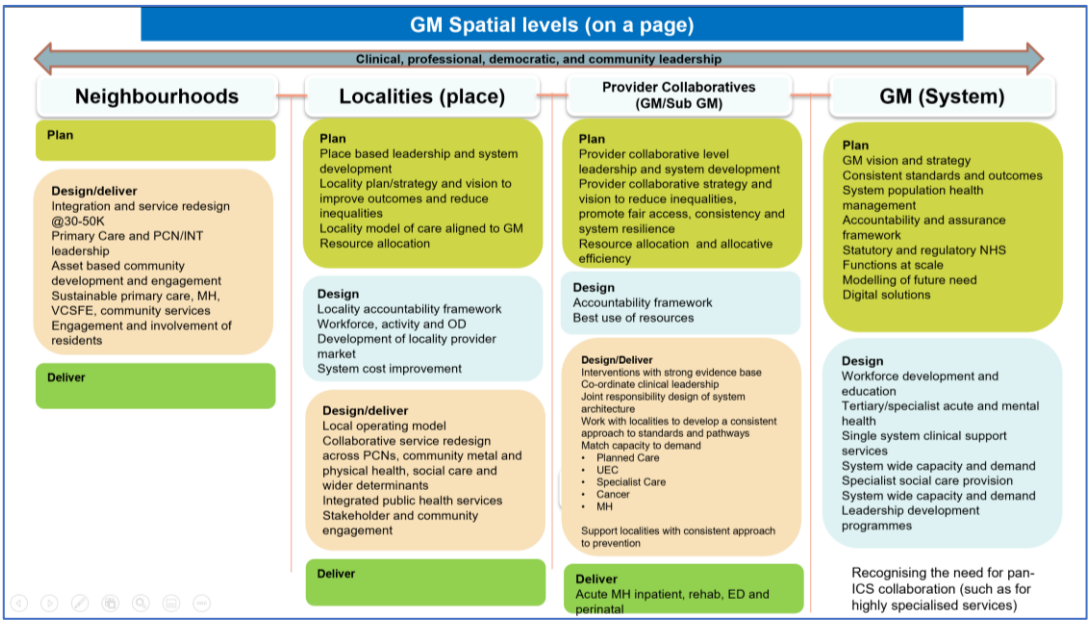

GM ICS - Partnership functions
GM ICS - NHS functions
Council
Locality System Partnership Board
Provider Collaboratives
Primary care
Locality Integrated Delivery Collaborative
Pan-locality collaboration
Locality integrated neighbourhood delivery teams

## G) Greater Manchester Integrated Care System

*NB – this section is consistently described in the Oldham and also Rochdale Locality Plan – reflecting our ambition to share learning and develop a consistent approach to working within the GM ICS arrangements.*

31) GM already has developed an architecture that set the pace for the national model of neighbourhoods, localities / places, provider collaboratives and an ICS (manifest in the Health & Social Care Partnership and governance structures). This is well understood, and leaders are clear that this architecture should remain the basis of the new operating model.

32) Equally there has been considerable work done on the spatial level at which service planning and delivery should be organised and undertaken.




33) In some specialities and conditions, such as mental health, these spatial levels have been taken to a more detailed and granular level with a clear explanation as to how services and programmes could address the challenge GM faces.

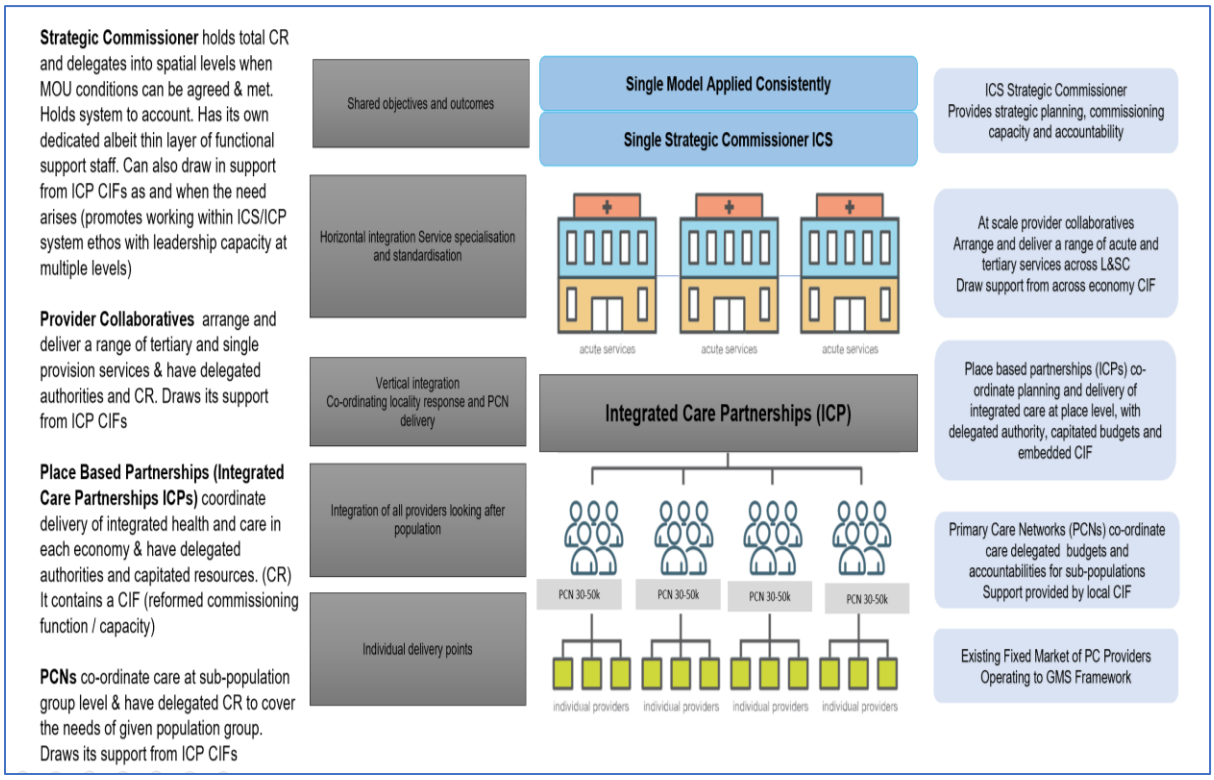
34) Provider Collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care as defined in the spatial model. The governance arrangements must enable the constituent organisations to hold/manage a shared budget and to address the associated shared risks and 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.

35) 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.

36) 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

37) 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 (e.g 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.).

38) The following diagram provides an overview of what this would likely look like.




39) The longer-term aim would be for other reform areas locally to be brought more closely into the Locality Board space, to help with the issues around the wider determinants of health and other local reforms

## H. Values and Behaviours of the Bury Integrated Care Partnership

40) The effective operation of the Bury Integrated Care Partnership is a matter for all partners to positively commit and engage in accordance with an agreed set of values and principles. These have been developed through the IDCB and will be adopted across the whole Health and Care System. In summary, all partners to the partnership arrangements commit to the following 7 Values and Behaviours

***Collaboration***

Working cooperatively to achieve a common purpose, sharing responsibility and accountability.

- I take responsibility for developing and maintaining good relationships with all partners
- I take accountability for delivering on our collective purpose, vision and staying aligned to our principles, values and behaviours
- I will share organisational perspectives/challenges etc but remain focussed on putting the people of Bury first
- I will act with empathy to understand and appreciate the challenges and pressures that my colleagues are facing I keep others informed in a timely manner
- I will bring back the perspective of the IDC into my own organisation
- I will actively encourage participation/create the conditions that enable others to participate
- I will be proactive in participating
- I will role model the behaviours outside Board meetings as a system leader

***Courage***

Pushing past our comfort zone to take risks, challenge each other, have the hard conversations, and take the difficult decisions.

- I will contribute to difficult conversations/meetings and decisions
- I will choose courage over comfort by facing the difficult conversations/decisions
- I will stay aligned to our values when facing tough decisions
- I will take a risk even when the outcome isn't certain
- I surface concerns when I anticipate/experience conflict with a positive intent to seek resolution
- I will embrace challenge, fears, and feelings

***Creativity***

Trying new things together that we know will add value/improve outcomes.

- I look for the opportunities to try new things together
- I create a culture where people are given permission and psychological safety to fail and feel supported to learn from their experiences, free from blame.
- I am pragmatic in my approach to excellence
- I provide challenge or question the status quo/traditional way of doing things in a positive manner and am open to new ideas
- I will provide the space for new ideas, thinking, learning, discussion

***Integrity***

Consistently to do what we say we are going to do in accordance with our purpose, principles, values and behaviours.

- I act with honesty and truthfulness
- I keep my word
- I consistently practice and model the values rather than just professing them
- I will be honest about potential conflicts of intentions
- I act with the best of intentions

- I will act in the interest for the greater good

***Inclusion***

We will be inclusive in everything we do and address any potential barriers to this.

- I seek out and actively listen and involve others' views to develop ideas and solutions
- I will create a culture where everyone can feel safe, seen, heard, understood, and are respected
- I will create the conditions where everyone feels like they belong.
- I look for the strengths/talents in everyone and am inclusive in my daily practice
- I value and encourage diverse thinking and experiences and will be open in learning and understanding including what this means
- I will call out a lack of inclusion and discrimination where I see, hear, experience, or become aware of this
- I take decisions that will address the inequalities that exist within our population
- I will ensure we listen and coproduce with those who are seldom heard and most likely to experience discrimination and inequality.
- I actively seek to understand and remove barriers to inclusion
- I act with empathy, compassion, kindness to everyone

***Making a difference***

By doing together what no one partner can achieve on their own.

- I will look for the opportunities to work together that collectively add value
- I recognise what works already and build on that
- I will share information in an open transparent way in support of our collective goals
- I will share strengths/assets in the pursuit of our ambition, and I recognise that I may need to give something up for the benefit of the system.
- I will endeavour to bring my organisational colleagues along the journey with us to enable system working
- I will enable system working and remove organisational barriers/challenges to this
- I will adopt the methodology of co-production with partners, our staff and our communities
- I will strive for improvement

***Trust***

To be vulnerable with one another by being willing to admit our mistakes, share our struggles, or ask for help/support from others

- I am open and honest with my communication about what is going on in my organisation including when I don't know
- I communicate where there are any conflicting/competing priorities
- I consistently do what I say I am going to do
- I will not take action that could damage trust
- I will use curiosity to explore confusions
- I act with empathy and compassion to understand and appreciate everyone's individual pressures/challenges
- I am open and honest about any mistakes and own my mistakes
- I ask for support and clarify needs
- I will give and receive feedback in situations where it is felt trust has been damaged to restore trust
- I will not have conversations without the involvement/knowledge of our partners about actions that affect us
- I put my trust in my colleagues' abilities, knowledge and expertise