AGENDA FOR

STRATEGIC COMMISSIONING BOARD

You are invited to attend a meeting of the STRATEGIC COMMISSIONING BOARD which will be held as follows:-

Date:	Monday, 5 October 2020
Place:	
Time:	4.30 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 WELCOME, APOLOGIES & QUORACY

2 DECLARATION OF INTERESTS *(Pages 1 - 10)*

3 MINUTES OF THE LAST MEETING AND ACTION LOG *(Pages 11 - 22)*

- 7 September 2020

4 PUBLIC QUESTIONS

5 CHIEF EXECUTIVE AND ACCOUNTABLE OFFICER UPDATE

6 SYSTEM FINANCIAL OUTLOOK AND UPDATE

7 PERFORMANCE REPORT *(Pages 23 - 32)*

8 RISK REPORT *(Pages 33 - 44)*

9 COVID UPDATE

10 RECOVERY UPDATE *(Pages 45 - 48)*

11 INTERMEDIATE TIER REVIEW *(Pages 49 - 84)*

12 STRATEGIC APPROACH TO ALL AGE LEARNING DISABILITIES *(Pages 85 - 96)*

13 ADULT COMMUNITY CRISIS SERVICE *(Pages 97 - 130)*

14 BURY 2030 STRATEGY *(Pages 131 - 140)*

15 SRFT – PAT TRANSACTION BUSINESS CASE *(Pages 141 - 168)*

16 EQUALITY STRATEGY IMPLEMENTATION PLAN UPDATE *(Pages 169 - 174)*

17 FORM AND FUNCTION OF LCO *(Pages 175 - 186)*

18 FEEDBACK FROM GREATER MANCHESTER JOINT COMMISSIONING BOARD

19 MINUTES OF MEETINGS *(Pages 187 - 216)*

- 18 June 2020
- 21 July 2020
- 19 August 2020

20 AOB AND CLOSING MATTERS

Agenda Item 2

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	05 October 2020	**Action**	Receive
Item No	2	**Confidential / Freedom of Information Status**	No
Title	Declarations of Interest Register		
Presented By	Cllr E O'Brien, Co-chair of the SCB and Bury Council Leader / Dr J Schryer, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author	Emma Kennett, Head of Corporate Affairs and Governance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

- The CCG and Local Authority both have statutory responsibilities in relation to declarations of interest as part of their respective governance arrangements.
- The CCG has a statutory requirement to keep, maintain and make publicly available a register of declarations of interest under Section 14O of the national Health Service Act 2006 (as inserted by section 25 of the Health and Social Care Act 2012).
- The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the latest Declarations of interest Register;
- Considers whether there are any interests that may impact on the business to be transacted at the meeting on the 5 October 2020; and
- Provides any further updates to existing Declarations of Interest includes within the Register.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	N/A
Add details here.	

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	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk	Yes	☐	No	☐	N/A	☒

Implications						
Register?						
Additional details	Conflicts of Interest not being declared in line with statutory obligations					

Governance and Reporting		
Meeting	**Date**	**Outcome**

Declarations of Interest

1. Register for the Strategic Commissioning Board

1.1 This report includes a copy of the latest Declarations of Interest Register for the Strategic Commissioning Board.

1.2 Strategic Commissioning Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on meeting agendas or as soon as a potential conflict becomes apparent as part of meeting discussions.

1.3 There is a need for Strategic Commissioning Board Members to ensure that any changes to their existing conflicts of interest are notified to the Business Support Unit, via either the CCG Corporate Officer or Council Democratic Services team within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

1.4 The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Strategic Commissioning Board with an accurate record of the action being taken captured as part of the meeting minutes.

Emma Kennett
Head of Corporate Affairs and Governance
October 2020

Register of Interests for Strategic Commissioning Board

Members - Voting

Name	Current position (s) held i.e. Governing Body, Member Practice, Employee	Declared Interest- (Name of organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate Interest
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the Interest direct or indirect?		From	To	
Cllr Jane Black	Councillor	Bury Council	X				Councillor	Sep-18		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Essity UK Ltd			X	Indirect	Spouse: Senior IT Business Analyst			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Sedgley Park Community Primary School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Village Green Community Co-Operative Prestwich	X				Shareholder			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Village Green Community Co-Operative Prestwich				Indirect	Spouse: Shareholder			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Manchester Reform Synagogue		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Manchester Jewish Museum		X			Friend			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Unison		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Greater Manchester Muslim Jewish Forum		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Jewish Labour Movement		X			Chair of NW Branch			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Will Blandamer	Executive Director of Strategic Commissioning	Ashton on Mersey Football Club (Trafford)			X		Director (Chairman)	2018		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Manchester Football Association (MFA)			X		Board Champion for Safeguarding	2018		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Fiona Boyd	Governing Body Registered Nurse	NHS Heywood, Middleton & Rochdale CCG		X			Employed (substantive) as Quality & Safety Lead	Apr-13		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Tameside Hospital		X			Seconded to Head of Nursing - Urgent Care	Sep-19	22-Sep-20	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		DWF Law		X			Medical Assessor	03/08/2020		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Peter Bury	Lay Member Quality & Performance	Labour Party		x			Member	1979		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury College		x			Member - Board of Governors	2008		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Unite the Union		X			Member	1974		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Dr Daniel Cooke	Clinical Lead - Elective Care	Whittaker Lane Medical Centre	X				GP Partner	01/04/2019		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		University of Manchester		X			Undergraduate Tutor	Aug-16		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury GP Federation	X				Practice is a member	Aug-16		Specific arrangements in respect of potential conflicts arising be given further consideration when situation arises.
		Prestwich Primary Care Network	X				Practice is a member	Apr-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Clare Cummins	Councillor Bury Council	Mental Health	X				Deputy Manager			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		ADT			X	Indirect	Spouse / Civic Partner: Salespearson			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Dr Cathy Fines	Clinical Director	Greenmount Medical Centre	X				GP (Member practice is part of Tower Family	Apr-18		Needs to be excluded from any discussions and decisions that are related to possible primary care procurement in respect of Greenmount Medical Centre / Tower Family
		Bury GP Federation	X				Member	2013		Specific arrangements in respect of potential conflicts arising from Bury GP Federation to be given further consideration when situation arises.
		Horizon Clinical Network	X				Practice is a member	2019		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Central Manchester Foundation Trust				Indirect	Spouse works as a Consultant			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Howard Hughes	Clinical Director	Prestwich Pharmacy LTD	X			Indirect	Spouse is a Director	1996		Specific arrangements in respect of potential conflicts arising from Prestwich Pharmacy to be given further consideration when situation arises.
		Greater Manchester Mental Health Foundation Trust		X		Indirect	Sister is Performance Manager	2014		Specific arrangements in respect of potential conflicts arising from Prestwich Pharmacy to be given further consideration when situation arises.
		Prestwich Pharmacy LTD	X				Director	1996		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Hughes McCaul LTD (Dormant Company)	X			Indirect	Spouse is a Director	1995		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Hughes McCaul LTD (Dormant Company)	X				Director	1995		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.

Members - Voting

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Cllr David Jones	Councillor Bury Council	Bury Council	X				Councillor	Jul-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		National Association of Retired Police Officers		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Spouse Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Hollins Institute Educational Fund		X			Trustee			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Vision Multi-Academy Trust		X			Chair			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		United Reformed Church			X		Elder			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		International Police Association		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury South CLP		X						General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Geoff Little	Chief Executive, Bury Council, Accountable Officer Bury CCG	Ratio Research a Community Interest Company				Indirect	Close family member is a Director of Ratio Research	Apr-19		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
David McCann	Lay Member - Patient & Public Involvement	PCL (CIP) GP LTD - Nature of Business Asset Management	X				Director	Jul-15		Confirmed that this company doesn't have a relationship or business within the health economy. General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Praxis Capital LTD - Nature of Business Asset Management	X				Director & Majority Shareholder	Jul-14		Confirmed that this company doesn't have a relationship or business within the health economy. General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Praxis Real Estate Management LTD, Manchester	X				Director, General / Legal Counsel & Chief of Staff	Nov-11		Confirmed that this company doesn't have a relationship or business within the health economy. General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Praxis Law Ltd	X				Managing Director & 50% Shareholder	Feb-18		Confirmed that this company doesn't have a relationship or business within the health economy. General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Praxis Facilities Management Ltd	X				Director	Nov-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		The Airfields Commercial Management Company Limited	X				Director	Feb-20		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		The Airfields Residential Management Company Ltd	X				Director	Oct-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		The Aldermaston Estate Management Company Ltd	X				Director	Oct-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury Council				Indirect	Daughter - Employee	2012		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Eamonn O'Brien	Councillor	Bury Council	X				Councillor	Jul-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Young Christian Workers	X				Training & Development Team			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Prestwich Arts College		X			Chair of Governors			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury Corporate Parenting Board		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		No Barriers Foundation		X			Trustee			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		CAFOD Salford		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Prestwich Methodist Youth Association		X			Trustee			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Unite the Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Alan Quinn	Councillor	Bury Council	X				Councillor	Jul-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		BAE Systems - Military Aircraft	X				Skilled Aircraft Fitter			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Harrogate and District NHS Foundation Trust			X	Indirect	Son and Daughter in Law			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Citizens Advice Bureau					Spouse - Trainee Advisor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Greater Manchester Waste Disposal Authority		X			Member / Council Representative			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.

Members - Voting

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the Interest direct or indirect?		From	To	
Cllr Alan Quinn (cont)		Trees of Greater Manchester		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		University of Manchester		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Co-Operative Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Unite the Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		North West Rivers Floods and Coastal Committee								General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		GM Green City Partnership (via the Waste Authority)								General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Downs Sysndrome Association					Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Permanent UK Mission to UN in Geneva					Daughter works for UK Government in Switzerland			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Tahir Rafiq	Councillor Bury Council	Juris Solicitors	X							General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Hollins Grundy Primary School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Vision Multi-Academy Trust		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Hollins Institute Educational Fund		X			Trustee			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Law Society (England & Wales)		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Law Society (Ireland)		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Punjab Bar Council Pakistan		X			Member / High Court Advocate			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Dr Jeffrey Schryer	CCG Chair	Whittaker Lane Medical Centre	X			Indirect	Wife receives income from Practice	1990		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Whittaker Lane Medical Centre	X				Managing Partner	1990		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		NHS GP Trainer		X				1991		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		University of Manchester		X			Undergraduate Tutor	1991		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Prestwich Primary Care Network	X				Practice is a member	2019		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury GP Federation	X				Practice is a member	2018		Specific arrangements in respect of potential conflicts arising from Bury GP Federation to be given further consideration when situation arises.
		Bury LCO	X				Bury Federation is a member	2018		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Andrea Simpson	Councillor	Bury Council	X				Councillor	Jul-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Silverdale Medical Practice	X				Practice Manager			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Community Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Community Union		X			Spouse / Civil Partner - Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Jo Hague Photography				Indirect	Spouse / Civil Partner: Owner			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Parrenthorn High School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Ribble Drive Primary School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Salford LMC Subcommittee		X			Neighbourhood lead for Swinton			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Village Greens	X				Shareholder			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Medical Defence Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Lucy Smith	Councillor Bury Council	The Christie NHS Foundation Trust			X	Indirect	Spouse / Civic Partner			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Community the Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Socialist Health Association		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.

Members - Voting

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the Interest direct or indirect?		From	To	
Cllr Lucy Smith (cont)	Councillor Bury Council	Catholics for Labour		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Tamoor Tariq	Councillor	Bury Council	X				Councillor	May-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		GM Health & Social Care Partnership	X				Children & Young People Access & Waiting Time			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Lancashire BME Network				Indirect	Spouse / Civil Partnership: Senior Project Officer			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Tamoor Tariq (cont)		GM Police & Crime Panel		X			Chair			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Domestic Violence Steering Group		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		St Lukes Primary School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		The Derby High School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Community Safety Partnership		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Unite the Union		X			Community Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Peter Thompson	Secondary Care Clinician	Medico-legal work carried out for both claimants and defendants in the field of obstetrics	X				Could involve cases in Bury	Jun-20	23/09/2020	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Shrewsbury and Telford Hospitals	X				Seconded for 2 days a week as a Consultant Obstetrician giving advice on their Maternity Services	Sep-20		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Chris Wild	Lay Member - Finance & Audit	Secure Generation Limited	X				Shareholder / Director	Nov-15		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Efficient Generation Limited	X				Shareholder / Director	Nov-15		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		McNally Wild Limited	X				Shareholder / Director	Jul-14		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Capitas Finance Limited	X				Shareholder / Director	May-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Lower 48 Energy Limited	X				Shareholder / Director	Jul-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Close Brothers PLC	X				Retained Advisor	Sep-14		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury College	X			Indirect	Wife employed by Bury College	Feb-20		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Mike Woodhead	Joint Chief Finance Officer	Heads in the Woods (designs and produces environmentally friendly items for wholesale and retail)	X			Indirect	Partner owns business	Nov-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		CFO/s 151 Officer for Bury MBC	X	X				Jun-19		Transparent in decision making. Adherence to professional codes and regulations. Audit.

In Attendance - Non-Voting

Name	Current position (s) held i.e. Governing Body, Member Practice, Employee	Declared Interest- (Name of organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate Interest
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the Interest direct or indirect?		From	To	
Donna Ball	Bury Council Executive Director of Operations	Oldham Pathology (Pennine Acute)			X	Indirect	Husband works for Oldham Pathology	2010	2020	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Karen Dolton	Executive Director, Children & Young People, Bury Council						None Declared	Jun-19		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Julie Gonda	Director of Community Commissioning Bury Council						Nothing to declare			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Catherine Jackson	Director of Nursing and Quality Improvement	Marple Cottage Surgery (Stockport CCG)		X			Role as Advanced Nurse Practitioner	Aug-05		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Lesley Jones	Director of Public Health, Bury Council						None Declared	Apr-18		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Nick Jones	Councillor	Arum Systems Ltd (Arum)	X				Account Director			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Elms Bank			X		Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Conservative Friends of Israel			X		Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		PLC Flats Management Limited	X				Director			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		RNLI					Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Anglo-Swedish Association					Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Friends of the British Overseas Territories					Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury North & South Conservative Association		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		The Conservative & Unionist Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Conservative Councillors Association		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr Michael Powell	Councillor Bury Council	St Thomas Primary School	X				Teacher - Employed by Stockport Council	Nov-19	03/08/2020	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Elms Bank School	X			Indirect	Spouse / civic partner: Teacher - employed by Oak Learning Partnerhsip	Sep-17		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Liberal Democrats		X			Member	Jan-12		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		National Educaton Union (NEU)		X			Member	Sep-17		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Lynne Ridsdale	Executive Director of Transformation & Strategy, Bury Council						None Declared	Feb-20		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Nicky Parker	Programme Manager	Youth Focus North West (they have a contract to run the GMCA Youth Cabinet and funding for MH projects)		X		Direct	Director	Sep-10		General arrangements for declaring Conflicts of Interest to be followed.
		Common Purpose GM Advisory Group		X		Direct	Member	Sep-18		General arrangements for declaring Conflicts of Interest to be followed.

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Agenda Item 3

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	05 October 2020	**Action**	Approve
Item No	3	**Confidential / Freedom of Information Status**	No
Title	Minutes of Last meeting and Action Log		
Presented By	Cllr E O'Brien, Co-chair of the SCB and Bury Council Leader / Dr J Schryer, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author	Emma Kennett, Head of Corporate Affairs and Governance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

The attached minutes reflect the discussion from the Strategic Commissioning Board held on 7 September 2020.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the Minutes of the Meeting held on 7 September 2020 as an accurate record; and
- Note progress in respect to agreed actions captured on the Action Log.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	N/A
Add details here.	

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	☒

Implications						
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	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**

Title	**Minutes of the Strategic Commissioning Board Virtual Meeting on 7 September 2020**
Author	Emma Kennett, Head of Corporate Affairs and Governance
Version	0.1
Target Audience	Strategic Commissioning Board Members / Members of the Public
Date Created	September 2020
Date of Issue	September 2020
To be Agreed	October 2020
Document Status (Draft/Final)	Draft
Description	Minutes of the Strategic Commissioning Board on 7 September 2020

Document History:

Date	Version	Author	Notes
	0.1	Emma Kennett	Forwarded to Chair for review.

Approved:	
Signature:	..... **Cllr O'Brien**

Strategic Commissioning Board Virtual Meeting

MINUTES OF MEETING
Strategic Commissioning Board Virtual Meeting 7 September 2020 16.00 – 17.00 **Chair – Cllr O'Brien**

Voting Members	
Cllr Eamonn O'Brien	Leader, Finance & Growth, Bury Council (Chair)
Dr Jeff Schryer	NHS Bury CCG Chair
Cllr Jane Black	Cabinet Member Corporate Affairs & HR, Bury Council
Mr Will Blandamer	Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG
Fiona Boyd	Registered Lay Nurse of the Governing Body, NHS Bury CCG
Mr Peter Bury	Lay Member Quality & Performance, NHS Bury CCG
Dr Daniel Cooke	Clinical Director, NHS Bury CCG
Dr Cathy Fines	Clinical Director, NHS Bury CCG
Mr Howard Hughes	Clinical Director, NHS Bury CCG
Mr David McCann	Lay Member Patient & Public Involvement, NHS Bury CCG
Cllr Tahir Rafiq	Corporate Affairs & HR, Bury Council
Cllr Andrea Simpson	First Deputy Leader, Health & Wellbeing, Bury Council
Cllr Lucy Smith	Transport & Infrastructure, Bury Council
Cllr Tamoor Tariq	Deputy Leader, Children, Young People & Skills, Bury Council
Mr Mike Woodhead	Joint Chief Finance Officer, NHS Bury CCG and Bury Council
Others in attendance	
Mrs Catherine Jackson	Director of Nursing and Quality Improvement, NHS Bury CCG
Ms Lesley Jones	Director of Public Health, Bury Council
Cllr Nick Jones	Council Opposition Member, Bury Council
Cllr Michael Powell	Council Opposition Member, Bury Council
Mrs Carrie Dearden	Communications and Engagement Manager, NHS Bury CCG
Mrs Julie Gonda	Director of Community Commissioning (DASS)
Mrs Lynne Ridsdale	Deputy Chief Executive, Bury Council
Ms Janet Witkowski	Head of Legal Services, Deputy Monitoring Officer and Data Protection Officer
Mrs Emma Kennett	Head of Corporate Affairs and Governance, NHS Bury CCG / Business Support (minutes)

Public Members	
Mr Peter Magill	Bury Times
Ms Barbara Barlow	Public Meeting

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies And Quoracy
1.1	The Chair welcomed those present to the meeting and noted apologies had been received from: - • Cllr Cummins, Housing Services, Bury Council

	• Cllr David Jones, Communities & Emergency Planning, Bury Council • Mr Geoff Little, Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG • Mr Chris Wild, Lay Member, NHS Bury CCG
1.2	The Chair advised that the quoracy had been satisfied.
1.3	The Chair reported that there originally wasn't a Public Meeting planned this month however due to the current Covid-19 position, a meeting had been deemed necessary.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/01	Decision	Noted the information.	

2	Declarations Of Interest
2.1	The Chair reported that the CCG and Council both have statutory responsibilities in relation to the declarations of interest as part of their respective governance arrangements.
2.2	It was reported that the CCG had a statutory requirement to keep, maintain and make publicly available a register of declarations of interest under Section 14O of the National Health Service Act 2006 (as inserted by Section 25 of the Health and Social Care Act 2012). The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.
2.3	The Chair reminded the CCG and Council members of their obligation to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Strategic Commissioning Board.
2.4	Declarations made by members of the Strategic Commissioning Board are listed in the CCG's Register of Interests which is presented under this agenda and is also available from the CCG's Corporate Office or via the CCG website. • **Declarations of interest from today's meeting**
2.5	The Registered Lay Nurse of the Governing Body, NHS Bury CCG reported that there had been an update to her declaration of interest in light of a temporary appointment at DWF Law. It was noted that a new declaration form had been submitted in this regard and a new resister would be made available for the next SCB meeting. • **Declarations of Interest from the previous meeting**
2.6	There were no declarations of interest from the previous meeting raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/02	Decision	Noted the published register of interests.	

3	Minutes of the last Meetings and Action Log
	• **Minutes** The minutes of the Strategic Commissioning Board meeting held on 3 August 2020 were agreed as an accurate record.

3.1	• **Action Log** There were no updates in relation to the Action Log.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/03	Decision	Approved the minutes of the meeting held on the 3 August 2020.	

4	Public Questions
4.1	There were no public questions raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/04	Decision	Noted the information.	

5.	Covid-19 and the Bury Response
5.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG provided a presentation in relation to the latest Covid-19 position and the Bury Response. The Director of Public Health also provided an update on the position. It was reported that: - • Bury now had one of the highest coronavirus infection rates in England, falling within the top 10 areas. While rates across Greater Manchester were dropping, Bury's continued to rise – and was now three times the national average. This was Bury's sixth weekly rise in a row. • Current statistics were indicating a Covid-19 rate of 45 per 100,000 population. • Household transmission remained an important source of new infections, as people spread the virus they had caught in the community to their families. Those aged 18 – 39 accounted for more than half of the new cases in Bury, and the percentage of positive tests had also increased. The cases were spread across all of the wards in the borough. • Given the geographically dispersed nature of the cases across the borough and that household transmission was significant, it was possible at least some of the rises related to flows of people to adjacent boroughs for reasons of work and leisure. The ethnic profile of cases is beginning to change from July where 50% of cases identified as Asian and 50% White British to 14% and 57% in mid Aug. • The governance / partnership approach being adopted within the borough was outlined. • The digital communications undertaken in relation to the Covid-19 were outlined. • Looking forward, Bury needed to strengthen its Covid-19 response in order to address some of the challenges ahead. • The latest testing information was available on the Council website which had been subject to a number of changes to cope with demand.
5.2	The following comments/observations were made by Strategic Commissioning Board members: - • The need to ensure that appropriate resources are available to act upon any breaches in Covid-19 rules in the locality. • The need to review the current local position in relation to staff working from home given some of the recent changes in national guidance. The Director of Public Health commented that Bury had a higher proportion of people that were unable to work from home than in other boroughs due to the type of jobs that people hold.

	• The consequences of 'Business as Usual' not occurring in some areas needed to be assessed in terms of any adverse consequences in the short, medium and long term. • Some examples of where Covid-19 measures had worked well were provided including good compliance with mask wearing in Scotland. It was highlighted that there was a need to reinforce the local messaging within this area. • There were significant challenges in relation to enforcement, policing, licensing and communications.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/09/05	Decision	Noted the update.	

6.	**Covid-19 Testing**
6.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG and the Director of Nursing and Quality Improvement presented a report in relation to Covid-19 testing.
6.2	The paper outlined the plans for a resilient and longer-term (>6 months) testing solution to manage the borough response to Covid-19 disease.
6.3	The cost for this service was estimated at a monthly cost of £92,000. It was noted that this was the upper estimate and it was anticipated that costs would reduce as the exact requirements were established with providers, but it was felt prudent to have costs in at the upper estimate.
6.4	It was highlighted that the Locality Outbreak Plan detailed the strategic response for widening testing across the borough to respond to increasing prevalence of Coronavirus disease locally. It was noted that by ensuring the CCG and Council have the right plan and resources in place we will be able to deliver the testing response required to meet national or local requirements.
6.5	The strategic testing response had different components to ensure all people have equal opportunity to get tested if they have symptoms.
6.6	Additionally, built into the plan was a structure that could deliver mass testing of asymptomatic public should the EWS triggers indicate a need to do this. The diagram showed the way we would deliver testing across the borough with a range of testing mechanisms providing a robust response
6.7	It was reported to date that Walk up testing sites had been set up at Mosses Centre and Chesham Fold for individuals who are experiencing symptoms of the virus. The plans for further sites across the borough were outlined.
6.8	The Joint Chief Finance Officer referred to the £92k funding and commented that there was no specific budget to cover these costs. It was highlighted that the majority of costs related to the Out of Hours testing component and commented that there was a need to ensure there was no duplication of existing spend. It was reported that this funding should fall within the scope of the Pooled Budget arrangements and any overspend would need to be risk shared across the CCG and Council. The Director of Nursing and Quality Improvement commented that there was still potential for some NHS Covid-19 funding to support some of these costs however nothing had been confirmed as yet. It was agreed that the Joint Chief Finance Officer would review the funding for this area once the exact costs were known and assess whether any additional national funds have been provided.

	The governance for this would need to be aligned with existing Pooled Budget arrangements / agreed delegations to ensure no Ultra Vires decisions were being made.
6.9	The following comments/observations were made by Strategic Commissioning Board members: - • The need for a community based testing approach with easy access to those with symptoms. The communication within this area needed to be clear.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/06	Decision	Noted the content of this paper and supported in principle the funding outlined within the paper for a resilient Covid-19 borough-based testing service subject to the Joint Chief Finance Officer confirming the exact funding arrangements.	
A/01/01	Action	It was agreed that the Joint Chief Finance Officer would review the funding for this area once the exact costs were known and assess whether any additional national funds have been provided. The governance for this would need to be in line with existing Pooled Budget arrangements / agreed delegations to ensure no *Ultra Vires* decisions were being made	Mr Woodhead

7.	CHC Recovery
7.1	The Director of Nursing and Quality Improvement presented a report in relation to CHC Recovery.
7.2	It was reported that the National framework for NHS CHC was suspended in March 2020 in response to the Covid-19 outbreak and the Rapid Discharge Pathway was implemented. As part of the phase 3 guidance we have been advised that the confirmed CHC re-start date is the 1st September 2020. Following discussions with the Regional/GM CHC leads and NHSEI, there was now further clarity on what this would look like and how localities would need to respond.
7.3	It was noted that there would need to be a CHC Recovery Team in place for 7 months to address the backlog of approximately 400 assessments that have built up since the suspension of the CHC process.
7.4	It was highlighted that the minimum cost of the recovery team was approximately £462k, this takes in to account agency fees, as agency is the likely source of these staff. In a national webinar on 25th August it was confirmed that there would be national funding to support the recruitment of these staff but the value and nature of this was not confirmed.
7.5	The key recovery points were: - • There would be now allowances made for the Greater Manchester local lockdown in terms of a delay to the re-start date. It was expected that there will be a number of local lockdowns moving forward so local areas are asked to adjust locally how they deliver the service in response to these. This will mean that a number of assessments will need to take place virtually using technology to support the assessment process. • NHSEI have stated (although not had it in writing) that they expect anyone who received a package of support under the new guidance to continue to receive this

	until 31st March 2020 at which point they except that all will have had an assessment to establish a long-term package of support and funding pathway. • Any new cases would receive a package of transitional funding for 6 weeks after this irrespective of whether the assessment has taken place then funding will be picked up by the local CCG. • The CCG will be asked for a trajectory for how we manage the cases from 1st September to 31st March and this will be monitored on a monthly basis by NHSEI. • The regional leads have asked for a communication strategy to come centrally as many individuals may be unaware that the funding is only interim and that they will be expected to pay or contribute towards care. Locally we have asked for additional support with top ups and other cases where families may be asked to contribute to care costs. • There was expected to be a significant increase in the number of complaints and appeals (local and independent reviews at NHSEI). The CCG was aware the claims companies have already been in contact with individuals and are expecting this increase. They have advised this will have an impact upon CHC for a number of years and it is likened to the PUPOCs (Previously Unassessed Periods of Care). • There was additional guidance expected centrally but it is unlikely that this will streamline or change the CHC assessment process as they need it to withstand legal challenge in the future and not render us at risk of retrospective reviews. • Central funding had not yet been clarified to support CCGs with staffing requirements for the additional work and managing the backlog.
7.6	The Director of Nursing and Quality Improvement envisaged that there would be funding available to support this work however this was not confirmed as yet.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/07	Decision	Considered the report and supported the recruitment of the additional staff as laid out in this report subject to the specific funding streams being confirmed.	

8.	Hospital Discharge and Covid-19
8.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG submitted a report in relation to Hospital Discharge and Covid-19. It was reported that: - • The paper explained the new arrangements for hospital discharge introduced on March 19th 2020 to respond to the COVID-19 pandemic. It illustrated the effects on the Bury System and recommended rationalisation of the provision to remove waste whilst ensuring sufficient provision remains to allow the ongoing delivery of the Covid-19 Hospital Discharge Guidance. • Spurr House would stop admitting hospital patients from 1st September 2020 with remaining patients continuing to be funded, their care would be free and they would have their long term needs assessed within 6 weeks. Spurr House would return to delivering respite. • The 2 extra care flats would be returned to general let and the occupants would have their long term needs assessed. • The 11 COVID beds at Gorsey Clough would transition to Non Covid beds and deliver nursing discharge to assess and end of life care. • Heathlands would continue to deliver 19 D2A nursing beds.

	• There would be a continuation of purchasing home care from the independent sector, it would be provided free of charge for the patient for up to 6 weeks and delivered with a reablement focus during which time the patients will have their long term needs assessed. • There would be a continuation of spot purchase care homes beds where patients will stay for up to six weeks for end of life care or to have their future care needs assessed. • Continuing Health Care and Funded Nursing Care Assessments would restart on 1st September, these assessments would be carried out in the community and will be completed within the 6 weeks of free care. They will not take place in the hospital. • Hospital discharge pathways will continue and MOATS continue to be minimised.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/08	Decision	Approved the content of the report.	

9	Any Other Business and Closing Matters
9.1	The Chair summarised the main discussion points from today's meeting and thanked members for their contributions.

ID	Type	The Strategic Commissioning Board:	Owner
D/09/09	Decision	Noted the information.	

Next Meetings in Public	**Strategic Commissioning Board Meeting:** • Monday, 5th October 2020, 4.30 p.m., Formal Public meeting via Microsoft Teams (Chair: Cllr E O'Brien / Dr J Schryer)
Enquiries	Emma Kennett, Head of Corporate Affairs and Governance emma.kennett@nhs.net

Strategic Commissioning Board Action Log – September 2020

Status Rating - In Progress - Completed - Not Yet Due - Overdue

A/09/01	It was agreed that the Joint Chief Finance Officer would review the funding for this area once the exact costs were known and assess whether any additional national funds have been provided. The governance for this would need to be in line with existing Pooled Budget arrangements/ agreed delegations to ensure no *Ultra Vires* decisions were being made	Mr Woodhead		October 2020	

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Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Receive
Item No	7	**Confidential / Freedom of Information Status**	No
Title	Performance Report		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The CCG, alongside other CCGs in Greater Manchester, has challenges in achieving the national Constitutional Standards in a number of key areas. This report sets out the current position against a number of the main CCG Performance Indicators along with an overview of the impact to these during the current response to the COVID-19 pandemic. A further, more detailed, report setting out the position on all the indicators is presented to the Quality and Performance sub-committee on a monthly basis and to the Governing Body every two months.

This report also includes a summary of the CCG's COVID-19 Phase 3 activity submission made on 14th September.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives this performance update, noting the areas of challenge and action being taken.

Links to Strategic Objectives/Corporate Plan	Choose an
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

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	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

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

1. Introduction

1.1. The purpose of this report is to provide an overview of performance in the key areas of urgent, elective, cancer and mental health care along with an overview of the impact of the COVID-19 response to these areas as the locality moves through the phases of the COVID response.

2. Background

2.1. This paper is a summary of the information presented to the CCG's Quality and Performance Committee in September which related to the published position as at June 2020. However, as some July data has now been published, this too is referenced within this report.

2.2. A summary of NHS Bury CCG's performance against key NHS Constitution standards is shown at Appendix A and this includes a comparison with the Greater Manchester (GM), North West and England averages. The period to which the data relates is included for each metric. This varies across the metrics, firstly because data is published at different times and secondly due to some data collections having been paused as part of the COVID-19 response.

2.3. During this unprecedented period, there will be an impact, both positive and negative, on health care delivery and performance. Although some of the data that allows us to fully understand the impact will not become available for some time, some information has started to be presented and is considered below.

2.4. National planning with regard to the COVID-19 response has been split into three phases. Phase one covered the period March to the end of April, Phase 2 from April to July and Phase three from August through to March 2021.

2.5 Phase 3 guidance set the following as the main areas of focus for localities:

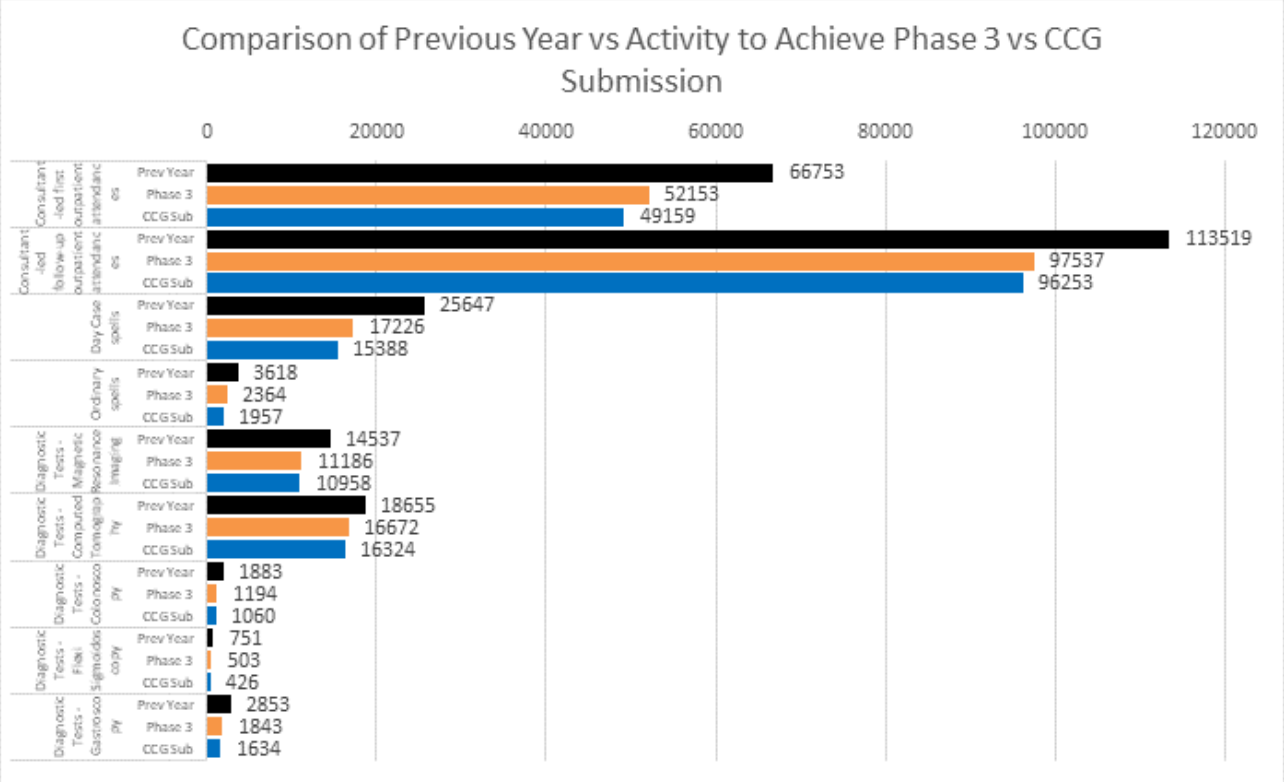
- Accelerate a return to near-normal levels of non-COVID health services, optimising opportunities of available capacity, including the independent sector, between now and the winter period. This includes planning for:
    - Suspected cancer referrals to return to the pre-COVID-19 level;
    - Elective activity to reach 80% of the 2019-20 level in September, rising to 90% in October;
    - Diagnostic activity for Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) and Endoscopy to be at 90% of 2019-20 levels immediately, reaching 100% in October; and
    - Outpatient activity to be at 90% of the 2019-20 level in August, rising to 100% in September.
- Prepare for winter pressures with continued vigilance for COVID spikes; and
- Lock in benefits and lessons learned from the first COVID peak and to tackle challenges such as support for staff and action on inequalities and prevention.

2.6 To support the Phase 3 requirements, both CCGs and NHS acute provider organisations submitted data returns that set out intended activity levels between September 2020 and March 2021. Locally, the Bury return was submitted to the Greater Manchester Health and Social Care Partnership (GMHSCP) for inclusion in

a single Greater Manchester (GM) plan to be submitted on 21st September. The Bury CCG plan was accompanied by a narrative submission outlining the methodology adopted in formulating the plan along with details of some of the schemes to be implemented across the locality to realise the plan.

2.7 As far as possible, the Bury CCG plan is aligned with those of the main local acute providers, particularly the Northern Care Alliance (NCA) organisations. The outcome of this is that in some areas the plans do not reach the ambition of the Phase 3 requirements. However, this should also be seen in the context of CCG and NCA plans reflecting alignment to the recovery programme of the Bury system which, in part, has a focus on reducing demand for secondary care services. This includes the schemes to reform outpatient care delivery as part of the elective care programme.

2.8 The chart below shows a high-level view of Bury's plan against the Phase 3 requirements. The black bar shows the activity levels for 2019-20 against the various points of delivery whilst the orange bar shows the activity level required to meet the Phase 3 requirements with the blue bar showing Bury's plan against this target.



3. Constitutional Standards and COVID-19 Impact Review

Planned (Elective) Care

3.1 In terms of waiting list management, the target changed in April to an expectation that there will be no more patients waiting in January 2021 than there were in January 2020. This sets the target for Bury for there to be no more than 15800 patients waiting to commence treatment by January 2021.

3.2 In June there were 15348 patients waiting, 2.9% lower than there had been in January. This is in the context of demand into secondary care being much lower across Q1 than in previous months (COVID effect). Q4 had also seen waiting list validation take place at both PAHT and SRFT, resulting in some patients being removed from waiting lists. The waiting list had increased to 15973 by the end of July, marking a 1.1% increase on the January 2020 position.

3.3 Bury's Phase 3 plan predicts the waiting list will increase to 19318 by March 2021. If realised, this would be 22.3% above the January 2020 threshold.

3.4 Similarly, Bury's Phase 3 plan shows a significant increase in the number of patients waiting in excess of 52 weeks with a prediction that this figure will reach 982 by March 2021. The June figure stood at 200 for Bury with an increase to 371 noted in July data.

3.5 At the lowest point, GP referrals had reduced by 79% in April when compared to the average for 2019-20. There has since been a month on month increase with referrals in July being 26% below the 2019-20 average and 34% below the July 2019 position.

3.6 Available data also shows a month on month increase in outpatient attendances taking place. In particular, there has been a significant swing towards telephone consultants which accounted for just 2.0% of outpatient contacts in the first 18 weeks of 2019-20 compared to 53.5% for the same period this year.

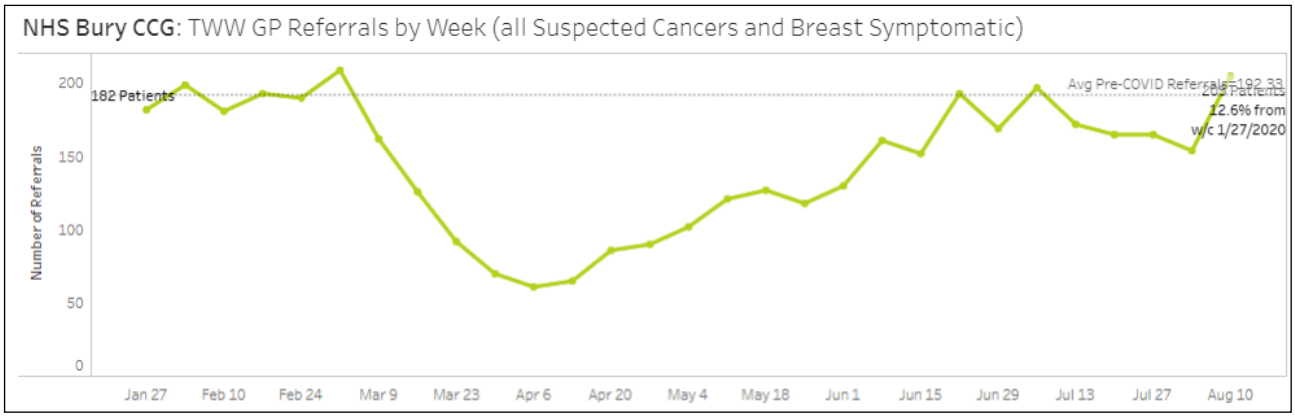
3.7 Restoration of diagnostic services, particularly imaging and endoscopy, is another key requirement of Phase 3 planning. A Single System Management approach across GM is being applied to endoscopy to ensure that capacity is increased and that there is equity in access across GM. Plans include a new mobile endoscopy unit being placed at a PAHT site where the need across GM is considered to be the greatest.

Cancer Care

3.8 During the COVID-19 response period, the system management and oversight of cancer services across GM has been delegated to The Christie NHS FT and a number of cancer treatment hubs have been set up across GM with Rochdale Infirmary being the host for the Surgical Hub.

3.9 Phase 3 guidance is for suspected cancer referrals (2WW) and cancer treatment to be restored to their pre-COVID levels and this ambition has been reflected in the CCG plan.

3.10 Data shows that 2WW referral levels have increased more quickly in Bury than in many other localities. The chart below combines 2WW and 2WW breast symptomatic referral levels for Bury CCG patients with a comparison between week commencing (w/c) 27th January and w/c 10th August. This demonstrates a gradual increase in referrals following the initial decline. There can be fluctuation from week to week though referrals in w/c 10th August are shown to be 12.6% higher than w/c 27th January.



Source: GM Tableau: Cancer > Cancer PTL Metrics > GP referrals by type (taken on 25/08/2020)

3.11 The variance between CCGs for these two given weeks ranges from +12.6% for Bury CCG to -21.4% for Wigan Borough CCG. Across all GM providers, referrals were 9.6% lower in the same reference period.

3.12 In terms of the latest in-month performance, July data shows that all 2WW and 31-day wait standards were achieved in Bury. The main challenge remains with 62 day waits, particularly following GP referral, with diagnostic delays, particularly for endoscopy, being a major factor in this. Risk stratification using the Faecal Immunochemical Test (FIT) is now underway for those patients awaiting a scope procedure and new referral pathways for use across GM have been shared with general practice colleagues.

Urgent Care

A&E Attendances

3.13 At 88.8%, A&E performance at PAHT in June remained below the constitutional standard of 95%. For Fairfield General Hospital (FGH) specifically, performance was 99.8% in June, placing FGH third best Type 1 unit across GM in Q1. Type 1 refers to what might be classed as a 'traditional' A&E department with a full resuscitation facility. In Q2 (to the end of August), FGH was second best with only the children's hospital performing better.

3.14 In terms of A&E attendances, to February 2020 there had been a 7.3% increase in Type 1 attendances at PAHT (7.0% at FGH specifically) when compared to the previous year. The impact of 'lockdown' on 23rd March resulted in the year end increase being 4.7% at PAHT and 4.5% at FGH.

3.15 Moving into 2020-21, there were almost 28,000 fewer Type 1 attendances at PAHT sites between April and August than in the same period of 2019. This equates to a 23.2% decrease with a similar reduction of 24.3% noted for FGH specifically. The PAHT variance at the end of April had been -44.8% (-44.0% at FGH) though a month on month reduction in this variance has been evident since then.

3.16 In terms of daily attendances at FGH, the average between December and February was 212 per day. This dropped to 123 in April before increasing to 152 in May and 173 in June, averaging 149 per day across Q1 as a whole. Moving into

Q2, the average at FGH to the end of August has been 185 per day with attendances exceeding 200 per day having been seen on a number of occasions. This Q2 average of 185 compares to an average of 213 attendances per day in July and August 2019.

Stranded Patients

3.17 A patient is considered to be 'stranded' if their admission to an inpatient bed lasts for seven days or more. The term 'super stranded' relates to those admissions of 21 days or more. Data for this section is sourced from the GMHSCP tableau dashboard.

3.18 Across Q1, PAHT had the best stranded patient rate in GM; 30.5% compared to a GM average of 45.4%, though a month on month increase in the rate was noted. In Q2 (to end of August), PAHT has dropped to 3rd best with a rate of 40.1% against a GM average of 46.5%. Tameside & Glossop FT and Bolton FT are currently above PAHT.

3.19 Similarly, with a super-stranded patient rate of 9.1% against a GM average of 16.8%, PAHT also performed best across GM on this measure in Q1 though the trust has dropped to 4th best in Q2 (to the end of August) with a rate of 13.0% against a GM average of 16.8%.

3.20 Good stranded and super-stranded rates are in the context of the Integrated Discharge Team (IDT) working with a new rapid discharge process with regular conference calls taking place with health and social care partners to ensure patient flow is optimised.

Mental Health

3.21 As anticipated, published data to May shows the Improving Access to Psychological Therapies (IAPT) prevalence and 6 week wait measures remaining a challenge despite strong performance in previous years. This picture is expected to continue with more positive performance evident for the IAPT Recovery and 18 week wait measures.

3.22 Demand and capacity modelling work carried out jointly between the CCG and PCFT had demonstrated that if fully staffed, the PCFT service is funded sufficiently to deliver against the national targets, albeit in terms of the existing therapy offer which is acknowledged to not fully align with the IAPT guidance. This baseline position will be revisited to ensure that the new model of working that includes digital therapy is reflected and that the service can develop to meet the anticipated growth in demand and that the workforce model is aligned to national guidance.

3.23 National modelling suggests that demand will increase following COVID with the increase being a combination of 'suppressed' demand and new COVID-generated demand.

3.24 The implementation of a digital therapy solution was expedited as part of the COVID-19 response with Phase 2 of the project having gone live in June. This phase sees service users able to self-refer and supports the move towards a 'Digital

First' model where it is envisaged eventually that 70% of service users will receive digital therapy rather than face to face.

3.25 Most IAPT therapy is currently taking place via telephone whilst various video platforms are tested. PCFT has contacted all existing patients on a waiting list, many of whom have positively received the offer of redirection to digital support whilst they continue to wait

3.26 The Phase 3 requirements included the CCG submitting plans for performance against a number of mental health and learning disability metrics. These included access to mental health services for children and young people, perinatal mental health service access, the reliance on inpatient care for CCG-commissioned and NHSE-commissioned learning disability inpatients and health checks being completed for patients on the learning disability register. Trajectories for these metrics were agreed with relevant commissioning and clinical leads within the CCG.

4 Actions Required

4.1 The audience of this report is asked to:

- Receive this report.

Susan Sawbridge
Head of Performance
susansawbridge@nhs.net
September 2020

Appendix A: Greater Manchester Constitutional Standards Summary

Measure Name	Standard	Latest Data	GM	Bury	North West	England
Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95.0%	Aug-20	86.2%	85.3%	87.9%	89.3%
A&E 12 Hour Trolley Wait	0	Aug-20	5	0	14	326
Delayed Transfers of Care - Bed Days *(PAHT)*	200	Feb-20	2425	35.1	917.1	5371.8
Delayed Transfers of Care - Bed Days *(PCFT)*				30.1		
Delayed Transfers of Care - Per 100,000	Null	Feb-20	19.2	12.2	15.6	12.4
Stranded Patients (LOS 7+ Days)	2196	Jul-20	1836	356	4970	
Super-Stranded Patients (LOS 21+ Days)	Null	Jul-20	628	117	1796	
Referral To Treatment - 18 Weeks	92.0%	Jul-20	46.1%	47.4%	47.7%	46.8%
Referral To Treatment - 52+ Weeks	0	Jul-20	5526	371	10445	83799
Diagnostics Tests Waiting Times	1.0%	Jul-20	47.6%	47.6%	41.3%	39.6%
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93.0%	Jul-20	87.1%	93.2%	90.7%	90.4%
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93.0%	Jul-20	70.7%	95.0%	80.1%	86.4%
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96.0%	Jul-20	95.5%	97.2%	95.0%	95.1%
Cancer - 31-Day Wait For Subsequent Surgery	94.0%	Jul-20	93.5%	100.0%	84.7%	87.9%
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98.0%	Jul-20	99.5%	100.0%	99.5%	99.3%
Cancer - 31-Day Wait For Subsequent Radiotherapy	94.0%	Jul-20	99.7%	100.0%	98.2%	96.0%
Cancer - 62-Day Wait From Referral To Treatment	85.0%	Jul-20	73.7%	73.0%	75.8%	78.4%
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90.0%	Jul-20	23.1%	0.0%	30.0%	25.4%
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade	Null	Jul-20	79.7%	73.7%	82.6%	85.2%
Cancer - 104-Day Wait	0.0%	Jul-20	92	11	210	1462
Breast Cancer Screening Coverage (Aged 50-70)	70.0%	Jan-20	68.8%	75.2%	71.1%	72.1%
Bowel Cancer Screening Uptake (Aged 60-74)	60.0%	Jan-20	63.1%	64.4%	64.3%	65.1%
Cervical Cancer Screening Coverage (Aged Under 50)	80.0%	Jan-20	71.3%	73.1%	72.4%	70.0%
Cervical Cancer Screening Coverage (Aged 50-64)	80.0%	Jan-20	76.0%	76.3%	75.7%	76.1%
MRSA	0.0%	Jul-20	6	0	10	48
E.Coli	Null	Jul-20	149	15	353	3207
Estimated Diagnosis Rate for People with Dementia	66.7%	Jul-20	69.60%	76.2%	66.8%	63.2%
Improving Access to Psychological Therapies Access Rate	5.3%	Jun-20	3.25%	1.89%	2.96%	3.20%
Improving Access to Psychological Therapies Recovery Rate	50.0%	Jun-20	48.3%	48.1%	46.5%	49.6%
Improving Access to Psychological Therapies Seen Within 6 Weeks	75.0%	Jun-20	78.5%	54.3%	84.9%	86.5%
Improving Access to Psychological Therapies Seen Within 18 Weeks	95.0%	Jun-20	96.8%	97.1%	97.6%	97.4%
Early Intervention in Psychosis - Treated Within 2 Weeks of Referral	56.0%	Jun-20	80.4%	89.0%	72.8%	73.0%
First Treatment For Eating Disorders Within 1 Week Of Urgent Referral	95.0%	Jun-20	97.5%	100.0%	94.7%	76.4%
First Treatment For Eating Disorders Within 4 Weeks Of Routine Referral	95.0%	Jun-20	97.6%	100.0%	97.1%	81.7%
Access Rate to Children and Young People's Mental Health Services	33.2%	Jun-20		46.6%	39.50%	39.1%
CPA follow up within 7 days	95.0%	Dec-19	96.2%	98.1%	96.6%	95.5%
Mixed Sex Accommodation	0.0%	Feb-20	1.9	1.5	1.3	3.00
Cancelled Operations	Null	Dec-19	1.7%	2.0%	1.3%	1.1%
Ambulance: Category 1 Average Response Time	420	Jul-20	6:34	06:35	07:06	06:47
Ambulance: Category 1 90th Percentile	900	Jul-20	10:35	10:08	11:55	12:02
Ambulance: Category 2 Average Response Time	1080	Jul-20	22:29	22:52	20:54	16:39
Ambulance: Category 2 90th Percentile	2400	Jul-20	44:44	20:36:00	42:02	32:33
Ambulance: Handover Delays (>60 Mins)	Null	Jul-20	0.5%	0.8%	0.4%	0.6%
Cancer Patient Experience	Null	Apr-18	8.88	8.72	8.87	8.80
General Practice Extended Access	Null	Mar-19	100.0%	100.0%		

Data source: GM Tableau on 13/07/2020

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NHS
Bury
Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	**Consider**
Item No.	8	**Confidential**	No
Title	Strategic Commissioning Board Risk Register		
Presented By	Lisa Featherstone, Deputy Director		
Author	Lynne Byers, Interim Risk Manager		
Clinical Lead	-		

Executive Summary

Risk Management is the process of identifying, analysing, evaluating, treating, monitoring and communicating **risks** associated with any activity, function or process in a way that will enable organisations to deliver against or manage challenges to its agreed objectives.

The CCG's Risk Management Strategy sets out that all risks will be assigned to a Committee and / or Sub-Committee of the Governing Body for oversight.

This report provides an update in respect to the four (4) strategic risks, which are captured on the Governing Body Assurance Framework (GBAF), that have been assigned to the Strategic Commissioning Board for oversight.

- Urgent Care System - Re-design (level 20)
- Lack of effective working with key partners which influence the wider determinants of health (level 15);
- Assuring decisions are influenced by all staff including clinicians (level 15); and
- Lack of effective engagement with communities (level 15).

Reviews have been completed against 3 of these risks in the last month, however it should be noted that the ' lack of effective engagement with communities' has not yet been subject to a formal review with the risk owner, however this is scheduled November 2020.

The Strategic Commissioning Board is advised that of the risks presented in this report, 2[1] risks remain static with no change in current level of risk with the other two risks reporting a reduction in the level of risk presented.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receive the Strategic Commissioning Board Risk Register;
- Review the information presented; and

[1] *Risk score assumption has been made for risk 'Lack of effective engagement with communities' as this risk has not been assessed at this time*

- Provide a Strategic Commissioning Board opinion on the risks reported and any reflections for future development.

Links to CCG Strategic Objectives	
SO1 People and Place To enable the people of Bury to live in a place where they can co-create their own good health and well-being and to provide good quality care when it is needed to help people return to the best possible quality of life	☒
SO2 Inclusive Growth To increase the productivity of Bury's economy by enabling all Bury people to contribute to and benefit from growth by accessing good jobs with good career prospects and through commissioning for social value	☒
SO3 Budget To deliver a balanced budget	☐
SO4 Staff Wellbeing To increase the involvement and wellbeing of all staff in scope of the OCO.	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below	Yes
GB2021_PR_1.3 Urgent Care System - Re-design 2020/21 **GB2021_PR_2.1 Lack of effective working with key partners which influence the wider determinants of the health** **GB2021_PR_4.1 Assuring decisions are influenced by all staff including clinicians** **GB2021_PR_1.1 Lack of effective engagement with communities**	

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	☒
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
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 risks are articulated within the report and managed through the respective committee as appropriate						

Governance and Reporting		
Meeting	**Date**	**Outcome**

Strategic Commissioning Board Risk Register

1. Introduction

1.1. The Strategic Commissioning Board Risk Register reflects those risks which have been identified as potential to impact on delivery of the agreed strategic objectives and are assigned to the Strategic Commissioning Board, as a sub-committee of the Governing Body for oversight.

1.2. The report presents the risk position and status as at 31st August 2020.

2. Background

2.1. Risk Management is the process of identifying, analysing, evaluating, treating, monitoring and communicating **risks** associated with any activity, function or process in a way that will enable organisations to deliver against or manage challenges to its agreed objectives.

2.2. Once identified, each risk should be assigned a risk owner, who is responsible for ensuring day-to-day management and undertaking regular re-assessment of the risk level, taking into account changes in context, controls and assurance.

2.3. Good practice also recommends assigning risks to Boards, Committees and Sub-Committees to provide a further level of objective and collective oversight, review and assurance. The CCG supports this level of good practice as set out in the CCG's approved Risk Management Strategy.

2.4. The report includes a summary risk register (Appendix A) and a more detailed reflection of each risk (Appendix B) along with a narrative of the key changes in the reporting period relevant to each risk.

2.5. The Strategic Commissioning Board should consider the updates provided in the context of the wider agenda, raising any additional points for consideration.

3. Strategic Commissioning Board Risk Register

3.1 There are currently four risks included on the Strategic Commissioning Board Risk Register.

3.2 The following narrative reflects the current position of each risk following review by the risk owner and risk manager.

Risks with no reported change

3.3 During the reporting period **1** risk has remained unchanged.

- **GB2021_PR_1.3 Urgent Care – Re-design 2020/21**

3.4 This risk has been reworded to reflect the current year rather than 2019/20 as previously recorded. It remains at its current level of 20, against a target level of 12 to

be achieved by March 2021.

3.5 Whilst decisions have been reached in respect to the Urgent Care re-design proposal, the risk owner considered that the risk should not be reduced at this time whilst the CCG more comprehensively understands the implications of COVID-19 on the demand in the system. Additionally, the rapid deployment of the GM Urgent Care by Appointment Project needs to be considered in parallel and any associated risks factored into the overall urgent care work programme.

3.6 Arrangements to support the redesign of urgent care are in place, with the Primary Care Networks (PCNs) and Neighbourhood Teams working well, although it should be noted that these are still developing and maturing.

3.7 The proposed model for Intermediate Care (IMC) will be subject to a review by the Strategic Commissioning Board on 05 October 2020.

3.8 Discussions are underway with the LCO to implement the IMC model; however, this is subject to further dialogue regarding the form and function of the LCO.

Risks that have reached their target level

3.9 During the reporting period **0** risks have reached their target score.

Risks that have reduced in score

3.10 During the reporting period **2** risks have reduced in score.

- **GB2021_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health**

3.11 This risk has reduced from a level 20 to a level 15. Additionally, the review has seen the new risk owner adjust the target level of risk to be achieved from a level 15 to a level 10, by March 2021.

3.12 Given the progress that has been made through the current integration and wider system working, additional clarity on the Bury 2030 and emerging revisions to the health strategy, air quality arrangements and economic ambition for the Borough, it was determined that the current level of risk has reduced from the last assessment.

3.13 Covid-19 has been a catalyst in developing more mature relationships and ways of working across the CCG, Council and Partners and at a pace greater than was previously envisaged, which has created significant benefits.

3.14 Additionally, significant progress through routine day-to-day operations, as outlined below, do and / or will provide a level of re-assurance on the effectiveness of these relationships:

- Implementation of neighbourhood working, operating on the same spatial level of neighbour working as the wider council view and reporting through the refreshed health and transformation programme;
- The wider Council view of neighbourhood working is clarified and the role of Public Service Reform (PSR) is being delivered on the confirmed footprint;

- the appointment of a PSR manager role in the Council who will be working closely with the OCO/LCO;
- the impending finalisation of the Bury 2030 vision which will prioritise health and wellbeing and neighbourhood working

- **GB2021_PR_4.1 Assuring decisions are influenced by all staff including clinicians**

3.15 The latest review has seen the risk reduce from level 20 to a level 15, against a target level of 10 to be achieved by March 2021.

3.16 The main driver for this reduction is greater integrated working across the OCO, and also within the wider CCG and Council, which is seeing relationships becoming more developed than they were and maturing well, resulting in the likelihood score being reduced from a level 4 (likely) to a level 3 (possible).

3.17 Progress continues to be made with the single leadership structure following the formal consultation process, with the Executive Director of Strategic Commissioning commencing in post in July 2020 to further drive forward the OCO development. Additionally, the Clinical Leadership of the CCG remains central and again has been pivotal to the management of the Covid-19 pandemic response. Further work is being progressed over the next three months to ensure a strengthened System Wide Clinical Reference Group is in place to continue to inform clinical commissioning, and the outcome from the Internal Audit on Clinical Engagement in Decision Making should be concluded.

3.18 Continued development, engagement and involvement of all staff is on-going through progression of the Organisation Development (OD) Programme, and recently the CCG was able to invite staff members to apply for a leadership development programme funded through the Council's Apprenticeship Levy. This will provide opportunities to develop local leadership across the partnership.

Risks that have increased in score

3.19 During the reporting period **0** risks have increased in score.

Risks recommended for closure

3.20 During the reporting period **0** risks have been recommended for closure by the risk owner.

New Risks

3.21 During the reporting periods **0** new risks have been added to the risk register.

Risks that have not been reviewed in the reporting period

3.22 During the reporting period **1** risk has not yet been reviewed.

- **GB2021_PR_1.1 Lack of effective engagement with communities**

3.23 This risk was last reviewed January 2020 and resulted in no change to the risk score

of 15.

3.24 Although this risk has not been reviewed prior to the drafting of this report, the risk was considered by the CCG's Audit Committee and presented in the GBAF report to the Governing Body in September 2020 for continued inclusion as a strategic risk.

3.25 This is a long-standing risk, initially identified in September 2017, with no change in risk score since that time, however it is anticipated that the next review scheduled in November 2020 will see a level of reduction and / or increased assurance given the good progress that has been made.

3.26 It has long been recognised that a different type of engagement is needed if improved outcomes for the population are to be achieved. Whilst Covid-19 has presented a number of challenges to the health and care economy, the level of engagement and different conversations has been apparent, across our communities and wider population. Through working in partnership with Bury Council as part of the emergency response to Covid-19, a number of Community Hubs have been established to support those in greatest need, alongside a cadre of community volunteers. The system is keen to grasp hold of the momentum that has been created and to continue to develop Community engagement networks and partnerships that have emerged and to this extent has committed to a Director of Communities post as part of the Corporate Core.

4 Risk Summary

4.1 The following summary is provided to the Strategic Commissioning Board:

	August	**Aug %**
Total Risks on Report	**4**	
New Risks	0	
Risks reduced since last report	2	50.0%
Risks increased since last report	0	0.0%
Risk that have reached target level	0	0.0%
Low Risks (1-3)	0	0.0%
Medium Risks (4-6)	0	0.0%
High Risks (8-12)	0	0.0%
Significant Risks (15-25)	4	100%
Risks reviewed in this period (August 2020)	3	75.5%
Risks yet to be reviewed (August 2020)	1	25.0%
Risks to be reviewed for next report (November due date)	4	100.0%

5 Recommendations

5.1 The Strategic Commissioning Board is asked to:

- Receive the Strategic Commissioning Board Risk Register;

- Review the information presented;
- Provide a Strategic Commissioning Board opinion on the risks reported and any reflections for future development.

Appendix A: Strategic Commissioning Board Risk Register: Summary

Risk Management	Risk Id	Risk Description	Date Risk Identified	Original Risk Score	Risk Last Reviewed	Current Risk Score	Target Risk Score	Direction of Travel	Next Risk Review
GBAF	GB2021_PR_1.3	Urgent Care System - Re-design 2020/21	14-Aug-2019	20	**14-Aug-2020**	20	12	-	**Nov-2020**
GBAF	GB2021_PR_1.1	Lack of effective engagement with communities	28-Nov-2016	20	14-Jan-2020	15	10	-	**Nov-2020**
GBAF	GB2021_PR_2.1	Lack of effective working with key partners which influence the wider determinants of health	14-Aug-2019	20	**14-Aug-2020**	15	10	↓	**Nov-2020**
GBAF	GB2021_PR_4.1	Assuring decisions are influenced by all staff including clinicians	29-Nov-2016	20	**14-Aug-2020**	15	10	↓	**Nov-2020**

Appendix B: : Strategic Commissioning Board : Detailed Risk

Risk Code & Title	GB2021_PR_1.3 Urgent Care System - Re-design **2020/21**				
Risk Statement	1.3 - Because of long standing pressures on urgent care there is a risk that improvements across the wider health and care economy will not materialise, impacting upon patient experience and CCG reputation, if the urgent care system re-design **(which also takes in to account an element of the programme related to GM urgent care by appointment strategy)** is not implemented in a timely manner.	**Assigned To**	**Current Risk Status**	**Direction of Travel**	**Annual profile**
		Will Blandamer			
Current Issues					

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
14-Aug-2019	4	5	20	14-Aug-2020	4	5	20	**Nov-2020**	4	3	12	**31-Mar-2021**

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Bury System Board 2. Governing Body oversight of performance reports 3. Detailed scrutiny by the Recovery and Transformation Board 4. Primary Care Commissioning Committee oversee the development of the Primary Care Networks and alignment with Neighbourhoods 5. Oversight by the Strategic Commissioning Board (SCB) 6. Clinical/Cabinet/Professional Congress	1. Review of the system wide urgent care facilities 2. Implementation of a suite of initiatives under Transformation Programme 5 (urgent care treatment centre, NWAS Green Car, same day emergency/ambulatory care established) 3. Implementation of the redesign of intermediate care including the development of integrated neighbourhood teams, rapid response to minimise demand in the system 4. Engagement with GM Urgent and Emergency Care Board to explore system wide solutions to address urgent care demand and capacity	**Gap(s) in controls:** 1. Financial sustainability of the Urgent Care Treatment Centre **to be** determined as part of the urgent care review 2. Sufficient recruitment to enable Intermediate Care Transformation (LCO remit) 3. Impact of the development of Primary care networks unknown 4. Capacity of LCO to oversee implementation of new model **Gap(s) in assurances:**

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
1.3e Primary Care Committee to ensure the development of Primary Care Networks is aligned with the Neighbourhood Teams	**31-Mar-2021**	Will Blandamer	**PCNs & Neighbourhood working still developing and maturing**	90%		In Progress
1.3f Bury System Board and Strategic Commissioning Board to receive and agree proposals of IMC	**30-Nov-2020**	Will Blandamer	**IMC proposed model being submitted to the SCB 5/10/2020**	**80%**		In Progress
1.3i Discussions commenced to hand over implementation of new model when agreed to the LCO	**31-Oct-2020**	Will Blandamer	**Subject to further discussions regarding form and function of the LCO**	20%		In Progress

Risk Code & Title	GB2021_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health				
Risk Statement	2.1 Because of the significant impact that the Public Sector Services has on health, there is a risk that opportunities to reduce inequalities will be minimised if health does not influence and work in harmony with key partners impacting on outcomes and experience for our population	**Assigned To**	**Current Risk Status**	**Direction of Travel**	**Annual profile**
		Will Blandamer			
Current Issues					

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
14-Aug-2019	5	4	20	14-Aug-2020	5	**3**	15	**-Nov-2020**	5	**2**	10	**31-Mar-2021**

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Health and Well-Being Board 2. Governing Body 3. Council Cabinet (key partner) 4. Joint Strategic Commissioning Board	1. Bury 2030 Strategy under development, including supporting strategies and delivery plans (e.g. Housing, Industry, Environment) 2. Development of a Commissioning Strategy which will include commissioning for social value (e.g. maximise the CCG's potential to become an anchor organisation by supporting the local supply chain/local recruitment, being an exemplar organisation, inclusion of social value goals in Provider contracts, support environmental sustainability etc.) 3. Refresh of Locality Plan completed emphasising the importance of wider Public Sector Reform on improving health and reducing health in-equalities	Gap(s) in controls: 1. Potential failure of a systematic process to oversee the implementation of a number of high-level strategies which together could have a major impact in reducing health inequalities/improving health and well-being 2. Resources required to support the Bury 2030 Strategy is unclear Gap(s) in assurances: 1. None identified

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
2.1d Continue with on-going engagement as the Bury 2030 Strategy develops	**31-Mar-2021**	Will Blandamer	**Awaiting the next iteration of the Strategy expected October 2020**	50%		In Progress

Risk Code & Title	GB2021_PR_4.1 Assuring decisions are influenced by all staff including clinicians				
Risk Statement	4.1 - Because of the commitment to work as one commissioner there is a risk that the new governance structure fails to recognise the importance of staff and clinicians in shaping the One Commissioning Organisation (OCO) and its decision making	**Assigned To**	**Current Risk Status**	**Direction of Travel**	**Annual profile**
		Will Blandamer			
Current Issues					

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
29-Nov-2016	5	4	20	14-Aug-2020	5	**3**	15	**Nov-2020**	5	2	10	**31-Mar-2021**

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Reports to GB on progress and development 2. GB and Clinical Cabinet sessions - stakeholder engagement 3. Joint Executive Team meetings 4. Primary Care Working Together meetings 5. Monthly EMT meetings with Clinical Directors 6. Bury System Board 7. Strategic Commissioning Board **8. Executive Director in Post (July 2020)** **9. System Wide Clinical Reference Group**	1. Clinical Director and Executive Director involvement in all key decision-making Committees/ Groups / Boards 2. Regular meetings across Health and Social Care to shape the working arrangements for integrated commissioning 3. Staff engagement events ongoing 4. Use of and access to all OD opportunities available to all staff (e.g. Employee Assistance Programme(EAP) , Perform @ Your Peak NHS North West Leadership Academy, Advancing Quality Alliance (AQuA)) 5. External capacity secured to support OCO transformation which has development of a comprehensive OD programme as a priority area which will ensure alignment across CCG and Council offer. 6. Senior Team restructure now nearly complete	**Gap(s) in controls:** 1. Clarity regarding support available to staff during the period of restructure 2. Sub Senior structure still under review **Gap(s) in assurances:** 1. Different decision-making cultures 2. Clarification of the committee substructure and role of clinicians in future sub-committees being explored **3. System wide Clinical Reference Group yet to be strengthened**

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
4.1b Continued development, engagement and involvement of all staff	31-Mar-2021	Will Blandamer	New OD Programme to be put in place.	50%		In Progress
4.1e Strengthening relations between the OCO and LCO	**31-Mar-2021**	Will Blandamer	**Joint meetings routinely held**	**70%**		In Progress

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Receive
Item No	10	**Confidential / Freedom of Information Status**	No
Title	Recovery and Transformation Update		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Will Blandamer, Executive Director of Strategic Commissioning		
Clinical Lead	Howard Hughes, Clinical Director		
Council Lead			

Executive Summary

The latest Health and Care System Recovery and Transformation Highlight report is attached for Strategic Commissioning Board information.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Consider the Report

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

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	Yes	☐	No	☐	N/A	☒

Implications						
requested?						
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
NHS Bury CCG Governing Body Meeting	23/09/2020	

Bury Health and Care System Recovery and Transformation Programme Highlight Report

Programme	Health and Care System Recovery and Transformation	**Status:**	**Amber**	**Lead**	Howard Highes	**Date**	09 September 2020
				Programme Lead	Matt Wright		

Key actions this period	Activity
Programme	Programmes developing implementation plans to support delivery of finalised programme charters, supported by PMO Programme audit continued to ensure robust approach is maintained and provides level of assurance and confidence for delivery. Feedback directly given to SRO's and leads New programme framework agreed to include transformation as next step of recovery and include new programmes (Children, Community Based Health and Care) Community based Health and Care charter drafted for approval, feedback provided. Community transformation board established to oversee and coordinate delivery LD interim transformation board established to align previous transformation work with updated approach Planned Care transformation board established and met for first time to oversee and drive delivery Childrens charter drafted and audited Evaluation of exisiting financial efficiciency schemes underway with SRO's Evaluation underway with feedback report to be delivered in October. APEX performance measures drafted for discussion Workshop planned for 16th Sept to understand estates opportunites within transformation programme and to align with overall estates strategy System wide workforce group established to cordinate requirements across system.

Key actions next period	Activity
Programme	Finalisation of all programme documentation and central support to be given to programmes as required All programmes to move to highlight report by exception, template and guidance supplied Complete programme audit checklist, provide detailed feedback and ensure robust documentation is finalised and in place Develop and align financial efficiencies to programme of work, SROs to agree and sign off. To be included in outcome measures. Finalise APEX outcome measures and work with SRO's to develop reporting framework Provide direct programme support to digital programme

Key Issues and Risks that require escalation

1) Impact of escalating COVID response on delivery of programme
2) Completion of phase 3 response
3) Financial position impacts on transformation opportunities as a system

Programme KPIs

			Robust Delivery Documentation			
Programme	SRO	Lead	Charter	Plan	Risk/Issue Log	Highlight report
Planned Care	Leah Robins	Sarah Wiseley				
Urgent Care	Lindsey Darley					
Strategic Finance	Mike Woodhead	Simon O'Hare				
Community Based Health and Care	Julie Gonda and Kath Wynne-Jones	TBC				
Children	Karen Dolton	Karen Richardson				
Population Health	Lesley Jones	Jon Hobday				
Mental Health	Julie Gonda	Kez Hayat				
Enablers	**SRO**	**Lead**				
Digital	Kate Waterhouse					
Workforce	Lindsey Darley					
Neighbourhood Development	Will Blandemer and Kath Wynne-Jones					
Estates	Mike Woodhead	Paul Lakin				

Key

	Complete and audited as robust
	In development
	Outstanding

Audit Scores

Programme	Charter (48)	Plan (16)	Risk (30)	Total (94)
Population Health	48	0	30	**78**
Strategic Finance	48	0	30	**78**
Mental Health	48	0	30	**78**
Planned care	45	0	30	**75**
Urgent care	48	16	30	**94**
Community Health and Care	46	0	30	**76**
Children	46	0	30	**76**
				Not yet audited
			Total	555
			Max Total	658

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Approve
Item No	11	**Confidential / Freedom of Information Status**	No
Title	Intermediate Tier Review		
Presented By	Julie Gonda		
Author	Adrian Crook, Julie Munn		
Clinical Lead	Howard Hughes		
Council Lead	Cllr Andrea Simpson, Portfolio Holder Health & Wellbeing		

Executive Summary

This report highlights progress against the review of Intermediate Tier Services in Bury and makes recommendations for changes to the nature of service provision.

At present, people don't have the same opportunity to access home based intermediate care in Bury, when compared to other areas in the country. We want people to have the option to receive personalised care in their own home where it is safe and appropriate to do so. The growth in home based services means that fewer bed based services will be required in future. This report therefore seeks permission to undertake a public consultation on the proposed reduction of bed based services within the intermediate tier.

By considering our aims of delivering more care at home, of focussing our care to maximise recovery and of providing high quality accommodation when that is needed, we are led to the outcomes of this report and seek permission to undertake consultation.

Recommendations

As a result of refocusing Intermediate Tier Services to become more home based, the need for bed based services reduces. Therefore in order to reduce bed based services, the following recommendations are made:

- Permission is sought to undertake public consultation for a period of 30 days on the recommendation to decommission Bealey Intermediate Care Facility and re-provide Intermediate Care beds in the Independent Care Sector.

- Following a 30 day consultation a paper containing recommendations for implementation will be bought to December Strategic Commissioning Board for implementation as dictated by notice and recommissioning periods which will be by the end of June 2021 at the latest.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	No

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	☒
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Development of Intermediate Tier falls within the remit of developing health and care services in Bury and is part of the Health & Wellbeing Strategy.					
How do proposals align with Locality Plan?	Intermediate Tier is one of the priorities identified in the Bury Locality Plan.					
How do proposals align with the Commissioning Strategy?	Intermediate Tier is part of the Commissioning Strategy.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	Intermediate Tier Services will reduce health inequalities and improve the mental, physical and wellbeing of the Bury population.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?	None					

Implications						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.	15/01/2020	High level principles of the intermediate tier rebalance discussed at Clinical Cabinet and Health Scrutiny Committee. Request for final proposals to be reviewed.

Intermediate Tier Service Rebalance

1. Introduction

1.1. Intermediate care services support people in the community, helping to promote independence and providing care, therapies and rehabilitation. Intermediate Tier:

- provides short-term rehabilitation to enable service users to regain their optimal levels of independence;
- prevents people from being admitted to hospital, supports people to return home after a recent hospital admission, and enables people to live at home rather than in a care home, if they choose; and
- provides multi-disciplinary teams that support people and their carers when they are in transition between hospital and home or have entered some kind of health and/or social care crisis at home.

At present, people in Bury don't have the same opportunity to access home based intermediate care, compared to other areas in the country. We want people to have the option to receive personalised care in their own home where it is safe and appropriate to do so.

Providing more care at home will mean we don't need as many bed based facilities in the future. Where individuals do need bed based care, we want this to be in fit for purpose and cost effective settings where a team of health and social care professionals co-ordinate care and support that is personalised to their needs.

By reorganising our intermediate care services, providing less bed based care and more home based care, and providing that bed based care in a more cost effective environment more Bury residents will benefit from the opportunity to recover and rehabilitate with the support of our services, reducing the likelihood of a hospital admission and need for ongoing care services

The following services will be included in the scope of this project

- Bealey;
- Killelea;
- Reablement;
- Discharge to Assess beds.

The report will also demonstrate the additional capacity that will be delivered by our enhanced Rapid Response service and our new Intermediate Care at Home service which are funded through Bury's Greater Manchester Transformation Fund, however they are not in scope of any changes recommended as a result of this project.

2. Background and context

Bury is experiencing unprecedented demands on its health and social care services. Bury's Locality Plan, which describes the compelling case for change, and upon which current transformation work is based highlights that:

- healthy life expectancy is significantly lower than the national average – meaning that people become ill earlier than they should;
- there will be a dramatic increase in the number of older people in Bury as well as an increase in the overall complexity of care needs – with which current services are not equipped to cope;
- the care system is financially unsustainable without radical transformation of how care is delivered – with a current do-nothing scenario of a financial deficit of £76m by 2020/21;
- transformation funding is only available for 2 years needs and sustainable methods of funding services need to be identified.

Now more than ever there is an urgent need to deliver services more cost effectively whilst ensuring activity levels, so important to managing demand in our Adult Social Care and Urgent Care system, are maintained or enhanced.

Benchmarking, as referenced below, clearly illustrates that Bury is too reliant on bed-based services delivering too much of its Intermediate Tier activity in Bealey, Killelea and its Discharge to Assess beds. This rebalance will see the location of where intermediate care is delivered focused more on people's own homes rather than beds and where beds are used, they will be delivered in locations that are the most cost effective and deliver the best experience and quality of care.

This rebalance will see clear activity expectations for our newly enhanced Intermediate Care at Home and Rapid Response services set and with it an increase in support to our Urgent Care system.

The rebalance will therefore be based on an in-depth analysis of episodic cost data to ensure that the budget available delivers the greatest number of episodes of care of the greatest effectiveness. Performance and budget data from the last 21 months will be used to inform this review, including comparison to Best practice from the National Audit of Intermediate Care[1], NICE, The Social Care Institute for Excellence[2], LGA Social Care Efficiency Programme[3] and IPC Brookes Managing Demand in Adult Social Care[4] .

[1] https://www.nhsbenchmarking.nhs.uk/naic

[2] https://www.scie.org.uk/prevention/independence/intermediate-care/

[3] https://www.local.gov.uk/our-support/efficiency-and-income-generation/care-and-health-efficiency

[4] https://ipc.brookes.ac.uk/publications/Six_Steps_to_Managing_Demand_in_Adult_Social_Care_Exec_Summary.pdf

3. Definition and Legal Framework for Intermediate Tier Services

Section 2 of the Care Act 2014 and its associated guidance[5] places a statutory duty on a local authority and its NHS partners to 'Prevent, Reduce and Delay' the need for Care and Support and encourages authorities and their NHS partners to deliver targeted interventions to do so, recommending Intermediate Care and Reablement as a core component of this range of interventions.

Intermediate Care was first developed in 2001 in response to the government's National Service Framework for Older People[6] which saw the government reset the priorities of the NHS and local authorities towards helping older adults stay well, by helping older people to stay as healthy, active and independent as possible, for as long as possible.

It stated together we must:

- ensure that older people are treated with respect;
- prevent unnecessary hospital admission, and support early discharge;
- reduce long term illness by providing specialist care;
- promote healthy lifestyles and independence for those in older age.

Later this guidance was updated in the Department of Health's guidance 'Intermediate Care - Halfway Home' published in 2009.[7]

Intermediate Care and Reablement are also further defined with the Care and Support (Charging and Assessment of Resources) Regulations 2014[8].

"Intermediate care and reablement support services" means care and support, or support provided to an adult by the local authority which –

- consists of a programme of care and support, or support;
- is for a specified period of time; and
- has as its purpose the provision of assistance to an adult to enable the adult to maintain or regain the ability needed to live independently in their own home.

This statute states a local authority must not make a charge for meeting needs under section 14(1) of the Care Act where the care and support, or support which is provided to an adult, is covered by the definition above.

[5] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-2

[6] National Service Framework for Older People 2001

[7] Intermediate Care - Halfway Home 2009

[8] http://www.legislation.gov.uk/uksi/2014/2672/pdfs/uksi_20142672_en.pdf

The National Audit of Intermediate Care, which is now the country's largest health and care audit, defines intermediate care as "*a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually time limited, normally no longer than six weeks and frequently as little as one or two weeks. Intermediate care should be available to adults age 18 or over*." [9]

There are four primary categories of intermediate care:

- Rapid Community Response (crisis response);
- Home-based intermediate care;
- Bed-based intermediate care; and
- Reablement.

[9] National Audit of Intermediate care Report 2017

4. Current Service Provision in Bury

The current structure of services in Bury is as follows:

Rapid Response

Bury has an existing Rapid Community Response service which primarily offers rapid social care support to individuals, with the aim of preventing non-elective admissions to hospital or unnecessary or premature admission to residential or care homes. The rapid community response team currently has a staffing model of:

- Nursing;
- social work;
- occupational therapy;
- physiotherapy;
- night-sitting

Home Based Intermediate Care

Despite being a core component of intermediate care, empowering individuals to maintain their independence and helping to prevent unnecessary admissions to hospital and care homes, there is currently no home-based intermediate care offered in Bury. This is being addressed by the Greater Manchester Transformation Scheme funding and has just begun operating. Intermediate Care at Home comprises of Occupational Therapy and Physiotherapy delivered in a person's own home for a short period to aid recovery.

Reablement

Reablement is the assessment and interventions provided to people in their home aiming to help them to recover skills and confidence and maximise their independence. Bury's current reablement service, supports individuals after a recent hospital admission or crisis at home with up to six weeks of intensive support in their own home. A wide range of services are now offered as part of Bury's Choices for Living Well service. Unlike intermediate care at home Reablement meets people's daily personal care needs such as washing, dressing and making meals in addition to any therapy needs.

The recent combination of the Killelea unit with the reablement team has provided a more streamlined and integrated service to support flow of users through rehabilitation and reablement, from bed-based to home-based. However, feedback from local stakeholders is that there is further requirement to supplement these services with more robust and consistent support from pharmacy, therapy, nursing and medical cover.

Bed based Intermediate Care

Currently, the largest proportion of the intermediate care activity undertaken within Bury is comprised of bed-based services. The current facilities available in the locality are outlined in the table 1 below.

Location	Beds	Description
Bealey Intermediate Care Facility	13*	• Bealey is a 13-bed intermediate care facility which provides adult intermediate care; • The unit has access to a small multi-disciplinary team which is primarily nursing led but has access to local GPs, Occupational Therapy and Physiotherapy. Provided until recently by Pennine Care NHS Foundation Trust it has recently transferred to the Northern Care Alliance; • The current patient cohort for the facility is individuals requiring symptom management for chronic disease; palliative and end-of-life comfort care; rehabilitation and tissue viability management.
Killelea House Intermediate Care Facility	36	• A newly redeveloped adult rehabilitation unit consisting of 36 beds to support individuals following illness or injury; • The unit contains four 'rehabilitation flats' designed to allow assessment of an individual before they return home following a hospital or care home admission.
Discharge to Assess (D2A)	19	• Within Bury, there are 19 discharge-to-assess beds available for assisting individuals to leave hospital in a supported manner; • Previously, these were located across three care homes (Burrswood, Rose Court, Carders Court); • As of November 2018, these beds are now entirely located at Heathlands Village.

* Bealey has reduced its capacity from 19 to 13 in response to deliver the required infection prevention space around its beds which are in part in open bays. This change will be permanent

This reliance on beds has resulted in the lack of development of home-based services that has happened over recent years in many areas in the UK. The development of home-based services is now underway in Bury and will be fully operational from April 2021 onwards. This provides the basis on which the changes to the bed based set of services can be proposed.

5. Bury Performance Headlines

Rapid Response

After its development through transformation funding Bury's Rapid Response service responds nearly 150 referrals a month, assessing all of them and providing a short service to **90**.

If Bury was to provide a Rapid Response service the average size of other local authorities in England it would it would provide a service to **73** people per month therefor we can see that we are currently providing a service in excess of other areas of England providing more opportunities for people to avoid unnecessary hospital admission or premature admission to care services.

It is important this this service continues to grow and transformation funding is made sustainable to ensure ongoing delivery of this service.

Home Based Intermediate Care

Developed with the support of temporary transformation funding Bury currently delivers Intermediate Care at home to only 10 people per month, but this is growing.

If Bury was to provide an Intermediate Care Service the average size of other Clinical Commissioning Groups in England it would it would provide a service to **67** people per month.

It is important this this service continues to grow and transformation funding is made sustainable to allow continued development.

Reablement

Reablement currently provides a service to **66** new people per month on average each user receives 1.28 hours per day and remains on the service for 16 days.

It is funded partly through temporary transformation funding and partly through recurrent funding

If Bury's reablement service delivered activity in line with England averages it would provide a service to **69** new people per month and they would stay on average 34 days.

It is important this this service continues to maintain current capacity and activity levels and transformation funding is made sustainable as without it the service would only be able to support **30** people per month at home.

Bed based Intermediate Care

Currently, the largest proportion of the intermediate care activity undertaken within Bury is comprised of bed-based services. The current facilities available in the locality are outlined in the table 2 below.

Location	Beds	Activity per month		Occupancy	Avg. LOS
		Admissions	Bed Nights		
Bealeys Intermediate Care Facility	19/13*	12	4752	81%	33
Killelea House Intermediate Care Facility	36	38	8275	63%	15
Discharge to Assess (D2A)	19	13	6380	76%	40
Total	74/68*	63	20264/19407*	75%	34

* *Bealey has recently had to reduce to 13 beds from 19 due to new requirements for infection prevention spacing around beds in bays part way through the year.*

Utilising only 75% of the available bed nights means on average 18 beds were not used.

The average length of stay in an Intermediate Care bed in in Bury is 34 days. The average in England is 26.7 days showing in addition to not fully utilising its capacity, Bury's productivity is lower than most areas in England. An efficient length of stay is considered 21 days

If Bury was to provide the average number of Intermediate Care beds as commonly available across England it would have **49** Intermediate Care beds. Currently we have **68** beds, delivering the England average would be a reduction of **19** beds.

If Bury delivered a length of stay of 21 days with 90% bed occupancy it would only need **48** beds, not the 68 we currently have. Delivering the average length of stay of 26 days would require more 10 more beds but can be overcome by supporting no more than **11** more people at home each month, or 2 per week.

Table 4 demonstrates the activity that would be delivered if Bury performed at the average levels of other Clinical Commissioning Groups and Local Authorities in the United Kingdom. It shows that Bury over delivers on the number of beds, and needs to expand its services delivered through the teams delivery care in people's own home.

Table 4 – Bury's Intermediate Care Activity compared with National Average

Annual Admissions by Service Type	Bury Performance	National Average	Difference
Rapid Response	377	882	**505**
Bed Based	788	436	**352**
Intermediate Care at Home	120	811	**691**
Reablement	725	829	**104**
Total	2010	2958	**948**

Bury's Symptoms

Table 4 shows that unlike other Clinical Commissioning Groups and Local Authorities Bury has not developed its home-based intermediate care services with either no service provision available in Bury or the amount delivered being lower than elsewhere.

Table 4 also shows that Bury is more reliant on beds and provides more of its services in beds than others, 352 more episodes of intermediate care are delivered in beds in Bury than would ordinarily be in other parts of the UK.

Table 2 shows that the average length of stay in Bury's Intermediate Care services is 34 days. This compares with a national average of 26.7 days. Reducing the length of stay each person remains in a service increases the number of people who can benefit from the service and also reduces the cost of each episode of care. This table shows that Bealey and our Discharge to Assess beds are particularly inefficient and is one of the reasons why the costs also expensive.

Table 2 also shows that despite having a lot of beds only 75% of the bed capacity was used throughout the year meaning Bury is paying for beds that are empty. This represents nearly £1.5m a year spent on beds that no one used.

Intermediate Care and Reablement in people's own homes is considered an essential element of an efficient and effective intermediate care system. Services delivered in people's own homes are ordinarily more cost effective than delivery solely in a bed

based unit and can cost up around 1/3 of the cost, meaning that the same budget that supports one person can support over 3 if the balance between care at home and care in a care home or hospital bed is correct.

It's also important to deliver care at home as this is an essential component to make sure that the people who use these services make the most progress possible. Care in a care home or hospital environment can greatly aid the recovery and rehabilitation of very dependent adults, but after a degree of progress is made their abilities plateau. If once home they are able to access ongoing rehabilitation from a reablement and/or intermediate care at home service their abilities make further progress increasing their independence and reducing or preventing their need for care.

If an adult is cared for in a bed-based service when they could actually be cared for in their own home because services are not available, this can actually increase their dependence and reduce their resilience making a return to independence far less likely.

As a result of this over reliance on beds Bury is delivering less intermediate care to its residents than is commonly available in other areas and this care will be overall less effective in its aim of increasing independence and preventing, reducing and delaying the need for care.

It is vital to address this imbalance to ensure we have services available that deliver the greatest progress possible to our residents.

6. Rebalance Principles and consideration of doing nothing

This project's aims are to

- Rebalance Intermediate Care services to deliver an equal if not greater number of episodes across Intermediate Care services for an overall reduced cost;
- Redesign to simplify service offer and pathways;
- Improve effectiveness and user experience.

It will do this by

- Aligning our services to Best Practice and Evidence to ensure the services provided are available to as many people as possible within the budget available;
- Ensuring services are delivered more efficiently and all waste is removed and value for money is assured;
- Protecting our high-quality estate and removing estate that is of poorer quality;
- Increasing the activity delivered and improving people's experience whilst receiving the service.

The option of doing nothing poses a significant risk to the system, both in terms of finances and in terms of paying and delivering inappropriate activity in the intermediate tier of services: The implications are that

- If no change is made, intermediate tier services will continue to provide on average 1500 episodes of care each year. If the changes are made this would rise to over 1600 meaning more people will benefit;

- Bury will continue to pay £2m a year more than it needs to in order to deliver a greater volume of care. This is inefficient and does not deliver value for money. In addition it will mean that £2m of saving will have to be delivered elsewhere which could see services cut and activity reduced elsewhere;

- Changing Bury's Intermediate care will deliver these savings whilst at the same time increasing the number of people who can benefit from these services;

- If no changes were made to Intermediate Care our residents would continue to receive the majority of care in beds. Whilst care in beds is important there comes a point where recovery and progress plateaus and further recovery is only possible with further therapy and rehabilitation at home. By not making any changes our residents will not have the opportunity to make further progress and our services will not be as effective as they could be or as they are in neighbouring boroughs

7. Analysis

It can be seen from the findings of this analysis that Bury delivers too much of its intermediate care in bed-based services; benchmarking shows that many of these bed-based services are more expensive than others and also less efficient. Some are also delivered in buildings that are no longer aligned to modern standards.

Bury must consider reducing the number of beds it delivers and where it does use bed-based services make sure they run as efficiently and effectively as many others do in the UK and that they are delivered as cost effectively as others.

It is evident also that the capacity of home-based services must increase, both reablement and intermediate care at home, where fewer Bury residents have opportunity to benefit from compared to if they lived elsewhere in the UK.

Intermediate Care at Home services, therapy in a person's own home, are currently being developed as part of Bury's Greater Manchester Health and Social Care Transformation plan but work is needed on increasing the efficiency of Reablement to ensure this recovery focused home care is delivered to a greater number of Bury residents and as a result its cost effectiveness and value for money also increased.

The following table 7 shows the activity that can be delivered if Bury had the average number of intermediate care beds as other areas of the UK and delivers them as effectively as others do.

Benchmarking available from the National Audit of Intermediate Care demonstrates, using NHS weighted population figures, the median number of beds for a population the size and demographic of Bury would be 49.

The table below shows the activity that can be delivered by these beds assuming 95% occupancy is delivered, which removes all the previous waste and they function effectively by delivering an average length of stay of 26 days, which is the national average and commonly achieved in other parts of the United Kingdom.

The table also shows the activity that can be delivered in reablement by releasing underused capacity. An in-depth analysis of the hours of direct care delivered and those available and not used shows an additional 8161 hours of care are available which would support an additional 258 people per year and increase the size of the caseload by 10. This can be delivered by making changes to the effectiveness of rota systems and scheduling, increasing the responsiveness of the service to rapid changes and removing downtime and waste.

	Recommended			18/19			
	Bed Based	Reablement	Total	Bed Based	Reablement	Total	Difference
Places	49	70	**119**	74*	60	**134**	**-15**
Admissions per month	54	82	**136**	66	60	**126**	**+10**
Annual admissions	653	983	**1636**	788	725	**1513**	**+123**

*This data was calculated prior to the reduction of beds in Bealey

This modelling demonstrates that despite a reduction in beds of 25 using bed-based and reablement more efficiently delivers an extra 10 episodes of care a month and 123 over the course of a year. This achieves one of the principle aims of this project; to maintain or increase the number of episodes on intermediate care delivered.

These changes would mean 135 people receiving their intermediate care at home instead of a bed, or 11 per month. However, the number receiving care in a bed would still be greater than commonly found in other areas of the UK where the number for a population the size of Bury would only be 436, rather than the 653 delivered by this model.

In addition to making these changes Bury is also delivering its Intermediate Care at Home service as part of Bury's Greater Manchester Health and Social Care transformation plans. This will see the following additional activity delivered.

	New Intermediate Care at Home	Total all Intermediate Care Services
Places	85	**204**
Admissions per month	100	**236**
Annual admissions	1200	**2836**

In total, changes to the bed based and reablement services plus the new Intermediate Care at home service will see 2836 people have the opportunity to receive a service providing the support needed to Prevent, Reduce and Delay the need for care and support. This is 1323 more per year than currently achieved.

A further 250 episodes of care per month will also be delivered by Bury's newly enhanced Rapid Response service, increasing the total number of episodes to 5,836.

8. Analysis Recommendations

This model shows that by removing waste, aligning our services to best practice and evidence and delivering services efficiently and effectively Bury need to make the following changes to its Intermediate Care System

Bury only requires 49 bed, as it currently has 68 it therefore must reduce its number of beds by 19.

Bury must increase its Intermediate Care at home activity to at least 811 episodes per year or 68 per month. Transformation plans are projected to deliver up to 100 episodes a month, however this funding for this new service is temporary so must be made sustainable.

Bury must increase its reablement activity to 69 per month. Bury delivered 60 per month in the year 18/19 but is currently delivering an average of is current delivering 68 per month in 19/20 reaching a peak of 99 in August and an average of 90 per month is the most recent quarter. £600,000 of this funding is temporary which if not made sustainable will reduce the activity to an average of 30 per month.

9. Cost Efficiency

Bury only requires 49 bed, as it currently has 68 it therefore must reduce its number of beds by 19

This reduction must be done with regard to the remaining principles of this project; to protect high quality estate improving people's experience of care and ensure we deliver that care as cost effectively as possible, therefore we must also explore if the remaining 49 beds can be provided more effectively.

This table shows the annual costs of the services in scope of this project at 19/20 rates

What	2020/21 Budget	LA or CCG budget	Contract with	Notice Period	Funding Source
Bealey	£1,723,904	CCG	Salford Royal NHS FT	6 months	Core Budgets
GP Support @ Bealey	£120,276	CCG	GP Federation	3 months	Core Budgets
Reablement	£593,000	LA	In House Service	N/A	Savings
Killelea	£3,929,800	LA	In House Service	N/A	Core Budgets
D2A beds	£391,957	LA	Heathlands Village	No active contract but expected 1 months notice	One of funding from reserves*
D2A beds	£611,000				CCG Recharge
Total	**£7,369,937**				

* As £391,957 of the D2A beds where funded from a one off use of reserves, this is not available for a recurrent saving, but show here to demonstrate the full cost of these beds. If these beds were to close only £611,000 would be saved recurrently.

This table shows the direct costs of care per episode of care and compares this to benchmarked averages available from the National Audit of Community Hospitals[10] and the national Audit of Intermediate Care services[11]. The cost of an episode of care is affected by the costs of delivering the service and the amount of activity it delivers and is therefore a useful measure when comparing efficiency and effectiveness.

[10] NHS Benchmarking Community Hospitals

[11] NHS Benchmarking National Audit of Intermediate Care

Service	Benchmark Cost	Episode Cost
Bealey	£5,780	£9,375*
Killelea	£5,408	£3,460
Reablement	£1,560	£1,859
Discharge to Assess	£2,852	£5,784

* This episode cost is calculated using the operating budget, not the commissioning budget. The commissioning budget sees an episode cost of £13,122. Since reducing the bed space the average monthly admissions have been 9 making the episode cost £17,500.

This shows that an episode of care at Killelea compares very well with other services delivering care efficiently and demonstrating value for money.

However, the cost of care in Bealey and Discharge to Assess Beds are considerably more expensive than the average cost of care in similar services elsewhere in the UK demonstrating these services are not operating as efficiently as others and can be procured more cost effectively delivering value for money

10. Quality of Estate

Bury's bed based Intermediate Care services are currently delivered in 3 locations across the Borough.

Bealey Intermediate Care Facility

Bealey is an intermediate care facility delivering 13 intermediate care beds on Dumers Lane in Radcliffe south of the centre of Bury. Built around 1903 as Bealey Memorial Convalescence hospital it has had a number of purposes including as a maternity home, community hospital and now intermediate care facility. It provides a number of single rooms with the remaining care being delivered in four bedded single sex bays all of which are based on the ground floor. It does not provide ensuite accommodation and has no facilities on site for the cooking of food which is bought in from a nearby hospital. Its age means it is in need of modernisation to keep pace with ever progressing hygiene and safety standards and there is a risk it will be unable to meet these standards in the near future.

Providing care to only 13 people at any one time means it cannot benefit from economies of scale and the cost of providing care remains higher than more modern larger units. Its layout prevents further conversion to deliver a greater number of beds and it would also be impossible to convert in to single rooms or deliver ensuite facilities. It was found to comply with all the required standards when last inspected by the Care Quality Commission (CQC) in 2012. The way the CQC rate services, has changed since but it has been inspected by Bury Care Organisation and complies with required standards.

Killelea Intermediate Care Facility

Killelea is an intermediate care facility delivering 36 single rooms all with ensuite facilities. It is located on Brandlesholme Road and is north of the centre of Bury. Built in the 1960s it recently benefitted from a complete refurbishment and now boasts a fully equipped therapy hub to help people regain confidence and skills to manage everyday tasks, as well as a bistro and hairdressers. Whilst residents are encouraged to prepare their own meals wherever possible hot food is prepared and available on site. Four of the larger single rooms are set up as flats equipped with assistive technology enabling residents to test out equipment before they go home. It is rated Good by the Care Quality Commission when last inspected in 2019.

Discharge to Assess Beds

Bury's Discharge to Assess beds are 19 beds delivered within the Heathlands Village Care Home in Prestwich. Located in the south of the Borough very close to Manchester.
The Heathlands Village provides a wide range of care services for up to 214 older people from both the Jewish and Non–Jewish community. The Heathlands Village is divided into six units. Beach House, residential dementia, Wolfson, residential, Unit 2 residential, First floor residential, the Simon Jenkins nursing unit and Oakwood nursing dementia unit. Bury's discharge to assess beds are located in one of these units. All are single rooms and benefit from ensuite facilities. The care home has many communal lounges and facilities on its large site. The service was rated Good by the Care Quality Commission in October 2018.

11. Recommendations

Following a review of the cost effectiveness of bed based service provision and quality of estate it is recommended the following changes are made to Bury's Intermediate Care Bed based services.

The table below shows the changes in bed capacity and an associated changes in costs

Proposed Changes	Current Capacity	New Capacity	Cost/Saving
Decommission Bealey Intermediate Care Facility (3)	13	0	- £1,723,904
Decommission Bealey GP cover			- £120,276
Decommission 19 D2A beds at Heathlands	19	0	- £611,000
Retain Killelea Intermediate Care Facility and expand nursing capacity to 24 nursing beds (1)	36	36	+ £185,000
Commission 13 residential intermediate care beds from the independent sector * (2)	0	13	+ £440,583
Total	**68**	**49**	**- £1,829,597**

* It is recommended these beds are purchased in the south of the borough to provide better geographical spread of the services

1, Killelea currently delivers 8 nursing beds, this will see the number of nursing beds increase to 24

2, There are currently a large number of vacancies across the independent care sector care homes and it is recommended a competitive tender is carried out to purchase 13 residential beds to be used for intermediate care delivery. These would be on one site and as a preference the south of the borough. The indicative cost above is at £650 per bed per week but may change following competitive tender.

3, The Bealey site, if no longer used, following this consultation should be included in the Radcliffe regeneration plans

12. Recommendations for Strategic Commissioning Board

As a result of refocusing Intermediate Tier Services to become more home based, the need for bed based services reduces. Therefore in order to reduce bed based services, the following recommendations are made:

- Permission is sought to undertake public consultation for a period of 30 days on the recommendation to decommission Bealey Intermediate Care Facility and re-provide Intermediate Care beds in the Independent Care Sector.

- Following a 30 day consultation a paper containing recommendations for implementation will be bought to December Strategic Commissioning Board for implementation as dictated by notice and recommissioning periods which will be by the end of June 2021 at the latest.

Appendices

1, Equality Impact Assessment

Equality Impact Analysis Form		
	The following questions will document the effect of your activity on equality, and demonstrate that you have paid due regard to the Public Sector Equality Duty. The Equality Analysis (EA) guidance should be used read before completing this form.	
	To be completed at the earliest stages of the activity and before submitted to any decision making meeting and returned via email to GMCSU Equality and Diversity Consultant for NHS Bury CCG akhtar.zaman4@nhs.net for Quality Assurance:	
Section 1: Responsibility (Refer to Equality Analysis Guidance Page 8)		
1	Name & role of person completing the EA:	Adrian Crook
2	Directorate/ Corporate Area	Commissioning
3	Head of or Director (as appropriate):	Julie Gonda
4	Who is the EA for?	The Intermediate Care (IMC) Review
4.1	Name of Other organisation if appropriate	Bury Local Authority (as IMC Review Team Leads)
Section 2: Aims & Outcomes (Refer to Equality Analysis Guidance Page 8-9)		
5	What is being proposed? Please give a brief description of the activity.	The IMC Review identifies a range of measures under consideration. Whilst all are inter-related and should be considered in the whole the IMT Review Team has asked the CCG for an EIA to be performed on the impact of Bealey Community Hospital being decommissioned, Heathlands Beds being decommissioning and new beds being commissioned from the independent sector. .
6	Why is it needed? Please give a brief description of the activity.	A restructuring of the bed based to deliver cost efficiencies and improved experience
7	What are the intended outcomes of the activity?	Closure of an expensive bed based service delivered in poor quality estate and reprovision in a more cost effective bed base of higher quality will both improve experience and save cost. Additional beds not required will also be removed, removing waste

8	Date of completion of analysis (and date of implementation if different). Please explain any difference	Analysis completed in September 2020 at the request of the IMT Review Team. The proposed change would require the outcome of consultation to be considered. This will then require analysis and recommendations to be approved. It is not anticipated that the change, if approved, would commence until 2021.
9	Who does it affect?	The proposed change is to close Bealey Hospital, this would affect those Bury adult patients that require IMC support if no suitable alternative was secured.

Section 3: Establishing Relevance to Equality & Human Rights
(Refer to Equality Analysis Guidance Page 9-10)

10 **What is the relevance of the activity to the Public Sector Equality Duty? Select from the drop down box and provide a reason.**

	General Public Sector Equality Duties	Relevance (Yes/No)	Reason for Relevance
	To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010	No	This service is currently open to all protected characteristics and all other population groups.
	To advance equality of opportunity between people who share a protected characteristic and those who do not.	No	This service is currently open to all protected characteristics and all other population groups
	To foster good relations between people who share a protected characteristic and those who do not	No	This service is currently open to all protected characteristics and all other population groups

10.1 **Select and advise whether the activity has a positive or negative effect on any of the groups of people with protected equality characteristics and on Human Right**

	Protected Equality Characteristic	Positive (Yes/No)	Negative (Yes/No)	Explanation
	Age			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Disability			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Gender			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Pregnancy or maternity			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Race			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Religion and belief			If the closure of Bealey forms part of a better system with

				better outcomes then all will benefit.
	Sexual Orientation			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Other vulnerable group			If the closure of Bealey is forms part of a better system with better outcomes then all will benefit.
	Marriage or Civil Partnership			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Gender Reassignment			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	Human Rights **(refer to Appendix 1 and 2)**			If the closure of Bealey forms part of a better system with better outcomes then all will benefit.
	If you have answered No to all the questions above and in question 10 explain below why you feel your activity has no relevance to Equality and Human Rights.			
	If the closure of Bealey is replaced by a better system with better outcomes then all will benefit.			
Section 4: Equality Information and Engagement (Refer to Equality Analysis Guidance Page 10-11)				
11	**What equality information or engagement with protected groups has been used or undertaken to inform the activity. Please provide details. (Refer to Equality Analysis Guidance Page 11-12)**			
	Details of Equality Information or Engagement with protected groups	**Internet link if published & date last published**		
	None as this is an initial EIA requested by the IMT Review Group	There is a planned public consultation exercise set to commence in October 2020		
11.1	**Are there any information gaps, and if so how do you plan to address them**			
Section 5: Outcomes of Equality Analysis (Refer to Equality Analysis Guidance Page 12)				
12	**Complete the questions below to conclude the EA.**			
	What will the likely overall effect of your activity be on equality?	As a stand alone exercise it would reduce the number of IMC beds by 19 in Bury. As part of wider suite of proposals, it would help to deliver a better IMC offer across Bury		

	What recommendations are in place to mitigate any negative effects identified in 10.1?	
	What opportunities have been identified for the activity to add value by advancing equality and/or foster good relations?	The current service and any future delivery models would seek to add value where possible.
	What steps are to be taken now in relation to the implementation of the activity?	Public consultation is planned for October 2020.
	Section 6: Monitoring and Review	
13	If it is intended to proceed with the activity, please detail what monitoring arrangements (if appropriate) will be in place to monitor ongoing effects? Also state when the activity will be reviewed.	
	To be determined.	

2, Quality Impact Assessment

Quality Impact Assessment Tool – Bury CCG

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive, neutral or adverse) on quality from any proposal to change the way services are delivered. Where potential adverse impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially adverse risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	**1**	INSIGNIFICANT
2	UNLIKELY	**2**	MINOR
3	MODERATE / POSSIBLE	**3**	MODERATE
4	LIKELY	**4**	MAJOR
5	ALMOST CERTAIN	**5**	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

		IMPACT				
		1	**2**	**3**	**4**	**5**
LIKELIHOOD	**1**	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

A fuller description of impact scores can be found at appendix 1.
Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 6 areas of delivery in relation to Quality. Each proposal will need to be assessed whether it will impact positively, adversely or have a neutral impact on patients / staff / organisations. Where adverse impacts score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Safeguarding and Quality team.

Title of the scheme/project being assessed: Intermediate Care Rebalance

Brief overview of the scheme:

Key questions to consider

- What is the specific change that the scheme will deliver?

The IMC Review identifies a range of measures under consideration to totally redesign the way IMT services are delivered across Bury.

- What are the outcomes that will be delivered by the change?

Decommission 19 IMC Beds

- What is the impact of the scheme from a financial and workforce perspective?

Would form part of suit of recommendations to save £2m

Answer positive, neutral or adverse (P/N/A) against each area. If A score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question Decommissioning of Bealey Intermediate Care Facility and D2A beds and re-provision of beds in the independent sector	P/N/A	Impact	Likeli-hood	Score	Full Assessment required
Duty of Quality	Could the proposal impact in a positive, neutral or adverse way on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	N				
Patient/Staff Experience	Could the proposal impact in a positive, neutral or adverse way on the following - positive survey results from patients and staff, patient choice, personalised & compassionate care?	N				

Patient Safety	Could the proposal impact in a positive, neutral or adverse way on the following – safety, systems in place to safeguard patients to prevent harm, including infections?	P				
Clinical Effectiveness	Could the proposal impact in a positive, neutral or adverse way on evidence based practice, clinical leadership, clinical engagement and high quality standards?	P				
Prevention	Could the proposal impact in a positive, neutral or adverse way on the promotion of self-care and improving health equality?	N				
Productivity and Innovation	Could the proposal impact in a positive, neutral or adverse way on - the best setting to deliver the best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P				

Please describe the rationale for any positive impacts here:

Patient Safety – Bealeys is an old estate and not best equipped for privacy, same sex accommodation or for hospital comparable safety. If Bealey was closed and no further system changes made then patients who needed it would have to be admitted to hospital, however provision is to be made in the independent sector in better quality estate delivering single rooms.

Clinical Effectiveness – Whilst the quality of clinical care at Bealey is not on the CCG risk register it is acknowledged that the LOS at Bealey is greater than the national average for patients in a similar facility.

Productivity and Innovation – It is recognised that Bealey is more expensive that other options available.

Approval

Signature:	Designation:	Date:
	Project Manager/Commissioning Manager	
	Clinical Lead	
	Deputy Head/Head of Commissioning	

Stage 2

Area of quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides; in accordance with 'NHS Outcomes Framework 2015-16'					
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?					
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?					
	What is the impact on strategic partnerships and shared risk?					.
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual access to services and experience of using the NHS (Refer to Trust Equality Impact Assessment Tool)?					
	Will this impact on the organisation's duty to protect children, young people and adults?					

PATIENT EXPERIENCE	What impact is it likely to have on self reported experience of patients and service users? (Response to local surveys/complaints/PALS/incidents)					
	How will it impact on patient choice? For example choice being influenced by wait times, access to services and clinical outcomes.					
	Does it support the compassionate and personalised care agenda?					

PATIENT/STAFF SAFETY	How will it impact on patient safety?					
	How will it impact on preventable harm?					
	Will it maximise reliability of safety systems?					
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?					
	What is the impact on clinical workforce capability care and skills?					
	How will it impact staff safety incidents?					
	How will it impact staff satisfaction?					

CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?					
	How will it impact on clinical leadership?					
	Does it reduce/impact on variations in care?					
	Are systems for monitoring clinical quality supported by good information?					
	Does it impact on clinical engagement?					
PREVENTION	Does it support people to stay well?					
	Does it promote self-care for people with long term conditions?					
	Does it tackle health inequalities, focusing resources where they are needed most?					
PRODUCTIVITY AND INNOVATION	Does it ensure care is delivered in the most clinically and cost effective way?					
	Does it eliminate inefficiency and waste?					
	Does it support low carbon pathways?					
	Does it lead to improvements in care pathway(s)?					

Appendix 1

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
			Major patient safety implications if findings are not acted on		
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Consider
Item No	12	**Confidential / Freedom of Information Status**	No
Title	Strategic Approach to All Age Learning Disabilities		
Presented By	Will Blandamer, Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG Julie Gonda, Director of Community Commissioning (DASS), Bury Council		
Author	Will Blandamer, Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG Julie Gonda, Director of Community Commissioning (DASS), Bury Council		
Clinical Lead			
Council Lead			

Executive Summary
• Update on Learning Disability "all age" Health and Care – Recovery and Transformation
Recommendations
It is recommended that the Strategic Commissioning Board: • Consider the Learning Disability "all age" Health and Care: Recovery and Transformation update

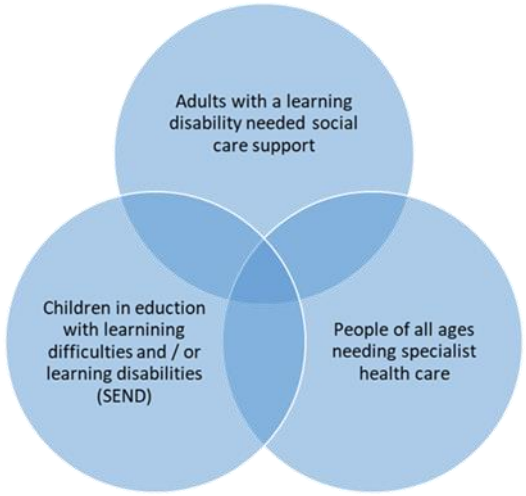
Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

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	Yes	☐	No	☐	N/A	☐

Implications						
will be affected been consulted ?						
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	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.		

Learning Disability 'all age' Health and Care: Recovery and Transformation



Strategic approach

- All age services removing the trend towards over protection of young adults.
- Streamline services and ensure value for money in respect of full life costs
- Improved outcomes for young people with learning disabilities and their families and help their understanding how becoming an adult will impact their life
- Ensure joined up approach regarding health with a focus on reducing health inequalities for people with learning disabilities
- Co-production / co-design at the heart of transformation

- **The aim is for individuals to secure independence through work, housing and community connections, providing support where needed, as light touch as possible**

Suggested Programme themes – proposed and co-produced with adults with a learning disability (pre covid)

- Belonging not isolation
- Housing
- Improving Health
- Risk and crisis
- Workforce and employment
- Transitions

- **First step?** - Creation of all age LD Hub
- To better co-ordinate existing services and avoid duplication
- For effective communication, information, living options and healthcare delivery during 2020/21
- Develop strength based approach, creating better connection to community offer

Work underway:

- Some key priorities for adult social care jointly led by Persona and the Council
  - re-design of some adult supported living arrangements to develop new models of care
  - re-design of Persona LD day care to support younger people
  - new housing models to support people with really complex needs / OoB
  - increase in Shared Lives

- Some key priorities for children's services
  - For the SEND cohort to reduce the number of out of borough and residential placements and broaden the local offer
  - On social care to develop a new specification for Short Breaks and tender so a new service from March 21

- Some key priorities for health
  - LD respite review

Improving Health Outcomes

Reducing health inequalities for people with learning disabilities: Are there some specific health issues we need to address in Bury?

Research by British Journal of Family Medicine (2019) shows that common health issues face by people with a learning disability are:

- Mental health, including anxiety and
- Epilepsy
- Weight management
- Respiratory disease
- Dental problems
- Early onset dementia
- 50% of people with a learning disability have poor eyesight

- Using Health Checks to tell us about our population of Bury

Programme approach

- Currently in pre-programme / interim phase
- Programme transformation group in place meeting fortnightly, including Finance and BI
- Stand up fuller programme board to ensure full representation from partners, residents carers and others in due course
- Group will drive forward transformation and efficiencies
- Connections into Community Health & Care Recovery & Transformation, Children's Recovery & Transformation and work on High Cost Packages of Care

Initial Key Tasks

- Scoping of all LD services currently commissioned and spend, including health and education – complete by end September
- Identify potential for overall savings through benchmarking for all services complete by end October
- Overall design of programme and detailed action plan complete by mid November

System Spend

Client Group	Minor(T)	Month 5 Revenue Budget Forecast: Sum of Current Budget	YTD	Sum of Forecast	Sum of Variance Over/(Under)	Number of Clients
Learning Disabilities	Care at Home complex/community support	350,800	59,341	338,300	-12,500	25
	Domiciliary Care	3,900	1,067	3,900	0	4
	Private day care	115,600	14,136	110,800	-4,800	12
	Private Residential Nursing Homes	85,900	27,742	60,400	-25,500	3
	Private residential rest homes	3,724,400	1,610,014	3,754,600	30,200	59
	Private respite care nursing homes	4,100	0	0	-4,100	1
	Private respite care rest homes	466,400	224,324	376,300	-90,100	16
	Self Directed Support - Direct	3,314,700	1,803,441	3,349,100	34,400	183
	Shared Lives	169,300	111,732	169,300	0	20
	Supported Living	[illegible]	3,007,663	9,666,400	187,000	174
	Total	**17,714,500**	**6,859,460**	**17,829,100**	**114,600**	**497**

LD Planned expenditure - Bury CCG				FYR £
PCFT - 19/20 closing contract plus 1.4% inflation				
Cambeck Close				954,058
LD Team				1,073,815
Cheshire & Wirall Partnership - 19/20 plus 1.4%				
GM Contribution to crisis beds (LD A&T beds - Eastway)				43,476
Merseycare FT - 19/20 plus 1.4%				
GM Contribution to Specialist Support Team				58,139
Placements (based on M5 actual 20/21)	CC	YTD £	Patients	
LD - non CHC (mostly S117)	488531	585,730	22	1,141,460
CHC adult fully funded	488682	989,201	13	1,893,720
CHC Adult fully funded PHB	488683	390,750	10	779,366
CHC Adult Jt funded	488684	1,175,433	46	2,340,352
CHC Children	488685	78,043	2	251,839
		3,219,157		6,406,736
Total CCG expected spend				**8,536,224**

Client Group	Budget Stream/Line	Category	Budget	Number of Pupils
Children's Learning Disabilities	DEDICATED SCHOOLS GRANT (DSG) HIGH NEEDS BLOCK	Primary - Placements	£1,337,401	65
		Secondary - Placements	£4,127,543	123
		Post 16 schools - SEND top up	£1,750,250	51
		Post 16 colleges - SEND top up	£694,780	32
		Out of borough SEND	**£7,909,974**	**271**
		Early Years Inclusion Fund	£299,121	108
		Primary - SEND EHCP top up	£2,559,621	408
		Secondary - SEND EHCP top up	£3,469,455	417
		Bury Schools (maintained & academies)	**£6,328,197**	**933**
		Bury Colleges - SEND EHCP top up	£742,140.47	113
	TOTAL Education		£14,980,311.47	1,317
	SOCIAL CARE Children's with Disability and Agency	Short Breaks - Direct Payments	£1,008,100	58
		Short Breaks - Commissioned incl provision	£1,041,900	62
		Looked After Children Residential Care	£383,500	2
		Social Care CWD	**£2,433,500**	**122**
	TOTAL Social Care		**£16,671,671**	**1,326**

System Spend

Persona Contract 2020/21		
Client Group	Description	Value
Learning Disability	Day Centres Under 65	2,449,780
	Woodbury	297,412
	Supported Living	5,271,416
	Shared Lives	108,738
	Pennine	[illegible]
Sub Total		8,918,541
Older People	Elmhurst	[illegible]
	Spurr House	1,195,670
	Grundy	391,938
	Pinfold	469,809
	Peachment Place	251,397
	Falcon & Griffin	51,095
	Redbank	109,326
Sub Total		3,474,868
	Total	12,393,409

Element	Spend
CCG	8,536,224
Childrens	16,671,671
Local Authority	17,714,500
Persona	8,918,541
Total	**51,840,936**

Next Steps

- Understanding priorities / themes
- Modelling efficiencies
- Developing programme framework with leads
- Implementation plan
- Communication

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Approve
Item No	13	**Confidential / Freedom of Information Status**	No
Title	Adult Community Crisis Service		
Presented By	Julie Gonda		
Author	Kez Hayat / Jannine Robinson		
Clinical Lead	Dan Cooke		
Council Lead	Julie Gonda		

Executive Summary

This report sets out the requirements for a community support service for people experiencing mental health crisis and are at risk of self-harm or suicide, the funding will allow the service to operate 3 evenings a week and provide daytime aftercare. The service would be for adults (18 years+) and a 12 month pilot is proposed, with thorough evaluations to determine future plans.

The rationale for this approach is to support the Bury Mental Health Recovery & Transformation work, which aims to ensure that support for people with mental health illness is as non-clinical as possible, whenever this is safe. The proposed service will operate a person-centered peer led crisis support model, in a theraputic environment, providing local people with a choice of non-clinical community based crisis care.

Other points to note include:

- National requirement in the NHS Long Term Plan; provide a range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways.
- Localities across GM have Safe Haven crisis provision (Oldham, HMR, Tameside & Glossop and Stockport)
- Engagement with local community providers, clinical providers and service users supports the need for this type of service.
- Clinical Cabinet has previously signed off the approval of a Mental Health Safe Haven crisis service in August 2018 (paper attached for information).
- Bury admission data for adult and older people's mental health wards confirms the highest number of admissions are Monday to Friday, with Friday having the highest number of admissions. Over 45% of people are admitted between 6pm and midnight.
- In depth discussions have been held with the VCFA, BIG, Beacon Service, Earlybreak and PCFT, all agree there is a need for this type of service.

- Detailed evaluation will inform future commissions and the shape of a future service.
- The expenditure is within the original approved budget. This project will be funded from Greater Manchester Mental Health Transformation Fund already allocated to Bury CCG (GM CCGs share of the £10.8 million).
- Support the wider Urgent Care redesign underway at Fairfield Hospital.
- Supports the local and national priorities identified as part of the response to covid-19 and building back better.

7.1 Bury-safe-haven-BC-final.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the commissioning of a Bury Adult Community Crisis Safe Haven evening service pilot for 12 months, operating 3 days a week.

- Approve a 5 days a week daytime follow up aftercare support service, to provide additional support to people who have accessed the Safe Haven, with a view to preventing future crisis situations.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

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	☐

Implications						
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☒	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☒	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The Mental Health framework is part of the Health & Wellbeing Strategy.					
How do proposals align with Locality Plan?	Mental health is one of the priorities identified in the Bury Locality Plan.					
How do proposals align with the Commissioning Strategy?	Mental health is part of the Commissioning Strategy.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	The implementation of the Community Crisis Service will reduce health inequalities and provide non-clinical crisis support for the Bury population.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?	As per standard IG requests.					
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Clinical Cabinet	01/08/2018	Safe Haven paper was approved.

Adult Community Crisis Service

1. Introduction

1.1. This report sets out the requirements for a community support service for people experiencing mental health crisis and are at risk of suicide, the funding will allow the service to operate 3 evenings a week and provide daytime aftercare.

1.2. The original Safe Haven paper was presented to Clinical Cabinet in August 2018, the clinical elements have been implemented with PCFT, and the community element was approved but not, as yet commissioned.

1.3. Strategic Commissioning Board is requested to consider the information in the report and approve the recommendation to commission a 12 month pilot, with thorough monitoring and evaluations to determine future plans.

2. Background

2.1. National, GM and Local Context

2.2. The National requirement in the NHS Long Term Plan stipulates that a range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) should be present within all local mental health crisis pathways.

2.3. Currently in Bury, people experiencing a mental health crisis have the option of presenting at A&E where they would be assessed by the Mental Health Liaison service, or accessing the Home Treatment Team via the Access & Crisis Service. Both of these services have been commissioned as part of the Pennine Care Mental Health contract and form the current mental health acute pathway. There is no formal acute metal health community provision in Bury, however several community groups report that people have presented at their premises in crisis.

2.4. Over a 12 month period, there were 4,333 referrals to the A&E Mental Health Liaison service at Fairfield Hospital, and there were 2,366 admissions to the inpatient mental health ward.

2.5. In response to covid-19, GM has bolstered crisis services with a number of 24/7 phone lines such as the GM expanded Clinical Assessment Service (CAS) and Trust helplines for patients and carers. These services are part of a GM wide plan to facilitate a centralised 24/7 crisis response for urgent mental health needs with the aim of trying to diverts activity away from hospital A&E and into the most appropriate mental health provision for service users.

2.6. Greater Manchester Health & Social Care Partnership is reviewing options to develop 24/7 mental health crisis services further to meet the expedited requirements of the NHS Long Term Plan. There are 4 options being considered, 3 of the options focus on improving the efficiency and effectiveness of the recently established mental health acute trust 24/7 crisis phone lines and option 4 proposes a wider review of existing and new crisis services. Option 4 does include a possible redesign of existing Safe Haven models. Those currently in operation in Oldham, HMR, Tameside & Glossop

and Stockport are clinical models delivered by PCFT and it is proposed these will be reviewed as part of the PCFT footprint and GM review/ redesign.

2.7. A new Bury community mental health Safe Haven would offer an alternative to the clinical approach that is currently being operated in the other PCFT footprint Safe Havens. The Bury model would focus more on delivering a peer led bio-social support to de-escalate crisis in a non-clinical environment with a solution focused approach.

2.8. Locality Work Undertaken

2.9. The Bury Community Safe Haven model and pathway is supported by and has been developed in conjunction with the PCFT lead consultant for Bury and service leads from the A&E Liaison, Home Treatment, Access & Crisis and Community Mental Health teams. It will strengthen existing local crisis pathways, link in with the wider GM crisis pathways and the local social prescribing team to offer person centered support to prevent further episodes of crisis.

2.10. Bury OCO has invested additional resource into the expansion of the PCFT Home Treatment Team. This includes additional Mental Health Therapists and a dedicated Consultant who will also support the Access & Crisis team, Primary Care GP's and initiate Clozoril initiation in the community.

2.11. Bury OCO has contributed to the development of the Core 24 Greater Manchester Mental Health Liaison service standards. Bury OCO is currently working in partnership with HMR CCG and PCFT to commission an all age Mental Health Liaison service that meets Core 24 standards. This will not only expand the resource of the current PCFT Mental Health Liaison Team but will also support the redesign of the urgent care provision at Fairfield General Hospital, by putting mental health assessment and support within the front door function.

2.12. Bury OCO has also commissioned a 10 month pilot for a new voluntary sector mental health support service, The Getting Help Line. It provides access to local mental health services, self-help tools and signposting. It should be noted it is not a crisis service, however it will be linked into the aftercare pathway for visitors accessing the crisis service.

2.13. For information; a London based charity, Maytree Trust, is planning to open a mental health crisis service to replicate their London set up, in Manchester. The house will be in Prestwich, it will provide non-clinical residential care for up to 4 people for a maximum of 4 nights / 5 days. Maytree will accept referrals from anywhere in the UK and the Director from Maytree is keen to establish local pathway links and Bury people could stay there. Capacity is limited and the opening of this service doesn't remove the need for a community crisis service in Bury.

2.14. Bury admission data for adult and older people's mental health wards at Fairfield Hospital confirms the highest number of admissions are Monday to Friday, with Thursday and Friday having the highest number of admissions. 45% of people are admitted between 6pm and midnight. It is anticipated that people experiencing a crisis will start to need help several hours before these times during the escalation period.

2.15. Over 60% of referrals to A&E Mental Health Liaison occur between midday and midnight.

2.16. In Bury, there were 12 deaths from suicide in 2019 and 20 in 2018, with men three times more likely to die by suicide than women.

2.17. A significant number of people experience mental health crisis that are not known to any services. Core mental health services report that social determinants such as housing, relationships, substance misuse and finance difficulties are often factors impacting on a person's crisis. The Bury Crisis Safe Haven and subsequent day time offer will support individuals to manage these issues and prevent people from escalating into crisis situations.

2.18. Commissioning the Voluntary Sector

2.19. The VCF sector is best placed to deliver this type of service, it is proposed that the Bury VCFA oversee the delivery of this new service. The contract will be awarded to the VCFA as a Supplementary Agreement to the main VCFA agreement.

2.20. The main Agreement is due to expire on 31 March 2021, a clause will be inserted into the Supplementary Agreement similar to that used for the Beacon Service to ensure the pilot operates for the full intended period of 12 months.

2.21. The agreement will request the VCFA to sub contract the lead provider role and the responsibility for all operational aspects of the evening crisis service to Bury Involvement Group (BIG). Following engagement work, BIG has been identified as the most suitable provider, other providers may be involved as required.

2.22. The agreement will request the VCFA to identify a suitable organisation to provide the daytime follow up support service, for example via the Social Prescribing team. A dedicated mental health support worker is required to work closely with BIG to provide essential daytime follow up for visitors accessing the evening crisis service.

2.23. The NHS Shared Business Service procurement team has advised that it is possible to make a direct award for this service to the VCFA. The justification for this decision is based on; local knowledge of the market, sub-contracts will be awarded to local providers, the service will be shared across several providers and the value of the contract is below the threshold for a full procurement process.

2.24. A contract exemption form will be prepared.

3. Adult Community Crisis Service

3.1 Service Outcomes

3.2 The locally defined outcomes for the service will include;

- People will have increased choice and access to non-clinical mental health service when experiencing a crisis.
- People will be given the skills to manage future crisis situations, they will be

offered support to recognise and develop their own strategies for crisis prevention.
- People will receive aftercare following a visit to the service to further support their recovery following a crisis and help to address social determinants.
- Opportunities for people with lived experience to work as volunteers and/or peer mentors.

3.3 Service Delivery

3.4 The service delivery model will be shaped by the experienced provider, however the service will be required to;

- Operate the evening service 3 days a week; suggested Monday, Thursday and Friday evenings, between the hours of 6pm and 11pm, based on demand on A&E Mental Health Liaison services at Fairfield Hospital and inpatient admissions to mental health wards.
- The service will be based in a central, accessible Bury location.
- Provide 5 days a week daytime follow up aftercare support service for visitors, to provide additional support with their mental wellbeing, with a view to preventing future crisis situations. The aftercare would link into the Bury Voluntary Sector Mental Health Support Service.
- Samaritans Bury branch have offered to provide out-reach support to people accessing the service on a Friday evening, over the weekend.
- Be staffed by experienced workers both qualified and non-qualified, including people with lived experience, with support from an external clinical facilitator.
- Deliver a preventive model of support providing short term practical and emotional interventions to manage a crisis as an alternative to admission to statutory services where appropriate.
- Work within the proposed crisis pathway and keep up to date with changes.
- Establish an information governance protocol, so visitor information can be shared with consent, with health and social care partners.
- Develop effective links with local clinical services, namely Mental Health Liaison, Access & Crisis Service and the Home treatment Team at Fairfield Hospital, to ensure an operational handover each day the evening service operates.
- Operate a resilience plan to maintain service continuity in the event of staffing absences.
- Draft pathway attached.

Community Safe Haven pathway draf

3.5 Staff Training and Competencies

3.6 The nature of this service carries risks, both to the staff and visitors to the service, all providers must ensure staff and volunteers are trained and developed for their roles.

3.7 Providers must have detailed training records available at the commissioner's request.

3.8 All staff and volunteers should be DBS (Disclosure and Baring Service) checked.

3.9 It is the responsibility of all staff to report any issues of concern in respect of the safe operation of the service.

3.10 The lead provider, BIG, will use an external facilitator with a clinical background, and experience in providing individual and group supervision, to develop the crisis team. Group sessions will be used to reflect on work within the setting as well as any team level issues. Individual supervision will focus on the experience of each practitioner and their emotional wellbeing.

3.11 Capacity

3.12 The number of visitors able to access the Community Crisis Service each evening is projected to be between 4 and 7, if staffing is reduced to 2, the service will still operate on a reduced visitor capacity of between 2 and 4.

3.13 The capacity will be agreed with the provider once the final delivery model is agreed.

3.14 Some visitors will require more support than others from the follow up daytime service, and it is expected a small percentage of visitors will be referred into clinical services and equally some visitors will not require any further support.

3.15 The Daytime Mental Health Link Worker will liaise with the evening Service Manager to review capacity.

3.16 Quality Assurance and Monitoring

3.17 The providers will develop robust procedure and policy documents to ensure the safety of staff, volunteers and visitors. The Standard Operating Procedure document has been developed with partners from the wider crisis pathway. Documents will be reviewed and updated periodically as the service develops.

3.18 The service will be closely monitored, meetings will be held fortnightly for the first 2 months of the service going live, then monthly thereafter.

3.19 The monitoring meetings will involve all partners in the Crisis Pathway including representatives from the evening and daytime services, Home Treatment Team, Mental Health Liaison, Access & Crisis and Commissioners. The frequency of these meetings will be adjusted as necessary.

3.20 Before the end of the contract, the provider will work with Commissioners to evaluate:
(i) The impact the service (day and evening) has had supporting people in crisis.
(ii) How effective a role the service (day and evening) plays in the wider crisis pathway.

3.21 In addition, the VCFA will complete a Service Level Agreement Monitoring Report at quarterly intervals and submit it to the Commissioner.

3.22 Evaluation

3.23 To begin with a period of baseline measurement will be required, this will build a picture for future performance and outcome measures, within the first month of the service going live reporting and evaluation criteria will be agreed.

3.24 There is an anticipation that demand will increase for mental health crisis services, as a direct result of covid-19, this combined with the service operating for a limited number of days / hours, will be taken into account when setting performance measures.

3.25 Evaluation will include;

- Number of people visiting the Community Safe Haven.
- Evaluation of visitor experience of the evening service (using a Goal based outcomes tool)
- Number of people supported by the daytime follow up service
- Evaluation of visitor experience of the daytime service (using a Goal based outcomes tool)
- Reduction in the number of repeat or frequent users of the A&E Mental Health Liaison Service.
- Reduction in the number of inappropriate attendances to A&E, with evidence that service users are accessing the community crisis service.
- Evaluation across the wider crisis pathway of processes and the experiences of services interlinking with the Community Safe Haven.

3.26 Costs

3.27 This new service will provide significant learning, the pilot investment budget of £161,627, will provide a 3 day community evening crisis service and 5 day a week daytime follow up support.

3.28 The cost of this service is **£161,627 for 12 months**.

3.29 The expenditure is within the original approved budget. This project is funded from Greater Manchester (GM) Mental Health Transformation Fund already allocated to Bury CCG (GM CCGs share of the £10.8 million).

3.30 Interdependencies with other services

3.31 This service has a strong interdependency with the A&E Mental Health Liaison service, and clear links with the Home Treatment Team and Community Mental Health Team. The demand on these services will impact the number of referrals into the Community Safe Haven service.

3.32 A paper is also being presented to implement a Core 24 compliant model for A&E Liaison Mental Health service across Bury and HMR. The aim of the Core 24 standard is to provide urgent and emergency liaison mental health services for adults and older adults in emergency departments and general hospital wards.

3.33 This service has links with developments to provide ongoing support in both the VCF sector and to universal services.

3.34 This service will be integral to the wider 24/7 mental health crisis pathway that is being developed across the PCFT footprint and GM.

3.35 The services will support the Urgent Care redesign underway at Fairfield Hospital and be part of the wider urgent care pathway for Bury.

4 Associated Risks

4.1 There is a risk the service may not be able to recruit to the fixed term posts. The mental health Commissioning team will work with the Provider to mobilise the recruitment ASAP subject to approval and monitor progress.

4.2 There is a risk that any activity this scheme deflects may be replaced by new activity, therefore not alleviating the pressures in the system. The Mental Health Commissioning team will monitor the impact of the service on the wider system and are working together with NES, footprint and GM colleagues to implement a 24/7 MH Crisis system

4.3 The CCG doesn't currently have evidence to prove the service will provide the required return on investment (2:1) for a transformational scheme. The pilot will be used to test the proof of concept and ascertain the evidence of value for money. A review of the service will be undertaken at 6 months and 12 months.

5 Recommendations

5.1 The Strategic Commissioning Board is recommended to;

- Approve the commissioning of a Bury adult community crisis Safe Haven evening service pilot for 12 months, operating 3 days a week.

- Approve a 5 days a week daytime follow up aftercare support service for visitors, to provide additional support with their mental wellbeing, with a view to preventing future crisis situations.

6 Actions Required

6.1 The Strategic Commissioning Board is required to:

- Approve the commissioning of a Bury adult community crisis Safe Haven service pilot for 12 months.
- Prepare a Supplementary Agreement for this service, to the main VCFA contract.
- Develop the high level mobilisation timeline into a more detailed action plan to support the role out of the service. It is anticipated the service will go live in February 2021.
- Integrate the Bury Community Crisis Safe Haven as part of the wider Local/NES/GM Mental Health crisis pathway in development.

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September 2020

NHS
Bury
Clinical Commissioning Group

Meeting: Clinical Cabinet			
Meeting Date	01 August 2018	**Action**	Approve
Item No.		**Confidential**	No
Title	Integrated Safe Haven and Home Treatment Team – Bury CCG Business Case		
Presented By	Dr Jeff Schryer, Clinical Chair and Mental Health Clinical Lead, Bury CCG		
Author	Catherine Tickle, Programme Manager, Bury CCG		
Clinical Lead	Dr Jeff Schryer, Clinical Chair and Mental Health Clinical Lead, Bury CCG		

Executive Summary

Clinical Cabinet is asked to consider and support the following Business Case to pilot a proof of concept for an Integrated Crisis Safe Haven and Home Treatment Team Model in Bury. The model has been developed across the North East Sector (NES), with Clinical Commissioning Groups (CCG) and Pennine Care Foundation Trust (PCFT) working in partnership, to define the key principles and evidence base of a Safe Haven and Home Treatment service.

NES CCGs have tailored the model to address the demand within their locality and as a result the models vary in terms of delivery location, operational times and days. The Safe Haven will move the Bury locality closer towards the core fidelity model for Home Treatment Teams, as outlined in the 5 Year Forward View for Mental Health.

The main aim of the Safe Haven in the initial pilot stage is to improve outcomes for patients, ease pressures on A&E and inpatient activity, including out of area activity, by ensuring that the right patients are managed in the right place at the right time. If successful, it is envisaged that this model will evolve to adopt an approach that also focuses on early intervention and prevention and during the pilot this element of the model will be further explored.

The Safe Haven will become a new facet of and the principle activity of a new Home Treatment Team 'out of hours' enhancement to staffing. The service will operate from 6pm-9pm, to align with a hand over to the current Home Treatment Team.

Oldham CCG and HMR CCG are also developing Business Cases to support the development of an Integrated Safe Haven and Home Treatment Team locally, which will be considered in parallel to the Bury proposal through their local governance routes. The proposition is for the three CCGs to work together to explore a core specification, evaluation, opportunities for cost sharing and PCFT will coordinate a single recruitment process for the localities.

Clinical Cabinet is asked to consider the options and associated costs for a 3 day, 4 day and a 5 day model and agree the most appropriate option.

Clinical Cabinet is asked to support this business case and agree local investment to pilot the proof of concept from the Greater Manchester (GM) Mental Health Transformation Fund already allocated to Bury CCG (GM CCGs share of the £10.8 million). If supported, it is recommended that the pilot is evaluated after the first 6 months of the service delivery to monitor its progress, delivery against the agreed objectives and value for money.

Recommendations

Clinical Cabinet is asked to:

- Support in principle, subject to Governing Body approval in September, the 5 day model as a 12 month pilot to test the proof of concept at a cost of £228,584 (PYE) in 18/19 (£403,936 FYE), with a further 40k to facilitate 3rd sector involvement in year 1.

- Support a 6 month review to ensure the pilot is meeting the desired objectives and has robust monitoring data to evidence the impact. If at this point the service does not appear to be demonstrating value for money, it is recommended that the CCG re-considers the delivery model.
- Support an evaluation of the 12 pilot coming to Clinical Cabinet to discuss the future of the Safe Haven Model.
- To note further work will now commence to develop a detailed implementation plan, complete the pathway mapping and engage with the 3rd sector.

Links to CCG Strategic Objectives	
To empower patients so that they want to, and do, take responsibility for their own healthcare. This includes prevention, self-care and navigation of the system.	☒
To deliver system wide transformation in priority areas through innovation	☒
To develop Primary Care to become excellent and high performing commissioners	☐
To work with the Local Authority to establish a single commissioning organization	☐
To maintain and further develop robust and effective working relationships with all stakeholders and partners to drive integrated commissioning.	☐
To deliver long term financial sustainability in partnership with all stakeholders through innovative investment which will benefit the whole Bury economy.	☒
To develop the Locality Care Organisation to a level of maturity such that it can consistently deliver high quality services in line with Commissioner's intentions.	☐
Supports NHS Bury CCG Governance arrangements	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	No
GBAF *[Insert Risk Number and Detail Here]*	

Implications						
Are there any quality, safeguarding or patient experience implications?	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	☐
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Clinical Cabinet	02/05/2018	These boxes are for recording where the report has also been considered and what the outcome was. This will include internal meetings like SMT.
		If the report has not been discussed at any other meeting, these boxes can remain empty.

Integrated Safe Haven and Home Treatment Team – Bury CCG Business Case

1. Introduction

1.1 This paper outlines to Clinical Cabinet a proposal to pilot a proof of concept for a Safe Haven Service in Bury. The aim of the service is to improve outcomes for mental health patients, reduce the burden on A&E and inpatients activity for mental health presentations.

1.2 The proposal is in line with the requirements of the 5 Year Forward View (5YFV) to enhance adult crisis and urgent care and will enable Bury to move closer towards the CORE Fidelity model for Home Treatment Team through an enhanced integrated model.

1.3 The 5YFV establishes that all Crisis Resolution Home treatment Teams (CRHTT) should be compliant against specific requirements by 2020 - being operational 24/7 is one of those requirements. The proposal to make Safe Haven integral to Crisis Resolution Home Treatment Teams is intended to achieve the most benefit from this requirement. The demand for home treatment for those on the established caseload of the team is low with most need satisfied with home visits through the day and at night.

1.4 The main benefit intended by the requirement of CRHTT to cover 24/7 is to respond to the needs of people who present in crisis and do so at any time over the 24hr day. The naturally sporadic nature of presentations of people in crisis with high levels of clinical need determines that there has to be an ever present sufficiency of staff to meet the needs of those who are acutely mentally ill and/or very distressed and/or threatening serious self-harm or suicide. Working exclusively to this cohort with a dedicated staff group sufficient to meet their needs would lead to some time when the staff would be under-utilised with no demand present, therefore the Bury Safe Haven will look to cater for 4 distinct cohorts of patients as outlined in section 13.

1.5 The paper seeks to gain Cabinets support to pilot the model with PCFT for 12 months as a proof of concept, with an evaluation at 6 months, to allow the model to be revised where possible during the pilot period.

1.6 Clinical Cabinet is asked to support this business case and agree local investment to pilot the proof of concept from the GM Mental Health Transformation Fund allocated to CCGs (GM CCGs share of the £10.8 million), of which Bury CCGs share is £1,057k in total, with £423k in 2018/19. The expectation from GM is that this resource will support the development of 'enhanced adult crisis and urgent care options'.

2. Background

2.1 The North East Sector (NES) Clinical Commissioning Groups (CCGs) have been working in partnership with Pennine Care Foundation Trust (PCFT) through the Mental Health Acute and Crisis Care Task and Finish Group and NES Transformation Group, to develop a proposal for a Safe Haven Model.

2.2 The prime function of the Safe Haven service is to provide an alternative to hospital admissions for mental health patients, to improve the outcomes and experience for these patients and to address the increasing pressures on A&E and inpatient activity.

2.3 Each GM CCG has been given a proportion of the £10.8m Greater Manchester (GM) Mental Health Transformation monies, to support 'enhanced adult crisis and urgent care options'.

2.4 The following key principles for the investment were collectively agreed through the Task and Finish Group, as set out below:

- Development of an approach that is integrated within the current mental health offer – inter-connecting with/embedded within Access Teams, Community Mental Health Teams, Home Treatment, CMHT, Healthy Minds.
- The model is built into/aligned with Locality Urgent Care and Neighbourhood developments to support effective pathways and cost effectiveness.
- Primarily focus is on mental health crisis support out of hours, however recognising that there are presentations at all times, notably late afternoon and early evening.
- Focus is on people at risk of hospital admission who require specialist input.
- Help-line function needs to be integral.
- Expand and broaden remit of home treatment model to work with people in crisis, particularly out of hours.
- Establish a 'Safe Haven' for people as an alternative to the Emergency Department (ED, recognising that for some people ED is a place to get away from the home environment.
- Learning from Stockport STEM pilot will be used, as well as models elsewhere in the country.
- Challenges around the estate and the need to be co-located near other 24/7 services may mean that in the first instance the 'Safe Haven ' is developed on a hospital site.
- Service users and carers need to be engaged to shape the model to meet challenges faced, particularly out of hours, and what support they would like to see
- The approach should include peer support and ideally be a multi-agency approach (Voluntary and Community Sector in the first instance, housing, employment in the longer term).
- The approach will be iterative and one that responds to evaluation.

2.5 A single Safe Haven Model across the NES CCG was explored at the Task and Finish Group supported by a joint Business Case. Given the vulnerability of the cohort of patients the service will support, Bury CCG had concerns about the single site model and requirement to transport patients to a proposed site in Oldham.

2.6 Commissioners have worked with PCFT to identify space in the Irwell Unit at Fairfield Hospital to allow a locality based model. Despite the locality delivery, the approach will be aligned across all boroughs where possible, to ease pressures across the wider system. The services, all of which will be delivered by PCFT, will adopt the same key principles and objectives, but will be tailored in terms of location, and operational times to meet local need and investment envelopes.

3. National Picture

3.1 The biggest challenge in transforming mental health services is the need to develop alternatives to admission for people in crisis or mental distress during the evening, overnight and at weekends.

3.2 The 5YFV for Mental Health establishes "A 7 day NHS – right care, right time, right quality" as its first priority for action, recognising that currently there is little choice for patients outside of core hours, but to go to A&E.

3.3 Finding alternatives to acute admission to mental health wards is crucial, not least because of the high cost of inpatient care. Feedback from service user and carers shows that for the most part, people prefer to receive care and support outside of a hospital setting, remaining closer to their homes and support networks.

3.4 The 5YFV directs the expansion of proven community-based services for people with severe mental health problems (such as schizophrenia or personality disorder) who need support to live safely as close to home as possible.

3.5 It asserts that a 24/7 service is required to save lives by reducing suicide. It acknowledges that the majority of Crisis Resolution Home Treatment Teams (CRHTTs) are not currently resourced to operate 24/7 and are compromised in their effectiveness by high caseloads, too narrow a

range of skills and professional disciplines held within the team and a distraction from core function by absorption of other wider responsibilities. Localities are instructed to reach an understanding of their gap by assessment of their teams against the CORE fidelity criteria.

3.6 A CORE study found widespread evidence across the country of CRHT teams compromising their effectiveness in reducing hospital admissions through “mission creep”, with teams over-extended beyond their prime and intended function in compensation for deficiency elsewhere in services.

3.7 Many teams were also found to be further compromised by being too small to provide the necessary intensity of care and too restricted in the diversity of skill mix to provide the work with families that is required to be effective.

4. Evidence Base

4.1 In developing the proposal for a Safe Haven Model, members of the multi stakeholder task and finish group visited a Vanguard Project in Aldershot and reviewed Enhanced HTT/Safe Haven services in other areas of the country, where evidence showed a reduction in acute mental health admissions and reduction in A&E attendance.

4.2 The Aldershot service, targeted at individuals already known to community mental health services, achieved a number of positive outcomes for patients. This included:

- 25% reduction in admissions to acute mental health beds
- 16% reduction in A&E attendances for mental health assessments
- Positive feedback from service users including patient reported outcomes of averted suicide attempts, reduced social isolation, loneliness and improved service satisfaction
- Providing an opportunity for peer support and volunteering
- Linking those met in crisis with the health and wellbeing service
- HTT focused on a manageable caseload (including 25% reduction in cohort of patients that would previously have attended hospital but now attend Safe Haven)

4.3 Enhanced Home Treatment Teams and Safe Haven services in other CCGs with similar mental health epidemiology and demographic profiles have realised significant benefits.

4.4 In 2016, Bradford eliminated all non-specialists out of area placements[1] (saving £1.8m) and Sheffield has had no out of area placements for over two years, reinvesting a previous out of area placement spend of nearly £2.0m in an improved community offer that provides care closer to home.[2]

4.5 Safe Haven services that have had a positive impact on patient outcomes have all had statutory service involvement. Whilst services with no clinical input may be beneficial for some people, the Safe Haven must have clinical involvement in order for it to operate at a higher threshold and ensure that it is able to meet the needs of those currently, but inappropriately, admitted. The cohort with short term additional need outside the operational hours of the secondary care team supporting them to absorb some of the work that the HTT currently delivers, outside of its own remit or its core hours.

4.6 If the effectiveness of the HTT is optimised, and the service is appropriately resourced, the care provided to those in acute crisis will be in a position to achieve demonstrably better outcomes than treatment offered in hospital.

4.7 Care delivered at home (or close to home) rather than hospital is better placed to retain or enhance support from social networks, address environmental stressors precipitating the crisis and help develop sustainable coping strategies.

[1] https://www.rcpsych.ac.uk/pdf/Workshop%20C%20Slides%20-%20UE%20Event.pdf (last accessed 14th June 2018)
[2] https://www.england.nhs.uk/mental-health/case-studies/sheffield/ (last accessed 14th June 2018)

4.8 The financial evidence is also clear, with alternatives to A&E representing a lower spend and improved return on investment for commissioners.

5. Pennine Care's Mental Health Strategy

5.1 The PCFT Mental health Strategy identifies the development of alternatives to hospital admission as essential to its transformed and sustainable future. Out of hospital services which have been independently evaluated to demonstrably reduced inpatient demand in other areas of the country are currently absent across the Pennine Care footprint. Development of the Safe Haven Model will support delivery of the strategy.

6. Bury CCG – Current Activity

6.1 The Crisis Safe Haven /HTT service is being designed as an alternative to admission, and therefore the expected cohort of people who will access this service is based on 2 cohorts of people:

- People referred to RAID out of hours who are known to secondary care teams (i.e. EIP, CMHT, OP) and in many cases may be 'repeat attenders'; and
- People who are admitted on a 'short-stay' basis, often informally (i.e. non-MHA admission).

6.2 Table 1 shows a heat map of admissions to Pennine Care beds by day and time. It indicates that weekday evenings generate most admissions. The same variation is evident when admissions to North and South wards at Bury's Irwell Unit are considered as shown in table 2.

Table 1: Heat Map –Admissions PCFT Footprint

Admissions By Day and Time

Hour of Adm.. (AdmissionDay)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
3 AM	5	9	5	10	11	9	4	53
4 AM	7	16	10	11	15	6	3	68
5 AM	8	12	12	7	18	8	3	68
6 AM	2	7	9	12	6	9	5	50
7 AM	2	5	4	4	8	3	1	27
8 AM	2	5	2	1	5	5	3	23
9 AM	7	4	2	5	7	5	2	32
10 AM	5	11	5	5	5	4	7	42
11 AM	2	1	2	10	6	6	4	31
12 PM	3	7	8	5	9	10	10	52
1 PM	16	10	9	14	16	7	10	82
2 PM	11	14	19	14	16	7	7	88
3 PM	14	20	24	14	20	7	9	108
4 PM	27	31	22	25	38	13	9	165
5 PM	27	32	39	31	38	10	10	187
6 PM	25	18	40	29	40	18	9	179
7 PM	44	39	27	25	35	15	16	201
8 PM	38	43	35	50	40	15	20	241
9 PM	25	31	32	26	21	15	6	156
10 PM	17	25	12	22	15	8	13	112
11 PM	24	30	28	24	31	21	10	168
Grand Total	328	405	384	384	439	244	182	2,366

Table 2: Heat Map – Admissions Bury (North and South Ward, Irwell Unit)

Admissions By Day and Time

Hour of Admission Date	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
12 AM			4	2	1	1	1	9
1 AM	1	4	5	2	2	6		20
2 AM	1	3	2		2	3	1	12
3 AM	1		1	2	1	1		6
4 AM	2	3	2	3	3	1	1	15
5 AM	5		1	1	4	1	2	14
6 AM	1	1		4	1	1	1	9
7 AM		1			1			2
8 AM	1	2		1	2			6
9 AM			1			1	1	3
10 AM		4			2	1	1	8
11 AM				3	1		1	5
12 PM	1	2	2	2	3	3	2	15
1 PM	5	4	2	5	2	2	2	22
2 PM	3	3	5	2	2		2	17
3 PM	2	4	8	3	4	1		22
4 PM	6	13	6	5	3	5	1	39
5 PM	7	7	19	6	4	3	3	49
6 PM	8	4	5	5	12	3		37
7 PM	10	9	3	6	3	5	3	39
8 PM	11	9	4	11	13	4	6	58
9 PM	4	4	6	5	3	3		25
10 PM	3	10	1	3	2	2		21
11 PM	5	4	3	2	4	6	2	26
Grand Total	77	91	80	73	75	53	30	479

6.3 As the heat map in table 2 indicates higher number of admissions mid-week it is proposed that to test the proof of concept the Bury service is operational during Monday – Friday (exact number of days to be agreed as outlined in this business case).

6.4 It is recommended that this is monitored throughout the pilot and reviewed at 6 months to ensure the service is operating on the optimal days to support the system.

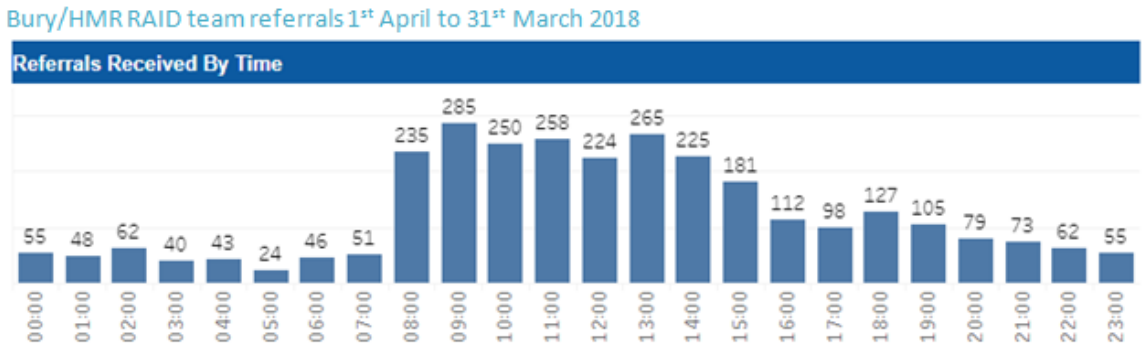
6.5 The Bury data in table 3 shows that more than half of all admissions occur in less than a third of the day (5pm to midnight).

Table 3 – Admission Time Periods by CCG

Admissions by CCG Apr17-Apr18	Total number	Day 9am to 5pm	Evening 5pm to 12am	Night 12am to 9am
Bury	358	28%	54%	18%
Oldham	402	21%	55%	24%
HMR	425	25%	55%	20%
Stockport	358	27%	55%	18%
Tameside and Glossop	389	30%	49%	21%
Trust		**26%**	**53%**	**21%**

6.6 Diagram 1 shows that referrals to RAID after 5pm and before 9am are significant, constituting 46% of all referrals for Bury RAID.

Diagram 1 – RAID Team Referrals 1st April 17 – 31st March 18



6.7 Pressure on assessing clinicians to admit patients following assessment in A&E, out of hours, is increased because of the lack of immediately available service to connect patients to. This is a very significant factor when assessing clinicians are assessing patients who are not known to the service.

6.8 Diagram 2 shows that of all the patients referred to RAID after 5pm and before 9am in A&E more than 75% are not currently on caseload of CMHT, or EIT, and neither are they being seen as an outpatient by a psychiatrist.

6.9 Diagram 3 shows the high numbers of people seen by RAID practitioners in A&E who are not known to services are carried through to the high numbers of patients (43%) not open to services who are admitted to Bury's Adult wards.

Diagram 2: Status of Patients Referred to RAID between 5pm-9am

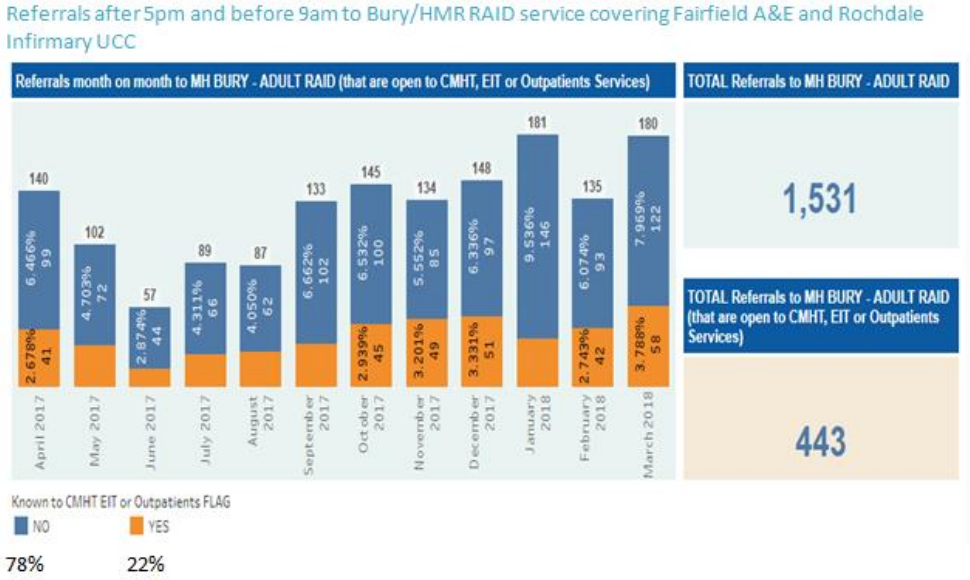
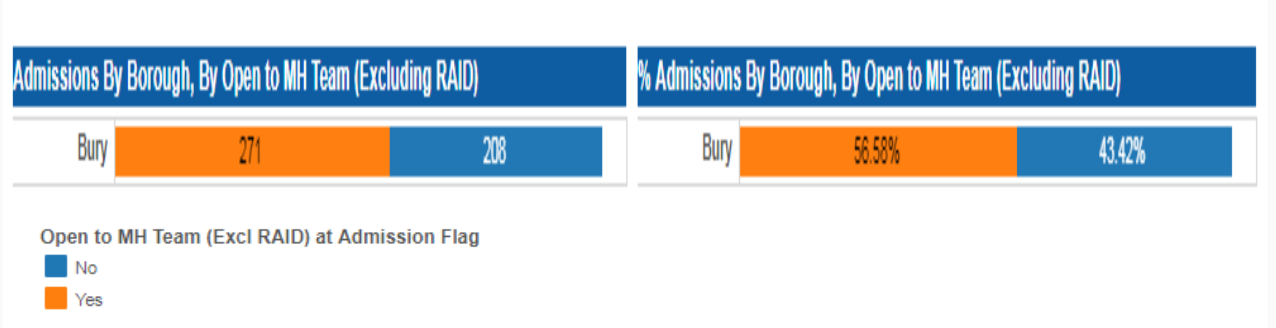


Diagram 3: Percentage of Patients Open to a Mental Health Team on Admission



6.10 This Safe Haven provides assessing clinicians, concerned about risk and safety, a new option of supervised care in the evening and at night that doesn't require admission to hospital.

6.11 This will be especially effective in cases where the clinician has assessed a patient not known to service and on the grounds of safety based only on the presentation before them (there is no history) is reluctant to discharge into the night and therefore defaults to a decision to admit.

7. Bury Safe Haven Proposed Operational Times

7.1 Based on the data in section 6, it is recommended that the Bury Safe Haven service operational times cover the period 5pm -12am, to offer an alternative to admission and that the operational time runs to 8am to align with the handover times of the Bury Home Treatment Team.

7.2 As with the operational days, it is proposed the operational times are monitoring in the pilot and where necessary, and can be facilitated within the financial envelope, these are amended to meet any change in local need.

8. Key Principles of the Bury Service Model

8.1 The Safe Haven will provide out of hours help and support to people and their carers who are experiencing a mental health crisis or emotional distress.

8.2 The service will be staffed by a partnership of mental health professionals and PCFT will be working with the Bury voluntary and community sector providers to support the model, as 3rd sector input into the development and delivery of the model is a key principle for Bury CCG.

8.3 The Safe Haven will offer information and advice about other relevant services in the area and support people in crisis to stay well at home and provide advice, support and guidance to carers and family members.

8.4 The Safe Haven is for patients:

- Who are experiencing mental distress or feel that they are in crisis but who are not acutely unwell
- Who may have underlying mental health issues and may already be accessing mental health services
- Who require immediate short-term support outside of typical service opening hours.

8.5 The Safe Haven environment will provide:

- A safe and calm environment to support patients in crisis overnight as an alternative to A&E attendance and/or admission
- Advice and support to help patients manage their emotional wellbeing and mental health
- Integration with local HTTs for assessment, signposting and ongoing support

8.6 The CCG will work closely with PCFT and other partners to ensure the Safe Haven does not become:

- An open access service for patients who haven't received a mental health assessment
- An accident and emergency service for patients with mental health issues
- A 'holding' service for people requiring an inpatient bed while an appropriate facility is found.

8.7 The recommendation longer terms, subject to the pilot being a success, is to incrementally work towards the development of a hub and spoke approach, with the Safe Haven providing a place away from the person's home, as well as away from A&E, for all people to access mental health crisis support, together with a 24/7 home treatment offer to work at home with those specifically at risk of admission. (check PCFT Bury Team vision also)

8.8 It is proposed that subject to a successful pilot, the service would be developed to provide out of hours mental health support and aim to:

- Prevent escalation of mental health problems to avoid a mental health crisis;
- Prevent unnecessary referrals to secondary mental health services, A&E departments and other emergency out of hours services;
- Improve mental health and wellbeing;
- Increase independence and self-management;
- Help to identify groups, organisations and opportunities in the community that can support people in building social networks and develop coping skills to prevent mental health crises in the future;
- Reduce isolation.

8.9 The pilot service will be developed based on the existing Home Treatment Team resource, with the practitioners being available from 4pm to review any referral information and take a handover from core mental health services (such as CMHT or the Access Team).

8.10 This will also provide the team with the opportunity to make onward referrals and contact other services in relation to signposting and advice and administration time to document contacts and interventions, complete care plans etc.

8.11 The service will be available to known secondary care service users from CMHT, EIT and Outpatients, those recently discharged from these services, or recently discharged from inpatient services, and those signposted from RAID and Access for brief follow up intervention,

or extended assessment and those open to Home Treatment.

8.12 The integrated home treatment / Safe Haven will provide a safe and therapeutic environment, which allows a person to deescalate, discuss their thoughts and feelings supported by a mental health professional.

8.13 Safe Haven provides crisis support and planning, psycho-education around managing emotional wellbeing and mental health, examples of this include: exploring distraction methods and techniques, relapse prevention planning and keeping safe plans in order to offer an alternative to admission into hospital.

8.14 Safe Haven provides low level input for people expressing social crisis and emotional distress, rather than acute mental illness. It provides a safe place for them to work through crisis points and prevents them from being admitted to the acute wards in the absence of an alternative mental health offer. Safe Haven will signpost to third sector service in the community, to offer support and social inclusion.

8.15 As the service will operate throughout the night it will enable it to form part of the 24/7 Home Treatment Offer and support the CCGs in working towards achieving this 5FYV target.

9. Service Description/Care Pathway

9.1 Service user not known to other services will present to A&E out of hours and will be assessed by the RAID team if a mental health assessment is deemed appropriate. The practitioner will have three options to consider – discharge with RAID follow-up if required, admission to a mental health inpatient bed or transfer to the Safe Haven.

9.2 If the Safe Haven is assessed as a safe and appropriate pathway for the patient then the RAID team will make contact with the Safe Haven team and arrange for a supported transfer from A&E to the Safe Haven base.

9.3 The Safe Haven cannot be accessed directly by someone not previously known to mental health services or someone without a current risk assessment or care plan. In this instance, the initial mental health assessment and risk evaluation will need to be completed by the RAID practitioner in A&E.

9.4 For service users already known to mental health services (i.e. with a care coordinator within the CMHT or within EIT), Safe Haven can be identified as part of their care plan / risk management plan. Particularly for those service users known to services who regularly access mental health support out of hours (traditionally through the A&E department), making contact and accessing support through the Safe Haven can be agreed as part of their care plan in conjunction with their mental health worker.

9.5 A copy of their care plan and risk assessment will then be shared with the Safe Haven to ensure safe and appropriate support is provided out of hours. In this instance the service user can then access the Safe Haven directly out of hours without needing to come via the A&E department. This will be encouraged with those service users identified as frequent flyers and high users of urgent care services.

9.6 The Bury service referral process will be fully determined as part of the service specification developed to support the pilot and modified as the pilot progresses.

9.7 Going forward, it is envisaged the RAID practitioners will have a role in the Bury Urgent Treatment Centre in identifying people appropriate for Safe Haven before they hit A&E and moving them swiftly to the Safe Haven, whilst also providing in-reach into A&E.

9.8 Having RAID practitioners earlier in the pathway will improve the outcome for patients, reduce

pressure on the system and spend. Discussions are taking place between Mental Health and Urgent Care colleagues to agree this approach.

9.9 The Crisis Safe Haven will take telephone referrals at any time during their hours of operation and agree arrangements for accepted patients to arrive at the Safe Haven within an hour of referral.

9.10 The Crisis Safe Haven team has a core responsibility to provide an in-depth assessment for each patient that is seen to ensure a mandatory full risk assessment, a mental state examination and pro-forma information is completed within every assessment that the practitioner completes.

9.11 This enables the practitioners to formulate a treatment plan tailored to the specific needs of the individual as a formulation and are key components of the role. If somebody presents who is known to services, the practitioner would only complete the presenting complaint, and Mental State Examination (MSE) and update the existing risk assessment.

9.12 Following on from the in-depth assessment a clinical formulation is carried out which is a theoretically based explanation and conceptualisation of the information obtained from the clinical assessment. This offers a hypothesis about the cause and nature of the presenting problems. In the Crisis Safe Haven, formulations are used to communicate the hypothesis and provide a framework for developing the most suitable treatment approach.

9.13 Crisis Safe Haven would implement a plan following assessment which may consist of the following:

- When to discuss a case with a Consultant Psychiatrist
- When to make a referral to other services
- Always include carers and family members
- Always complete an adult or child safeguarding where appropriate
- To complete a keeping safe plan with each patient

9.14 The keeping safe plan would then be provided to the patient upon discharge, this would include:

- Distraction techniques which were discussed as a part of the assessment
- A plan of care and treatment to be provided following discharge from Crisis Safe Haven, and this is signed by both the patient and practitioner.
- Contact telephone numbers for additional support outside of the Crisis Safe Haven team, e.g. Samaritans.

9.15 The service will offer the following interventions:

- Comprehensive psychosocial assessments and risk assessments
- Mental state review and monitoring
- Informal peer support
- A range of structured group and 1:1 brief interventions to support with:
- Coping strategy enhancement,
- Symptom awareness and management,
- Recovery and staying well planning,
- Reducing self-harm,
- Anxiety management
- Relaxation
- Signposting
- Onward referral

9.16 The team will actively involve the service user, family and carers in all stages of their intervention including assessment and development of care plans. The service will aim to help the service user to learn from the crisis, thus reducing their vulnerability and maximise their resilience. They will at all times empower service users by respecting their independence.

9.17 The team will accept referrals for all service users meeting the threshold for secondary care mental health services and with an identified mental health condition.

9.18 The Safe Haven team will admit to inpatient wards if deemed appropriate following further assessment.

9.19 The proximity of the service, located in the Irwell Unit, to A&E will allow for a wraparound model should acute services be required by the patient.

10. Bury Third Sector Involvement

10.1 A key principle of the Bury model is 3rd sector involvement to support patients exiting from the Safe Haven , but also to in-reach into the Safe Haven , where appropriate, to allow a holistic offer to patients addressing the wider determinates impacting on an individual's mental health.

10.2 At the time of writing the Business Case, 3rd sector input has not been appropriately mapped out and a workshop is being arranged by PCFT to bring together third sector colleagues to support development of the model, identify appropriate third sector input and support the evaluation of the pilot. It is also recognised that there is a need to understand the third sector landscape by scoping the services currently available in Bury.

10.3 To ensure 3rd sector input from the outset, opportunities will be explored in the short term to develop pathways to existing 3rd sector services within the locality, to support patients exiting the Safe Haven. The 3rd sector workshop will outline with key partners the requirements for in reach into the Safe Haven and the interventions that can be delivered by the sector and where possible these will be progressed at pace.

10.4 Cabinet is asked to recognise that as this work with 3rd sector is pending, it is not possible to provide an accurate figure of potential costs. It is therefore recommended that the Cabinet approves the inclusion of an indicative sum in the financial envelope to enable 3rd sector involvement, up to £40k which will be retained by the CCG.

11. Interdependencies with the Wider System

11.1 There will be interdependencies with the following services in Bury and subject to Cabinet approval, a workshop is being arranged for early September 18 to work with key partners to agree the pathways for the Safe Haven and outline how the services will work together:

- A&E
- Access Team
- HTT
- Urgent Care Treatment Centre
- RAID/Community RAID
- Bury Healthy Minds
- One Recovery Drug and Alcohol Service
- Inpatient Services
- EIP
- Social Care Services commissioned by LA
- 3rd sector services
- Community Mental Health Team

11.2 The Safe Haven will be included in the care plans for people on a CMHT/HTT caseload but there may be interdependencies with other MH teams with the Trust such as EIP and Inpatient services.

12. Benefits/Outcomes

12.1 Appendix 2 provides a summary of the anticipated impact the service will have in helping alleviate the significant pressures CCGs and providers are facing across community, crisis and acute pathways.

12.2 There will be locally defined outcomes developed for the service that will be based on the following expectations of the service to:

- Divert activity from A&E between the hours of 5pm and 8am, to relieve existing pressures as a significant number of breaches currently relate to limited options for mental health presentations.
- Provide an alternative to admission between the hours of 5pm and 8am;
- Support reduction in short term admissions of 0-5 days.

13. Service Model and Financial Envelope

13.1 The Staffing model and costings have been shared by PCFT Finance with Bury Finance for a 3, 4 and 5 day Safe Haven Model, to allow Clinical Cabinet to consider its options in terms of the level of investment (see appendix 2).

13.2 The indicative cost envelope for the service in year 1, determined by the number of days the service is operational, ranges from:

- £256,533 for a 3 day service
- £332,148 for a 4 day service
- £403,936 for a 5 day service

The above includes non-recurrent costs for estates/security and set up costs. The CCG has not yet validated these costs.

The recurrent costs are:

- £208,259 for a 3 day service
- £281,680 for a 4 day service
- £350,705 for a 5 day service

It should be noted that these figures are FYE and due to the proposed start date of the pilot of November 1st the cost in 18/19 will be lower due to a partial year effect. The costs are included in Appendix 2.

The funding received from the GM Transformation fund is shown below in Table 6. It should be noted that the recurrent funding is only £333k. The costs include overheads at 14%, and in line with the recently agreed letter from Emma Tilston, regarding investments, this uplift needs further breakdown, as it should only include identifiable clinical delivery support costs, not general overheads and surplus contribution.

The staffing costs appear to be reasonable, although they could potentially be explored to see if different shift patterns i.e. long shifts could reduce the total cost given the recurrent level of funding being made available from GM, and that the maximum capacity at any time is 4 patients.

13.3 The costing takes account of shift enhancements, estates costs non recurrent set up costs and transport to enable patients to be transferred between Safe Haven s in the PCFT footprint as an alternative to admission where the local Safe Haven is at capacity. This will be standard process where it is considered in the best interest of the patient to avoid an unnecessary admission.

13.4 The Safe Haven facility can provide care for up to 4 patients at the same time. Given that not all attendees will arrive at the same time and not all will stay until it closes the service has the

rolling the capacity to absorb new demand as it presents through the night so access is not foreseen as a problem.

13.5 To maximise the utility of the Safe Haven its use is extended over four cohorts for whom otherwise there is no access to a service out of hours other than through attending A&E or being a patient on a ward. These cohorts are:

- Those currently admitted to an acute mental health bed because the assessing clinician believes the identified risks are too high to just discharge them into the night from A&.E. This cohort is drawn from the patients currently admitted - 72% of whom are admitted after 5pm and before 9am.
- Those currently sent home following assessment from A&E where the clinician has outstanding serious concerns for safety but recognises that using the very scarce resource of an acute bed would be inappropriate – serious untoward incidents of self-harm and suicide have occurred with this discharged group. This cohort are drawn from the 3000/year patients assessed by Bury RAID – 1531 of whom are seen after 5pm and before 9am - 78% of this 1531 are not known to secondary care mental health services at the time of assessment making safe discharge into no immediate support a risky proposition for some patients.
- Those on caseload of the CRHTT that could be more inclusive to higher threshold of acuity if Home treatment included a required option to support patients at night. The third cohort includes those currently on CRHTT (25-30) but also enables lifting the threshold of acuity of that caseload by extension of their cover over 24 hrs i.e. some admissions could be avoided through the availability of 24hr (rather than 12hr) out of hospital treatment and support.
- Those on CMHT and EIT caseloads that currently in times of crisis attend A&E out of hours because they have nowhere else to turn at that time. This cohort is drawn from the hundreds of patients held on CMHT and EIT caseload that may fall into crisis during 120+ hours per week CMHT is not available.

13.6 Using data for 17/18 there have been approximately 260 inpatient episodes at PAHT (estimated using Month 11 SLAM) which are MH primary diagnosis admitted treated by a non specialist MH provider. The cost of this is was £510k and assuming that the evidence from Aldershot Model is transferable to Bury, it shows that the safe haven model could have the potential to reduce this type of activity by 25%, then this could free up resources within the acute system. The length of stay has not been determined but the cost reduction could potentially be estimated at £128k based on the actual cohort.

13.7 Similarly, of the activity estimated in table 3 (section 6) it indicates that approximately 258 patients could be directed to the Safe Haven instead of being placed in a MH bed. However this could be significantly lower and will be determined through the pilot. Assuming an average cost of £450 to £500 per bed (say £475) this could also save potentially £119k and avoid an out of area placement in the event that PCFT beds were unavailable and conversely freeing up beds for those who require admission to a bed.

13.8 Given that the service model can only look after a maximum of 4 patients at any time, it is important to understand what else the service will be providing, e.g. care plans, signposting etc. and how this impacts on the wider mental health service offer e.g. home treatment teams, community MH teams, RAID etc. There is a risk that if this added value (outlined in 13.4) cannot be demonstrated, then the service shows significant over capacity (table 5) when looking at a potential cohort of 258 patient's pa.

Table 5: Bury CCG Finance Capacity Modelling

Maximum annual capacity		% occupied	% void
3 day model	624	41.3	58.7
5 day model	1,040	24.8	75.2
7 day model	1,456	17.7	82.3

13.9 Table 6 below shows the GM contribution to Locality Mental Health Plans for Bury CCG up to 20/21.

Table 6: Bury Locality GM MH Investment

GM TF Contribution to Locality MH Plans [£000s]	GMTF to Localities: Cash-flow "profile"					
	17/18	18/19	19/20	20/21	Total	Recurrent TBC
Bury	£0	£423	£423	£211	£1,057	£333

13.10 Based on the available investment and the outline costs, Clinical Cabinet is asked to consider supporting a 5 day model for the purpose of the pilot. This will allow what appears to be the optimal model to address the current pressures in the system to be tested, to determine the level of impact on the system and value for money and potential for further investments post the pilot period.

13.11 It is recommended that the CCG considers utlising slippage from the GM Year 1 investment to fund the 3rd sector involvement for the duration of the 12 month pilot. As the pilot commences in November, the year 1 figures are based on a partial year effect.

13.12 The pilot would be utilised as the mechanism to test the third sector involvement and determine the longer term requirements should the pilot be a success and be continued into year 2. The CCG and PCFT will need to monitor the return on investment from the services, deflections and wider impacts on the system and consider if funding can be moved around the system to support future investment into the model.

14. Identified Risks

14.1 The following risks have been identified for the pilot:

- There is a risk the trust may not be able to recruitment to the fixed term posts as the trust is expiring recruitment issues. The CCG will work with PCFT to mobilise the recruitment ASAP subject to approval and monitor progress.
- There is a risk that any activity this scheme deflects may be replaced by new activity, therefore not alleviating the pressures in the system. The CCG and PCFT will monitor the impact of the service on the wider system and are working together to map the acute pathways and solutions to address current pressures. Through transformation the CCG and partners will consider opportunities to work differently and focus on lower tier interventions and preventative work to stop the cycle.
- Currently the CCG and PCFT cannot quantify the impact the service will have on OOA inpatient activity and the anticipated reduction in NEL activity and costs. The CCG will work with NES Commissioners and PCFT to ensure robust monitoring processes are in place.
- The CCG doesn't currently have evidence to prove the service will provide the required return on investment (2:1) for a transformational scheme. The pilot will be used to test the proof of concept and ascertain the evidence of value for money. A review of the service will be undertaken at 6 months and 12 months.
- Third sector involvement required may be more costly than the nominal fee of 40k included in the paper. The CCG and PCFT will consider opportunities for further 3rd sector input through wider Bury Transformation Schemes.

15. Transforming MH Services Across the Bury Locality

15.1 Cabinet is asked to note a meeting being held on 31st July to discuss mental health Transformation in Bury, agree a shared vision and objectives and establish a transformation

group supported by the Transformation PMO to deliver this transformation.

15.2 The Safe Haven model will be discussed at this meeting and opportunities for investment from the Bury Transformation allocation explored.

15.3 The CCG and PCFT are currently planning a multi stakeholder process mapping exercise to map the current acute and crisis pathways, to develop proposals to transform the pathway, including the introduction of the Safe Haven Model. This exercise will help to inform the priorities for the transformation group.

16. Recommendation

16.1 Cabinet is asked to:

- Support in principle, subject to Governing Body approval in September, the 5 day model as a 12 month pilot to test the proof of concept at a cost of £228,584 (PYE) in 18/19 (£403,936 FYE), with a further 40k to facilitate 3rd sector involvement in year 1.
- Support a 6 month review to ensure the pilot is meeting the desired objectives and has robust monitoring data to evidence the impact. If at this point the service does not appear to be demonstrating value for money, it is recommended that the CCG re-considers the delivery model.
- Support an evaluation of the 12 pilot coming to Clinical Cabinet to discuss the future of the Safe Haven Model.
- To note further work will now commence to develop a detailed implementation plan, complete the pathway mapping and engage with the 3rd sector.

17. Next Steps

- Undertaken a process mapping work shop for the acute and crisis pathway with key partners to explore opportunities to improve the pathway for patients and identify efficiencies.
- Work with key partners, including the 3rd sector to development the pathways for the Safe Haven.
- Develop the high level mobilisation timeline in appendix 3 into a more detailed action plan to support the role out of the service from 1st November 2018.

Catherine Tickle
Commissioning Programme Manager, Bury CCG

Dr Jeff Schryer
Clinical Chair and Mental Health Clinical Lead, Bury CCG

Sue Hargreaves
Assistant Chief Finance Officer Non Acute and Primary Care, Bury CCG

Kez Hayat
Senior Commissioning Manager, Bury CCG

Dil Jauffur
Associate Director, Mental Health & Specialist Services Bury, Pennine Care Foundation Trust

Appendix 1: Expected Impact on the Wider System from the Safe Haven

System Pressure	Impact
Reducing no. of admissions to MH ward	Yes – directly support reduction for short-stay to everyone irrespective of known to services or not, who requires support overnight
Reducing no. of admissions OOA	Yes – indirectly as should lead to increased bed availability with the Trust
Reducing MH A&E attendances	Yes – directly where clinically appropriate
DTOCs from MH wards	Yes – directly as CRHTT provides early supported discharge and crisis Safe Haven as part of supported discharge
Readmission rates to MH wards	Yes – directly, as would be known to CRHTT and could form part of a supported discharge package
4 hour A&E breaches	Yes – as alternative to A&E for patients who do not need full RAID assessment or are waiting for admission
12 hour A&E breaches	Yes – indirectly with reduction in overall MH admissions creating capacity
Use of lounge on MH ward	Yes – indirectly with reduction in overall MH admissions creating capacity
Lack of out of hours provision – known to services	Yes – directly as no current provision outside ED setting for MH crisis support. The model would support wider spectrum of MH need
Lack of out of hours – not known to services	Yes – the model would support wider spectrum of MH need

Appendix 2: Safe Haven Financial Modelling

Bury Safe Haven

Please find below the requested costs for 3, 4 and 5 day Safe Haven service in Bury.
Please note that the costs for the voluntary sector have not been included, this is not information that is available to Pennine Care and would need to be provided by the CCG.

BURY

3 day (assumed weekdays)

Bury Safe Haven and Hub 3 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6mths)	FYE Recurrent Cost
Pay	£174,667	£0	£174,667	£87,334	£174,667
Non-pay	£7,632	£42,257	£49,889	£46,073	£7,632
Clinical Delivery Support Costs/Surplus (14%)	£25,959	£6,017	£31,977	£18,997	£25,959
Total Cost	**£208,259**	**£48,275**	**£256,533**	**£152,404**	**£208,259**

Skill Mix	Band	Requirement per shift	WTE Required for Service
Qualified Practitioner 5pm-1am	Band 6	2 per shift	1.50
Qualified Practitioner 12am - 8am	Band 6	2 per shift	1.50
Support worker 5pm - 1am	Band 3	1 per shift	0.75
Support worker 12am - 8am	Band 3	1 per shift	0.75
Total			**4.50**

4 day (assumed weekdays)

Bury Safe Haven and Hub 4 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6mths)	FYE Recurrent Cost
Pay	£236,937	£0	£236,937	£118,468	£236,937
Non-pay	£9,632	£44,177	£53,809	£48,993	£9,632
Clinical Delivery Support Costs/Surplus (14%)	£35,111	£6,291	£41,402	£23,846	£35,111
Total Cost	**£281,680**	**£50,467**	**£332,148**	**£191,307**	**£281,680**

Skill Mix	Band	Requirement per shift	WTE Required for Service
Qualified Practitioner 5pm-1am	Band 6	2 per shift	2.00
Qualified Practitioner 12am - 8am	Band 6	2 per shift	2.00
Support worker 5pm - 1am	Band 3	1 per shift	1.00
Support worker 12am - 8am	Band 3	1 per shift	1.00
Total			**6.00**

5 day (assumed weekdays)

Bury Safe Haven and Hub 5 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6mths)	FYE Recurrent Cost
Pay	£293,950	£0	£293,950	£146,975	£293,950
Non-pay	£13,040	£46,596	£59,636	£53,116	£13,040
Clinical Delivery Support Costs/Surplus (14%)	£43,715	£6,635	£50,351	£28,493	£43,715
Total Cost	**£350,705**	**£53,231**	**£403,936**	**£228,584**	**£350,705**

Skill Mix	Band	Requirement per shift	WTE Required for Service
Qualified Practitioner 5pm-1am	Band 6	2 per shift	2.50
Qualified Practitioner 12am - 8am	Band 6	2 per shift	2.50
Support worker 5pm - 1am	Band 3	1 per shift	1.25
Support worker 12am - 8am	Band 3	1 per shift	1.25
Total			**7.50**

Assumptions:

- *All pay costs are based on the 2018/19 proposed transitional pay rates at mid-point*
- *All posts include enhancements as per the proposed shift pattern and requirements*
- *All pay costs include on costs to PCFT*
- *The costings are based on the 3, 4 and 5 days being worked on weekdays only Mon - Fri*
- *The PYE 2018/19 pay costs assume a mobilisation date of 1st October 2018 and are therefore pro rata*
- *The PYE 2018/19 costs include non-recurrent set up costs of £5,757, £7,677 and £9,596 respectively (3, 4 and 5 days) for mobile working; mobile devices and phones are assumed to be personal issue and are based on the wte*
- *Non-recurrent furniture and fittings costs of £500 (3 and 4 day) and £1,000 (5 day) have been included to set up the Safe Haven within the estate*
- *Non-recurrent estate works, including security CCTV, of £36,000 have been included in the setup costs*
- *Recurrent non-pay costs include travel/printing & stationery/mobile running costs/patient transport*
- *The patient transport figure is unknown, therefore a figure of £5,000, £7,000 and £9,000 respectively (3, 4 and 5 days) has been allocated. This will require further analysis which may result in requiring an adjustment to funding*
- *PCFT clinical delivery support costs and surplus have been applied based on the costing policy*
- *CQUIN has not been calculated on this costing*
- *The FYE recurrent costs are based on 2018/19 and have not been uplifted for inflation*
- *The costings do not include any provision for voluntary sector workforce*

Appendix 3: High level Mobilisation Timelines – Safe Haven

Mobilisation Timescales

Safe Haven Bury	**Action**	**Timescale**
Business case approved	Clinical cabinet approval	1st August 2018
Funding approval	CCG Board	TBC by CCG
Confirmation of intention to invest	Formal letter of approved investment to PCFT to enable recruitment to commence.	TBC by CCG
Recruitment to commence	Posts to be advertised, interviews and recruitment	2/3 months – August to October 2018
Operational	Operational policies and procedures to be developed, clinical pathways and referral processes.	October to November 2018
Estates	To make space within the existing outpatient department at Irwell Unit, Roch House, FGH fit for purpose and installation of anti-ligature furniture.	Design August 2018 Tender September 2018 Construction October 2018
Communication Plan	Communication plan to be developed to ensure all partners briefed on new service offer	October/November
Staff induction	Induction for new staff	By mid-November 2018
Service Launch		1 November 2018

Community Safe Haven (non clinical) DRAFT PATHWAY

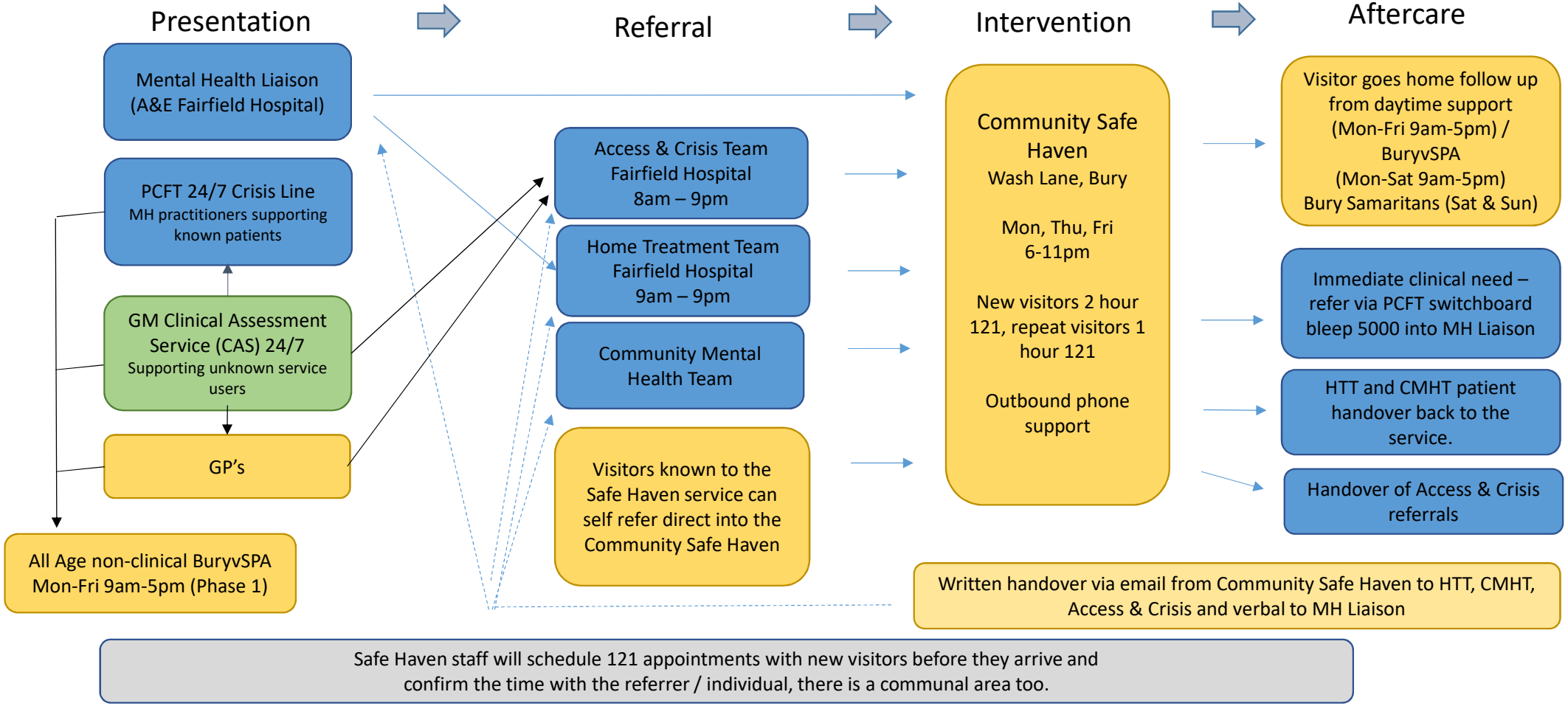
12 month pilot, 3 days a week (Mon, Thu and Fri)

Open 6pm – 11pm, staff hours 5pm until 12.30pm

Green = GM

Blue = PCFT

Yellow = Locality



Safe Haven staff will schedule 121 appointments with new visitors before they arrive and confirm the time with the referrer / individual, there is a communal area too.

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	05 October 2020	**Action**	Receive
Item No	14	**Confidential / Freedom of Information Status**	No
Title	Bury 2030 Strategy		
Presented By	Ms Lynne Ridsdale, Deputy Chief Executive (Corporate Core)		
Author	Ms Lynne Ridsdale, Deputy Chief Executive (Corporate Core)		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

- An update in relation to the Bury 2030 Strategy is attached for information

Recommendations

It is recommended that the Strategic Commissioning Board:

- Consider the Bury 2030 Strategy presentation

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	N/A
Add details here.	

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	☒

Implications						
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**

Bury 2030
Update & Summary

Lynne Ridsdale, Deputy Chief Executive (Corporate Core)

Bury COUNCIL

NHS Bury Clinical Commissioning Group

Reminder – Proposed Bury 2030 Vision

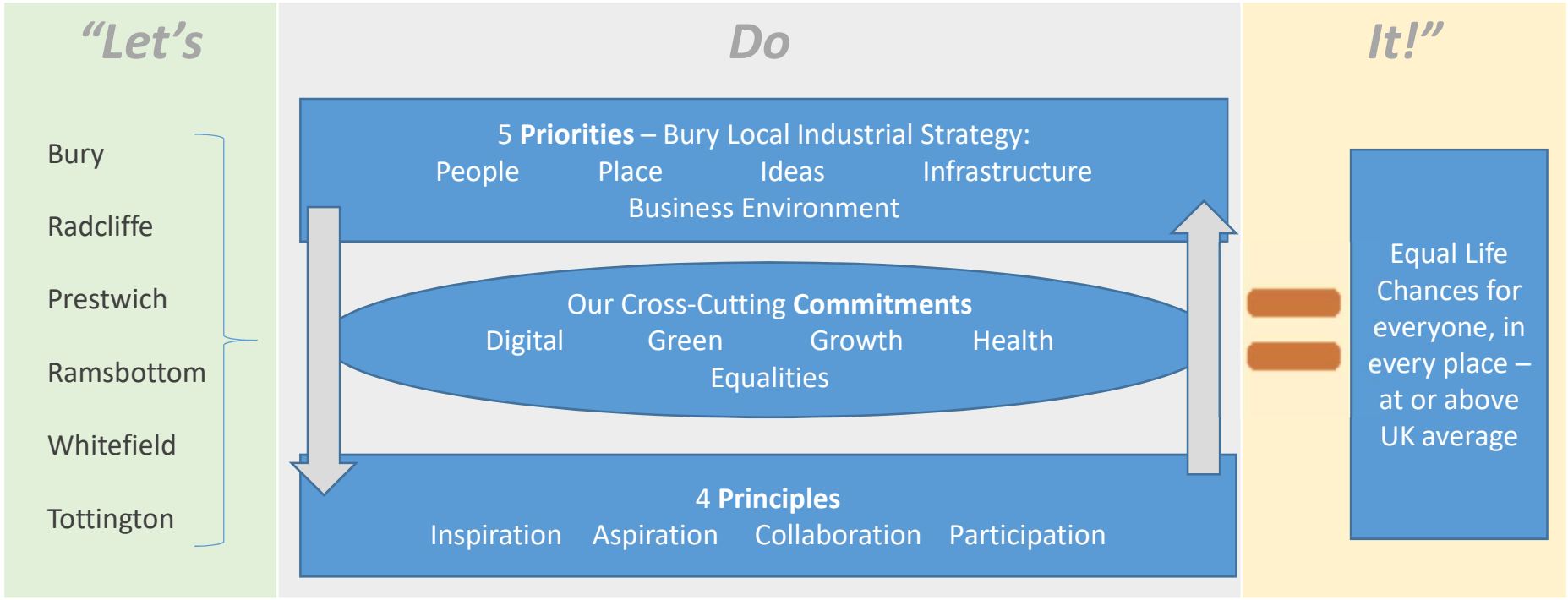
"Equal life chances for all our residents, across every township and at a level which surpasses the UK average"

- Our objective - Bury stands out
  - Gaps between lives narrowed
  - Economy recovered
  - Six places we are happy to call home
  - The value of community
  - System sustainability
- Proposed Outcomes
  - Rate of economic growth/relative deprivation
  - Education and skills
  - Carbon neutral

Strategy development – reminder of process to date

- Consultation exercise autumn 2019
  - Team Bury partnerships
  - One Community survey and f2f fieldwork
  - Faith Leaders & CVS Chief Officers
- “People Powered” workshop January 2020
- Partnership away day January 2020
- Individual strategy development:
  - Health & Care Locality plan
  - Regeneration framework
  - Housing strategy
- Bury Leadership Board discussions. Key messages: equality; accessibility; social value and community empowerment
- Emergent thinking tested in practice through emergency response

Proposed Framework
Let's Do It! ….



Outline Delivery Plan 2020-22 (Recovery)

People	Places	Ideas	Infrastructure	Business
We will drive the health, wellbeing and connectedness of our people through: • a new physical activity strategy; • mental health review And by embedding progress with: • community healthcare; • children's school readiness and early help and • educational attainment	We will develop: • Place regeneration plans to the point of business case within Radcliffe, Prestwich and Bury town centre • a One Public Estate • Carbon?	We will harness Ideas through: • the establishment of a community fora; • equalities strategy; • strengthening the Youth Cabinet • a refresh of the Armed Forces' Covenant and • new infrastructure organisation and strategy for the voluntary & community sector	Infrastructure improvements will include: • 5G roll out • upgrades to 42 Kilometres (26 miles) of highway • Through the GM mayors cycling and walking challenge fund initiative residents of Bury will benefit from around 10m worth of new cycling and walking infrastructure by mid 2022 • We will implement the housing strategy, including homelessness prevention	Local Business will benefit from: • large-scale land release in the Northern Gateway • a borough skills strategy • a partnership with Bolton University and • a COVID economic recovery strategy with a focus on local spend

Proposed Principals

Inspiration; Aspiration; Participation; Collaboration

Inspiration – **we are proactive and creative, building on our collective strengths to make a difference to what matters most to us by:**

- Really listening to understand each other and our shared potential
- Growing relationships & new connections across boundaries
- Being open to trying new things and doing things differently
- Valuing the skills, strengths and successes of individuals and communities

Aspiration – **We realise hopes and dreams by:**

- Demonstrating pride in our collective and individual achievements and of our place
- Ensuring everyone has an equal voice and equal life chances
- Championing innovation, always looking for ways to improve quality of life for all
- Being courageous and stepping out of our comfort zone
- Harnessing and nurturing all talents
- Opening doors at every opportunity

Participation – **We all take responsibility for making a difference by:**

- being solutions-focussed in addressing in tackling our challenges
- Asking “what matters to you? How can I help”?
- Being flexible and putting our energies where we can make most difference
- Demonstrating dignity, kindness and respect in everything we do

Collaboration - **We will bring our collective talents, energies and power together for the greater good by:**

- Bringing people together from all corners of life
- Listening and learning from all voices
- Trusting and helping each other, always working together
- Listening when others talk: responding, helping and enabling
- Supporting development and growth and removing barriers to collaboration

Next Steps & Ask from Leaders

- Overall framework to be tested with all system leaders by mid-October:
  - Bury Leadership Board
  - Systems Board & LCO
  - Community safety Partnership
  - Bury Business Leaders
  - Bury Councillors
- Additions/comments incorporated
- Approval as basis for consultation by end of October
- Consultation November / December 2020 for launch early 2021
- Asks from Partners:
  - Input & ownership; borough not council vision
  - Priorities 2023 onwards?

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Consider
Item No	17	**Confidential / Freedom of Information Status**	No
Title	Salford Royal Foundation Trust (SRFT) – Pennine Acute Trust (PAT) Transaction Business Case		
Presented By	Simon Neville – Transaction Director Oz Khan – Programme Director, NCA		
Author	Simon Neville – Transaction Director Oz Khan – Programme Director, NCA		
Clinical Lead	-		
Council Lead	-		

Executive Summary
A presentation in relation to the Salford Royal Foundation Trust (SRFT) – Pennine Acute Trust (PAT) Transaction Business Case is attached for consideration. Representatives from the Northern Care Alliance will be attending the meeting to discuss the Business Care in further detail.
Recommendations
It is recommended that the Strategic Commissioning Board: • Consider and comment upon the PAT Transaction Business Case

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

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	☐

Implications						
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	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.		

NHS

Northern Care Alliance

NHS Group

Transaction FBC Presentation

DRAFT – FOR DISCUSSION

Simon Neville – Transaction Director
Oz Khan – Programme Director, NCA
Nicky Tamanis – Deputy Group CFO

Saving *lives*, Improving *lives*

Patient and People Focus | Accountability | Continuous Improvement | Respect

Photo: Future Royal Oldham Hospital Site

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Family slams hospital trust after coroner rules there were 'gross failings' in care of mental health patient
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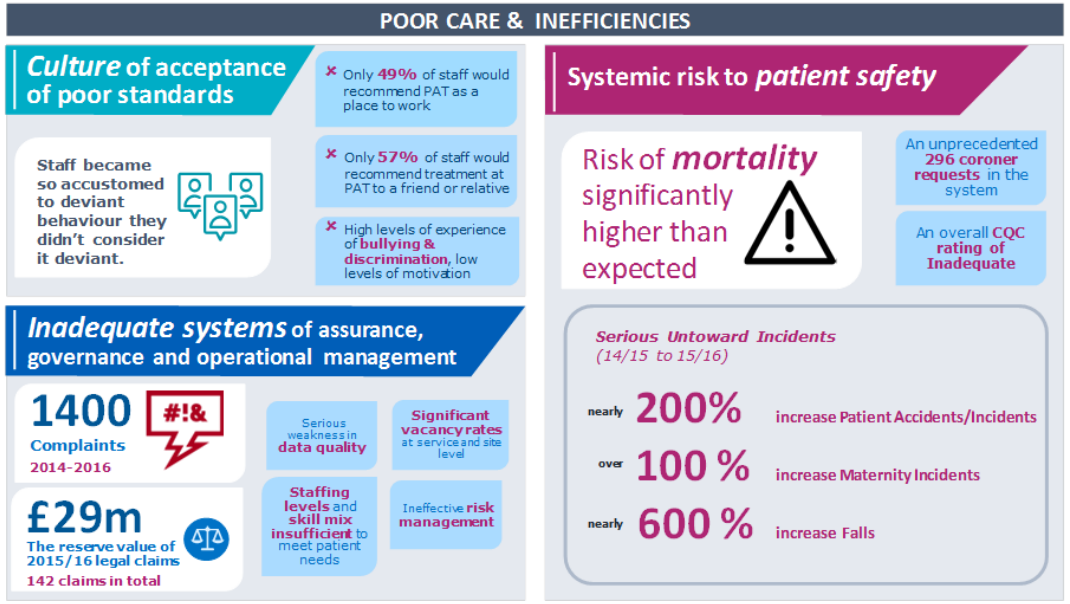
A damning Care Quality Commission inspection and a high-level risk summit amid failings in A&E and maternity

The case for change

Quality and Safety



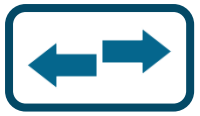
Financial

£15.4m Structural	• Historic quality impact on CNST premium • Old and poorly laid out estate
£28.5m Strategic	• Systemic staff recruitment and retention issues linked to CQC ratings, poor estate and clinical configuration uncertainty • Diseconomies of scale linked to duplication of range of services across four small sites • Case mix (non-elective/elective)
£16.2m Operational	• Theatre and outpatient productivity • Suboptimal ward configuration and access to effective ward rostering tool

PAHT "Drivers of the Deficit" report, commissioned by NHSI in 2018. Costs are broken down into: **Structural drivers** which are outside the immediate short/medium term control of the Trust or local health economy. **Strategic drivers** which are issues that are outside the control of a single organisation but within the control of the system as a whole. **Operational drivers** are issues that would be considered broadly within the control of the Trust in the short/medium term.

Case for change

- The transaction is just as important for Salford as it is for Oldham, Rochdale and Bury Care Organsiations.
- Salford has been a high performing organisation for a number of years in both quality and finance. In 2015, looking forward, the board came to the conclusion that in order to continue operating as an outstanding organisation we would need to invest in digital innovations to drive further quality and productivity gains.
- The Group approach is what will allow us to continue our improvement journey, due to the following key areas:

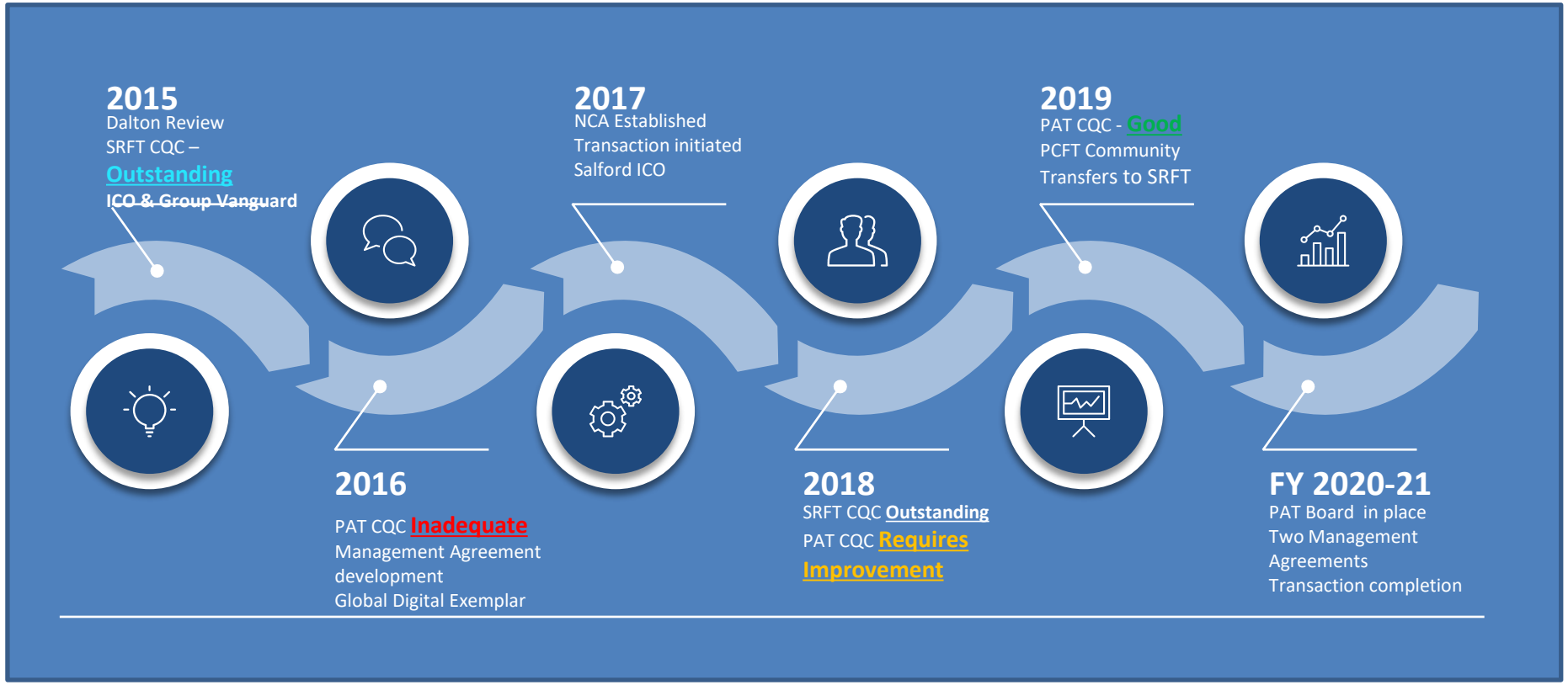


Horizontal integration – enables economies of scale in non patient facing areas (corporate services), and ability to deliver clinical services to a larger footprint meaning that we can offer more sub specialty services which in turn helps us recruit the best clinical staff.

Vertical integration – allows us to realise economies of scale for the system by adopting a more population focussed approach to health, meaning that overall cost of care should be lowered. This also drives an integrated locality and place based approach.

Digital & innovation – this is a key area for our future sustainability. By operating across a larger footprint we are able to invest more into digital and other innovations we can further drive both quality and productivity gains

The NCA's Journey So Far
There's been significant work to get us here



The Improvement has been dramatic

The CQC's assessment means that Pennine Acute's rating and standards of care have improved, year on year, from 'Inadequate' in 2016 to overall 'Good' in just three years. Of the PAT service areas inspected across the CQC domains, 90% are now Good or Outstanding. The CQC rated 15 services, 3 as outstanding, 11 as good and one as requires improvement.

Key

Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings

Ratings for acute services / acute trust

2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
North Manchester General Hospital	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
The Royal Oldham Hospital	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016
Fairfield General Hospital	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016	Requires Improvement Aug 2016
Rochdale Infirmary	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall trust	Inadequate Aug 2016	Requires Improvement Aug 2016	Good Aug 2016	Requires Improvement Aug 2016	Inadequate Aug 2016	Inadequate Aug 2016

2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
North Manchester General Hospital	Requires Improvement → Feb 2020	Good ↑ Feb 2020	Good → Feb 2020	Requires Improvement → Feb 2020	Good → Feb 2020	Requires Improvement → Feb 2020
The Royal Oldham Hospital	Requires Improvement → Feb 2020	Good → Feb 2020	Good → Feb 2020	Requires Improvement → Feb 2020	Good → Feb 2020	Requires Improvement → Feb 2020
Fairfield General Hospital	Good ↑ Feb 2020	Good → Feb 2020	Outstanding ↑ Feb 2020	Outstanding ↑ Feb 2020	Good → Feb 2020	Outstanding ↑ Feb 2020
Rochdale Infirmary	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020	Good → Feb 2020
Overall trust	Requires Improvement → Feb 2020	Good ↑ Feb 2020	Good → Feb 2020	Requires Improvement → Feb 2020	Good ↑↑ Feb 2020	Good ↑ Feb 2020

Areas of focus and benefits to date

Through the Acquisition we are able to leverage scale to deliver further efficiencies and value accelerating People Centred Care by continuing to develop our core assets and collaborating on commissioner requirements:






<u>Economies of Scale</u>:

The transactions will continue to drive procurement and contractual savings

<u>Developing Standard Operating Models:</u>

ROI is significant enhanced by scale e.g. Staffing - Trendcare Developments

<u>Enhancing our capacity to deliver "The Method":</u>

Economies of scale enable the creation of a more expert and deeper talent pool of people qualified in continuous improvement shared across our populations

<u>Deployment of digitisation:</u>

ROI is significantly enhanced by scale eg reducing length of stay, asset management.

This will also drive the new model of digital driven by Covid-19.

<u>Estate rationalisation:</u>

at scale through investing in new estate to enable consolidation and new models of care.

<u>Workforce resilience</u>:

i.e. consolidating service lines so that they are able to meet commissioner service standards

<u>Financial resilience</u>:

The transaction will ensure a stable group financial position

<u>Integration</u>:

The transaction furthers our ability to improve outcomes for patients through working across organisations, and across the group

Example Benefits Created to Date

- £10m reduction in corporate
- Group diagnostic / pharmacy
- Outsourced transactional process

- Trendcare
- Elective access programme
- Eliminated 12hr waits
- 4hr performance improved

- HSMR now as expected
- Reduction in all harms
- Ward standards – NAAS

- Stabilising infrastructure
- Upgraded PAS
- Improved data quality
- Trendcare

- Theatre optimisation
- Optimised Estate Configurations
- Integrated models of delivery

- Site based leadership model
- Reduced vacancies and agency
- Talent management programme

- £50m stabilisation fund
- £24m BCLC 18/19

- LCO lead contract
- Single shared services
- Single assurance framework
- Combined standing orders

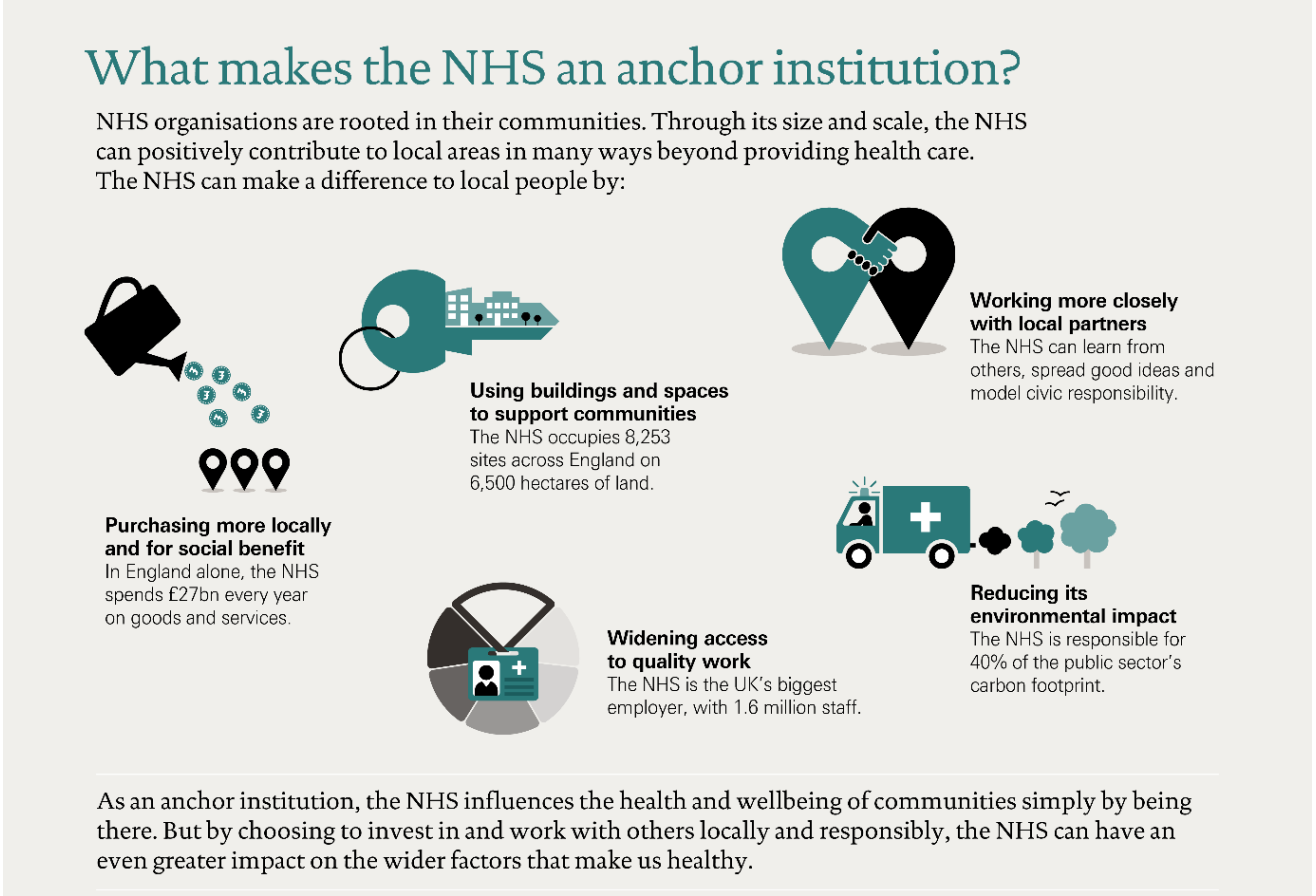
Funding and investments secured and made to date

- The NCA have secured and implemented over £50m in investment to date for improvements at PAT including:
  - IM&T Stabilisation – significant network and server improvement with over £20m of investment secured and sharing of Global digital exemplar knowledge.
  - Estates improvements: including over £4m for NMGH ICF extensions
  - Over £8m invested in NMGH/ROH energy schemes
- 20/21 GM prioritised £25m for IM&T (£11.9m) and estate funding (£13.1m)
- Significant investments and programmes of work have also been secured for SRFT including the ICO and ACC Vanguards, Global Digital Exemplar status

02. The NCA: why the transaction matters

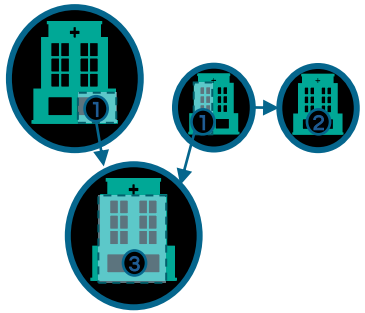
Partnerships and the importance of Place

- We will increase our focus on and positive role in each of our localities, helping local people and communities to thrive.
- Each of our areas differ and we will ensure local leaders, staff and services are better able to reflect their distinct characteristics.
- Integrated care will be provided across all our localities.
- We are a significant part of the fabric of local communities and our long-term sustainability is closely linked to the wellbeing of our populations – meaning we are an 'Anchor institution' in each Place, as explained to the right.



The transaction will support unlocking key attributes to improving patient care

1 Reconfiguration of services across sites and populations at pace, a place based approach



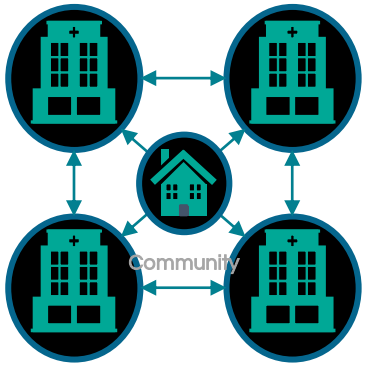
Service reconfiguration is vital for improved patient outcomes & resilience e.g. stroke.
Currently it happens far too slowly, mainly because of organisational boundaries
Group models remove down the boundaries that slow pace of patient improvement

The transaction will allow implementation and focus on our place based strategy

2 Optimise investment in staff, estates, and technology and the resulting rate of return

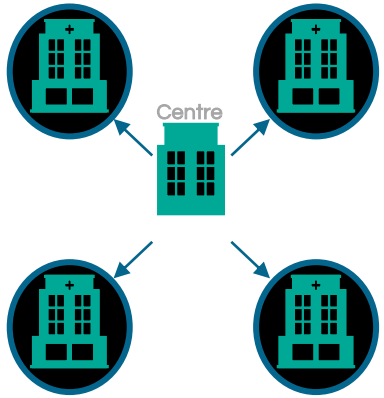
Investment in staff development and career opportunities is fragmented and spread too thin, consolidation will allow economies of scale and leverage
Fixed costs of technology can be spread across more patient activity, eg leverage Salford Royals electronic patient record
Estate planning can utilise a wider a wider base of possibilities

3 Standard Operating Models



Avoiding the costs of "re-inventing the wheel" on what should be common for all localities and the costs of duplicated services, saves time and money
Innovations and technology, afforded by group, will enable patient/local customisation

4 Scale enables economies of scale



Consolidation of functions and services can spread fixed costs across wider activity base

Significant work has been undertaken developing business cases for SRFT and NES

Healthier Together
A review of health & care in Greater Manchester

HT: High risk General Surgery

- Currently with Treasury
- Implementation of HT model
- Approx. £27.9m

SRFT Acute Receiving Centre

- Currently with Treasury
- Includes implementation of HT model
- Approx. £69m

Oldham Hospital Transformation

- Wave 4b: Capacity to support commissioner strategic intent, urgent care standards and address areas of backlog maintenance.
- Approx. £87m

Further benefits will be created through the transaction

Northern Care Alliance NHS Group






Partnerships in Place

- Increase local employment by 750
- Expand strength based approaches
- Safest H&SC organisation in England
- Reduce "never" events to 0
- Integrated model of paediatric care
- Achieve GM Good Employer standard
- Include skills and work in delivery of health services
- Contribute to GM strategy target of reducing falls

Clinical and Operational Excellence

- Development of a one-stop RDC for cancer diagnoses – diagnostic access target of 99%
- Year of year reduction in unwarranted variation
- Roll out further SOMs
- 20% reduction in RTT times for 2 week wait dermatology patients
- SHMI less than 100, and in the top quartile nationally
- Reduce DNA rates through digital systems
- Further clinical time savings through Trendcare
- Deliver 85% cancer performance

Caring For and Inspiring Our Staff

- Continue rollout of CF2 coaching approach
- 10% vacancy reduction in medical and nursing posts as a result of health and wellbeing strategy
- Increase % of staff wellbeing reporting measures by 5%
- Reduce reported stress related absence by 10%
- NCA recruitment and retention strategy to reduce turnover
- Clinical workforce transformation to reduce unwarranted variation
- High performance management system for operational managers

Digital, Research and Innovation

- Utilise digital technologies to automate functions where possible to improve productivity
- Stable network and infrastructure
- Digital Control Centre to support decision making and automation
- Become safety H&SC organisation in England through use of QI methodologies
- Embed innovation and research across specialties
- Enhance and support patient care through digital technologies such as video care and 3D printing

Sustainable Futures

- £13.1m BCLC benefits expected for 2020/21 beyond those managed by COs.
- Estates masterplan to consolidate services to meet the need of the expanded organisation
- Consolidation of services across NCA to single sites, reducing footpring
- Generation of savings from standardisation and rationalisation
- Bringing outsourced services back in-house
- ROH Healthier Together build

New Models of Care

- Consolidate elective activity from SRFT to FGH – 1000 anticipated bed day savings
- ROH as GM hub for general surgery
- Standardised pathways across NCA into communities
- Development of further NCA clinical shared services to drive further efficiencies and improve outcomes
- Development of training academies
- Consolidation of radiology, pathology and pharmacy services
- Networked critical care model

*See impact of covid slide

Why transacting early is important to SRFT

System savings

Significant money will be saved standing down the majority of the PMO.
Funding has not yet been agreed with GM.
Opportunity costs.
~3 years of sunk transaction costs.

Hearts and minds

SRFT have been working with PAT since 2016 and there has been with the transaction starting in 2017.
As the "majority", staff deserve to transfer and understand future destination as soon as possible.

The transaction review could also take significant time to approve by NHSI.

Strategic Priority

The long-term integration and future of the NCA is a top strategic priority.

The acquisition of NES is just as important to the future of SRFT as it is to NES.

Transformation

Transformation efforts and executive attention has been diverted significantly since the start of the transaction.
It is essential we now complete the transaction and deliver the transformation and reconfiguration as soon as possible.

In Summary

The acquisition will address and provide a solution to PAT's on-going and extensive challenges, creating a high quality and financially sustainable future for the services provided across NES sites and Salford.

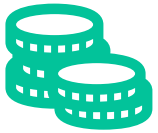
Through approval of the Transaction we will be able to drive recovery, digital and process transformation, standards, productivity and quality at new levels of pace and scale.

This is whilst giving staff the future certainty which they so thoroughly deserve.

The future success and sustainability of local healthcare services across Salford, Oldham, Bury and Rochdale can only be truly achieved through the acquisition, genuine partnership working, and a joint ambition to reform and transform.

This partnership working and scale is needed now more than ever.

We understand the risks and issues across PAT and SRFT and have the solutions to create transformation across the NCA. Our plans present an investible proposition aligned with local, regional and national strategies. The people of Salford, Bury, Rochdale and Oldham deserve high quality and sustainable services.



The Full Business case articulates capital funding and sol to deliver vital estates and IT improvements. This is required to stabilise and update IT infrastructure and to provide fit-for-purpose facilities.

This will also drive a significant return on investment and improvement for all stakeholders.

Together across our localities, over 4 years, we have made significant improvements across the PAT footprint taking the organisation from CQC "Inadequate" to "Good". Through the transaction we can now drive further financial and care improvement.

03. The Financial Challenge and Programme Risks

Financial Solution: balance by 2025/26

	2025/26			
	PAHT		SRFT	NCA
	NES £m	NM £m	£m	£m
Counterfactual (v18)	**-134.2**		**-24.2**	**-158.4**
Remove BCLC	-57.3		-81.1	-138.4
Counterfactual (v18) pre BCLC	**-191.5**		**-105.3**	**-296.8**
BCLC pre Transformation	27.8	16.0	44.5	88.3
Financing costs of investment in the disaggregation of IT	-5.7	0	0	-5.7
Adjusted Counterfactual	**-104.2**	**-49.2**	**-60.8**	**-214.2**
Adjusted Counterfactual Excl. NMGH	**-104.2**		**-60.8**	**-165.0**
Benefits Post Transformation	25.9		75.8	101.7
MRET	2.4		1.7	4.1
FRF	34.3		8.0	42.3
NES Clinical Services Reconfiguration	2.9		3.6	6.5
GM Clinical Services Reconfiguration	10.4		0	10.4
Final Position	**-28.3**		**28.3**	**0**

The updated counterfactual presents a financial challenge of £158.4m. This is addressed through:

- £88.3m of BAU productivity savings
- Transformation savings of £101.7m by 2025/26 linked to the scale, standardisation and digital opportunities created through the transaction.
- National funding solutions of £46.4m through FRF and MRET funding
- £6.5m of benefits from clinical service reconfiguration within the NCA. These savings flow from the SOC and are consistent with outline commissioner intentions.
- £10.4m of savings that are anticipated from GM strategic decision making to address the diseconomies of scale identified in the Drivers of the Deficit report. (It is noted that there are other strategic deficits in GM that need resolution and therefore these cost reductions are phased in the later phases of the FBC to reflect decision lead in times).

These actions and solutions are envisaged to deliver a break even position by 2025/26.

Estimate NES costs of disaggregation: Exclusive from financial model

Cost arising from	Detail	Estimate (£M)
Corporate Disaggregation – Stranded costs	Cost estimated based department by department review of PAH-wide & NCA-wide posts. **Single year stranded costs – £6.62m** – stranded costs paper Feb 2020 Profiled over 5 years with 20% reduction each year 6.62+5.29+3.97+2.65+1.32 = **£19.85m**	19.85
Clinical and Corporate Disaggregation change costs	Significant change management will be required across services and pathways. Estimates : £1m for equipment £2m for change management.	3
Procurement – loss of scale benefits	This will be a for a minimum of year and may cross multi year.	0.5
SLA Management	Initial estimate of additional capacity required to oversee SLA and management agreement development	0.3
IM&T costs	Overhead £25.8 plus £7.9m	33.7
IM&T contract and licensing	Capgemini estimate further £8-10m costs	9
Current working estimate	DOES NOT INCLUDE MFT SIDE CLIENT/ADDITIONAL COSTS	**£66.35**

Under further review

- Consistent with our SOC all costs of disaggregation are assumed to be outside of the NCA FBC.
- The disaggregation costs of £66.4m compare favourably with the £146m counterfactual presented in the previous slide

Key risks to transaction timelines

Clinical Disaggregation and Corporates Safe Transition Plans

- A significant amount of effort has been applied to ensure disaggregation of services is undertaken accurately. Agreements will be put in place with MFT for changes to any service post-transfer.

Patient Pathways

- A significant amount of effort has been applied by all clinical services to ensure that patient pathways are not affected and that patients continue to receive quality care and that the financial position of each trust is safeguarded. Agreements will be put in place with MFT for changes to any pathway or service post-transfer.

IM&T Disaggregation and decision making

- The Digital landscape in PAHT was identified as highly fragile as part of initial exploratory work by SRFT in 2015. Whilst a significant amount of stabilisation has taken place, Deloitte noted as part of the acquirer due diligence that "*the PAHT current state environment is not a secure basis on which to disaggregate transition and transform*". In addition, the PAHT digital landscape is complex and highly integrated across the Trust, meaning a significant amount of care must therefore be taken whilst disaggregating this workstream.

Disaggregation funding

- It remains the funding must be secured for safe disaggregation in a timeline. Currently the source has not been confirmed.

04. Next steps and support

The impact of Covid

- We acknowledge the profound consequences of Covid and how this will impact the need to work flexibly. We are working with commissioners to overcome the challenges created by the pandemic, setting up a joint Recovery Coordination Group with the NCA across NES sites and Salford.
- The pandemic will have long term consequences on delivery, pace and prioritisation on components of the transaction. Within the business case we acknowledge the impact and uncertainty and that sensitivities will need to be built into our long term financial model.
- The financial impact of Covid is unknown, but any uncertainty would relate equally to the counterfactual

Next steps

As we move into the Business Case review stage with NHSI there are several areas where we will need your support and commitment.

Support of business case

Sharing the business case and key messages with CCG Accountable Officers. Development of joint communications.

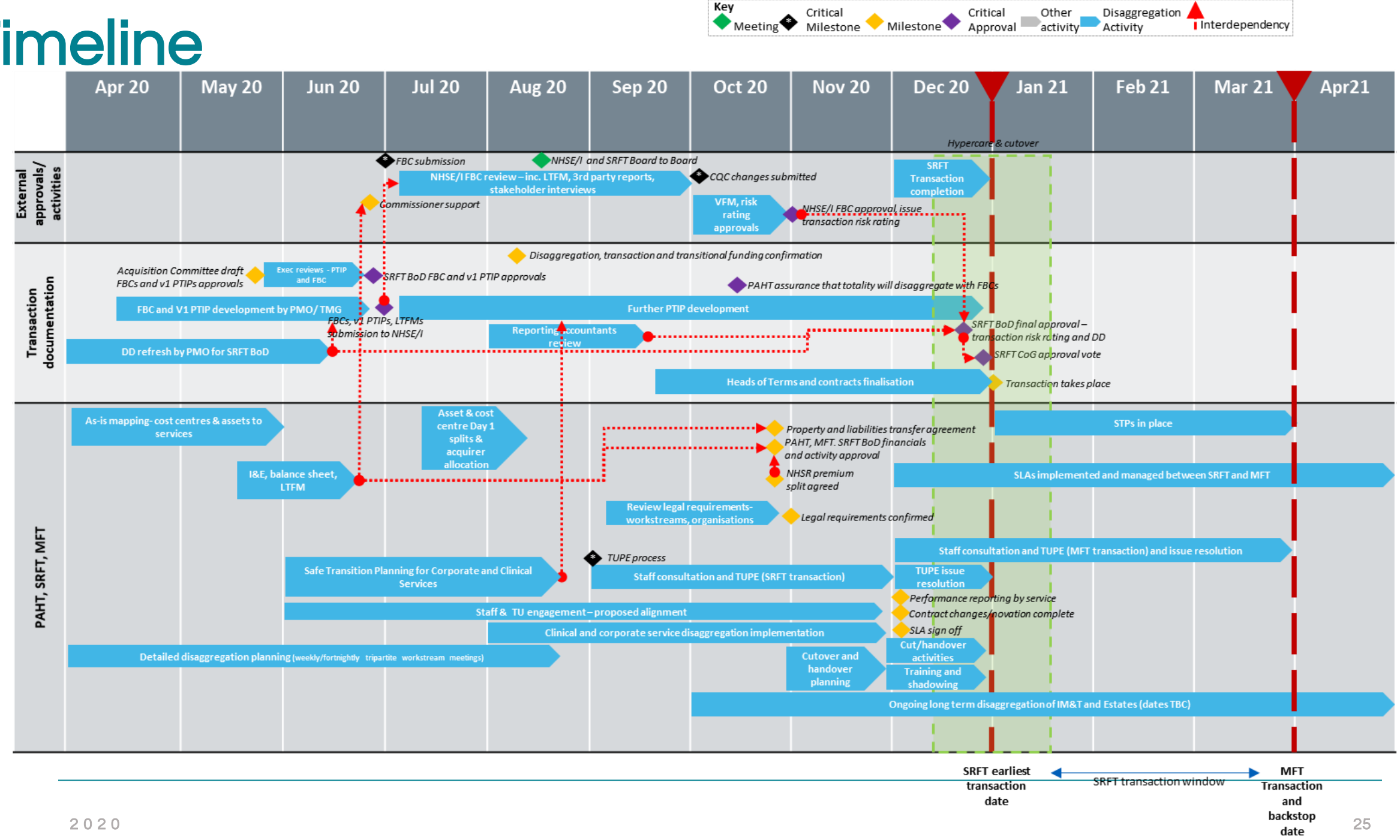
Funding

Supporting key investment programmes such as the development of Salford and Oldham sites and support securing funds for disaggregation.

Ongoing collaboration to timely disaggregation and transaction

We're here to help, and are committed to delivering the earliest possible transaction as agreed with a NHSI. We continue to work together across stakeholders and with you to remove any blockers which may hinder progress to this.

Timeline


Key
Meeting
Critical Milestone
Milestone
Critical Approval
Other activity
Disaggregation Activity
Interdependency
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr21
External approvals/ activities
Transaction documentation
PAHT, SRFT, MFT
Hypercare & cutover
FBC submission
NHSE/I and SRFT Board to Board
NHSE/I FBC review – inc. LTFM, 3rd party reports, stakeholder interviews
CQC changes submitted
Commissioner support
VFM, risk rating approvals
NHSE/I FBC approval, issue transaction risk rating
SRFT Transaction completion
Disaggregation, transaction and transitional funding confirmation
Acquisition Committee draft FBCs and v1 PTIPs approvals
Exec reviews - PTIP and FBC
SRFT BoD FBC and v1 PTIP approvals
PAHT assurance that totality will disaggregate with FBCs
FBC and V1 PTIP development by PMO/ TMG
Further PTIP development
FBCs, v1 PTIPs, LTFMs submission to NHSE/I
Reporting accountants review
SRFT BoD final approval – transaction risk rating and DD
DD refresh by PMO for SRFT BoD
SRFT CoG approval vote
Heads of Terms and contracts finalisation
Transaction takes place
As-is mapping- cost centres & assets to services
Asset & cost centre Day 1 splits & acquirer allocation
Property and liabilities transfer agreement PAHT, MFT. SRFT BoD financials and activity approval
STPs in place
I&E, balance sheet, LTFM
NHSR premium split agreed
SLAs implemented and managed between SRFT and MFT
Review legal requirements- workstreams, organisations
Legal requirements confirmed
Staff consultation and TUPE (MFT transaction) and issue resolution
TUPE process
Safe Transition Planning for Corporate and Clinical Services
Staff consultation and TUPE (SRFT transaction)
TUPE issue resolution
Performance reporting by service
Staff & TU engagement – proposed alignment
Contract changes/novation complete
Clinical and corporate service disaggregation implementation
SLA sign off
Detailed disaggregation planning (weekly/fortnightly tripartite workstream meetings)
Cut/handover activities
Cutover and handover planning
Training and shadowing
Ongoing long term disaggregation of IM&T and Estates (dates TBC)
SRFT earliest transaction date
SRFT transaction window
MFT Transaction and backstop date

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Consider
Item No	16	**Confidential / Freedom of Information Status**	No
Title	Bury Equalities Review		
Presented By	Councillor Tahir Rafiq		
Author	Chris Woodhouse, Strategic Partnerships Manager		
Clinical Lead	Howard Hughes/ Dr. Jeff Schryer		
Council Lead	Councillor Tahir Rafiq/ Lynne Ridsdale		

Executive Summary

In June 2020 Bury Council and Bury CCG proposed the undertaking on an Equalities Review, to inform a joint Equalities Strategy and Outcomes Framework. This report provides an update on the work of the Review.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note the progress which has taken place on the Equalities Review and receive a further verbal update at the meeting in relation to the high level findings of the review (which will be available at the time of the meeting).

- That a substantive item of the Strategic Commissioning Board meeting in December 2020 focus on the Equality review findings and draft joint Equalities Strategy.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Yes

The Public Sector Equalities Duties covers both the Council and CCG. Bury CCG are mandated through the Equalities Delivery Standards. Promoting equalities within the Council is through the Equality Framework for Local Government.

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	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The respective equality frameworks, which the review is assessing the locality against includes considerations of understanding and working with communities to deliver better outcomes and responsive Services and improved customer/patient access and experience – including health and care provision across the Borough					
How do proposals align with Locality Plan?	As per Health and Wellbeing Strategy					
How do proposals align with the Commissioning Strategy?	As per Health and Wellbeing Strategy. Commissioning activity should take account of all Protected Characteristics and an Equality Impact Assessment be made against any policy or investment decision. This Review will provide a joint strategy and implementation plan (including training and culture) to ensure good practice in this area is being followed.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	This review is assessing adherence to the respective Equality Frameworks, with a joint strategy and implementation plan to address inequalities across all protected characteristics.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐

Implications						
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details	Note that this report is an update on the Equalities Review, there will be specific implications arising from any approval of a Joint Equalities Strategy which is to be tabled at a future meeting					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury Council Cabinet	*10/06/2020*	*Initial report to commence review – approved*
Bury CCG Governing Body	*24/06/2020*	*Initial report to commence review – approved*
Joint Executive Team	14/09/2020	Report noted
Cabinet Portfolio	14/09/2020	Report noted
Policy Advisory Group	21/09/2020	Report noted

Bury Equalities Review update

1. Background

1.1 In June 2020 Bury Council and Bury CCG proposed that an independent partner be engaged to undertake an equalities audit across both the Council and the OCO, with reference to the Equality Framework for Local Government (EFLG) and NHS Equality Delivery System (ESD2).

1.2 The review was to result in a strategy and outcomes framework in the context of an objective, best practice standard, across all protected characteristics.

1.3 The reports to the Council's Cabinet and CCG's Governing Body outlined that the review will report to the Strategic Commissioning Board, as a partnership deliverable and to take the opportunity of furthering system-wide partnership leadership on

equalities which will be an intrinsic part of the organisational transformation to which the Council has committed.

1.4 As such this report is to provide an update on activity in relation to the review as a pre-cursor to the review findings, strategy and outcomes framework being completed for approval at the December Strategic Commissioning Board

2. Update on the Review

2.1 A procurement exercise took place in late June 2020 through which an independent reviewer was secured. Their brief included the following tasks:

- Undertake an assessment of the partnership's current performance in relation to equalities, identifying areas of strength and specific areas for improvement. The assessment will be based on a review of relevant policies and procedures as well as consultation and engagement with community leaders from all protected characteristics and the relevant staff-side groups

- Produce a proposed Equalities Strategy in the context of key findings, which is aligned to our Bury 2030 strategy and emerging neighbourhood model.

- Alongside the strategy, to develop equality objectives, based on sector experience and understanding of best practice – and advising on actions that are required to achieve those objectives

- Develop an implementation plan setting out the actions required to meet key recommendations. Actions are likely to include policy and procedural work as well as training and organisational culture development

- To secure skills transfer through this work to officers in the team to develop and sustain a culture of embedding equality into core organisational practices.

- To produce recommendations on the partnership equality training offer for staff.

2.2 A kick-off meeting took place with key stakeholders on 20th July in relation to the four domains of the respective equality frameworks, namely;

- Understanding and working with communities to deliver better outcomes

- Inclusive leadership and organisational commitment

- Responsive Services and improved customer/patient access and experience

- A representative, engaged and supportive workforce.

2.3 This session allowed the reviewer to introduce themselves and outline the methodology to be followed. It was held online given existing social distancing restrictions and included representation from across the Council, including the Chairs

of the organisation employee groups which are open to all Bury Council and Bury CCG staff.

2.4 Evidence has been requested, collated and is being analysed from across the Council and CCG in relation to the respective equality frameworks. The collation stage was primarily completed at the end of August, with a final task of gathering a further sample of Equality Impact Assessments from 2016-to-date across all departments to conclude at the start of September. The analysis of this evidence is taking place against the criteria set out against each area of focus within the EFLG and EDS2.

2.5 From a CCG perspective, in addition to reviewing progress in relation to EDS2 there this review is also identifying progress made (and/or any gaps in progress) against the actions outlined in the Annual Equality Publication and NHS Workforce Race Equality Standards.

2.6 To support the desktop research, a series of interviews have been held with workforce representatives and leadership across the Council and CCG, to garner further insight in relation to adherence with Public Sector Equality Duties and to review internal structures to support equality, diversity and inclusion.

2.7 Further interviews and consultation has taken place with external stakeholders, including addressing the Bury Voluntary, Community and Faith Alliance (VCFA) Chief Officers Group on the 6th August 2020 and a survey of community leaders which ran for three weeks from the 14th August. This wider engagement is being fed into the drafting of the review and used to inform the developing Strategy and Outcomes Framework.

2.8 In addition, the drafting of the Strategy will reflect best practice and the latest developments in relation to equalities, diversity and inclusion; drawing from regional, national and international standards and activity. Examples of this include findings from activity in relation to the impact of Coronavirus, such as the GM Disabled Peoples Panel's Big Disability Survey recommendations; the changing landscape and governance on equalities in Greater Manchester including the Youth Forum, Women and Girls Equality Panel; and the latest policies and publications, such as Aging in Place for Minority Ethnic Communities.

3 Next Steps

3.1 The review conclusions are being drawn together during September; bringing together the desktop analysis, interviews and wider findings, with a draft Strategy to be complete by the end of the month (September 2020).

3.2 Timetabling of papers for the Strategic Commissioning Board mean that these outputs are not available for inclusion in the reports pack for the October meeting, rather this report has been prepared to provide an update and will be accompanied by a verbal update at the meeting on the high level findings of the review.

3.3 A more detailed report will be tabled at the December Strategic Commissioning Board meeting outlining the full findings of the review and to seek approval of a joint Equalities Strategy.

4 Recommendations

4.1 It is recommended that this updated be noted and that the Strategic Commissioning Board receive a further verbal update at the meeting in relation to the high level findings of the review which will be available at the time of the meeting.

4.2 That a substantive item of the Strategic Commissioning Board meeting in December 2020 focus on the Equality review findings and draft joint Equalities Strategy.

Chris Woodhouse
Strategic Partnerships Manager
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September 2020

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Consider
Item No	17	**Confidential / Freedom of Information Status**	No
Title	Form and Function of the Local Care Organisation		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Will Blandamer, Executive Director of Strategic Commissioning		
Clinical Lead			
Council Lead			

Executive Summary

The purpose of this paper is to consider the organisational form for the Local Care Organisation (LCO) in Bury.

The LCO has been operating as an alliance partnership in Bury for some time and have made a valuable contribution in bringing a focus on the integration of community based health and care services in the borough, and taking lead responsibility for a number of the recovery and transformation programmes of work.

Leadership from both CO and LCO in Bury consider it important to clarify for the medium term, the form of the LCO, in order to provide certainty and to allow the LCO to focus on delivery. Likewise, partners within the LCO have recognised the need to address the LCO's organisational form at various points since its inception but only recently has there been a consensus that the sustainability and effectiveness of the LCO require a conclusion to be drawn on organisational form.

Recommendations

It is recommended that the Strategic Commissioning Board:

- is invited to receive the paper and comment on the rationale and description of the lead provider role for the LCO
- is invited to note the next steps being taken and to provide comment.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or	Yes	☐	No	☐	N/A	☐

Implications						
patient experience implications?						
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	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐

Implications	
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.		

Paper for Strategic Commissioning Board – October 2020

Form and Function of the Local Care Organisation.

1. Introduction

The purpose of this paper is to consider the organisational form for the Local Care Organisation (LCO) in Bury.

The LCO has been operating as an alliance partnership in Bury for some time and have made a valuable contribution in bringing a focus on the integration of community based health and care services in the borough, and taking lead responsibility for a number of the recovery and transformation programmes of work.

Leadership from both CO and LCO in Bury consider it important to clarify for the medium term, the form of the LCO, in order to provide certainty and to allow the LCO to focus on delivery. Likewise, partners within the LCO have recognised the need to address the LCO's organisational form at various points since its inception but only recently has there been a consensus that the sustainability and effectiveness of the LCO require a conclusion to be drawn on organisational form.

There are a number of key drivers which make this an important issue to consider now and which have contributed to both the OCO and LCO agreeing that form needs to be decided. The wider system drivers include:

1. Recognition that much of the management capacity of the LCO is based on short-term transformational funding, available until April 2021, and resolution is required soon to avoid loss of staff and associated knowledge and expertise. The LCO has fulfilled a role in the system that individual organisations have been unable to do, due to capacity challenges and the independent and co-ordinating nature of the LCO team, in the main. This will create a void if the LCO is not there, thereby de-stabilising the ability of the system to deliver the level of transformation required to support recovery.
2. The OCO have been asked for a contribution to the funding of a Bury-based Northern Care Alliance NHS Group (NCA) leadership, reflecting the disaggregation of the Bury and Rochdale Care Organisation into two distinct teams (instigated by Rochdale but helpful to Bury to have the focused NCA leadership in this 'place' exclusively). This is an additional ask for management capacity in the economy, which needs to align with capacity and capability for the LCO.
3. The OCO need to resolve the question of re-procurement of the community health services contract due for commencement April 2021

As noted, the Board of Bury Local Care Organisation (LCO) is also keen to examine the best form of organisational and contractual structure to take effect from April 2021 in order to specific delivery issues including:

a) Strengthen the potential for further integration of health and social care services, capitalising on learning from the Covid-19 emergency period and the redesign of urgent care services

b) Provide the means to hold contracts from commissioners, and the means to hold sub-contracts with providers, e.g., those not currently members of the LCO

c) Provide a platform for 'blended roles' between Bury's One Commissioning Organisation and the LCO, e.g., to support pathway redesign
d) Maximise Bury's potential to adapt to a potential establishment of integrated care systems on a statutory footing

2. OCO specification for the LCO

The objective of the Bury LCO is to oversee and co-ordinate the delivery of good quality integrated community-based health and care services. These services are predicated on strengthened primary care, are based on the 5 neighbourhood model in the borough, are focused on prevention and early intervention, and are characterised by having a different and asset-based relationship with residents and communities. The LCO is a partnership between health services, social care and wider support and wellbeing services. It seeks at all times to be inclusive of its members' principles and to create an ethos in which there is 'parity of esteem' not only between physical and mental health but also between health and social care, between all the professions in the sector, and between organisations of the state and independent organisations working with the state, such as the voluntary and social enterprise sectors.

The LCO is expected to provide a focal point and integrated leadership arrangements for delivery of health and care, spanning a number of organisations and delivery mechanisms including:

- Primary Care and Primary Care Networks
- Social Work and elements of social care delivery (Bury MBC and commissioned providers)
- Mental Health (Pennine Care NHS Foundation Trust)
- Community health services (NCA),
- Voluntary, Community and Faith Alliance

All of these organisations and sectors are directly connected to the transformation of acute hospital services, which can only be truly radical with the right integrated community support in place. We would also see strong connections to other key providers in neighbourhoods such as care homes, care at home services and neighbourhood voluntary community and faith organisations, in line with the need to build on individual and community assets, reduce the risk of people's needs escalating, and of enabling everyone to maintain their independence for longer.

Integrated neighbourhood team leadership should be strengthened – co-ordinating and orchestrating the combined contribution of providers in the neighbourhood. We do not consider it necessary for all members of a high functioning multi-agency team to be employed by one organisation. We have demonstrated though our collective Covid-19 response that a common goal can bind teams together under distributed leadership regardless of employer or the formality of the partnership governance. The objective is to secure and build multi-agency teams, where front line staff are empowered and supported to be working together as if they were one organisation, being guided by expert leadership that is organising the most effective ways of working.

While employment arrangements may not need to change, we do need to establish a consensus on the extent to which authority to 'manage' staff can be ceded by different organisations into single management arrangement for multi-agency teams – particularly for NCA community nursing staff, council adult care staff, and Pennine Care neighbourhood team members. It is important to establish the principle that neighbourhood management team can direct and support the work of the multi-agency team in the neighbourhood. Neighbourhood working needs to be more than just co-located teams.

We also do not expect the notion of integrated team working to undermine professional accountability arrangements – for example in social care, accountability to the Director of Adult Services - or professional nursing networks. In fact, we believe that strong professional accountability networks are a pre-requisite of multi-agency neighbourhood based team working.

We expect an LCO to be the representative voice of all partners to the arrangement – and further expect that partners mandate the LCO board to make appropriate decisions, within a scheme of delegated authority, without the requirement to seek further endorsement from the board of each partner.

We will work to ensure that the OCO and the LCO have a positive working relationship – operating seamlessly as one health and care system on behalf of the residents of the borough. This reflects the principles and behaviours document governing the OCO/LCO relationship agreed in June 2019. In this we expect staff nominally associated with the OCO or the LCO to be supported to make the best contribution they can in a co-ordinated way to the operation of multi-agency neighbourhood based team working.

We are keen to create the space for the LCO to strengthen its delivery of integrated community services – through neighbourhoods and programmes like active case management implementation – at a scale that begins to impact on both on the key metrics for the system – urgent care demand, and formal packages of social care – and the wellbeing of Bury people.

An important characteristic of the LCO should be the ability to move money around the system to secure the investment required in community-based health and care. For example we currently have a relative surplus of intermediate care beds, but a reablement team funded almost entirely on short term transformation funding. Our ability to close beds and invest in the team is limited due to the block nature of the contract.

3. Options

The LCO and OCO have undertaken high level options appraisals independently, with the following perspectives being obtained:

No.	Option	Brief description	LCO perspective	OCO perspective
1	*Status quo*	The current arrangement is an alliance between seven organisations, governed by an Agreement which is not legally binding, supported by dedicated management capacity	Not sustainable in the long term as it does not provide sufficient capability to move integration to more advanced levels, e.g. cannot hold contracts and has no independent decision-making power	Not satisfactory because it does not create certainty and does not create the scope for moving money into community based prevention and early intervention

No.	Option	Brief description	LCO perspective	OCO perspective
2	*Section 75 arrangement*	A step on from the alliance would partners retaining all existing sovereignty, but to pool a proportion of the LCO in scope budget under a section 75 agreement – in a mirror to the pooled budget arrangement within the joint commissioning board.	Not sustainable in the long term as does not provide sufficient capability to move integration to more advanced levels, e.g. cannot hold contracts and has no independent decision-making power	This has potential depending on the scope of the pooled budget proposed, but may be regarded as avoiding a key question of drive and leadership for the ambition of the LCO. This should not be discounted as it is another way of maintaining independence and providing relentless focus on community based care capacity and integration
2	Contractual joint venture	This would not represent a major change from the status quo, as a contractual joint venture would have the same limitations as the current arrangements	Not sustainable in the long term as does not provide sufficient capability to move integration to more advanced levels, e.g. cannot hold contracts and has no independent decision-making power	This creates an additional player, management cost, and is contractually challenging for reasons of VAT.
3	Special purpose vehicle (SPV)	This could take a variety of forms, a social enterprise being the most likely and easiest to establish. The SPV would have a legal identity and be a body corporate and as such it could hold contracts and let contracts.	This model provides for maximal control of the LCO by its 'owners', the provider partnership but it would create a new organisation in the borough. Transferring existing contracts for services to the SPV would most likely require a procurement exercise, and could be costly and time consuming	The system cannot afford the additional overhead costs involved to build the necessary corporate and clinical governance arrangements.
4	Lead provider	This option could take a variety of forms including: a) a single organisation which holds a major contract from commissioners and which sub-contracts to other providers, integrating care and co-ordinating care pathways b) a single organisation which employs all or most community health and social care staff and which holds a major contract with commissioners which it largely or exclusively fulfils directly (i.e., not through an	Each of these options has its own profile of merits and demerits and there are variations of each not described here. A lead provider model with a strong focus and infrastructure to manage relationships and partnerships, would enable the LCO development to move to the next level, and to continue the focus on true integration	There is little support for a model which would mean large-scale organisational change and disquiet for front line staff, particularly in social care, at a time of considerable uncertainty. It is also likely that direct employment change, would also involve some challenge around VAT There is also a sense that building integrated neighbourhood teams with integrated leadership arrangements is not dependent on managerial authority derived from employment status.

No.	Option	Brief description	LCO perspective	OCO perspective
		independent network or supply chain) c) a single organisation which holds contracts and provides infrastructure support (and in addition some direct services) but which supports and sustains a concrete partnership of organisations to which it delegates as much decision-making power as possible		A lead provider arrangement would provide confidence and certainty in leadership - a 'cleaner' solution, and would create scope for a single management team nested within the corporate and clinical governance of a provider. However the partnership arrangements supporting decision making would need to be robust, so that community care would not be a secondary consideration, as out of hospital care is the prime focus for the LCO

Based on high level separate options appraisals undertaken separately by the LCO and the OCO, it was agreed by the LCO Board, that the description of the lead provider form should be progressed. This step has been taken principally because there is limited or no support within Bury for the creation of a new organisation (option 3) and the sustainability of the current arrangements is now generally agreed to be at risk as a result of a variety of factors, thereby eliminating options 1 and 2. There is strong consensus that any lead provider model established should not undermine the Partnership and relationships that have been built over recent years.

4. Assumptions

The LCO Board (which includes OCO membership) has agreed the following assumptions with regard to the next stage of its development

- The LCO will be a means of co-ordinating integrated out of hospital care and support, care and support that is itself fully aligned to the borough's hospital provision for physical and mental health, the provision of which is the direct responsibility of LCO members. The LCO will have a role in directly managing some aspects of provision (where appropriate), and integrating providers across the Borough to deliver more effective and efficient care. The LCO will include acute provision for urgent care, however where services are managed on a broader footprint than the Borough, the LCO will ensure robust connectivity into associated pathways e.g. surgery and diagnostics

- The LCO must preserve through the next stage of its development, the trust and relationships which have been built over recent years

- The LCO must focus on prevention, early intervention, and having a different relationship with residents, communities and service users. Social care, and the voluntary sector, must be seen as equal contributors within the LCO arrangements.

- The LCO arrangements should enable partnership working at an advanced level to support and enhance community healthcare services, currently hosted by Northern Care Alliance NHS Group

- The LCO must be able to co-ordinate the work of providers and commissioning staff (e.g., working in 'blended' roles) without triggering any organisational change process which would, e.g., result in a transfer of employment unless this is mutually agreed between affected parties

- The LCO must be future-proofed as far as possible so as to be able to operate in a variety of scenarios including the establishment of a statutory integrated care system for Greater Manchester – the direct provision of services

- The LCO should always minimise the risk of creating additional layers of management or duplicating arrangements in other organisations

The following principles of the lead provider model were approved by the Board

- The LCO needs to maintain a Board and infrastructure to support the integration and delivery agenda that operates at arm's length from the lead provider to support partnership working. This infrastructure may reduce over time, as confidence grows in new arrangements. It is anticipated that it will be required as a minimum for 1-2 years. The LCO must preserve the trust and relationships which have been built over time.

- Keeping the LCO structure as lean as possible to deliver the ambition of

    - Being an integrator of all health and social care services to transform the delivery of care across the Borough
    - Directly managing a suite of out of hospital services which are delegated to the management team of the LCO for transformation and day to day operational management

- Infrastructure and necessary HR processes must supports be designed to support business continuity, and in the context of the latest national, Greater Manchester and North East sector direction. The creation of the LCO form will minimise employment transfers as much as possible, and will not impact on VAT arrangements

- There will be a journey of contracts aligned and managed by the LCO rather than a wholesale change immediately

- All providers will be asked if they wish to express an interest based on the outline description of the lead provider model

5. Outline of Bury's lead provider model

5.1 Summary of LCO role

Bury Local Care Organisation will be a partnership between provider organisations in the context of a lead provider. The lead provider will be (most likely) a major provider of out of hospital services itself, though decisions about the transformation and delivery of these services will be delegated to the LCO Board.

The LCO will provide management including single line management for some community services and will act as an integrator for the wider community health and social care sector by co-ordinating the supply chain and associated pathways of care.

The LCO will seek at all times to maximise the value of a range of different and distinct providers in Bury, believing that Bury people are best served by co-ordinated care from a range of distinct, unique organisations, rather than from a single body or from a few organisations only.

5.2 Role of the lead provider

The role of the lead provider will be to:

- Employ the staff who manage the LCO (executive team and core team)
- Hold contracts from commissioners for services provided by the LCO
- Sub-contract to providers on behalf of the LCO, co-ordination and integrating the LCO supply chain, these contracts having been transferred to the lead provider by the commissioners
- Provide infrastructure support including technical and professional support
- Permit secondments, or forms of 'blended working' from LCO partner organisations and from commissioners
- Hold any programme budget or pooled fund on behalf of the LCO on the basis of an agreed risk-and-reward share with commissioners and providers. This will be of critical importance with regard to the urgent care programme budget
- Delegate the management of its own community services to the LCO Board, executive and management team on a day to day basis.

5.3 Role of the LCO Board

The LCO will be governed by a Board which shall consist of full members of the LCO. The Board shall be independently chaired, and will have delegated powers from the full members to make decisions about:

- Transformation and redesign of services
- Use of resources in the context of any programme budget or pooled fund
- Deployment of the LCO's resources i.e., those resources made available to the LCO by commissioners and LCO partners
- The performance and quality of services contracted from the LCO and from sub-contracted services
- Membership of the LCO

- Policies and procedures used by the LCO
- Recommendations being made to the lead provider in respect of contract variations and contract letting

The lead provider shall additionally delegate to the Board of the LCO the powers to:

- Transform and redesign community services provided by the lead provider or contracted for by the lead provider in order to maximise the opportunities from integration
- Manage the lead provider's community health services in the context of integrated health and social care services and pathways, on a day to day basis
- Make recommendations which the lead provider would accept in all but exceptional circumstances for the letting or variation of contracts and sub-contracts

Full members of the LCO shall be provider organisations which will delegate to the Board of the LCO, via the lead provider, the following powers:

- Power to manage contracts for services provided by the member organisation, whose contract or sub-contract is routed through the lead provider
- Power to transform or redesign services provided by the organisation in order to maximise the opportunities from integration
- Power to manage services from the organisation on a day to day basis, through the LCO management team and executive, reporting to the Board

The LCO Board may, in the future, be:

- A regulation 10 committee under Statutory Instrument 2000 617 in the event of the partners agreeing to establish a s75 agreement (NB, there is no current facility to include non-council or non-NHS bodies in a 75 agreement)

- A joint committee in common (NB, there is understood to be currently no facility for a non-NHS body to join a committee in common as a voting member)

- A sub-committee of the Board of Pennine Acute Hospitals NHS Trust (NB, there is understood to be no facility for a non-NHS body to join such a committee as a voting member)

These limitations may be addressed in the event of legislative changes to establish integrated care system as statutory bodies. In any case, the LCO Board needs to be able exercise autonomy within the context of the lead provider: in other words, the governance of the LCO needs to balance the regulatory and contractual obligations of the lead provider with the need for partners to exercise a genuinely meaningful decision-making power over matters which concern the LCO.

5.4 Implications for LCO member organisations

The following implications have been identified for LCO member organisations

- There is some loss of control of services, but this is partially mitigated by the voting rights that each organisation has on the LCO Board (which will remain one organisation, one vote)

- For some organisations and some services, their 'customer' may become the lead provider through the LCO Board, rather than the One Commissioning Organisation

- There will be some potential to increased exposure to financial risk, depending on how the risk-and-reward arrangements are operated but correspondingly there is likely to be an increased potential for financial reward for reinvestment

- There will be a significantly increased potential for seeking new business opportunities in partnership with the lead provider

6. Next steps

The LCO Board meeting on 7th October will be used for a discussion between partners to the LCO to be able to describe the key characteristics of the lead provider model and the LCO form and the conditions for success, based on the views of partners. Partners have been asked to complete a template gauging views on a number of aspects of the role and operation of a lead provider model and also provide an indicative view on their interest in becoming a lead provider.

7. Recommendations

1) The SCB is invited to receive the paper and comment on the rationale and description of the lead provider role for the LCO
2) The SCB is invited to note the next steps being taken and to provide comment.

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Information
Item No	19	**Confidential / Freedom of Information Status**	No
Title	Bury System Board Meetings – 18 June 2020, 21 July 2020 and 19 August 2020		
Presented By	Cllr E O'Brien, Co-chair of the SCB and Bury Council Leader / Dr J Schryer, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author	-		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The paper includes the minutes of :

- Bury System Board Meetings held on 18 June 2020, 21 July 2020 and 19 August 2020

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the Minutes of the Bury System Board Meetings held on 18 June 2020, 21 July 2020 and 19 August 2020.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	N/A
Add details here.	

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	Yes	☐	No	☒	N/A	☐

Implications						
requested?						
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	*N/A*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury System Board	18 June 2020 21 July 2020 19 August 2020	Minutes being submitted for ratification

Title	**Minutes of the Bury System Board** **18 June 2020**
Author	Jill Stott, LCO Governance Manager
Version	2.0
Target Audience	Members of the Bury System Board
Date Created	June 2020
Date of Issue	
To be Agreed	July 2020
Document Status (Draft/Final)	Draft

Document History:

Date	Version	Author	Notes
19.06.20	1.0	Jill Stott	Draft Minutes submitted to MO'D for checking
30.06.20	2.0		With amendments by MO'D
Approved:			
Signature:			.....

Bury System Board

MINUTES OF MEETING
18 June 2020, 10.30 – 12.30
Via Teams
Chair – Dr Jeff Schryer

Members Present:

Dr Jeff Schryer, Chair Bury CCG (Chair) (JS)
Cllr Eamonn O' Brien, Leader of the Council (EO'B)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
Ms Julie Gonda, Interim Executive Director, Communities and Wellbeing (JG)
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Mr Mike Woodhead, CFO, Bury CCG (MW)
Mr Chris O'Gorman, Independent Chair, LCO Board (CO'G)
Mr Dil Jauffur, Associate Director Mental Health and Learning Disability Services, Bury, PCFT (DJ), representing K Walker, PCFT
Ms Margaret O'Dwyer, Director of Commissioning & Business Delivery/Deputy Chief Officer, NHS Bury CCG (MO'D)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council (AS)
Mr Craig Carter, Director of Finance, NCA (CC)
Ms Leah Robins, Director of Operations, NCA, representing Simon Featherstone (LR)

Others in attendance:

Ms Lesley Jones, Director of Public Health, Bury Council (LJ)
Ms Nicky O'Connor, Interim Director of Transformation, Bury Council (NO'C)
Dr Sanjay Kotegaonkar, Clinical Lead IM&T Bury CCG (SK)
Ms Tracey Rawlinson, Programme Manager, AQuA (TR)
Ms Rebecca Adjibola, Programme Facilitator, AQuA (observer)
Ms Jill Stott, LCO Governance Manager (JMS)

Apologies

Apologies for absence were received from:

- Dr Cathy Fines, Clinical Director, Bury CCG
- Mr Keith Walker, Executive Director of Operations, PCFT
- Dr Daniel Cooke, Clinical Director, Bury CCG
- Mr Simon Featherstone, Interim Chief Officer/Director of Nursing, Bury Care Organisation

MEETING NARRATIVE & OUTCOMES

1.	**WELCOME AND APOLOGIES**
	JS welcomed those present to the Bury System Board and introductions took place. Apologies were noted as outlined above.
2.	**DECLARATIONS OF INTEREST**
	Members were asked to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Bury System Board. KWJ declared her coaching and consulting company as a new declaration of interest which will be added to the CCG's register.
3.	**MINUTES OF LAST MEETING (14 May 2020) /ACTION LOG**
	The minutes of the previous meeting were agreed as a correct record. The Action Log was noted, and updates were recorded within the log accordingly.
4.	**Covid-19 Response – latest update**
	GL updated the board on the latest number of cases across Bury, noting a slight downward trend of late. He noted that there was no cause for complacency, however, given that Bury has the second highest number of cases per 1000 in GM and 12th highest across 150 local authority areas. GL explained that consistent powerful messages will continue to be communicated, reiterating that the pandemic is not over and that lockdown will be lifted in as safe a way as possible. GL emphasised the need to adhere to the local outbreak plan and to support LJ's work in order to keep the recovery phase on track. He also highlighted the findings from a Public Health England (PHE) report on the impact of Covid-19 on older people, those with long term conditions (LTC), those living in more deprived communities and some members of the black, Asian and minority ethnic (BAME) community. He explained that the approach to population health as part of the Bury 2030 Strategy will include targeted public service interventions across all projects to ensure the cohorts listed above are given the necessary focus. GL reported that the council and the OCO are reviewing an approach to addressing inequalities in BAME representation at senior management level and that further proposals on this will be reported to this board. KWJ confirmed that the inequalities issue is a focus of the LCO's work which is being addressed via the workforce work programme; the intention is to provide a collective response across the system. The topic was discussed at length and the following areas covered: • Talent management approaches are being explored at a variety of levels in organisations • Fall in numbers of BAME volunteers across Bury

	• Jewish community included as part of the BAME community in Bury • Asylum seekers and refugees engaging with the system only at a point of crisis • Role of neighbourhoods and the integrated neighbourhood teams (INTs) in supporting this work • Impact of Covid-19 on aspects of both deprivation and the BAME community to be addressed • Both health and care staff and those cared for to be included in this work • Further work to be done on the definition of "population approaches" and "population health" • Locality to increase its scrutiny of equality and diversity issues GL noted that the priority projects in the recovery phase will be those around population health (to be at the core of the Bury 2030 Strategy) and neighbourhood work (with a focus on issues around ethnicity and deprivation).
5.	**Testing and Contact Tracing**
	Local Outbreak Plan LJ had shared the first iteration of the plan with the board; she explained that this will be an on-going piece of work and that the intention is for it to act as a handbook for the Bury system. GM are also working on an overarching plan and a deadline of 30 June 2020 has been set for local authorities to submit their version. LJ explained that additional resource has been provided to the areas of infection prevention and control, communications, data and the hubs. She said that individual organisations (via silver groups) still hold responsibility for minimising risks and managing any consequences. LJ reported on the 3 levels of track and trace (national, regional and local) and the work in progress around responsibilities and data flows between these. She noted the availability and quality of data as being an issue in this work. JG suggested that the clarity of purpose and the ask of individual agencies should be refined in the next iteration of the plan; LJ agreed with this and explained that an increased emphasis on prevention would also be part of the next draft. LJ reported that a communication and engagement plan (both at GM and OCO-level) are in development and that key contacts for the different sectors in the borough are part of this work, ensuring multiple contributions to the plan.
6	**Recovery Plan**
	A presentation had been shared with the group by HH outlining the work that has taken place since the last board meeting, challenges and next steps. This included: • Sub-groups for the 7 priority groups in place with named leads • Links with enablers to be enhanced • Audit tool to be developed • Visual system map in development • Template for programme reporting in development Challenges outlined in the presentation were around:

- Recovery being “the only show in town”
- Injection of pace into the work including appropriate governance
- A system approach to be taken, avoiding organisational protectionism
- Avoiding reverting to previous ways of working

There was much discussion on the topic and the following areas covered:

- UC implementation cannot be done in isolation but needs to include the intermediate care (IMC) and INT offer and other parts of the system (Fairfield, North Manchester, Bolton)
- Clinical and professional engagement key to the work
- Increased pace important but phasing and prioritisation are needed
- Focus to be on objectives without distraction
- Awareness that system demand is starting to increase
- Desire to retain efficiencies of work during the Covid period and not to revert to former ways of working
- Lack of government finance support could be a potential barrier to recovery work
- IT issues could be a potential barrier to recovery work
- Governance to be appropriate to the focus on recovery work and not over-burdensome
- Inequalities regarding access and outcomes to be addressed

GL alerted the board to a number of areas:

- the financial situation is uncertain and a new post-Covid imperative needs to be the focus
- need to sustain the shift of demand from acute to community services, supported by early interventions in the community
- awareness that NHS organisational change is likely, making the need to determine Bury’s future a priority

EO’B suggested an easy way to focus on recovery would be to include a section on the front sheet for any committee papers. He suggested that Bury’s approach should be to demonstrate how a pooled budget approach and devolved power have worked as the best solution.

DJ noted that not all patients are ready or able to accept the digital offer and that equality impact assessments for any projects should take this into account.

JS summarised the main points as:

- Recovery being the main area of focus for Bury
- Focus to be on objectives, work streams to be inclusive but aware of pace of work
- Intention not to twin track governance processes
- Consideration to be given to reporting systems
- Commitment to devolution and working as a Bury system

	• Awareness of the threat of NHS re-organisation and its consequences • Need for individual organisations to be aware of the current focus on the 7 priorities
7	**Urgent Care Update**
	KWJ had shared a number of papers with the board: a paper on the implementation of the UC recommendations, a GM paper on an urgent and emergency care (UEC) by appointment proposal and the UC recovery programme charter. KWJ updated the group on the UC Project Board which will be meeting on a weekly basis and on the recruitment to an UC programme manager role (interim support to be arranged). KWJ explained that over the next 6 weeks clinical workshops have been arranged to consider UC access via A&E, the clinical assessment service (CAS) and Primary Care. The focus will be on an alternative community offer. KWJ reported that LCO Board have approved this work and briefly updated on the NCA virtual hospital offer and its alignment with the Bury UC work. KWJ asked about savings plans, noting that the original implementation date of October 2020 has been extended. She noted the need to consider the effect of increased demand diverted from Prestwich walk-in service. DJ confirmed that from a mental health perspective there was a commitment to the proposed model and staff were ready to link with the INTs and community hubs as appropriate. He noted the current pressures on the community mental health team due to the number of cases in the system. GL responded to KWJ's overview by confirming that this is a priority project, with a focus on the £2.6m savings expected from it. There was discussion on the leads for the project, with GL confirming that Nicky Parker is available to lead the work until a programme manager is recruited. The success of the virtual hospital project was referred to and KWJ confirmed that this work would be captured as part of the mapping of the alternative out of hospital offer.
8	**Strategic Finance Update**
	MW updated the group on the latest financial position: • LA - £20m net pressure this financial year with a £27m savings target over the next 3 years • CCG – funded to break even by the end of month 4, with pressures expected during months 5-12, £12m deficit and a £44m gap • Providers – carrying deficits • Review of transformation funds and how they will be used MW explained that the financial position is uncertain and hard to predict, that the health and social care sector is expected to look different in the future, giving freedoms to take opportunities and accelerate transformation programmes. MW suggested that there will be opportunity to influence future finance and

contracting frameworks and that a shared ownership of the financial position is needed, with shared control totals and reports.

CC updated the board on the acute position:

- £4m per month being spent during the Covid period, which has been partly offset by an underspend on UC and elective care
- As recovery develops increased spend on all the above areas is expected, with A&E activity currently at 80-90% of pre-Covid
- Increased scrutiny on finances is expected between months 5-12

There was discussion around the opportunity to work differently and how services may be delivered in an alternative way. KWJ suggested that new contract arrangements may be required and that services and finance need to be aligned. MW confirmed that the Strategic Finance Group is focusing on best value and efficiency, with little priority paid to organisational impact. He suggested that there may be an opportunity to produce our own contracting framework and to consider an alternative flow of funds. He said that the appropriate strategic conversation will need to take place to discuss the sustainability of the LCO.

GL suggested that it was time to move away from a system based on income from increased demand and that place-based budgets and control totals need to be considered on a north east sector footprint with the NCA.

GL confirmed that a new proposition needs to be considered, whereby all health and social care budgets are centralised in the local system and the locality then demonstrates how these have been used effectively. MW suggested that September 2020 would be a realistic time for a model around local control totals to be produced.

ID	Type	The System Board:	Owner
A/06/01	Action	Timeline on the proposition for a NES/NCA local control total model to come to the July meeting	MW

9	**Values and Behaviours and the Way Forward**
	A short paper had been shared with the group, with a request that a workshop including LCO Board members, OCO leaders and the primary care network (PCN) CD's, takes place to progress this work.

ID	Type		Owner
A/06/02	Action	Details of the proposed values and behaviours workshop (agreed by GL, COG and KWJ) to come back to the next System Board meeting	KWJ

10	**Digital Plan**
	SK joined the meeting and gave a brief overview of the presentation which had previously been shared with the group. He explained the position Bury had come from in the digital agenda and the original aims, reminding the board that the deadline for full digitisation is 2030. He explained some of the current working and the digital changes the Covid period has allowed. He referred to the Bury Digital Strategy

	Group which is due to meet on 24 June and the importance of appropriate representation at this group. AS expressed concerns about digital exclusion creating health inequalities, from an access to equipment and ability to utilise point of view. MW noted that Digital is a key enabler but in the past there has been limited buy-in to solutions. SK concurred that not all organisations are currently signed up to a shared vision, but that appropriate representation, with the right level of seniority and requisite skillset, at the digital group should improve this situation, allowing the development of the digital opportunities available. JS suggested that issues around non-attendance at the digital group should be escalated within individual organisations and if necessary to this board. GL referred to the framework for the digital work stream which had begun pre-Covid. He committed to the necessary capacity to support Kate Waterhouse in order for the Digital Plan to be progressed. HH suggested some streamlining in the governance in that the digital sub-group of the Sustainability and Recovery Task and Finish Group should be stood down.
11	**Palliative and End of Life Care Diagnostic**
	LD introduced the AQuA representatives to the meeting, explaining their role in this piece of work over the last 6 months. The diagnostic report, 2 appendices and an overview presentation of the work had previously been shared with board. TR highlighted some of the main findings of the diagnostic work: • Currently no specific commissioning arrangements in place • No system wide data set available • Currently 7 different templates for recording care plans • No advanced care plan in place • 10 different IM&T systems of recording in place TR suggested that there is now a collective opportunity to build on integration, to co-design the patient journey, to strengthen financial and commissioning arrangements and create stronger links with other programmes. KWJ confirmed that the LCO Board had approved the request to move to the design phase of this work at its meeting on 17 June and rated this programme of work as a high priority. MO'D pointed out that many of the findings had already been identified in last year's commissioning framework and that the link between these and the AQuA work needs to be made. She said that more detailed data modelling is required to include the capacity needed in, for example, the hospice and the out of hours offer. LD agreed that capacity and demand are important issues to be addressed, but noted

	the difficulty of obtaining meaningful data. She said that design of a new model and contracting re-design were the next steps which needed to happen in tandem. LD remarked on the positive work that has happened between palliative and EOL teams during the Covid period, but noted that to sustain and develop these the modelling and contract re-design work now needs to be developed. JS suggested that a further conversation needs to take place on where this work programme should sit, suggesting that UC is not the correct place for it.

ID	Type	The System Board:	Owner
D/06/01	Approved	Approved the proposal to move to the next stage of the Palliative and EOL work	LD

12	**Closing Matters**
	Format of Future Meetings JS suggested that in order to get the best discussion from this senior decision-making group it would be better to avoid presentations and lengthy documents. He asked that future papers are clear in what is being asked of the board. He asked that the Recovery item is given greater prominence and moved higher up the agenda for future meetings.

Next Meeting	**Date: 21 July 2020, 10-12, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

Title	**Minutes of the Bury System Board** **21 July 2020**
Author	Jill Stott, LCO Governance Manager
Version	1.0
Target Audience	Members of the Bury System Board
Date Created	July 2020
Date of Issue	
To be Agreed	August 2020
Document Status (Draft/Final)	Draft

Document History:

Date	Version	Author	Notes
23.07.20	1.0	Jill Stott	Draft Minutes submitted to MO'D for checking
28.07.20	1.0		No amendments
Approved:			
Signature:			.....

Bury System Board

MINUTES OF MEETING
21 July 2020, 10.00 – 11.50 Via Teams **Chair –** Dr Jeff Schryer

Members Present:

Dr Jeff Schryer, Chair Bury CCG (Chair) (JS)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Mr Mike Woodhead, CFO, Bury CCG (MW)
Mr Simon Featherstone, Interim Chief Officer/Director of Nursing, Bury Care Organisation
Ms Karen Dolton, Executive Director Children's Services, Bury Council (KD)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Ms Mui Wan, Associate Director of Finance, Bury LCO (for Mr Craig Carter, Director of Finance, NCA) M Wan
Ms Margaret O'Dwyer, Director of Commissioning & Business Delivery/Deputy Chief Officer, NHS Bury CCG (MO'D)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council (AS)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Dr Kiran Patel, Medical Director, Bury LCO (KP)
Ms Sian Wimbury, Deputy Managing Director, PCFT (SW)

Others in attendance:

Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Mr Matthew Wright, Strategic Lead, Programme Management, OCO (M Wright)
Dr Sanjay Kotegaonkar, Clinical Lead IM&T Bury CCG (SK)
Ms Jill Stott, LCO Governance Manager (JMS)

Apologies

Apologies for absence were received from:

- Cllr Eamonn O' Brien, Leader of the Council
- Mr Keith Walker, Executive Director of Operations, PCFT
- Dr Daniel Cooke, Clinical Director, Bury CCG
- Mr Craig Carter, Director of Finance, NCA
- Ms Julie Gonda, Interim Executive Director, Communities and Wellbeing
- Mr Chris O'Gorman, Independent Chair, LCO Board
- Ms Kath Wynne-Jones, Chief Officer, Bury LCO
- Ms Lesley Jones, Director of Public Health, Bury Council

MEETING NARRATIVE & OUTCOMES

1.	**WELCOME AND APOLOGIES**
	JS welcomed those present to the Bury System Board and introductions took place. Apologies were noted as outlined above.
2.	**DECLARATIONS OF INTEREST**
	Members were asked to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Bury System Board. None were declared.
3.	**MINUTES OF LAST MEETING (18 June 2020) /ACTION LOG**
	The minutes of the previous meeting were agreed as a correct record. The Action Log was noted, and updates were recorded within the log accordingly.
4.	**Recovery Plan - update**
	Delivery of the 10 Point Plan GL gave an overview of the Bury 2020/21 Emergency Recovery Plan which had previously been shared with the group. He explained the need to connect the immediate (0-6 months) requirements of this plan with the wider health and care recovery plan, with a focus on controlling infection rates, planning for a Covid-driven recession and building resilience across the Bury system. GL emphasised the 3 key principles behind this work: 1. Targeted support to the individuals, families, communities and businesses most in need 2. A collective approach to the work, joining up communities, the voluntary sector, public services and businesses, with the community hubs being a focal point for this 3. Pace and decisiveness to be a key part of this work, as has been the case during the pandemic period GL noted the key role that health will play in all of the recovery priorities outlined in the plan and the need for the OCO and LCO to support these programmes of work. GL referred to the health and care priorities and said that focus would be on: • Integrated Neighbourhood Teams (INTs) being brought back to full strength with the inclusion of the Mental Health (MH) and social prescribing element and a further connection with the community hubs • Active Case Management (ACM) process to be back into operation, using the multi-disciplinary team (MDT) approach • Support to Primary Care, residential care homes and domiciliary work • Support to the Track and Trace programme, particularly for the most vulnerable, who may be required to self-isolate and require support from the community hubs Responding to a question from CJ on how the impact of the priorities would be measured GL explained that KPIs are in development, that the delivery aspects of the plan are clear and accountabilities agreed. He emphasised that many of the issues

are around inequalities and that the intention is for data to provide information on gaps across Bury and comparisons with other areas.

MO'D suggested that baselines needed to be developed for each programme, with greater granularity of detail and that members of this board should hold each other to account against delivery.

Responding to a question from HH on the Bury Council's wider health and care plan and the long term vision for Bury GL explained that the recovery programme will be the same as that outlined for the first 2 years of the Bury 2030 Strategy. He reported that a draft Bury Strategy 2030 document would be available in September or October and that it will align with the 10 Point Plan.

Responding to GL's update LD noted that the INTs have been re-instated and that blending from a number of groups into the INTs is already happening via other programmes. She said that the wider neighbourhood structure now needed to be put in place.

LD suggested that the rehab offer outlined in the plan was wider than the BEATS programme and that a better offer incorporating health aspects could be incorporated into the plan. She also suggested that the section on Urgent Care (UC) would benefit from re-wording.

LD highlighted that the Working Well initiative would link well with the LCO's Workforce Hub initiative due to the offer around health and care jobs. GL agreed with this, but also noted the pressures the social care system will be under and the intention to push for a suitable funding model to support this area.

LD emphasised the need to have clarity of purpose and on the expected outcomes for the neighbourhood work, so that residents are empowered to self-care and the appropriate cohort is targeted for support.

WB suggested that the OCO and LCO should work on a planned programme of alignment on neighbourhoods in the context of the wider ambition of the neighbourhood work so that a single version of the ambition can be described and delivered. He reported that he and Kath Wynne-Jones plan to discuss this further.

SH noted the VCFA's key role in the self-help agenda and asked that the wording on this in the action plan is made more explicit.

Health and Care Recovery Plan

An update presentation had been previously shared with the Board outlining progress to date and detailing the programmes of work in the 3 phases of the recovery work. This included:

- Programme highlight report
- Proposals for removing organisational boundaries across key work streams
- Improved neighbourhoods and population health
- Enabler update
- What does good look like?
- Key interdependencies

M Wright explained that work was underway to demonstrate success factors and their phasing, which would include the impact on services and service users. He reported that increased content is being developed in each of the programmes along with a process to show progress on delivery.

There was discussion around some of the key challenges in this work. MW listed some of these as being:

- A lack of understanding that Recovery is the "only show in town" in Bury
- Concern that following a successful system response to the emergency situation there is now a risk of returning to former ways of working
- Question over the Bury system having the necessary knowledge and skills to develop complex programmes
- Agreement needed on the culture which will facilitate a transformed system

HH noted that most elements of the 10 Point Plan could be easily incorporated into the Health and Care Recovery Plan. He explained that the patient voice would be an integral part of the on-going evaluation work.

SF highlighted the need for key aspects of this work to be done at pace, specifically the work around measurement and potential demands on services given that it is only 8 weeks until the winter period begins. He suggested that unless the pace of the work is increased there will be a challenge in meeting the necessary milestones, both at a local and national level.

GL agreed that this needed to be treated as an urgent exercise given the focus on a number of areas: winter pressures, managing infection rates, reforming the health and care system, potential increases in debt, unemployment and poverty. He explained that the aim is for the 10 Point Plan to be enacted by October/November and that an "attitudinal" approach to change will be a key element to the success of this work.

WB queried whether there was confusion across the system due to the range of recovery plans in place, with individual organisations holding their own plans. HH explained that provider plans will align with the overarching Bury plan, avoiding contradictions between them. He confirmed that there is work to do in the OCO around the messaging to internal teams on the priority of this work.

LD confirmed that the LCO Board and Management Team regularly discuss recovery but it was unclear how the messages were reflected back into individual organisations.

The importance of Communications in this issue was recognised and CJ noted the sometimes competing requirements of GM, NHSE and communications to the public.

As part of his summary of this item JS highlighted the need for a focus on cohort analysis and outcomes/metrics work. As part of this he commended the BI Team on their excellent work on providing data during the Covid period.

LD noted that as part of the cohort analysis work there needed to be an awareness that in some cases baseline information will not be available and that a different approach to measuring outcomes may be required.

ID	Type		Owner
A/07/01	Action	Draft Bury Strategy 2030 to come to this board	GL

		in September or October	
ID	**Type**		**Owner**
A/07/02	Action	LD to amend the wording around UC in the 10 Point Plan	LD
ID	**Type**		**Owner**
A/07/03	Action	SH to amend the wording around the VCFA's role in the 10 Point Plan	SH
ID	**Type**		**Owner**
A/07/04	Action	Communications around Recovery to be an item on the next agenda	JS
ID	**Type**		**Owner**
A/07/05	Action	Details on the process for measuring impact in the Recovery work to be an item on the next agenda	HH

5.	**Children's Recovery Plan**
	The draft Children's Recovery Plan had been shared with the board and KD explained that this is a working document, so will continue to develop. The plan outlined the plan on a page, risks, a SWOT analysis and the detailed recovery areas and their timelines. KD noted that the plan had been agreed pre-Covid but had now been amended in light of the pandemic; she explained that a key part of the thinking behind it had been about reviewing previous progress and the current position and then planning for the future. She confirmed that elements of the health and care recovery plan are now incorporated into the document. KD reported that the Children's Strategic Commissioning Partnership had met for the first time last week. This committee includes the Children's Trust Partnership and will report into the Strategic Commissioning Board. AS raised concerns about the number of children/young adults not in school, training or employment. She highlighted the need for an increase in offers from across the public sector and a further commitment to encourage the private sector to make a similar increase in offers. JS noted the value of the plan but questioned how it should best link in with other pertinent areas of the system e.g. vaccination programmes, ACM programme HH referred to the health and care charter for children which includes information from a range of programmes; he suggested that this is shared with KD for review. LD also referred to the interdependencies of programmes relating to children which are in place across the system, e.g. the UC charter and health teams in the community providing services for children. She reminded Board about the review of the INTs and the ACM process which had taken place at the end of 2019; this included reference to an all-age model for neighbourhoods. GL suggested that borough-wide Covid recovery would be connected by the timelines in the various plans, but that the focus needs to be on the immediate phase. He said that the neighbourhood model would act as the vehicle for connecting the various programmes of work and that the necessary pace is key to the success of the recovery work. He also noted the importance of relationships across the system, with

	a commitment to act as a single team for Bury, working for its residents.
6	**Strategic Finance Update**
	MW's presentation had been shared with the Board in advance of the meeting. He highlighted the main points from it: • Scale of the challenge - £120m savings required from the CCG/council over 5 years • Suggestion that work streams are allocated savings targets as a matter of urgency • Strategic finance work stream is focused on system savings, agnostic of organisational boundaries • Proposals on an NES control total planned for the end of September • GM expected to have its own system control total so the NES's to be a sub-set of that • Unprecedented financial uncertainty in the system with NHS financial operational guidance still awaited • Uncertainty around whether Transformation funding will still be available • On-going discussions are taking place with regards to funding for the LCO and its infrastructure HH pointed out that colleagues are sometimes nervous of developing financial targets and suggested that indicative targets may be a way forward; he noted that increasing secondary care costs may work against these so that the necessary caveats would need to be in place. MO'D reported back from the NW Covid recovery briefing which she had left this meeting to join: indications are that financial operational guidance is not expected until w/c 27 July and that there are suggestions that block arrangements will remain in place until the end of the year. LD reported that issues around Transformation funding had been discussed at LCO Board; she highlighted that some schemes are due to end in September next year. She also raised concerns about funding for the UC programme and its implementation, referring specifically to the lack of monies for capital expenditure. LD and CC are due to meet to discuss re-modelling options in the light of this. Action:

ID	Type		Owner
A/07/06	Action	Monthly Finance update to come to this Board, with details of the NES control total proposal to come to a Sept or Oct meeting	MW

7	**Digital Strategy Update**
	Digital Charter for Health and Care Recovery SK joined the meeting to outline the main highlights from the programme charter which had been previously shared. He explained that digital programmes are not currently in

alignment and that more work is needed on “what does success look like?”

SR explained that meetings of the Bury Digital Strategy Group have started to take place and the intention is that this will be the forum for finding solutions to digital issues across the system.

HH remarked that the charter still does not feel like a system-wide document and noted the gaps from some of the key organisations.

MW agreed that this is a fundamental piece of work across the system and should be viewed as high risk due to the lack of complete participation by all parties.

GL emphasised the need for full engagement from all partners at the Digital Strategy Group and the requirement for adequate capacity to support this programme of work. He confirmed that he is due to meet with SK and Kate Waterhouse on 24 July to discuss these issues in greater detail.

LD suggested that the virtual hospital work should be included in the Digital programme charter.

In summing up the item JS noted that the Board recognised the charter but noted the need for further development and input from all system partners. The Board also recognised the capacity issue in trying to deliver such an extensive programme of work.

Minutes of the Digital strategy group 24 June 2020
These had been shared for information.

Information Governance
There was discussion around IG and where it should sit in the system. LD referred to the possibility of a joint IG role for the LCO/OCO if the necessary funding remains in place.

It was agreed that the IG work stream should sit within the Bury Digital Strategy Group.

Via the Chat facility LD confirmed that she would be happy to link in with Kate Waterhouse and WB for a joint conversation re IG and progess made via the LCO.

Via the Chat facility SH and SR agreed to connect up to discuss the voluntary sector’s involvement the digital and IG agenda.

ID	Type		Owner
A/07/07	Action	Update report on progress with the Digital agenda and capacity to come to the next Board meeting	GL
ID	**Type**		**Owner**
	Agreed	It was agreed that the IG work stream should sit within the Bury Digital Strategy Group.	

ID	Type		Owner
A/07/08	Action	Board members to ensure appropriate representation from their own organisation is in place at the Bury Digital Strategy Group	All
ID	**Type**		**Owner**
A/07/09	Action	GL to confirm with relevant parties that IG sits within the Bury Digital Strategy Group	GL

8	**Closing Matters**
	Bury System Board Term of Reference JS alerted the group to personnel changes that have resulted in the current ToR being out of date and a need to review these. It was agreed that WB, KWJ and Lisa Featherstone should meet to discuss and the revised ToR to be shared at the next meeting. **Thanks to Margaret O'Dwyer** As this was her last System Board meeting, JS thanked MO'D on behalf of the Board for all her hard work and dedication to making it a success. He referred to her key role in the original design of this Board and wished her well in the future.

ID	Type		Owner
A/07/10	Action	WB, KWJ and Lisa Featherstone to meet to discuss this Board's terms of reference; revised version to be shared at the next meeting.	JS

Next Meeting	**Date: 19 August 2020, 2-4pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

Title	**Minutes of the Bury System Board** **19 August 2020**
Author	Julie Hall, Personal Assistant, Bury CCG
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Date	Version	Author	Notes
21.08.20	1.0	Julie Hall	Each item forwarded to presenter for checking and amendments made.
25.08.20	2.0	Julie Hall	Minutes forwarded to Chair for any final amendments.
Approved:			
Signature:			

Bury System Board

MINUTES OF MEETING
19 August 2020, 2.00 - 3.30pm Via Teams **Chair –** Dr Jeff Schryer

Members Present:

Dr Jeff Schryer, Chair Bury CCG (Chair) (JS)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Dr Kiran Patel, Medical Director, Bury LCO (KP)
Ms Sian Wimbury, Deputy Managing Director, PCFT (SW)
Mr Craig Carter, Director of Finance, NCA (CC)
Mr Chris O'Gorman, Independent Chair, LCO Board (CO'G)
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)
Ms Mui Wan, Associate Director of Finance, Bury LCO (for Mr Craig Carter, Director of Finance, NCA) (MW)
Dr Daniel Cooke, Clinical Director, Bury CCG (DC)
Mr Simon O'Hare, Associate Chief Finance Officer, Bury CCG (SO'H) (representing Mike Woodhead)

Others in attendance:

Ms Lesley Jones, Director of Public Health, Bury Council (LJ)

Apologies

Apologies for absence were received from:

- Cllr Eamonn O' Brien, Leader of the Council
- Mr Keith Walker, Executive Director of Operations, PCFT
- Ms Julie Gonda, Interim Executive Director, Communities and Wellbeing
- Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council
- Mr Mike Woodhead, CFO, Bury CCG
- Mr Simon Featherstone, Interim Chief Officer/Director of Nursing, Bury Care Organisation
- Ms Karen Dolton, Executive Director Children's Services, Bury Council
- Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council
- Ms Kate Waterhouse, Joint CIO, Bury Council and Bury CCG
- Mr Martin Clayton, Chief Officer, Bury GP Federation

MEETING NARRATIVE & OUTCOMES

1.	**WELCOME AND APOLOGIES**
	JS welcomed those present to the Bury System Board. Apologies were noted as outlined above.
2.	**DECLARATIONS OF INTEREST**
	Members were asked to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Bury System Board. None were declared.
3.	**MINUTES OF LAST MEETING (21 July 2020) /ACTION LOG**
	The minutes of the previous meeting were agreed as a correct record. The Action Log was noted, and updates were recorded within the log accordingly.
4.	**Recovery and Transformation Programme**
	The Programme Charter for the Bury Health and Care Recovery and Transformation Programme had been shared in advance of the meeting. HH provided an update on the Charter which included the overarching structure which is different to previous versions shared. Two additional sub groups have been added; Childrens, and Community based Health and Care which includes primary care and other pieces of work taking place. It was felt this provided more logical coordination of the work taking place. The focus on recovery and transformation is much clearer now; the overarching Charter is smarter than before. The work from the sub groups will include what success looks like and key points including finance and what this will look like in the new world. WB commented that Bury is working towards a single comprehensive recovery and transformation plan as a system to try and work towards a more connected community health and care service. SRO's are being held to account in the delivery of the programme. The Charter will be strengthened by the objectives and targets within each transformation programme. The work undertaken to commence alignment to financial savings and challenges directly into these programmes of work will be described in more detail in the finance update following this item. JS suggested success needs to be defined and gave reducing 25% of deflections from A&E as an example and asked how the qualitative and quantitative elements will be captured to show a difference is being made. WB reported that Business Intelligence (BI) teams across the system including the LCO are working on an outcomes and performance framework as a whole, to produce a more integrated framework; some outcomes are less easy to quantify than others. The structure of meetings is missing elements around qualitative experience of patients; more work is needed around this in terms of person centred approach models. LD commented that the LCO is keen on a person centred approach and has lots of family and user experience around palliative and end of life care. Discussions are now underway as to how this can be achieved; however the challenges around COVID has affected the speed of this work.

	LJ welcomed the idea of a single outcomes and performance framework and suggested ensuring impact on equality and inequity is measured across the different groups. KWJ suggested the LCO would need to revisit metrics in terms of what the new outcomes framework might look like. LD queried whether a borough wide approach could be taken; how lived experience could be built into improvement stories and how it would be shown that improvements had been made. The LCO Management Board receives improvement stories on a regular basis, joint work across wider systems could be undertaken on that. HH responded that lived experience and patient experience is powerful way of getting views across. Analysis and a retrospective piece of work is important, it would be expected improvement is seen in the evaluation work that has been undertaken during COVID. It needs to be defined what improvement is sought and whether that has happened or not. JS commented that improvement can be sequential; the different ways of looking at population experience and the people providing the care needs to be triangulated. The transformation hypothesis which needs to be achieved is a targeted neighbourhood response to reduce health inequalities. LJ referred to transformation and suggested looking at how to build in action learning in terms of how work is undertaken. All the components of the above discussion will be brought together as much as possible reflecting qualitative and quantitative analysis for the workshop in 2 months' time whilst recovery and transformation work continues.

ID	**Type**		**Owner**
A/08/01	**Action**	**A discussion will be coordinated between WB, KWJ and LD to discuss the performance framework/BI and triangulation of how to show successes and making a difference.**	**WB,KWJ,LD**
ID	**Type**		**Owner**
A/08/02	**Action**	**October meeting to be replaced by a workshop looking at recovery, outcome measures and behaviours.**	

5.	**Strategic Finance Update and the Recovery and Transformation Programme**
	SO'H provided a presentation which had been shared with the Board in advance of the meeting. The key points were highlighted: • Discussions are taking place across all partners around financial positions and the impact of this for the rest of 2020/21 and beyond. • The 2020/21 Health and Care savings plans developed pre COVID have been mapped across the Council and CCG Recovery and Transformation work programmes. SROs for each work programme to confirmed "cashability" of these in 2020/21 by 26th August and to develop financial values for new opportunities for 2020/21 and beyond by 9th September. • Of these initial plans, within adult care £2.5m of the savings were delivered to support a balanced budget at the start of the year.

- At this time the NHS financial framework for the rest of 2020/21 and beyond for both providers and commissioners is unknown.
- Across GM the NHS appears on course to spend over £150m more than the resources available to work within; Local Authorities face even greater resource gap of anything up £300m across the same time period. Therefore there is a significant financial issue with in keeping expenditure within actual and anticipated budgets for the rest of 2020/21.
- SO'H outlined the process for quantifying savings that can be delivered in the timescales highlighted earlier (26th August & 9th September). This will be alongside continuing to pursue activity reductions; the savings may not be deliverable this year or next but by continuing to do these expenditure will fall out of the system at a point.
- The high level timelines for SCB review and sign off of plans were outlined. These need to be firmed up. The amount the CCG is allocated for the rest of the year will have shape the CCG priorities that can be delivered.
- Across GM, the latest position for the phase 3 is that hospitals will be submitting activity numbers, in terms of what they can deliver this year and not what they are mandated to do; this will likely cause some friction and this will not improve the CCG financial position.
- Some likely cost pressures are not included in the £100m - £150m gap were outlined in the presentation.
- SO'H referred to the work being led by the GM Finance Advisory Committee (FAC). The FAC is going to bring forward difficult decisions that will have to be made to close the majority of the GM gap for 2020/21 only. Locally more will have to be done to balance the Bury Health and Care position in 2020/21 and in 2021/22.

HH commented that the presentation was commissioner focused; the System Board challenge is across the system in Bury including providers. CC remarked that he recognises the cashability and can deliver on achieving further improvements to make sure patients are seen in the right place at the right time. In terms of what is cashable, this will not be known until there is a clearer steer at the latter end of the financial year and from the framework going forward. A lot of work has been undertaken which can be shared which is reflective of what is happening on the Provider side across GM. CC reported a £4m per month deficit over and above the existing deficit due to COVID for the NCA. There are over £50m of COVID costs which is causing a stepped change in finances.

HH referred to the process for reviewing savings and determining new targets and commented he would like to see the positive side of the work being undertaken around recovery kept as a separate dialogue. Some things will make savings and have delivered in terms of service redesign; as an aside to that describe why savings cannot be delivered in year but outline what benefit there has been to patients and systems.

SO'H reported that there are plans to describe what can and cannot be achieved and include the positive side in terms of differences in activity and what can be delivered. Non delivery of things that are beyond the CCGs control will be added at the end.

KP asked if the difficult decision/options that may be presented in the next 6 weeks would be shared with this forum or wider. KP also asked if all Providers have been made aware of the situation so they are not hearing about it outside of forums here if there needs to be changes to pathways. Everyone needs to understand the challenges. CC commented Providers will have received messages from the LCO Board; it is not clear what the magnitude of questions will be.

It is difficult to say what action is being taken due to the financial constraints. There is low morale among staff, further correspondence will be shared once decisions are made.

WB commented that the message which needs to continue to be given to colleagues across health and care is to continue to drive and increase the pace of the transformation programme which will be motivating for people and patients.

HH suggested it would be helpful to have on an ongoing basis reports covering the system rather just commissioners. CC agreed to work on this for future meetings.

ID	Type		Owner
A/08/03	**Action**	**Future system finance paper should reflect the system finances therefore include providers.**	**CC**

6. Phase 3 Planning

WB referred to the Phase 3 guidance received recently with regard to starting up activity between now and winter to 90 – 100% levels in addition to winter planning and the work being undertaken on transformation programmes.

A template has been circulated which requires submission to GM; each area will be required to complete its own version of that. BI and Finance teams are currently working on this piece of work. The first submission is to be submitted on the 24 August with a date for the final version to be submitted towards the end of September.

A difficult conversation is to be had between providers and commissioners in terms of the expected activity levels; this is currently being worked through. There are a number of challenges in order to get services stood back up to the required level.

The CCG is keen that the phase 3 submission reflects some of the transformation ambition and hopefully delivery on urgent care and planned care.

The System Board will need to consider and approve the version of the template for submission including the narrative of each element. The date of the next meeting is too late and so the template may need to be circulated for discussion to ensure all parties are supportive of the submission. The submission will then be brought to the meeting in September for formal ratification.

LJ commented that there is a lot in the phase 3 letter beyond activity and the financial elements; will someone be looking at how some components fit with transformation recovery programmes and how that dovetails with the work that is currently being undertaken. WB commented that this element should be looked at.

SW referred to feedback from a GM level and how that would be fed though appropriately. WB reported that the submission would be the same as the Mental Health submission; it needs to be ensured what is happening locally is reflected. WB agreed to pick this up.

ID	Type		Owner
A/08/04	**Action**	**The draft phase 3 submission will be shared with this Board for comment and will be retrospectively signed off at the September meeting.**	**WB**

7	**Covid Update**

LJ provided a presentation updating the System Board on COVID, the key points were outlined:

- The North West has the highest percentage of cases across the UK.
- Latest data on the CCG website shows an increase in cases in Bury which can change day to day.
- The 7 day rolling average shows that Bury is holding steady, but this could still increase/decrease in trends going forward.
- Most cases are predominantly in the 18 – 39 age groups.
- Geographically cases are across the borough; however a predictable pattern is beginning to emerge which mirrors geographical inequalities.
- It is hoped the average number of contacts per case will be reduced since restrictions have been brought in.
- The outbreak plan was outlined which includes:
  - **Testing**

    There are various national models which are not fit for purpose. Bury is working on establishing its own local testing sites across Bury to increase accessibility of testing. This is being led by Catherine Jackson, supported by Carolyn Trembath. Seven local neighborhood walk up testing sites are being identified and being set up ready to commence testing. The roll out of wider testing locations commences on the 24 August with the first two sites at the Mosses Centre and Chesham.
  - **Contact tracing**

    There is a GM Proposal to develop locally supported contact tracing, this work is in development. A project team has been set up to support local contacting. The new model will not go live until there is assurance it is safe to go and will be successful; it is hoped there will be additional national resources available to help with this. The aim is to be operational for the 1st September across GM.
  - **Enforcement**

    GMP & the Council are working with partners undertaking proactive work with the hospitality services across the Borough; warning letters issued will be followed up. The 25 highest risk businesses have been identified based on their size, the nature of their operation or historic lack of compliance with health & safety measures. All 25 businesses are beign proactively followed up to provide advice and gain assurance they have appropriate COVID-19 measures in place.
  - **Communication and community engagement**

    Proactive work is being undertaken with community groups to get messages out including circulating flyers.

    There is a staff briefing on Friday 21 August for all CCG/LA staff, an invite via events team will be forwarded to all staff; for those unable to join the live meeting it will be recorded and made available to staff.

    The reopening of schools in September may have an impact on transmission rates to some extent. Workplaces need to be as COVID safe as possible to enable adults to go back to work.

KWJ asked whether schools would reopen in September if GM restrictions were still in place. LJ reported that a priority for Directors of Public Health and national Government is for schools to reopen. All restrictions have potential harm but after

careful consideration not opening schools would be a last resort and it is fully expected they will be reopened as planned.

JS raised a question on behalf of CF relating to the walk up testing centres; particularly in respect of every effort having been made to stop people from turning up for things to avoid queues. The walk up testing centres appear to contradict that effort.

LJ confirmed there are nationally approved protocols and guidance re walk up centres; people will be doing their own test and will be managed via safe queuing. It is not expected that everyone will come via the walk up route, there will be still be drive through testing, and home testing. The walk up testing is for a cohort of people where other options are not acceptable and to make testing as appropriate for local people as possible, i.e single sex sessions etc.

SH queried what impact the recent announcement about changes at Public Health England (PHE) will have. LJ commented that as this is a very recent announcement the implications on the wider role within health protection are still awaited. There is no notable impact as yet; at this moment in time Directors of Public Health are still working in strong partnership with PHE colleagues who are continuing to work with utmost professionalism, drive and commitment.

8 GMHSCP Locality Plan Evaluation - Interim Report (phase 2)

WB presented the report which supports the Locality Plan in 6 out of 10 districts across GM; 4 others made their own arrangements for the evaluation.

The report is an interim report for phase 2 of the work undertaken and relates to the field work undertaken some time ago. Colleagues may recognise the helpful caveats through lessons learned though all ambitious in terms of integrated commissioning and the Locality Plan.

The comments regarding the LCO are reflective of a point in time of the field work undertaken. There is a good story to tell in terms of moving the conversation forward; this was discussed at the LCO Board earlier today.

There are three requests of the System Board:

1) To recognise and sign off the interim report as phase 2 in a point in time;
2) The report stands alongside the evaluation of Bury's priorities and recovery and transformation plan;
3) Are there any reservations from the Board around sharing the report across the other 4 districts.

CO'G commented that the methodology used has not been useful in terms of capturing a wide range of views to enable a critical evaluation of the information. What is in the report about the LCO is not wrong but is not complete as it is a moment in time element.

CO'G also feels that the report should be shared in order to get value out of the money spent but with a caveat that it is recognised it was written in a point in time and the outcome of the method used.

KWJ commented that the report is factually incorrect in terms of the LCO scaling back and becoming integrated; at no time did the LCO stop managing services.

KWJ reported there had been no conversation with her or CO'G around this issue and until today neither had seen the report.

	LD commented that it would be interesting to see the evaluations of the other 4 districts. Many of the responses in the report are from the Bury community workforce; there are a lot of positives to draw on. KWJ suggested that when CordisBright undertake any further work they talk to the people who are involved and queried who provided the list of people to interview to CordisBright. LD confirmed it was a colleague in the Bury system who provided the list of Bury nominations. The report was considered as a System Board: ➢ There are some reservations re elements of the content and extracts. ➢ The System Board was pleased to see positive reports from the workforce. ➢ It was agreed clarity was needed regarding CordisBright next steps. ➢ The System Board is happy to share the report with the other 4 districts with the caveat as discussed and would like to see their reports in return.

ID	Type		Owner
A/08/05	**Action**	**GMHSCP Locality Plan Evaluation report to be shared with the other 4 districts with the caveat as discussed and would like to see their reports in return.**	**WB**

9	**GMHSCP Future Review – Managing Engagement Conversations**
	WB reported that there are a number of concerns around the GM Partnership arrangements to test and explore their services taking place in challenging circumstances. This is a genuine and appropriate attempt to look at this wider. Appendix 1 contains a set of questions to support the framing of the discussions and to ensure there is an opportunity as a system to reflect on some of the questions and come to the same shared view in response. WB suggested the System Board members reflect on the questions and forward views to him to collate. KWJ reported that the LCO has already provided a full response to the questions which can be shared with the System Board. KWJ comment that support was sought from the Academic Health Science Networks (AHSN) as the LCO does not feel connected it would find it difficult to answer the questions from a commissioner / provider perspective and to know what the impact to GM would be. JS commented it would be useful if the LCO responses were shared. There is an opportunity to reply as a whole system. LJ referred to previous consolidated questions from the Kings Fund and aligning those links. One thing to come out from that was GM cannot see how far Bury has come as a system compared to other places. LJ commented it would be interesting to explore more around how the partnership became an agent rather than another Tier of management and how GM teams locally see how that progresses going forward. There is an opportunity to help shape that relationship going forward.

ID	Type		Owner
A/08/06	**Action**	**LCO to share its response to the GMHSCP Future Review – Managing Engagement Conversations questions.**	**KWJ**

A/08/07	**Action**	**WB agreed to forward a draft response to the GMHSCP Future Review – Managing Engagement Conversations questions for the Board's consideration and comments.**	**WB**

10	**Closing Matters**
	There were no closing matters. JS commented there had been a useful discussion around transformation programme monitoring going forward and what the outturn might look like; some great work is being undertaken. Key points to note: • October meeting to be replaced by a workshop looking at recovery, outcome measures and behaviours. • Digital needs to be a standing item on the agenda, monthly report to be requested from Kate Waterhouse and Sanjay Kotegaonkar. Report should also highlight any problems with engagement from colleagues. • Next meeting will include a discussion about a new TOR for System Board. • System finance paper should reflect the system finances therefore include providers. • Draft response to the GMHSCP Future Review – Managing Engagement Conversations questions to be shared for the Board's consideration and comments. • The draft phase 3 submission will be shared with this Board for comment and will be retrospectively signed off at the September meeting.

Next Meeting	**Date: 16 September 2020, 1.30 – 3.30pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521