AGENDA FOR

STRATEGIC COMMISSIONING BOARD

To: All Members of Strategic Commissioning Board

Councillors : J Black, F Boyd, Dr D Cooke, C Cummins, D C Fines, H Hughes, D Jones, N Jones, G Little, D McCann, E O'Brien, A Quinn, T Rafiq, Dr J Schryer (Chair), A Simpson, L Smith, T Tariq, P Thompson, C Wild and M Woodhead

Dear Member/Colleague

STRATEGIC COMMISSIONING BOARD

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

Date:	Monday, 7 December 2020
Place:	Virtual Meeting
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 **DECLARATIONS OF INTEREST** *(Pages 3 - 12)*

3 **MINUTES OF THE LAST MEETING** *(Pages 13 - 26)*

4 **PUBLIC QUESTIONS**

5 **CHIEF EXECUTIVE AND ACCOUNTABLE OFFICER UPDATE** *(Pages 27 - 84)*

Future of Integrated Care Working

6 **INCLUSION STRATEGY** *(Pages 85 - 104)*

7 **2020/2021 FINANCE REPORT** *(Pages 105 - 160)*

a **2021/2022 AND FUTURE YEARS** *(Pages 161 - 194)*

8 **COUNCIL/CCG RISK REPORT** *(Pages 195 - 218)*

9 **COVID 19 UPDATE**

10 **SUPERVISED CONSUMPTION** *(Pages 219 - 226)*

11 **LCO BUSINESS CASE FOR FURTHER DEVELOPMENT OF UTC** *(Pages 227 - 262)*

12 **CONSIDERATION OF FUTURE ARRANGEMENTS FOR THE PROVISION OF COMMUNITY HEALTHCARE SERVICES** *(Pages 263 - 284)*

13 **LCO SERVICE AND INFRASTRUCTURE COSTS** *(Pages 285 - 304)*

14 **MINUTES OF MEETINGS - BURY SYSTEM BOARD MEETING** *(Pages 305 - 322)*

15 **ANY OTHER BUSINESS AND CLOSING MATTERS**

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	07 December 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 7 December 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					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						

Implications						
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	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
December 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	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				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.
		Bury Metropolitan Arts Association (The Met)		X			Trustee			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Jewis Labour Movement		X			Vice 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	Registered Nurse	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.
		NHS England / NHS Improvement (Cheshire & Merseyside)					23/09/2020			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 Director	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.
		JCI			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

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 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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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 Ltd	X							General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		KM Solicitors Ltd								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.
		Bury South CLP		X			BAME Officer			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.
		Unite Trade Union		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			SRA 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 *Strategic Commissioning Board	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.

Members - Voting

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Cllr Lucy Smith *(cont)*	Councillor Bury Council *Strategic Commissioning Board	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.
		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.
		Mersey 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.
		Whitefield 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.
		GMB Trade Union		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.
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.
		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 cliamants 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	07 December 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 2 November 2020.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the Minutes of the Meeting held on 2 November 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					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /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 2 November 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	November 2020
Date of Issue	November 2020
To be Agreed	December 2020
Document Status (Draft/Final)	Draft
Description	Minutes of the Strategic Commissioning Board on 2 November 2020

Document History:

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

Approved:	
Signature:	..... **Dr J Schryer**

Strategic Commissioning Board Virtual Meeting

MINUTES OF MEETING
Strategic Commissioning Board Virtual Meeting 2 November 2020 16.30 – 18.30 **Chair – Cllr E 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
Mrs 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
Cllr Clare Cummins	Cabinet Member Corporate Housing Services, Bury Council
Dr Cathy Fines	Clinical Director, NHS Bury CCG
Mr Howard Hughes	Clinical Director, NHS Bury CCG
Cllr David Jones	Cabinet Member Corporate Communities & Emergency Planning, Bury Council
Mr Geoff Little	Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG
Mr David McCann	Lay Member Patient & Public Involvement, NHS Bury CCG
Cllr Alan Quinn	Cabinet Member Corporate Environment & Climate Change, Bury Council
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 Chris Wild	Lay Member, NHS Bury CCG
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 Donna Ball	Executive Director of Operations, Bury Council
Ms Lesley Jones	Director of Public Health, Bury Council
Mr Ian Mello	Interim Director of Secondary Care, NHS Bury CCG
Ms Sheila Durr	Executive Director of Children and Young People, Bury Council
Mrs Lisa Kitto	Interim Deputy Chief Finance Officer, 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	
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.
1.2	The Chair advised that the quoracy had been satisfied.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/01	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	Dr Schryer, Dr Cooke and Dr Fines declared an interest in relation to Agenda Item Number 6 – NHS Health Checks and Covid-19 in their roles as GPs within Bury and their respective practices having a financial interest in relation to the proposal. It was agreed that Dr Schryer, Dr Cooke and Dr Fines could remain present for this item but would not be involved in the discussion of the item.
2.6	Mr Hughes declared an interest in relation to Agenda Item Number 8 – Supervised Consumption in light of the report relating to pharmacy funding. It was agreed that Mr Hughes could remain present for this item.
2.7	Cllr Tariq reported that he had a new interest in respect of his new role at Oldham Healthwatch which would need to be captured on future Declaration of Interest registers. • **Declarations of Interest from the previous meeting**
2.8	There were no declarations of interest from the previous meeting raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/02	Decision	Noted the published register of interests.	

3	Minutes of the last Meetings and Action Log
	• **Minutes**
3.1	The minutes of the Strategic Commissioning Board meeting held on 5 October 2020 were agreed as an accurate record.
	• **Action Log**
3.2	The following updates were provided in respect of the Action Log: - • A/09/01 - It was agreed that the Joint Chief Finance Officer would review the funding for this area (Covid testing) 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. The Joint Chief Finance Officer reported that this risk had been built into the Financial Plan and therefore this action could be removed from the Action Log. • A/10/03 - Agreed that the revised financial plan should be approved by the Joint Chief Finance Officer and the Accountable Officer in consultation with the Joint Chairs of the Strategic Commissioning Board, Dr Schryer and Council Leader, Cllr E O'Brien. It was noted that the Financial Plan had been submitted and therefore this action could be removed from the Action Log. • A/10/04 - The Director of Community Commissioning and / or the report author will liaise with the Chair of the Health Scrutiny Committee to agree the proposed length of the consultation, the length of the consultation will therefore be agreed in consultation with the Chair of the Health Scrutiny Committee. It was noted that the Intermediate Care Consultation was currently underway and the outcome of the Consultation would be shared with the SCB at its meeting in January 2021.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/03	Decision	Approved the minutes of the meeting held on the 5 October 2020.	

4	Public Questions
4.1	There were no public questions raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/04	Decision	Noted the information.	

5.	Chief Executive and Accountable Officer Update
5.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG provided an update on the latest CCG and Council developments. It was reported that: - • National Lockdown arrangements would come into force from the 5th November - 2nd December 2020 in line with the recent Government announcement. • There were concerns in relation to the capacity of local acute trusts in terms of both Covid and non Covid system pressures. Other providers such as Primary Care, Community Health Services and Mental Health Services were also experiencing pressures. • Some of form of local restrictions were likely to be implemented after the national lockdown has come to an end. It was not clear at this stage whether this would be

	the equivalent to Tier 2 or Tier 3 arrangements however there was a need to ensure that there was effective communication to Bury people in terms of what any changes mean. • There would be challenges over the next 6 months in relation to increasing testing capacity. • Continued support was required to local businesses and individuals who have been adversely affected during the pandemic. Discretionary grants were available to support businesses. • In terms of vulnerable people, it was likely that some form of shielding would be required and support services would be available in this regard. • Discussions were taking place at national level in relation to mass Covid testing with a pilot being rolled out in Liverpool. There was potential for a similar mass testing programme being rolled out in Greater Manchester this however had not been confirmed. • The Town Centre Recovery Board was being reactivated to look at some of the key challenges / actions required over the coming months in response to the Covid impact. • A strategic approach was required over the next 6 months in terms of supporting staff with pressures, communications and engagement with communities most at risk.
5.2	The following comments / observations were made by Strategic Commissioning Board members: - • The need to consider the implications for the self employed people who have been adversely impacted upon as a result of the pandemic. • The need for a further discussion in relation to the implications that Covid has had on the budget position. There would be a further discussion at the Council Cabinet meeting in relation to the wider Council implications. • The use of terminology to describe the Covid vulnerable categories was confusing and clarification was requested as to whether there was now a greater cohort of people included within these groups. It was reported that the extremely clinically vulnerable category included individuals who were at very high risk of severe illness from Covid-19 and clinically vulnerable included individuals who were at an increased risk (mild asthma, ethnicity) but had no immune system compromise. • There needed to be an improvement in the Track and Trace system at both national and local level

ID	Type	The Strategic Commissioning Board:	Owner
D/11/05	Decision	Noted the update.	

6.	NHS Health Checks and Covid-19
6.1	*Dr Schryer, Dr Cooke and Dr Fines declared an interest in relation to this agenda item in their roles as GPs within Bury. It was agreed that Dr Schryer, Dr Cooke and Dr Fines could remain present for this item but would not be involved in the discussion of the item.*
6.2	The Director of Public Health presented a report in relation to the NHS Health Checks Programme and the associated impact of Covid-19. It was reported that: - • the NHS Health Check programme had been paused during the Covid-19 pandemic. This paper reported on how this affected GP practices in 2019/20 and also outlined a financial proposal to practices for Quarters 1-2 of 2020/21, whilst

	taking into account the targets and structure underpinning the programme, but ensuring that practices were not unduly impacted financially. • the NHS Health Check programme was a public health programme in England for people aged 40-74 which aims to keep people well for longer. It was a risk assessment and management programme to prevent or delay the onset of diabetes, heart and kidney disease and stroke. NHS Health Check was a statutory Public Health responsibility, funded through the Public Health budget. • general practice had been significantly affected by taking necessary actions in regard to Covid 19. Many, if not all practices, cancelled all routine appointments with both GPs and Nurses mid March 2020. This had a substantial effect on the delivery of NHS Health Check programme in the final month of the financial year 2019/20. • A fair resolution was proposed by Public Health for the payment of activity in 2019/20 which was outlined in Appendix A of the report . All financial payments have been made to GP Practices and the information was submitted on the Public Health England (PHE) portal for quarter 4. The NHS Health Check programme was then paused from April 2020. • In terms of the NHS Health Checks for 2020/21, as in previous years, the eligible population and distribution of invite targets was calculated at the beginning of April, once the year end information has been submitted. Figures for total eligible population were obtained from the Informatica system (Health Check IT system) and checked against the calculated figures sent from Public Health England. The figures with Public Health England have now been agreed and submitted for 2020/21. • In April 2020 most of the GP locally commissioned services were paused and the CCG proposed a financial remuneration package to GP practices. The table in Appendix B of the report showed a column "Budget 20/21". Unfortunately, for NHS Health Checks this suggestion was unworkable as it did not take into account the updated eligible population per practice and so Public Health have developed a proposal to rectify this situation. • Public Health England were working with Local Authorities in regard to how they expect areas to reintroduce the NHS Health Check programme as the pandemic continues from Quarter 3 onwards. Communication would be disseminated to practices once this is received. • In the meantime, and so as not to create cash flow situations within practices, it is proposed that a nominal amount be paid to practices in respect of expected performance of NHS Health Checks throughout 2020/21. • a payment rate of £12 per check was usually paid each quarter based on activity completed, for Quarters 1-3. The final payment was calculated based on the uptake rate achieved of their individual invite targets, (using a sliding scale of payment ranging from £12 to £25).
6.3	The Director of Public Health informed members that Bury had achieved the highest ranking for the delivering NHS Health Checks in England (based on cumulative data since April 2016) which was a remarkable achievement. The Director of Public Health commended all Bury GPs for their hard work within this area and extended a thank you to members of the Public Health Team for their efforts in the successful delivery of this programme. The Leader and Deputy Leader of Bury Council paid tribute to the GP and Public Health staff for this hard work which was invaluable in the early detection of disease.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/06	Decision	Agreed to the proposed changes to the calculation used to award a nominal payment in respect of NHS Health Checks (based on 6 months activity at 75% of a practices invite target.)	

7.	Covid Rehab Pathway
7.1	The Executive Director of Strategic Commissioning presented a report which outlined the Bury approach in response to the Greater Manchester guidance to support the short, medium, and long-term recovery and rehabilitation of people with confirmed or suspected Covid-19 in the GM localities. It was highlighted that this work was subject to ongoing review and development through the working group established.
7.2	The following comments / observations were made by Strategic Commissioning Board members: - • A question was raised as to whether this work would look at different ethnic groups including digital poverty. It was reported that these issues were already being explored further as part of this work in terms of ensuring the pathways are much wider than physical health. • There was a query as to whether this work fits with the Covid antibody testing work. It was noted that this line of testing did not neatly fit into this work at present.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/07	Decision	Noted the progress to date	
D/11/08	Decision	Supported the further iteration of the work as evidence and best practice emerges	

8.	Supervised Consumption
8.1	*Mr Hughes declared an interest in relation to Agenda Item Number 8 – Supervised Consumption in light of the report relating to pharmacy funding. It was agreed that Mr Hughes could remain present for this item.*
8.2	The Director of Public Health submitted a report in relation to supervised consumption of opiate substation medication for individuals with substance misuse through pharmacies. It was reported that as a result of Covid-19 supervised consumption had changed from mostly daily to almost exclusively weekly or fortnightly pickups of medications.
8.3	It was reported that no negative patient outcomes have occurred as a result of these changes over the last 6 months.
8.4	It was highlighted that Pharmacies who receive payments for supervised consumption have been supported through these changes which have resulted in significantly reduced activity and income. Pharmacies have received average pay for the months of April to June based on national guidance.
8.5	It was proposed from October 1st 2020 Pharmacies no longer receive average pay and receive payment for activity only in line with Greater Manchester (GM). It is also proposed that changes to move to a model of weekly and / or fortnightly medication are made permanent.

8.6	It was highlighted that this would result in significant savings to Bury Council, and would reduce existing budget pressures within the substance misuse budget by approximately £20,250 for 20/21, and £40,500 annually after that. In addition this would align with the Greater Manchester approach.
8.7	The following comments / observations were made by Strategic Commissioning Board members: - • Despite the report having Dr Cooke's name listed as the lead, the paper had not been signed off from a clinical perspective. • There appeared to be a lack of stakeholder engagement in respect of the proposals included within the paper i.e. Local Pharmaceutical Committee were not fully sighted. • Any quality, risk and safeguarding implications did not appear to be adequately covered within the report. • An Equality Impact Assessment was not included. • The need to ensure the proposals within the report are in line with NICE Guidance. • The need for a clear evidence base within the report as to why these changes would be beneficial from a clinical perspective as the report appeared to focus more on the financial savings element. • Whether there was any data to assess the temporary changes to supervised consumption as a result of Covid-19 had led to an increase in people buying street drugs / crime. • The initial changes to this scheme had been made as a result of Covid and there was a need for a more detailed clinical view on whether this change in approach was prudent in the long term.
8.8	The Chair highlighted that there had clearly been a process issue in the production of this paper which needed to be appropriately addressed as part of future processes. It was concluded that there was further work to undertake in respect of this paper and it was suggested that this item be deferred and brought back to the December Strategic Commissioning Board meeting for discussion.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/09	Decision	Agreed that the report should be deferred.	
A/11/01	Action	A revised version of the Supervised Consumption paper to be submitted to the December Strategic Commissioning Board meeting once the appropriate engagement, clinical, quality, risk and safeguarding implications have been fully reviewed.	Mrs Jones

9.	Covid +ve Community Bed Capacity
9.1	The Executive Director of Strategic Commissioning presented a report in relation to the additional arrangements for hospital discharge updated on 12th October 2020 to respond to the Covid-19 pandemic which mandated the delivery of designated Covid +ve units and is updated to include the commissioning of additional Covid +ve beds to respond to increasing demand.
9.2	The following comments/observations were made by Strategic Commissioning Board members: -

	• There was a need to ensure that GP Practices were aware of the alternate commissioning arrangements available.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/10	Decision	Approved retrospectively the commissioning of designated units for Covid +ve patients at Gorsey Clough Nursing Home and Killelea Intermediate Care Home in line with the request from the DHSC, with awareness of the financial risk resulting from the misaligned national funding guidance.	
D/11/11	Decision	Supported the responsive rapid commissioning of additional capacity in forthcoming months should it be required. This will take the form of additional designated care home beds and home care, accepting a paper will be presented for retrospective approval. This would need to link to the Urgent / Operational Decision processes within the CCG and Council	

10.	**Proposal for Mental Health provision as part of the Urgent and Emergency Care by appointment model at Fairfield General Hospital.**
10.1	The Executive Director of Strategic Commissioning presented a report to seek approval to commission mental health provision as part of the Urgent and Emergency Care (UEC) by appointment model at Fairfield General Hospital (FGH). The business case which had been received from Pennine Care Foundation Trust (PCFT) outlines a proposal for providing a sustainable, effective and financially viable UEC by appointment service at FGH.
10.2	It was reported that in light of the current Covid-19 pandemic and wider impact on the urgent and emergency system, this PCFT proposal is replacing the Core 24 Business Case that was developed in March 2020 (Pre Covid-19) to mobilise a Mental Health Liaison service across Bury and Heywood Middleton and Rochdale (HMR).
10.3	The implementation of the Greater Manchester (GM) UEC by Appointment model from December 2020 would introduce significant changes to how patients access urgent and emergency care services. It was therefore important to ensure potential anticipated demand for Mental Health services can be resourced and managed in a coordinated way.
10.4	The proposed business case from PCFT was requesting funding to develop a mental health UEC by appointment model for Bury which would be situated at FGH and be part of the wider front-end UEC streaming service.
10.5	The following comments/observations were made by Strategic Commissioning Board members: - • The concept of the model was supported however significant work was required in relation to the process part of the proposal. • The need to assess how this proposal fits in with the available mental health funding.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/12	Decision	Noted the content of the paper and supported the concept to Develop a Mental Health UEC by appointment model in Bury as part of the Urgent and Emergency Care (UEC) by appointment model at Fairfield General Hospital (FGH).	
A/11/02	Action	Agreed that further work in relation to the processes associated with the mental health model for Urgent and Emergency Care by appointment model at Fairfield General Hospital were required which would need to be worked up in conjunction with the CCG Chair, Dr Cooke and the Joint Chief Finance Officer.	Dr Schryer, Dr Cooke and Mr Woodhead

11	Any Other Business and Closing Matters
10.1	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/11/14	Decision	Noted the information.	

Next Meetings in Public	**Strategic Commissioning Board Meetings:** • Monday, 7 December 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 – November 2020

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

A/11/01	A revised version of the Supervised Consumption paper to be submitted to the December Strategic Commissioning Board meeting once the appropriate engagement, clinical, quality, risk and safeguarding implications have been fully reviewed	Mrs Jones.		December 2020	
A/11/02	Agreed that further work in relation to the processes associated with the mental health model for Urgent and Emergency Care by appointment model at Fairfield General Hospital were required which would need to be worked up in conjunction with the CCG Chair, Dr Cooke and the Joint Chief Finance Officer.	Dr Schryer, Dr Cooke and Mr Woodhead		January 2021	

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	07 December 2020	**Action**	Consider
Item No	5	**Confidential / Freedom of Information Status**	No
Title	Future of Integrated Care Working		
Presented By	Geoff Little, Chief Executive Bury Council & Accountable Officer NHS Bury CCG Will Blandamer, Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG		
Author	Will Blandamer		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The report provides an update on the Bury Health and Care System Future Working arrangements in the context of the 'Integrating care Next steps to building strong and effective integrated care systems across England' document that has recently been produced.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note and discuss the national policy context afforded by the NHSE Guidance circulated on 26 November 2020.

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:	
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?	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					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐

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

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

Bury Health and Care System Future Working

Will Blandamer

Executive Director – Strategic Commissioning/One Commissioning Organisation

1. Context

- NHS Long Term Plan – Integrated Care Systems on formal footing and receiving NHS budget
- GM Health and Care Partnership Review – next stage of 'Taking Charge'
- National Phase 3 letter – 'Typically 1 CCG per ICS'
- Primary Care Network Development
- Financial Challenge for Council and CCG
- COVID 19
  - Current and Long term effect of COVID 19 on health, and economy
  - New ways of working
- Provider Collaboration in the NHS
- Inequality – of outcomes, of access, of health life expectancy
- Digitalisation – e.g. Ask my GP, Outpatients, Tech enabled care.
- Our health and care transformation journey in Bury
- Bury 2030 ambition – focus on inequality

2. Assumptions

- Commissioning will be streamlined with NHS funding flowing to an ICS footprint
- Strong locality arrangements will need to exist to maintain a focus on ‘place’
- There will be some acute services commissioned/managed at a GM level – e.g. Commissioning of Christie services
- Place/Locality arrangements will bring together:
  - Commissioning and Provision
  - Clinical, political and managerial leadership
- Place/Locality arrangements need to have responsibility for the capitated budget for the place.
- Place/Locality arrangements create the conditions to accelerate the work of integrated neighbourhood teams rooted to primary care and the communities they serve.

3. Potential Timeline

- Indication that NHSE/I will produce high level strategy framework for ICS/CCGs in early spring
- Any potential legislation around the formality of ICSs and the number of CCGs later in 2021 to be effected from 1st April 2020
- GM working with NHSE/I to proactively describe a vision for the GM health and care system – “ICS ++” - submission before Xmas
- Localities to progress alignment/shadow ways of working January to March 2021
- Can expect the year April 2021 to March 2022 to be a preparatory period

4. GM Partnership Review – 8 Statements of Intent

- We are part way through a journey we are still committed to.
- The breadth of our ambition is broad but our delivery will be focussed on fewer objectives. These will address both the essentials of a high performing system and the unique opportunities which GM can excel at.
- Our GM model is consistent with the NHS ICS definition and provides us with the structures to ensure that we continue to work in a way that encompasses the widest possible definition of integrated public service delivery
- We believe there is merit in the establishment of a statutory entity at the GM level to provide a vehicle through which further delegation and devolution can take place
- We need to ensure that we have a consistent definition of our place based arrangements
- There are a limited, but critical, number of key enablers central the ambitions of collaboration and integration (these include Digital Transformation, Financial Flows and Reform, Workforce, Estates, Sustainability and Climate Change, for our Boards and Committees to reflect the communities we serve, engagement and involvement of our communities in our work)
- We strongly support an expanded role for Provider Collaboratives
- We will commit to a single decision making board (joint committee) in each locality, bringing together provision and commissioning, that can deliver accountability for decisions and budgets at place level.

5. GM System Commitments/Agreements

- We will commit to a single decision making board (joint committee) in each locality, bringing together provision and commissioning, that can deliver accountability for decisions and budgets at place level.
- There is merit in the establishing a statutory entity at the GM level to provide a vehicle through which further delegation and devolution can take place (our version of an ICS that is broader than others as includes widest possible public service integration)
- There will be a consistent definition of our place based arrangements
- We strongly support an expanded role for Provider Collaboratives
- There are a limited, but critical, number of key enablers central the ambitions of collaboration and integration (these include Digital Transformation, Financial Flows and Reform, Workforce, Estates, Sustainability and Climate Change, for our Boards and Committees to reflect the communities we serve, engagement and involvement of our communities in our work)

The GM difference – collective Clinical, Political, and Managerial leadership

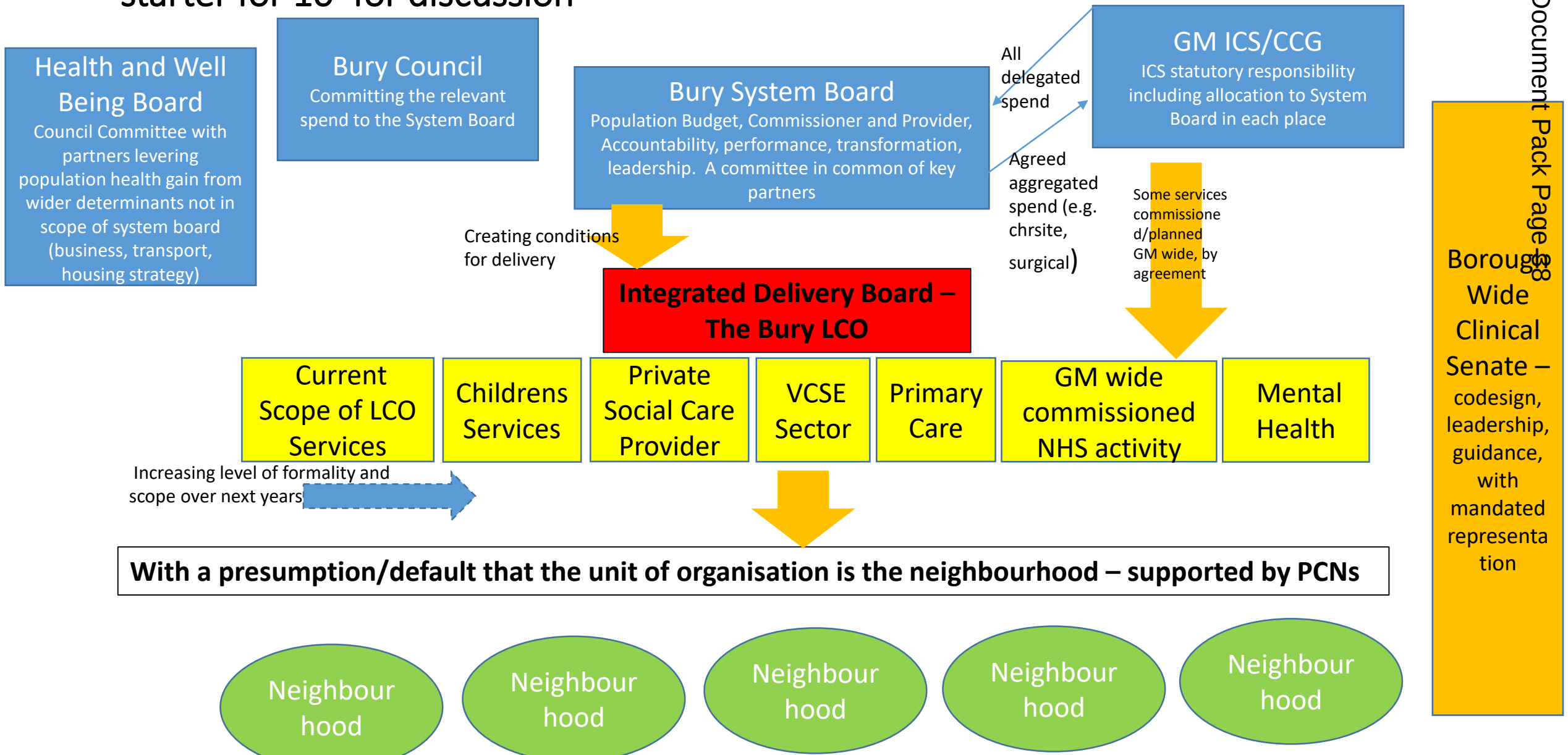
6. Current Position in Bury

- Strategic Commissioning Board – Council and CCG with delegated authority on pooled budget and sight of ‘aligned’ and ‘in view’.
- Local Care Organisation – Alliance based partnership of providers including Pennine Acute, Bardoc, GP Federation focused on delivering integrated community based health and care.
- LCO committed in theory to lead provider model as a future organisational form for in scope services
- One Commissioning Organisation – Council and CCG integrated management and staffing arrangements.
- Health and Well Being Board – recently recast to focus on population health system
- NCA Bury Care Organisation – borough based orientation of managerial and clinical leadership
- Primary Care Networks in Development
- VCFA as a key partner on System Board, HWBB and LCO
- Active partnership with CCGs in the North East Sector of GM
- Establishment of NCA including transfer of NMGH to MFT
- Some complexity on neighbourhood coterminosity – 5 neighbourhoods, 6 towns, 4 PCNs
- Health and Care Recovery and Transformation Programme

7. Core Characteristics of a Future System

- Neighbourhood Working is ‘currency of integration’ and as a foundation for scaled prevention and early intervention – in health and care, with wider public services, and with communities
- Services delivered closer to home/in home where possible
- Person and Community Centred Care is central to health and care transformation
- Residents in control of their health and the way services are organised around them
- Population Health and Inequality should be core to our work
- Clinical and political leadership should be central – not advising but leading
- Collaboration at a North East Sector and across GM required to transform hospital wide services

8. Bury Health and Care System Arrangements April 2021 – possible – just a 'starter for 10' for discussion



9. Elements (1)

1) Create the System Board by integrated the SCB functionality with mandated provider representation. System Board to…

- Be a relatively small board, setting strategic direction for the health and social care system in Bury
- Agreeing high level resource allocation
- Agreeing transformation plan objectives
- Assuring progress in delivering borough outcomes
- Align the borough strategic connection to Greater Manchester, North West, and national arrangements
- A focal point for the alignment and integration of enabling functionality across the borough as described in the locality place – system estates group, system IM&T strategy, System workforce reform.
- System Board Membership - example - Clinical Senate Chair, Chair of CCG, Exec Member for health and care, LA Chief Executive/CCG AO, Joint Finance lead, Chair of Integrated Delivery Board/LCO, Chief Officer Bury Care Organisation, Representative PCN Chair, VCFA Chair, Statutory Roles – DCS, DASS, DPH, Chief Nurse

2) Confirm the role of the Health and Well Being Board

- A focus on all 4 corners of the Kings Fund population health system model – wider determinants, lifestyles/behaviour, community/place, and public service reform.
- Health and Well Being Board Membership; example - Exec Member for health and care, Clinical Senate Rep, Business and Infrastructure Dept. Rep, VCSE, DPH

10. Elements (2)

3) Establish Clinical Senate for the borough

- A gateway for health and care system transformation – bringing clinical leadership together as a whole system
- Representation from PCNs, NCA, LMC, CCG, GP Fed, wider primary care, Pennine Care, Social Care (adults and children)
- Securing mandated representation on behalf the clinical senate to Bury partnership arrangements

4) Establish an Integrated Delivery Board

- This would be an extension of the current LCO Board, and would recognise it operates across the breadth of the system including those services not necessarily currently considered to be in the scope of the LCO
- A single Board co-ordinating the delivery of services and the delivery of transformation programmes. (Currently this functionality is split between the LCO management board and the system board/recovery and transformation board)
- It would recognise that the opportunity of binding partners together more formally (though joint assurance and formalised financial risk and gain share arrangements) for a particularly subset of all service delivery (e.g. the urgent care system), and the scope of such formality may increase over time.
- However the ambition of the LCO as the co-ordinator and integrator of services in the collaborative tier is not limited only to those services that are within its formal scope and accountability agreement.
- Take responsibility for creating the conditions for neighbourhood working to develop and thrive

11. Elements (3)

5) Neighbourhood Working

- Single and Shared Strategic Ambition for neighbourhood working in the borough – reflective of health and care integration including in scope community based health and care services, PCNs, children's services
- Development plan and support for Primary Care Networks
- Transition to primary care hubs/campuses (actual or virtual) as a foundation for the funded shift of diagnostic capacity close to residents
- Connected to Council leadership of wider Public Service Reform neighbourhood delivery programme
    - Targeted early years interventions
    - Early help for children and families
    - Virtual teams supporting local schools
    - Support for vulnerable tenants in the private and social rented sectors
    - Interventions to prevent anti-social behaviour and criminality
    - The variants of the Working Well programme, linked to the roles of the DWP and Job Centre Plus
- Connected to borough 2030 strategy – community connectedness, social value, residents in control

12. Key Issues to Resolve

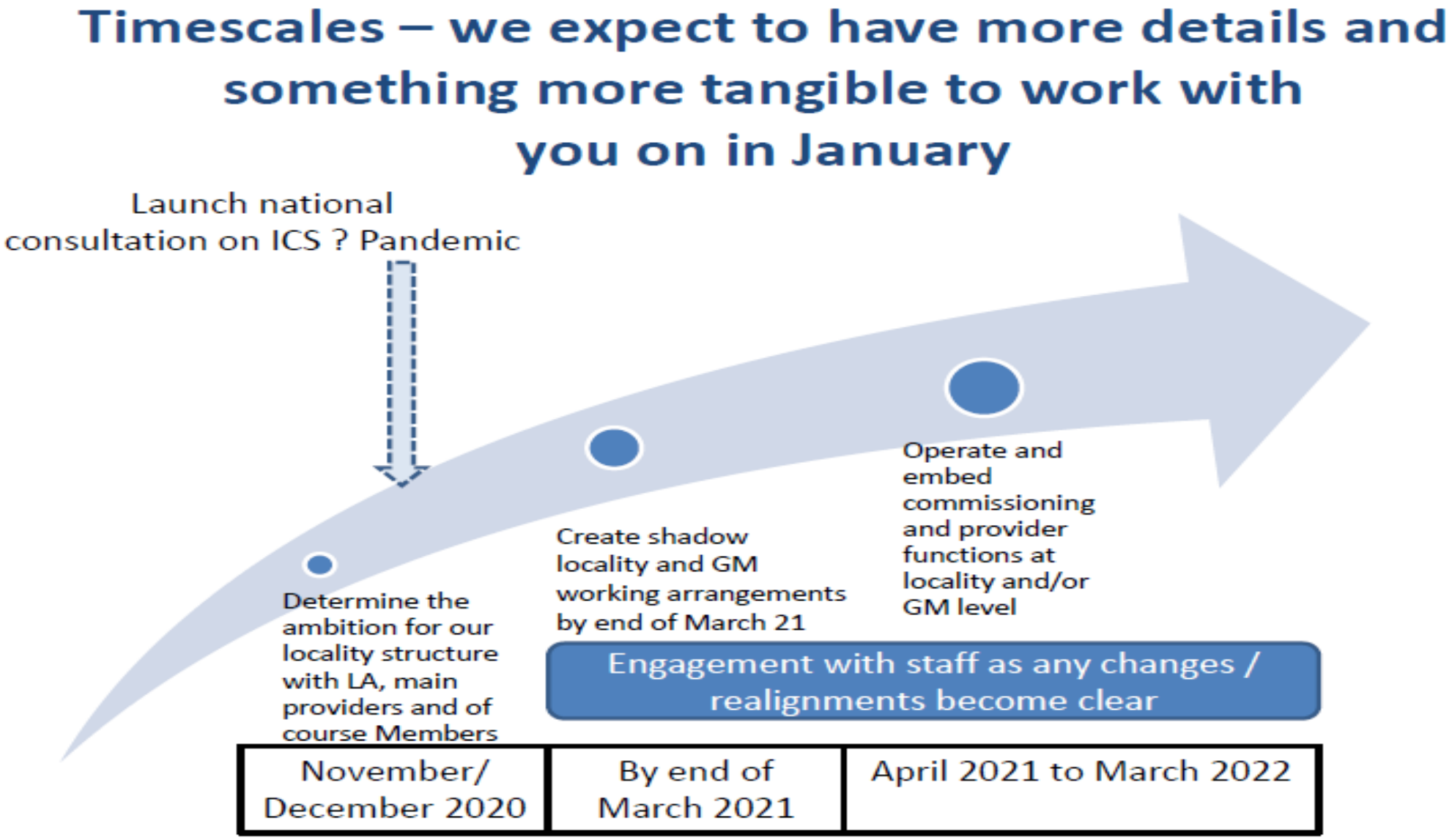
- Mechanism and mandate for clinical leadership reflective of neighbourhoods, and the wider locality system
- Governance of the local system board and the financial authority
- The role, funding, authority and scope of provider collaboratives across GM and the connection to local systems
- The mechanism of transition of funding from the GM ICS through to the local system board
- The scope and role and formality of the LCO in this context
- The relationship between PCNs and neighbourhood working
- Approach to Assurance and Improvement
- Spatial level of service design/commissioning/delivery. GM or local
- Engagement and co-design with clinicians and staff and political leadership across the whole locality

13. Next Steps

- Discussion across the Bury Health and Care Partnership of these proposals
  - System Board
  - CCG Membership
  - CCG and Staff Briefing Sessions
  - Strategic Commissioning Board
  - Bury LCO

- Continued participation in the GM Health and Care Partnership Review
-

14. High Level Timeline



Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

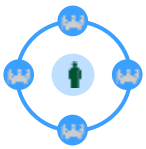
Devolution of functions and resources

1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- **improvement and transformation resource** that can be used flexibly to address system priorities;
- **operational delivery** arrangements that are based on collective accountability between partners;
- **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **emergency planning and response** to join up action at times of greatest need; and
- the use of **digital and data** to drive system working and improved outcomes.

"Place": an important building block for health and care integration



1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

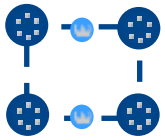
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above (‘vertical integration’); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;
- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
    i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
    ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
    iii. agreed joint decision-making arrangements with local government; and
    iv. representation on the ICS board.

  They may flexibly define:

    i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
    ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
    iii. the precise governance and decision-making arrangements that exist within each place; and
    iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
    ii. provider collaboratives represented on the appropriate ICS board(s).

  They may flexibly define:

    i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot**,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to ‘place’ level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.

- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.

- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:

    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning;
    - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the “Well Led” assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors’ and governors’ duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an ‘integration index’ for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority’s role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.

2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the “end state” for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by “re-purposing” CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS’s primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the ‘day job’: the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a ‘continued employment promise’ for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.

4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
- **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.

4.28. Please submit your response to this address: www.engage.england.nhs.uk/survey/building-a-strong-integrated-care-system

4.29. Alternatively you can also contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.

4.30. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

NHS England and NHS Improvement
Skipton House
80 London Road
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SE1 6LH

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Recommend
Item No	6	**Confidential / Freedom of Information Status**	No
Title	Inclusion Strategy 2020-2024		
Presented By	Lynne Ridsdale, Bury Council Deputy Chief Executive		
Author	Lynne Ridsdale, Bury Council Deputy Chief Executive		
Clinical Lead	Dr. Jeff Schryer, Bury CCG		
Council Lead	Cllr Tariq, Deputy Leader and Cabinet Member Children, Young People & Skills, Bury Council		

Executive Summary

The Bury Council and CCG partnership has, through the leadership of the Strategic Commissioning Board, made a commitment to make significant improvements in our equalities and inclusion practice as both an employer and service provider/commissioner. This commitment is made as part of our leadership role in delivering the Bury 2030 vision and wider organisational transformation.

An independent review into internal practice was undertaken in Summer 2020 and, as a result, this Inclusion Strategy has been co-produced with staff groups; community leaders and senior champions. It sets out:

- The context for this work including the current disparity in outcomes across different communities and how the Bury 2030 vision intends to address this
- The general legal equalities duties on the Council and CCG and how these will be met
- Organisation-specific inclusion objectives and an action plan initially for delivery to 2022.

The term inclusion has been intentionally used for this strategy as it incorporates equality, diversity and human rights, and our legal requirements under the Equality Act. Previously Bury Council and Bury CCG have used a combination of the these terms, so inclusion provides a common term to corral around given this is a joint strategy and encompasses the intent to promote equal access and take up of opportunities; to respect and celebrate diversity; to protect and raise human rights, of all people across the Borough.

Recommendations

The Strategic Commissioning Board is as to :

- Recommend the Inclusion Strategy for approval by the Council's Cabinet and CCG's Governing Body respectively.

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 Bury 2030 Strategy makes a "pledge" to community inclusion. The Corporate Plan sets out the Council and CCG Equality Objectives and the plan for delivery against them	

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?	TBD					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐

If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**
Strategic Commissioning Board	02/11/2020	Informal discussion at development session on feedback from Equalities Review

Bury Council and Bury Clinical Commissioning Group Inclusion Strategy 2020-2024 v4

1. Introduction

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The term inclusion has been intentionally used for this strategy as it incorporates equality, diversity and human rights, and our legal requirements under the Equality Act. Previously Bury Council and Bury CCG have used a combination of the these terms, so inclusion provides a common term to corral around given this is a joint strategy and encompasses the intent to promote equal access and take up of opportunities; to respect and celebrate diversity; to protect and raise human rights, of all people across the Borough.

2. Context

2.1 Outcomes

Bury is a vibrant, diverse and cohesive Borough. It is home to 190,000 people, every one of which should be enabled and empowered to maximise their life chances, play a full and active role in society and enjoy a high quality of life.

Sadly we know that this vision is not currently being fulfilled. Too often, too many people in the Borough have not had the opportunities to be heard, be included or feel represented. Social inequality produces an unacceptable variation in life chances between different communities and the Covid pandemic is likely to broaden social inequalities, including the disproportionate impact of the virus on black and minority ethnic (BAME) communities.

Comparison of whole life expectancy and healthy life expectancy between the Borough of and communities in Bury and national average are two overarching measures which tell us about the health of our population. After decades of improvement, increases in life expectancy for Bury people have stalled. Life expectancy and healthy life expectancy in Bury is lower than the rest of the country.

Beneath these overall trends lie stark inequalities with differences in life expectancy between the most and least deprived areas within Bury of 11.3 years for men and 8.5 years for women and of 14.8 years for males and 13.4 years for women for healthy life-expectancy. There are no signs of these inequalities narrowing.

While as a Borough we are still relatively less deprived than our statistical neighbours and other GM districts, our trend is a negative one with deprivation now getting worse relative to other places. Deprivation in Bury remains highly concentrated and centers on the same areas as before. In the most deprived parts of Bury the onset of poor health begins at age 54 for men and 56.5 for women, up to 13 years before state pension age and life-expectancy of only around 4.5 years beyond.

Inequalities also exist across other dimensions including ethnicity, gender, sexuality and having a disability. The workforce indicators show a decline of women in employment and also people with a disability. This suggests we are further away from creating an inclusive economy than we were five years ago.

2.2 Bury 2030 vision

The Bury 2030 strategy makes a strategic pledge to tackle inequalities with a clear pledge to drive inclusion, as one of five outcome measures which are:

- **Inclusive** communities
- **Healthy**, connected people
- A strong **economy**
- Be on the way to **carbon neutrality**
- A **digital**-first approach

The inclusion vision for Bury 2030 is to enable every person in the Borough to fully participate in and shape the collective, by supporting people to be themselves; to speak out about ideas and concerns and to be heard. It describes commitments to develop relationships; create new and developed fora to hear every voice and co-design services with the people who use them, as well as ongoing community safety activity which drives cohesion through a culture of trust, tolerance and understanding.

Four key principles underpin this vision, for a "people powered" Bury where everyone demonstrates common behaviors which support inclusion. The 2030 strategy will be led by the Team Bury partnership which includes a range of organisations and interest groups of particular relevance including the Voluntary, Community and Faith Alliance, ADAB, Faith Leaders' Forum and Healthwatch.

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 in the place where we live • Ensuring everyone has an equal voice and equal life chances by harnessing and nurturing all talents • Championing innovation, always looking for ways to improve quality of life for all • Being courageous and stepping out of our comfort zone to help ourselves and others • Opening doors at every opportunity
Participation – We all take responsibility for making a difference by: • Committing to making a positive, practical difference in addressing and tackling our challenges • Asking 'what matters to you?' and 'How can I help?' • Being flexible and putting our energies where we can make the most positive 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 and then responding, helping and enabling • Supporting development and growth and removing barriers to collaboration

The specific actions to drive inclusion, based on feedback from local people, are:

- Ensuring there is an understanding of the diverse communities in Bury; we will do this by acting to create a workforce that is representative of Bury's diverse communities, that our staff understand unconscious bias and how to overcome it and that all our services and processes further equality through high quality equality analysis of every change we make.
- further developing inclusive community engagement structures in order to strengthen engagement opportunities for Bury's diverse communities. This will range from encouraging communities of interest to share their views on how their needs are best met and influence how services should be delivered and commissioned to give communities the power to make and share decisions and provide services with us.

- Taking an equity-based approach to targeting public resources across the population in order to create the conditions where every person has access to the conditions to achieve their full potential.
- Celebrating and engaging the diversity of our borough by ensuring that our events, activities and service provision represent the strength of our entire community and invite and support 'difference'. During the year we celebrate Christmas; Easter; Diwali; Eid; Hanukkah; Rosh Hashanah and Yom Kippur. The Bury Pride festival is the second largest in Greater Manchester outside Manchester.
- Engaging our children in an inclusive society. For example, the Community Safety Partnership leads an annual event with school children to explore different faiths and promote cohesion.

More widely the overall philosophy of the strategy is to protect the most vulnerable; drive economic growth and ensure all residents have the skills, opportunity and confidence to access the opportunity growth brings. Other actions which support inclusion and tackle inequality within the vision include:

- safeguarding the welfare of vulnerable children and adults
- provision of all-age Learning Disabilities services
- the development of a neighbourhood model of public services to develop greater understanding of local community issues and joined-up public services to respond
- Ensuring that our streets and neighbourhoods are safe, cohesive and accessible
- raising the profile of volunteering and community action
- pursuing digital infrastructure as a lever for inclusion
- the use of apprenticeships to create opportunities for young people in particular and the wider Supported Employment offer including the current Kickstart initiative with DWP to give those not in education or employment placement opportunities and support to become work ready
- Ensuring that wider issues around vulnerability, disadvantage and poverty are at the heart of our decisions. The development of the Council's anti-poverty strategy is a key part of the Covid recovery work and includes work to support food banks; provide financial and benefits support to residents who are out of work or experiencing in-work poverty and to facilitate an "opportunity guarantee" to give every person looking for support, coaching or work opportunity the resources to progress

3 Compliance with legislative requirements

As public services the Council and CCG operate within the context of the following legislation:

- The *Equality Act 2010* (The Act) brings together all the legal requirements on equality that the public, private and voluntary sectors need to follow. It protects people from discrimination, harassment and victimisation on the basis of their 'protected characteristics', namely:

    - sex;
    - gender reassignment;
    - race;
    - disability;
    - sexual orientation;
    - age;
    - religion or belief (or lack thereof);
    - pregnancy and maternity and;
    - marriage or civil partnership.

    In addition, four further communities of interest have been identified locally which, in Bury, will be approached as protected characteristics and included in our Equalities Assessment process. These are:

    - carers
    - our Looked After Children and care leavers
    - Military Veterans
    - socio-economically vulnerable

    Under section 149 of the Act, 'the Public Sector Equality Duty', Bury Council and Bury CCG need to have 'due regard' in everything they do in order to:

    - Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
    - Take steps to meet the needs of people from protected groups where these are different from the needs of other people'
    - Foster good relations between people who share a protected characteristics and those who do not.

    Having due regard involves the Council and CCG:
    - Removing or minimising disadvantages suffered by people due to their protected characteristics.
    - Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
    - Encouraging people from protected groups to participate in public life or in order activities where their participation is disproportionately low.

Public sector equality duty also states that the council and CCG should have due regard to the need to:

- Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic
- Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
- Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

In addition, as public sector bodies, the council and CCG are required to meet some specific public sector equality duties. These are to:

- Publish the equality objectives which the partnership is seeking to deliver.
- Publish equality information annually to show how we are complying with the general equality duty, in relation to its workforce and its services. Information must be published at least annually.

- The *Human Rights Act* 1998 requires all public bodies, including the Council and CCG, and those acting on behalf of public bodies to act in a way that respects and protects an individual's human rights.

- The *Health and Social Care Act 2012* introduced legal duties to reduce health inequalities (for CCGs). The CCG is required to consistently 'have due regard' to the need to reduce inequalities between patients in access to health services and the outcomes achieved. Bury CCG have incorporated this into the Equality Analysis template to assist with the decision making process.

- The *Accessible Information Standard (AIS)* requires all organisations that provide health services (including GP practices or adult social care to identify, record, share and meet the communication needs of patients/ recipients of care who have a disability, impairment or sensory loss.

The Strategic Commissioning Board ensures compliance with these general equalities objectives by:

- Ensuring every decision is equality assessed, to ensure it reflects the duties of preventing discrimination; fostering good relations and advancing equality of opportunity. The strength of the Equality Assessment process is one of the areas of work that is proposed to be addressed this year.

- Articulating internal Inclusion Objectives in our capacity as both service provider/commissioner and employer at the heart of our Corporate Plan. The objectives for the next 12 months are set out below.
- Engaging Team Bury partners, businesses and investors in our Inclusion strategy to role model and seek to embed wider good practice, as community leaders
- Reporting progress and outcomes of the Inclusion Objectives to the Strategic Commissioning Board as part of quarterly reviews against the Corporate Plan set annually
- Overseeing the maintenance of Human Resources (HR) policies which are clear about eliminating discrimination in the workplace and ensuring fair and equal opportunity to staff from all groups

4. Bury Council and NHS Bury CCG's Inclusion Objectives 2020-24

4.1 Overarching objectives

The Council and CCG have defined the following seven joint Inclusion Objectives which apply to the next four years, consistent with the requirements of the Equalities Act, but will be reviewed annually as part of the Corporate Plan.

The objectives provide a continuum of activity, from regulatory compliance to leading the inclusion agenda through practice, which will help the Council and CCG deliver tangible actions to address inequality. Individually each objective is support by a series of specific and measurable actions to help us progress against this continuum.

1. Performance and Scrutiny : Establish effective governance arrangements in order to ensure that there is a robust performance management culture and scrutiny in relation to inclusion
Inclusion is to be at the heart of our strategic planning process, from Bury 2030, into the corporate plan, through the workplans of Cabinet members and portfolios and to the equality analysis of individual policy decisions. Scrutiny will take the form of both formal governance channels and through the wider sharing of inclusion intelligence across the Bury system and with our communities, to inform and empower, and in turn promote constructive challenge and change. The actions in the implementation plan will lead to an increasingly evidence-led based approach, aligned to the Greater Manchester reform principles to ensure resources, and in turn activity, are targeted to make the difference requirement to meet local needs and show the impact of such interventions.

2. Equality Data and Information: To use data more effectively to promote inclusion in all decision making by the Council and CCG, to help ensure due regard to the general equality duty
Linked heavily with objective one, data will inform the nature, format and degree of activity. The identification, collation, analysis and sharing of information will include that of our population, ensuring that there is a 'live' understanding of the diverse communities in Bury and levels of inequalities within and between these communities. Data and outcome measures across the Bury 2030 ambition is under development and will be key to informing this strategy. A critical element of this objective is the development of a high quality and robust approach to Equality Analysis on all policy decisions and proposed changes to services; being more data-driven, robustly reviewed, quality assured and consistently completed.
3. Community Engagement: Develop inclusive community engagement structures in order to strengthen community engagement opportunities for Bury's diverse communities
As outlined in relation to the Bury 2030 principles, communication and engagement with all local communities is a core priority of this strategy. This is about establishing dialogues and conversations with the diverse individuals and neighbourhoods which make up our six towns. Communication is two way and so is as much about amplifying voices as it is active listening. Different approaches will be needed to engage with the diversity of communities of interest and experience, to encourage people to share their views on how their needs are best met (particularly how people can be enabled to be able to do this for themselves as resilient, active, connected citizens) and influence how services should be commissioned, delivered and evaluated. This is about giving communities the power to make and share decisions, particularly through our new neighbourhood model, to not just have a voice but have fora to use it.
4. Representative Workforce: To take steps towards having a workforce that is representative of the diversity of the local population
Our workforce is one of our strongest assets - this strategy seeks to strengthen this further. As public services our duties are to facilitate local people to achieve the best outcomes and quality of life they can. This is best met when the workforce is representative of the people it carries out its functions with. We recognise the value of diverse workforce that reflects the community it serves. Increased diversity within the workforce leads to creativity and innovation, through a richer tapestry of skills, life experience and networks. A

more diverse workforce brings the internal operations and external reality of those operations closer together, identifying opportunities to work differently and better address needs, improving outcomes as well as being a more effective use of resource.

An inclusive workforce, with opportunities for all to excel and progress, will raise inspiration and aspiration for careers within the Council and CCG, including attracting the best talent from our local communities. Similarly it is important existing staff, regardless of their background, can see opportunities to progress so to retain existing talent to drive service improvements and develop greater representation of our communities at leadership levels.

5. **Training and Learning:** To raise awareness of people's rights and responsibilities, and to aid the delivery and embedding of the Inclusion Strategy

Inclusion, through the promotion of equality, diversity and human rights is everyone's business.

Internally it is essential our staff and non-executive members (Councillors/Clinical Leads) are fully aware, comply with and drive improvements in relation to inclusion frameworks as set out in objective 7. This includes for formal training, eg. on Equality Analysis, but also to embed a culture of learning and improvement. By learning about our diverse communities so to be better informed of particular priorities, opportunities and issues, services can be improved, whilst understanding unconscious bias and being able to overcome it will improve decision making at every level.

6. **Improve user access and experience**: Embedding inclusion into the commissioning cycle locally and seeking effective assurance, including from provider organisations

We will routinely harness the voices and creativity of all our residents in developing future plans. Bury 2030 is an example of this in action, the plan being by Bury, for Bury.

By improving local insight, including through inclusive engagement, and the learning outlined in objective 6, this allows for a more equity-based approach to targeting public resources across the population in order to create the conditions where every person has access to the conditions to achieve their full potential.

Through the development of the neighbourhood model of delivery, inclusion is to be a key consideration in the development of community self-care and prevention approaches to support people to live and stay well within their communities.

7. Framework Delivery: Take action to adopt and ensure real progress is made on the on the Equality Framework for Local Government (EFLG), Equality Delivery System 2 (EDS2); Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
The Inclusion Strategy sets out to deliver improved awareness and assurance on compliance with legislation and policy frameworks in relation to equalities, diversity and human rights. The strategy promotes the key components of the Equality Framework for Local Government and Equality Delivery System 2, the respective frameworks for assessing and improving inclusion for local authorities and CCGs respectively The NHS Workforce Race Equality Standard (WRES) is a mandated requirement for CCGs (as well as NHS provider organisations) and was introduced because reports had highlighted disparities in the number of Black, Asian and Minority Ethnic (BAME) people in senior leadership positions, as well as lower levels of wellbeing amongst the BAME population. As such the WRES is a set of specific measures which enable NHS organisations to compare the workplace and career experiences of BAME and non-BAME staff, to develop a local action plan to demonstrate progress against indicators of race equality. The WRES has been included in the CCG main provider contracts. Going forward the Council will also adopt the WRES, thereby going beyond its legal requirement in order to make real progress towards creating a more representative workforce. The NHS Workforce Disability Equality Standard (WDES) in part modelled on the WRES came into force in 2019 for providers. It is not a mandated requirement for CCGs but both Bury Council and Bury CCG will adopt the WDES. The overall approach to the development of this strategy goes beyond the law and regulation, allowing us to articulate what inclusion means for all our staff and communities; it aims to embed the inclusion objectives as our business as usual, it is not a bolt-on or nice-to-have.

4.2 Area of focus for 2021/22

The strategy is designed to further equality of opportunity across all protected characteristics equally. There will, however, be a particular characteristic agreed each year which will be as area of focus for the year ahead. The focus will be proposed by the staff-led Inclusion Working Group and approved by the Strategic Commissioning Board (SCB).

It is proposed to focus on addressing racism and inequality during 2021/22, on the basis of:

- The protests in the United States of America, this country and across the world following the killing of George Floyd in May 2020. The SCB resolved in June 2020 to be united in tackling racism and inequality and reaffirmed

that*, "as an employer and service provider, Bury Council and NHS Bury CCG remain determined to oppose racist attitudes in everything we do".*

- The Public Health England report *Disparities in the risk and outcomes of COVID-19* (June 2nd 2020) provided emerging evidence that black and minority ethnic (BAME) communities are disproportionately affected by COVID-19

A work plan for a particular focus on race equality over the next 12 months will be developed by the Inclusion Working Group, in consultation with community groups and presented to the SCB for approval.

5. Delivery Plan

Appended to this strategy is a delivery plan which sets out the work to pursue defined objectives. The delivery plan will be performance managed as a key aspect of the joint Corporate Plan which is approved by Bury Council and NHS Bury CCG Governing Body each year. Summary milestones are:

By the end of the 2020/2021 financial year:

- Investment made in additional leadership capacity to drive this agenda and post holder in place
- Equality assessment process updated and operating. Decisions will only be progressed if a robust assessment is in place
- Community engagement plan agreed and published, including plans for regular "listening events" with different community groups and action plans as a result
- A detailed plan will be developed for the focused work to tackle race inequality over the next 12 months

By Q2 2021/22

- Quarterly reports and scrutiny of progress towards inclusion objectives as part of wider corporate plan begin
- Clear plan for improving workforce and service user management information
- Workforce and Elected Member / Governing Body member learning and development offer updated
- HR policies reviewed and updated to reflect the ambition for greater representation
- Action plans for equality frameworks refreshed
- The ambition for improving workforce representation to be agreed and a plan to achieve it in place

By the end of the 2021/22 financial year:

- All staff training updated, with priority for those responsible for making Equality Assessments
- Meaningful progress being made towards equality frameworks

6. Governance

This is a joint strategy between Bury Council and Bury CCG and such ownership in terms of driving implementation and evaluation sits with the Strategic Commissioning Board (SCB) under the accountable leads of:

- The CCG Chair as Clinical Lead for Inclusion
- The Council's Cabinet Member for Corporate Affairs

Reporting against the Implementation Plan will take monthly to the Cabinet Member for Corporate Affairs and the Clinical Lead for inclusion; who together shall present joint updates to SCB every six months and to the respective scrutiny committees (Bury Council – Overview and Scrutiny Committee). As outlined above reporting on progress and outcomes of the Inclusion Objectives will also take place through the quarterly reviews of the Corporate Plan by the SCB.

Regular updates will also be provided to the Bury Strategy Board, to share learning and opportunities to promote best practice across the wider Bury system.

A Workforce Inclusion Group, comprised of the Chairs/representatives of workforce equality groups, the Trade Unions and key heads of service, meets fortnightly to deliver the actions in this plan. Updates to the Council and CCG workforce are provided quarterly by this group through the Inclusion Matters staff newsletter.

Appendix 1: Joint Implementation Plan

RAG as at 17th November 2020

Recommendation	Requirement	CCG	Council	Status
Inclusion Objective 1 : Performance and Scrutiny : **(a) ensure that there is a robust performance/scrutiny function in place for current and future Inclusion work** **(b) Establish effective governance arrangements** **(c) resource through internal staff expertise at a senior level and drive forward the implementation of the Inclusion Strategy**				
Council 1	Establish an Inclusion Implementation Group, with an Executive Lead, membership to be determined by the Council, in order to implement the Inclusion Strategy and actions monitored across the organisation		✓	**In progress**
Council 1	Identify and establish reporting arrangements for the Inclusion Implementation Group	✓	✓	**In progress**
CCG 1	Establish an annual review process of the equality objectives and implementation plans actions and set appropriate objectives and actions for subsequent year	✓	✓	**Complete**
	Produce an annual report on progress made against objectives and actions	✓	✓	**Complete**
CCG 1	Remove the responsibility for the monitoring of EDHR work from the Quality and Performance Committee and establish a CCG Inclusion Implementation Group with an Executive Lead	✓		**In progress**
Council 3	Identify a named senior leader who will act as a Champion for the Equality Employee Groups		✓	**In progress**
Council 3	Establish a Head of Equality post		✓	**In progress**
CCG 1	Establish a junior internal EDHR post to operationalise delivery working across the CCG and the Council	✓		**To be actioned**
Inclusion Objective 2 : Equality Data and Information : **(a) improve data collection with regard to the protected characteristics of employees and service users** **(b) ensure that the Council is meeting its legal obligations to have due regard to the general equality duty and to be able to demonstrate compliance** **(c) ensure that the CCG is meeting its legal obligations to have due regard to the general equality duty and to be able to demonstrate compliance**				
Council 7	Carry out a full data cleanse of the iTrent (HR system) in order to take the initial step of improving data collection on the protected characteristics of employees		✓	**In progress**
Council 7	Introduce consistent data collection requirements across the protected characteristics for all departments and service areas		✓	**In progress**
Council 2	Design and implement a robust system across each department to confirm, QA &	✓	✓	**To be actioned**

CCG 2	record EA screening of policies takes place			
	Insert an EA section into formal reports in order to provide a written explanation of the outcome(s) of either conducting an initial or full EA	✓	✓	**Complete**
	Implement a robust system whereby approval of a formal report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be given when this section is completed	✓	✓	**In progress**
	Identify all staff who are required to undertake EAs and implement a robust system to ensure these staff attend tutor-led EA training	✓	✓	**To be actioned**
	Establish a reporting mechanism of EA work conducted departmentally to the future Inclusion Implementation Group in order to monitor progress made and to establish an accountability and assurance function	✓	✓	**To be actioned**
	Update current EA Template and Guidance	✓	✓	**In progress**
CCG 2	Design and implement a central system to record EA work and their outcomes	✓		**To be actioned**
Inclusion Objective 3 : Community Engagement : **(a) improve community engagement** **(b) Ensure members of local BAME Communities, through the 'Listening Exercise', to have been genuinely heard**				
Council 6	Produce a Community Engagement Strategy co-designed with communities across the protected characteristics with a clear implementation plan		✓	**In progress**
Council 6	Introduce Regular Listening Events & reports back with members of communities with protected characteristics/community leaders/voluntary and community sector representatives		✓	**In progress**
CCG 5	Develop equality and health inequalities guidelines for commissioners embedding EDHR in strategies, commissioning intentions, policies, service specifications and service redesign	✓		**In progress**
CCG 5	Approve the draft Communications and Engagement Strategy 2020-2023 and take steps to implement the Strategy	✓		**In progress**
Council 8 **CCG 10**	Ensure the full findings of this exercise is shared with relevant key staff across departments	✓	✓	**In progress**
Council 8 **CCG 10**	Report on progress made against these actions to the Inclusion Implementation Group and to the people who participated in the Listening Exercise	✓	✓	**In progress**
Inclusion Objective 4 : Representative Workforce : **(a) Progress development of a Council workforce that is representative of Bury's population** **(b) Continue to create a more representative CCG workforce by identifying positive action measures** **(c) implement the actions relating to staff contained in the 'Workforce section of the current (CCG) Annual Equality Publication**				

(d) make real progress against the current WRES action plan				
Council 4	Open up vacancies for external recruitment		✓	**To be actioned**
	Where there is an under-representation of staff at all levels compared to the local population across the protected characteristics, identify positive action measures and take action to progress these, with a particular focus on Race in 2021 and a particular focus on Disability in 2022		✓	**To be actioned**
	Adopt the NHS Workforce Race Equality Standard (WRES) and produce a WRES Action Plan		✓	**In progress**
	Set workforce targets/aspirations, which are monitored across each department's performance against these targets		✓	**To be actioned**
Council 9 **CCG 11**	Adopt the NHS Workforce Disability Equality Standard (WDES) as part of their future objectives setting for 2022	✓	✓	**To be actioned**
CCG 11	Identify positive action measures and take action to progress these	✓		**To be actioned**
CCG 9	Ensure actions from workforce AEP are placed into an action plan with clear timescales	✓		**In progress**
CCG 8	Complete the examination of staff pay band data	✓		**In progress**
	Ensure recruitment panels are diverse and monitor regularly	✓		**To be actioned**
	Include on job advertisements a positive action statement	✓		**In progress**
	Assess how the CCG currently advertises posts and determine whether extra efforts to reach BAME communities is required	✓		**In progress**
	Agree incremental aspirational targets for the recruitment of BAME staff at senior levels and at Board level	✓		**To be actioned**
	Use recruitment agencies that specialise in diverse candidate attraction for posts at senior levels	✓		**Complete**
	Track and report applications, shortlisting, appointments, promotions and leavers by ethnicity	✓		**Complete**
	Develop a bank of recruitment champions who will provide checks on the recruitment process	✓		**In progress**
	Identify and agree further actions, where applicable, contained in the NHS Guidance – 'A Model Employer: Increasing BAME representation at senior levels across the NHS'	✓		**To be actioned**
Inclusion Objective 5 : Training and Learning				

(a) Upskill council staff and elected members and to enable them to effectively raise awareness and contribute to the implementation of the Inclusion Strategy **(b) to upskill CCG staff with regard to EDHR and provide bespoke tailor-made tutor-led equality and diversity training**				
Council 5	Provide tutor-led bespoke equality and diversity training and other learning opportunities to different cohorts within the Council. Take action to ensure compliance		✓	**To be actioned**
Council 11 **CCG 6**	Replace the mandatory e-learning EDHR module with tutor-led bespoke EDHR training	✓	✓	**To be actioned**
CCG 6	Introduce Fair and Inclusive Recruitment and Selection training for staff involved in recruitment and selection	✓		**In progress**
CCG 6	Introduce tutor-led Human Rights Act training for relevant staff and managers	✓		**To be actioned**
Council 11 **CCG 6**	Design and implement a Diversity-Based Reverse Mentoring Programme	✓	✓	**To be actioned**
Inclusion Objective 6 : Improve user access and experience **(a) CCG to assure itself that Providers are compliant with the EDHR contract requirements and to also help improve data collection on service users with protected characteristics** **(b) CCG to be assured of compliance against the Accessible Information Standard (AIS) and thereby improve patient access and experience** **(c) CCG to further demonstrate its commitment to ensuring that EDHR is at the heart of commissioning**				
CCG 3	Approve the draft Contract Management Policy 2020-2023 and take steps to implement the policy including arrangement for monitoring and reporting provider compliance	✓		**In progress**
CCG 4	Assess the CCG's compliance with the AIS for the CCG's main public-facing services and raise staff awareness of its requirements	✓		**In progress**
CCG 4	Seek assurance from provider organisations of their compliance with the standard	✓		**In progress**
CCG 4	Assess GP practices' compliance with the AIS	✓		**In progress**
Inclusion Objective 7 : Framework Delivery **(a) continually improve the Council's work on equality** **(b) progress against the goals in the EDS2**				
Council 10	Determine which EFLG criteria/sub criterion is prioritised on a yearly basis		✓	**To be actioned**
CCG 7	make an assessment against the evidence collected for grading purposes for Goal 1: Better Health Outcomes	✓		**In progress**
CCG 7	Identify the next Goal in the EDS2 and use the EDS2 Guidance Steps as a framework for progressing actions	✓		**In progress**

Appendix 2: Bury's Demography: 190k people, 6 towns, 1 Borough.

The gender split within Bury is 51% female and 49% male. This is the same as the gender split for England and Wales (2011 Census).

Bury has an age profile which is relatively younger than England overall, with more people aged between 30-39, and 50-59 (2018 Office of National Statistics MidYear Estimates) By 2021 the number of people aged under 20 years old is expected to increase by 2%. The over 65 year old population is expected to increase by 6%. The over 80 year old population is expected to increase by 11%.

In terms of race, Bury has a Black, Asian and Minority Ethnic (BAME) population of around 10.8% compared to 14.7% of the population of England and Wales (2011 Census). The Borough has a number of emerging communities' and data from the Government shows that there are 495 refugee and asylum seekers in Bury receiving section 95 support intended to meet essential living needs. In the North West region, the nationalities of those seeking asylum are predominantly from Pakistan, Iran, Iraq and Nigeria.

Over 21,224 people in Bury have a limiting long-term illness, health problem or disability equating to 11.24% of our resident population, compared to 18.8% of the population of England and Wales (2011 Census). Instances of disability rise significantly with age. As life expectancy increases, the number of people with complex care needs rises too.

The number of people providing unpaid care is around 19,954, of which 2.5% care for 50 hours or more.

The majority of Bury's residents indicate they identify as Christian faith (62.7%), followed by Muslim (6.1%) and Jewish (around 5.6%). 18.6% identified as having no religion. This compares to the population of England and Wales as Christian (59.3%), followed by Muslim (4.8%), Hindu (1.5%), Sikh (0.8%) and then Jewish (0.5%). 25.1% identified as having no religion (2011 Census).

There is currently no national or local data on gender identity. However, estimates provided by the Lesbian, Gay, Bisexual and Transgender (LGBT) Foundation that 1 in 4,000 people in the UK seek support to change their birth gender.

There is currently no national or local data on sexual orientation. However, estimates provided by the LGBT Foundation and Stonewall that between 5% and 7% of the population identify as Lesbian, Gay or Bisexual nationally

The Census 2011 showed those married as 70,088 and those in a registered same-sex civil partnership status as 253 in Bury.

Agenda Item 7

Classification Open / Closed	Item No.

Meeting:	Cabinet
Meeting date:	24 November 2020
Title of report:	The Council's Financial Position as at 30 September 2020
Report by:	Leader of the Council and Cabinet Member for Finance and Growth
Decision Type:	**Key Decision**
Ward(s) to which report relates	**All**

Executive Summary:

1.1 This report outlines the forecast financial position of the council at the end of 2020/21 based on the information known at the end of the second quarter (30 September 2020). The reports sets out the position for both revenue and capital and provides an analysis of the variances, both under and overspending. The report also sets out the performance on the treasury management activity, including investments and borrowing, against the agreed prudential indicators.

1.2 This is the second report of the financial year and reflects demand and the financial impact of Covid at that time. The continuation of the Covid pandemic and the additional measures that have been put in place, both nationally and across the Greater Manchester region, in response to this may impact further on demand for services and loss of income. There does therefore remain some significant challenges to forecasting as a result of COVID-19 and the financial position will continue to be closely monitored throughout the year.

1.3 In response to the COVID-19 crisis the government has made available £3.7bn to Local Authorities nationally and some additional specific grants have been made available to provide funding to cover additional costs that will be incurred as a result of specific grant criteria. The funding allocations that were made available have been reflected in the forecast out-turn.

1.4 Since the end of September the Government has announced further funding however the final allocations at a local level have not been issued. Where possible, an estimate of these has been made however are subject to change.

1.5 Progress on the capital programme has been slower than anticipated, some of this due to the impact of Covid. The forecast position is set out in the report and will inform the budget considerations that are being considered as part of the budget setting process for the 2021/22 financial year.

1.6 The treasury management activity for the mid-year position is reported and all activity has been carried out within he agreed parameters and prudential indicators as set out in the Council's treasury management strategy.

Recommendation(s)

That:

- **Note the forecast overspend of £6.931m on the revenue budget and that recently announced additional funding in relation to Covid is likely to reduce the forecast overspend to £1.707m;**
- **Note the significant uncertainties that exist, in particular Wave 2, and that there is likely to be further changes before the end of the financial year;**
- **Note the position on the Dedicated Schools Grant, Collection Fund and the Housing Revenue Account;**
- **Note the savings of £0.262m on the schemes to be funded from allocations from reserves and ha these funds will remain in general reserves**
- **Note the Council has made 3,727 grant payment to business across the Borough totalling £41.769m and that this scheme is now closed;**
- **Note forecast position on the capital programme and:**
    - **Approve that £4.028m be added to the 2020/21 capital programme to reflect the additional funding received for schemes;**
    - **Approve that £36.828m be carried forward into the 2021/22 financial year**
    - **Schemes totalling £0.488m be reduced/removed from the programme as set out in the report and that the reserves funding allocated for these purposes will remain with the general reserve;**
    - **Note the revised capital programme of £56.977m once all amendments have been taken into consideration;**
    - **The overspend on the Kay Street Bridge scheme and the Angouleme Way Roadworks be met from a reallocation of DfT and Growth Deal funding as set out in the report;**
    - **Note the risk of the Storm Ciara damage and that the potential cost of £6.4m may need to be managed within the capital programme should the Bellwin claim not be successful;**
- **Note the mid year report on the treasury management activity and that the Council has not breached any of the prudential indicators set at the beginning of the financial year.**

Key considerations

Background

2.1 The council is forecasting an overspend of £6.931m which is an improvement on the position at the end of June by £0.593m although this is largely due to additional funding that has been made available to local authorities and a return of some of the waste levy from the Greater Manchester Combined Authority (£3.271m) offset by an underlying increase in costs (£2.678m).

2.2 In October the government announced a further £1bn additional support for local authorities (£3.324m for Bury) and this, together with anticipated grant income to compensate for losses on sales, fees and charges grant (up to £1.9m) the overspend is forecast to reduce to £1.707m. This however assumes that there is no further movement in the underlying cost

base as a result of Covid Wave 2 and the local restrictions that have been imposed as part of the national and Greater Manchester response to the pandemic.

2.3 In July, Cabinet agreed a set of principles for managing the in-year gap and budget holders need to ensure these are being applied to ensure that as much as possible is being done to manage downwards the forecast overspend. These are:

- The Council will continue to spend where need exists on the COVID-19 response and all decisions will be taken under existing governance arrangements and will focus on value for money;
- The Council will seek to maintain services as far as possible and, in doing so, minimise the loss of income;
- The Council will seek to maximise the delivery of its savings plan;
- The Council will
    - Use the government grant funding in the first instance to fund additional COVID-19 related costs and loss of income;
    - Consider opportunities for stepping down or deferring the return of some services where resources can be deployed to emerging priorities;
    - Consider the use of reserves as a means of funding any residual financial gap subject to the approval and governance arrangements set out in the Council's reserves strategy.

2.4 The Council has operated with in these principles and, in response to this, some revised efficiency options are set out later in the report to replace some efficiencies agreed in February that are no longer considered deliverable as a result of Covid.

2.5 Within the Council's 2020/21 budget there was an expectation that savings of £4.162m would be delivered. The ability to deliver these in the context is continually being assessed and a total of £2.728m is deemed to be at risk although replacement options and stretched targets from the OCO Directorate have reduced this risk to £2.273m. This is a worsening of the position previously reported. The impact of this has already been factored into the monitoring position.

2.6 The Council has factored in £4.8m of costs that are to be funded through COVID-19 grant monies that have been made available to Clinical Commissioning Groups. The position beyond September still remains unclear and there is the potential for an adverse impact on the council's in year position that will need to be managed. Funding is likely to be made available through the Greater Manchester Health and Social Care Partnership though the exact level is not known.

2.7 The planned contribution to the pooled fund in 2020/21 will be £10.5m less than is budgeted for due to the fact that an additional contribution, to the same value, was made in 2019/20 as part of a strategy to access additional funding for the CCG. This has been reflected in the council's reserves position as set out later in the report and the funding has been confirmed by the CCG.

2.8 A tracker of all grants income is in place and details are set out at Appendix 1. Where grants are to fund new requirements, it has been assumed that additional expenditure to the grant level will be incurred.

2.9 Some of the losses faced by the Council directly relate to schools and the Council's relationship with schools. The opportunity to revisit the Council's position on schools and also mitigating some of the risk needs to be considered as part of the in-year position and also for the council's medium term financial strategy.

2.10 The Council's ability to deliver against the capital programme has been reduced due to Covid and the response that has been needed to deal with the impact of the pandemic. The proposed carry forward and re-phasing of the capital budget will enable the council to focus

on what is considered to be deliverable in the current financial year and the longer term re-phasing will be considered as part of the development of the 2021/22 capital programme. The opportunity to manage current risks, such as Storm Ciara, will be factored in to any future rephrasing.

3 FINANCIAL OVERVIEW - REVENUE

3.1 The forecast out turn position is set out in Table 1 below and shows a forecast overspend of £6.931m, representing 4.20% of the council's net revenue budget. The forecast is based on trends and information in the first half of the financial year and therefore will change as trends and assumptions crystallise. Assuming no further change, the overspend will reduce to c£1.7m, (1%), should the assumed additional funding be received from government.

Table 1

Forecast Out Turn Position 2020/21 – As At 30 September 2020					
Directorate	**Approved Budget**	**Revised Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**	**Change to June 2020**
	£m	**£m**	**£m**	**£m**	**£m**
One Commissioning Organisation	79.452	79.467	78.746	(0.721)	(0.888)
Children and Young People	41.778	41.778	43.018	1.240	0.364
Operations	16.247	16.247	24.031	7.784	1.203
Corporate Core	13.520	13.505	14.009	0.504	0.315
Business, Growth and Infrastructure	2.800	2.800	3.206	0.406	(0.153)
Arts and Museum	0.577	0.697	0.729	0.032	(0.030)
Housing General Fund	0.553	0.553	1.116	0.563	0.000
Non Service Specific	9.964	9.844	6.967	(2.877)	(1.404)
TOTAL	**164.891**	**164.891**	**171.822**	**6.931**	**(0.593)**
Funded By:					
Government Grants	25.718	25.718	25.718	0.000	0.000
Council Tax	89.020	89.020	89.020	0.000	0.000
Business Rates	50.153	50.153	50.153	0.000	0.000
TOTAL	**164.891**	**164.891**	**164.891**	**0.000**	**0.000**

3.2 Details on individual services are set out in the next section of the report.

One Commissioning Organisation – Forecast Underspend £0.721m

Table 2

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
One Commissioning Organisation	**Approved Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**
	£m	**£m**	**£m**
Adult Social Care Operations	7.616	7.108	(0.509)
Care in the Community	39.640	39.387	(0.253)
Commissioning & Procurement	17.090	171.120	0.030
Public Health	10.435	10.435	(0.002)
Departmental Support Services	4.607	4.621	0.017
Workforce Modernisation	0.078	0.078	0.000
TOTAL	**79.467**	**78.746**	**(0.721)**

3.3 The OCO budget is forecast to underspend by £0.721m which is an improvement of the position at the end of August when the Directorate was forecasting an overspend of £0.329m.

3.4 The main variances are as follows:

- **Care in the Community** is projecting an underspend of £0.253m and includes c£3.8m of Health Covid monies to offset Covid related expenditure. Care home deflection activity and reduced home care expenditure in recent months has seen a c.£2m net cost reduction in Older People expenditure activity which if viewed in isolation would result in the underspend position being much higher. However, in the same period there has been a significant increase in expenditure within the younger adult's cohort which has largely offset the older people reductions. This will be a key area of focus for the financial strategy.

- **Adult Social Care Operations** is projecting a £0.509m underspend due to underspends on staffing budgets within services that are undergoing transformation. The forecast assumes £1m of NHS Health Covid funding to offset Covid related health expenditure.

- **Commissioning and Procurement** is forecasting an overspend of £0.030m due to an under achievement of the in-year saving on the Persona contract offset by an underspend on salaries due to vacancies within the service.

Children and Young People – Forecast Overspend £1.239m

Table 3

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Children and Young People Directorate	**Approved Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**
	£m	**£m**	**£m**
Children's Commissioning	1.357	1.299	(0.057)
Early Help & School Readiness	1.755	1.702	(0.053)
Education & Inclusion	16.285	17.258	0.973
Social Care & Safeguarding	22,381	222.759	0.378
TOTAL	**41.778**	**43.018**	**1.239**

3.5 The Children and Young People's Directorate is forecast to overspend by £1.239m due to:

- **Children's Commissioning** The predicted underspend of £0.057m is largely due to 4 vacancies within the Social Care Admin team and a member of staff seconded to another service.

- **Early Help & School Readiness** is forecast to underspend by £0.053m due to a vacant Early Help worker post within the Locality Teams.

- **Education & Inclusion** The forecast overspend of £0.973m is due to increased demand on School Transport (£0.623m), increased costs on packages of care for children with disabilities (£0.107m) and the non-achievement of savings (£0.202) for which alternatives are currently being pursued.

- **Social Care & Safeguarding** – the forecast overspend of £0.378m includes Corporate Parenting (£0.162m) due to an increase in the number of Looked After Children (LAC), delays in discharging/stepping down of care, an increase in care leavers (£0.116m), agency costs to cover sickness and vacancies in safeguarding (£0.339m) as well as

additional building costs due to delays in vacating Higher Lane (£0.052m) and increased external legal fees in relation to two high-cost court cases (£0.142m). These overspends ae offset by additional tripartite funding on residential placements (-£0.306m).

Operations Directorate – Forecast Overspend £7.784m

Table 4

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Operations	**Approved Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**
	£m	**£m**	**£m**
Wellness Operations	2.992	4.932	1.942
Engineers (including Car Parking)	(0.206)	1.781	1.987
Street Scene	4.875	5.077	0.200
Commercial Services	(0.307)	1.668	2.040
Waste, Transport and Stores	6.541	6.840	0.298
Health & Environmental Protection	1.565	1.589	0.024
Operations Senior Management	1.911	1.905	(0.006)
Corporate Landlord	(1.124)	0.239	1.298
TOTAL	**16.247**	**24.031**	**7.784**

3.6 The Operations Directorate is forecasting an overspend of £7.784m mainly as a result of loss of income due COVID-19. Grant income to provide support for loss of income is expected but has not been reflected in these figures. The Directorate has recently restructured and the budgets have been adjusted to reflect this. The material variances within Operations are as follows:

- **Health & Environmental Protection** – the projected overspend is due to licensing due to the temporary deferral of licensing charges (£0.060m) offset by savings from vacancies within Trading Standards (-£0.036m);

- **Engineers** – the overspend largely due to suspension of car parking charges (£1.941m) and other minor variations across the service;

- **Street Scene** - the overspend is largely due to Pest Control loss of income as only emergency works being undertaken in April and May (£0.100m) , minor variations across Highways and reduced income in Grounds Maintenance services (0.030m)

- **Wellness Operations –** the overspend is due to income loss in the Leisure Services (£1.875m) and Loss of lettings income in libraries (£0.074m) ;

- **Commercial Services –** The overspend is due to loss of income in civic centres (£0.566m), an overspend on Catering due to loss of catering income from schools (£0.697m) and loss of market rental income due to agreed schemes to offer rent reliefs to market traders (£0.778m);

- **Corporate Landlord –** The Overspend is due to loss of income due to staff shortages, a reduction in chargeable work to the capital programme due to Covid19 (£0.469m) and an outstanding unachieved savings target (£0.033m) in Architects Service; pressures on rates, cleaning and utilities budgets (£0.277m) on admin buildings and unachieved savings on the corporate landlord model (£0.519m).

Corporate Core and Finance– Forecast Overspend £0.504m

Table 5

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Corporate Core and Finance	Approved Budget	Forecast Out Turn	Forecast (Under)/Over Spend
	£m	£m	£m
Corporate Core	3.600	3.798	0.198
Adult Learning	0.099	0.099	0.000
Corporate Core Finance	9.806	10.112	0.305
TOTAL	13.505	14.009	0.504

3.7 Corporate Core and Finance is forecasting an overspend of £0.504m which is a slight improvement on the period 4 position and is as a result of:-

- **Legal Services** – the overspend is due to reduced income relating to COVID 19 and additional agency costs (£0.198m);
- **Corporate Procurement** - a reduction in income from contract management (£0.017m);
- **Communications and Engagement** – additional costs to support the communciations team during Covid and to cover staff absences;
- **Customer Support and Collections** - Reduction in summons income due to the closure of courts (£0.206m) and increased staffing costs (£0.100m) due to Covid activity and regradings.

Business, Growth and Infrastructure – Forecast Overspend £0.406m

Table 6

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Business, Growth and Infrastructure Directorate	Approved Budget	Forecast Out Turn	Forecast (Under)/Over Spend
	£m	£m	£m
Economic Regeneration & Capital Growth	1.214	1.620	0.406
Housing Needs & Options	1.586	1.586	0.000
TOTAL	2.800	3.206	0.406

3.8 The Business, Growth and Infrastructure Directorate is forecasting an overspend of £0.406m as a result of:

- Property Income losses (£0.400m) some of which is resulting from an approved rent relief scheme to support businesses affected by COVID-19;

Art Gallery and Museum – Forecast Overspend £0.032m

Table 7

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Art Gallery and Museum	Approved Budget	Forecast Out Turn	Forecast (Under)/Over Spend
	£m	£m	£m
Art Gallery and Museum	0.697	0.729	0.032
TOTAL	0.697	0.729	0.032

3.9 The Art Gallery and Museum is forecast to overspend by £0.032m due to loss of income as a result of the service being closed and is an improvement on the previously reported position.

Housing General Fund – Forecast Overspend £0.563m

Table 8

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Housing General Fund	**Approved Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**
	£m	**£m**	**£m**
Housing General Fund	0.553	1.116	0.563
TOTAL	**0.553**	**1.116**	**0.563**

3.10 The Housing General Fund is forecast to overspend by £0.563m due to assumed required contribution to the bad debt provision and the projected net Housing Subsidy position.

Non Service Specific – Forecast Underspend £2.877m

Table 9

2020/21 Forecast Revenue Out Turn Position – as at 30 September 2020			
Non Service Specific	**Approved Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**
	£m	**£m**	**£m**
Accumulated Absences	1.120	1.120	0.000
Chief Executive's Office	0.377	0.377	0.000
Corporate Management	1.730	1.730	0.000
Cost of Borrowing	4.978	7.234	2.256
Grants/COVID-19	0.000	(8.752)	(8.752)
Disaster Expenses	0.011	0.011	0.000
Environment Agency	0.100	0.104	0.004
FRS17 Costs	(19.962)	(19.962)	0.000
GMWDA Levy	13.763	12.191	(1.572)
Manchester Airport	(5.635)	0.000	5.635
Ethical Lettings Agency	0.040	0.040	0.000
Passenger Transport Levy	13.456	13.010	(0.446)
Persona Dividend	(0.200)	(0.200)	0.000
Town of Culture	0.050	0.050	0.000
Provisions/Reserves	0.014	0.014	0.000
TOTAL	**9.844**	**6.967**	**(2.877)**

3.11 The Non Specific Service budget is forecasting an underspend of £2.877m due to:

- **Manchester airport** – loss of dividend (£5.635m) and loan interest repayment (£2.256m) due to the impact of COVID-19 on the travel industry;
- **Passenger Transport Levy** – levy is forecast to be lower than anticipated (-£0.446m);
- **Waste Levy**: A refund in the waste levy (-£1.572m)
- **Environment Agency** – slightly higher levy than expected (£0.004m);
- **Grants/COVID-19** – reflects the receipt of additional grant offset by expenditure within other departments and a budget imbalance relating to the New Homes Bonus (-£9.352m). (The infection control grant income has been reflected in the OCO position from period 4 onwards)

4 DELIVERY OF THE SAVINGS PLAN

4.1 Planned savings of £4.162m are included in the 2020/21 revenue budget. Of these £1.434m is considered delivered with the remaining £2.728m at risk. Work is currently underway with Directorates to establish whether savings can be delivered in the remainder of the year and, if not, whether any other compensating savings can be identified. A summary of the savings is set out in the table below.

Table 10

Assessment of Savings in the 2020/21 Budget			
Directorate	**Description**	**Amount £m**	**Assessment**
One Commissioning Organisation	Persona Contract	0.611	Amber
One Commissioning Organisation	Supporting People Review	0.177	Green
One Commissioning Organisation	Debt Recovery	0.100	Red
Children and Young People	School Improvement Service	0.330	Amber
Children and Young People	Early Help Model	0.102	Amber
Children and Young People	Procurement review of Contracts	0.100	Amber
Operations	Procurement Review of Contracts	0.085	Green
Operations	Corporate Landlord	0.585	Red
Operations	Architects Service Review	0.200	Red
Corporate	Contract Management	0.300	Amber
Corporate	Discretionary payments	0.350	Amber
One Commissioning Organisation	Provider Fees Review	1.107	Green
Operations	Re-Wilding Grass Verges	0.065	Green
Operations	Review of Highways Fees	0.050	Red
Total		**4.162**	

4.2 In addition to the above, care package reviews were expected to reduce the financial impact of increasing demand in adult social care. A further budget pressure of £0.478m is anticipated. This may no longer be achievable due to COVID-19.

4.3 The latest information shows a worsening of the position and that a significant number of savings will not be delivered in the current financial year. Covid has clearly played a part however the ability for the council to deliver savings. This is however likely to be an area of political focus given the work undertaken last year by Grant Thornton and the assurances previously provided that these were deliverable. It is proposed that Executive Directors provide information on why savings cannot be achieved.

4.4 In recognition of the fact that some of the savings in the OCO are 'at risk' a re-evaluation has been carried out and proposed alternative savings have been identified to offset the majority of the shortfall. Some of the current planned savings options are also projected to deliver more than is budgeted for. Work is underway to identify options to cover the outstanding amount (£0.276m). Details are set out in the table below:

Table 11

Revised OCO Savings				
Description	**Original Savings Target**	**Projected Shortfall/ (Surplus)**	**Proposed Alternative Savings**	**Shortfall on Savings**
	£m	**£m**	**£m**	**£m**
Persona Contract	0.611	0.458		0.153
Supporting People	0.177	0.250		(0.073)
Debt Recovery	0.100	0.000		0.100
Provider Fees Review	1.107	1.216		(0.109)
Care Packages	0.844	0.366		0.478
Learning Disability/Mental Health	0.000	0.000	(0.200)	(0.200)
Carers	0.000	0.000	(0.069)	(0.069)
Advocacy	0.000	0.000	(0.004)	(0.004)
TOTAL	2.839	2.290	(0.273)	0.276

4.5 A summary of the revised efficiency savings, subject to the approval of Cabinet, are:

- **Learning Disability/Mental Health** A review redesign and transformation of both commissioned and internal services and processes
- **Carers** – A new model to support carers over the age of 18, however the new framework has a significantly stronger emphasis on partnership working, in particular developing relations between young carer's services and adult carer's services, along with other partnerships across key services and sectors
- **Advocacy** – Retendering of a commissioned service

4.6 The overall risk of the efficiency savings is reduced to £2.273m for the 2020/21 financial year and the new savings have been reflected in the monitoring position.

5 RESERVES

5.1 The forecast position on reserves is set out at Appendix 2 and takes account of the planned contribution to reserves that were agreed as part of the 2020/21 budget and the release of funding from the collection fund that was also agreed. Whilst the position may appear not to have moved significantly, the cumulative movement masks the fact that over £26m has been added to reserves this year through the collection fund and the lower contribution to the pooled fund. When this is take into account, c£30m of reserves have been used.

5.2 The Council's new reserves policy was agreed at Cabinet in July and is now being applied. Planned allocations from reserves have been reviewed and the following savings are considered achievable due to opportunities presented through partnership working and the availability of grant funding hat have reduced the overall cos to the Council. The overall saving of £0.262k will therefore remain in general reserves:

- Tree Planting– reduced by £0.250m
- Win a bike scheme - £0.005m
- Increased cycling proficiency - £0.007

6 OTHER BUDGETS

Schools

6.1 The council's expenditure on schools is funded primarily by the Dedicated Schools Grant (DSG). The DSG is ringfenced and can only be spent on schools related activity as set out in the Schools Finance England) Regulations 2017. The Schools Budget includes funding for a range of educational and support services provided on an authority wide basis as well as individual Schools Budget. The Schools Forum oversee the allocation of funding to schools and the application of the funding formula.

6.2 The DSG has 4 main blocks:

Table 12

Block	2020/21 Budget
	£m
Schools	129.940
High Needs	33.209
Early Years	13.782
Central Support Services	0.774
TOTAL	**177.705**

6.3 Since the budget was set, schools and academies have also received further significant external funding of £25.004m, including new funding to support schools with the additional cost pressures arising from Covid. Details of the funding received are set out in the table below. Further information regarding funding received for Covid related purposes is set out in Appendix 1.

Table 13

Estimated External Income	
Grant	**£m**
Pupil Premium Grant	9.108
Universal Infant Fee Schools Meals Grant	2.369
Primary PE and Sport	1.147
Year 7 Catch Up Grant	0.195
Teacher's pay Grant	1.473
Teacher's Pension Grant	4.909
Devolved Formula capital	0.742
Covid Exceptional Cost Reimbursement Scheme	2.366
Covid Catch-Up Premium	2.695
TOTAL	**25.004**

6.4 At the end of 2019/20 there was a deficit on the Dedicated Schools Grant (DSG) of £20.067m and this is forecast to increase to £24.531m by the end of the current financial year. This is a significant risk to the council and one which needs to be kept under careful review as any deficit on the DSG reserve is currently offset by the council's general and earmarked reserves. Whilst the DfE has announced that DSG deficits will no longer be offset against Council reserves, the required changes to legislation have not been made. Until then, the position on the reserve remains a significant financial risk to the Council.

6.5 The Council has been identified as one of the Local Authorities across the country with one of the highest DSG deficits and has been invited to take part in discussions with the DfE with the aim of' agreeing a package of support and repot that will help the Council bring your DSG deficit under control and ultimately, to eliminate it'. To support the Council, some additional grant funding may be made available however the quantum and the conditions of any potential grant are not yet known. A date has been set for 17 December for an introductory meeting. Updates on progress will be reported to Cabinet as part of the quarterly monitoring process.

6.6 The main reason for the forecast increase in the deficit by the end of the financial year is due to:

- Inclusion Partnerships and SEMH Hubs (£0.36m)
- Paediatric Disability (£0.15m)
- SEND Preparation for Employment (£0.04m)
- SEND EHCP top up funding to comply with statutory finance and SEND requirements, including increased volumes (£2.3m)
- Increased capacity at Bury's special school provision (£1.6m)

Collection Fund

6.7 The tables below show the forecast outturn position for the collection fund and the share of balances of the forecast position.

Table 14

Forecast Position on the 2020/21 Collection Fund			
	Council Tax	Business Rates	Total
	£m	£m	£m
Balance Brought Forward	0.024	(0.279)	(0.255)
(Surplus)/Deficit for the year	1.646	26.647	28.293
Balance Carried Forward	**1.670**	**26.367**	**28.038**
Distributed:			
Bury Council	(1.409)	(26.104)	(27.512)
GMCA – Police and Crime Commissioner	(0.182)	0.000	(0.182)
GMCA – Fire and Rescue Service	(0.079)	(0.263)	(0.343)
Total	**(1.670)**	**(26.367)**	**(28.038)**
Section 31 Grants Received		26.061	26.061
TOTAL	**(1.670)**	**(0.306)**	**(1.976)**

6.8 The increasing prominence of council tax and business rates in helping fund council services means that the collection fund is monitored on an ongoing basis. A forecast in year deficit of £28.293m means that the projected year end collection fund position (council tax and business rates), taking into account the brought forward surplus, is a projected deficit of £28.038m of which the council's share is £27.512m and the Greater Manchester Combined Authority's share is £0.565m (for police and fire and rescue services).

6.9 The accounting treatment for the collection fund currently means that a deficit is required to be declared although these largely relate to additional business rates reliefs announced as a result of Covid (Extended Retail Relief and Nursery Relief). These reliefs are funded via Section 31 grant which will be used to repay a significant proportion of the deficit in future years. The expected Section 31 grant on the latest forecast is £26.061m which leaves a net deficit of £1.976m which can now be phased over 3 financial years. The exact timing of the repayment of the Section 31 grant and the re-phasing is still unknown and will be confirmed when guidance on the re-phasing of the deficit over 3 years is issued.

6.10 The Greater Manchester Combined Authority area continues to pilot 100% business rates retention. The pilot was first implemented on 1 April 2017. The purpose of the pilot is to develop and trial approaches to manage risk and reward in a local government finance system that includes full devolution of business rates revenues. Whilst the pilot is in place, a no detriment policy is in operation under which the government guarantees that the level of business rates income/grant that a council receives can be no less than it would have been if it was not in the pilot area. The council has so far gained from being a member of pilot scheme.

BUSINESS GRANTS

6.11 In response to Covid, the government announced a grants scheme for small businesses within the retail. leisure and hospitality sectors. Funding allocations were made to Councils based on information from the valuation office. Bury received £42.920m of which up to 5% of the grants paid out would be available for a discretionary scheme.

6.12 The council was responsible for administering the scheme until it closed at the end of September. In total, £41.769m was paid out to 3,727 business across the borough leaving a small surplus of £1.151m which, based on current guidance, will be recovered by central government. It should be noted that the Council is only able to pay to those businesses that met the government's grant criteria and therefore there is no other alternative way of utilising this funding. A summary of the grants paid are set out in the table below.

Table 15

Analysis of Covid Business Grants Scheme				
	£10k Grants	£25k Grants	Discretionary Grants	TOTAL
Number Paid	3,056	366	305	3,727
Value Paid (£m)	30.560	9.150	2.059	41.769
Total Paid	39.710		2.059	41.769
Grant Available	(40.865)		(2.055)	(42.920)
Surplus (To be repaid)	(1.155)		0.004	(1.151)

6.13 From the analysis it should be noted that the discretionary grant fund was overspent by £4,000. His cannot be offset against the main grant allocation and will therefore, subject to the approval of Cabinet, be met from corporate reserves.

HOUSING REVENUE ACCOUNT

6.14 The Housing Revenue Account (HRA) is forecasting a surplus of £1.075m and further information is set out in the table 12 below.

Table 16

2020/21 Forecast Revenue Out Turn Position – as at 30 Sept 2020			
Housing Revenue Account	Approved Budget	Forecast Out Turn	Forecast (Under)/Over Spend
	£m	£m	£m
Income			
Dwelling Rents	(29.963)	(29.907)	0.056
Non-Dwelling Rents	(0.194)	(0.191)	0.003
Other Charges	(1.036)	(1.032)	0.004
Total Income	**(31.193)**	**(31.130)**	**0.063**
Expenditure			
Repairs and Maintenance	7.039	6.902	(0.137)
General Management	7.452	7.350	(0.102)
Special Services	1.366	1.365	(0.001)
Rents, Rates and Other Charges	0.060	0.059	(0.001)
Increase in Bad Debts Provision	0.484	0.742	0.258
Capital Charge	4.632	4.632	-
Depreciation	8.587	7.362	(1.225)
Debt Management Expenses	0.041	0.041	-
Contribution to/(from) reserves	(1.925)	(1.925)	-
Total Expenditure	**27.736**	**26.528**	**(1.208)**
Net Cost of Services	**(3.457)**	**(4.602)**	**(1.145)**
Interest receivable	(0.067)	(0.063)	0.004
Principal Repayments	0.192	0.193	0.001
Revenue Contributions to Capital	3.322	3.387	0.065
Sub Total	**3.447**	**3.517**	**0.070**
Operating (Surplus)/Deficit	**(0.010)**	**(1.085)**	**(1.075)**

6.15 The main reasons for the forecast surplus are:

- **Depreciation** – the calculation method was reviewed in 2019/20 resulting in a reduction in the charge for future years. As the depreciation charge is ultimately used to fund capital programme expenditure this reduction has been taken into account in the forecast Revenue Contributions to Capital (see note below).

- **Revenue contributions to capital** – the change shows the net effect of schemes brought forward from 2019/20 and anticipated slippage in the programme for the current year; it is forecast that £2.681m of resources will need to be released back from the HRA balances (Business Plan Headroom Reserve) in 2021/22 to complete the 2020/21 programme.

6.16 As well as looking at the in-year financial position, it is useful to consider some of the other aspects of performance regarding the Housing revenue Account. These have all to some degree been affected by the operating restrictions and financial impacts resulting from the pandemic; this makes forecasting with any certainty very difficult.

- ***Voids*** The rent loss due to voids for April to September was on average 1.21% which is worse than the 1% void target level set in the original budget. If this performance continues, there will be a reduction in rental income of £0.064m over the original budget. Six Town Housing continue to review the voids processes and the various factors affecting demand.

- ***Arrears*** The rent arrears at the end of September totalled £2.415m, an increase of 16.4% since the end of March. Of the total arrears £0.889m relates to former tenants and £1.526m relates to current tenants. An estimated £1.106m of current tenant arrears are in cases where either the under occupancy charge applies or the tenants are in receipt of Universal Credit rather than Housing Benefit; this is an increase of £0.229m from the start of the year reflecting the increase in the number of tenants claiming Universal Credit and the impact this can have on the arrears position with payments received for a number of weeks, in arrears and sometimes with delays.

- **Bad Debts** The Council is required to make a provision for potential bad debts. The contribution for the year is calculated with reference to the type of arrear, the amount outstanding on each individual case and the balance remaining in the provision following write off of debts.

  The forecast increase in the required contribution to the Bad Debt Provision is based on an assessment of the arrears at the end of September and the potential change in arrears for the remainder of this financial year. This is very much an estimate based on current trends and expectations and is being closely monitored.

- ***Right to Buy Sales*** The forecast for 2020/21 was set at 60, this being an increase of 15 on the level of sales assumed for Bury in the Government's self–financing valuation. There have been 21 sales in the period April to September which is 4 less than at this point last year. The number of applications currently proceeding is higher than at this point last year (111 compared to 101); around half of the current applications are awaiting Right to Buy valuations before they can proceed. The valuation service, which was suspended at lockdown in March, has recently been resumed through an external provider. Given the current situation it is difficult to forecast how many applications will actually proceed to completion therefore the sales forecast has been kept at 60 and will be reviewed again at the end of quarter 3; the projections of rental income have been calculated on this basis.

7 CAPITAL PROGRAMME

7.1 The Council's capital programme is set at £86.562m including schemes rolled forward from the 2019/20 financial year. New schemes totalling £4.028m are recommended to be added to the programme in year, all of which are fully funded from external sources. The new schemes are set out below and, subject to approval, will increase the 2020/21 capital programme to £90.590m. Full Council approval is not required. However for governance purposes, these schemes need to be reflected in the capital programme so they can be monitored and reported on.

Table 17

Additions to the 2020/21 Capital Programme		
Project	£m	Reason
2020/21 Revised Capital programme	86.562	
Highways Planned Maintenance	0.049	Additional grant funding
Pothole Fund	1.523	Additional DfT funding via GMCA
Manchester Mesivita	0.008	Grant
Goshen Flood Work	0.511	Grant funding from the Football Foundation
Special Provision Grant	0.195	Additional Grant
Basic Need Grant (Schools)	(0.250)	Actual Grant lower than anticipated
School Condition Grant	1.202	Additional Grant
School Condition Grant	0.790	Additional Grant
Sub Total	**4.028**	
Revised 2020/21 Capital Programme	**90.590**	

7.2 Full details on the Capital programme are set out in Appendix 3 and a summary of the key elements are as follows:

- ***Carry Forward***

7.3 Expenditure on the capital programme is £20.148m of which £13.403m relates to the strategic investments with the airport. Expenditure is lower than anticipated however this needs to be considered in the wider context of the Covid pandemic. Delivery of the capital programme has been significantly affected by the Covid pandemic and the closure of many services. Additionally, resources that would have been delivering capital schemes and projects have been diverted to other areas as part of the Council's emergency response to the pandemic.

7.4 The Council recognises that the Covid pandemic has impacted in many different ways and has taken the opportunity to review its capital programme to ensure the programme remains focused on priorities, is realistic in terms of what can be delivered in the current financial year and enables schemes to continue in future years should they still be a priority. In considering the schemes we have identified those that are grant funded to ensure that the opportunity to bring in external income to the borough is not lost even if schemes have been delayed. The outcome of the review is as follows:

Project	Current Budget	Proposed Budget
	£m	£m
Schemes Recommended for Deletion		
Electric Vehicle Trials	0.075	0.000
Schemes Recommended to Reduce		
Community Climate Fund	0.600	0.187
TOTAL	**0.675**	**0.187**

7.5 It is proposed that the capital programme for 2020/21 be reduced by £0.488m. All of the proposals were to be funded from general reserves and this funding will therefore no longer be needed to be drawn down.

- ***Projected Expenditure 2020/21***

7.6 As it stands, £16.680m is forecast to be spent in the last half of the financial year. This includes the expenditure on the parks and green spaces strategy that is set out elsewhere on the agenda. Given the ongoing impact of the Covid pandemic the ability to forecast expenditure with any great certainty is reduced and therefore the situation will be kept under careful review. Further updates will be considered by Cabinet prior to the setting of the 2021/22 capital programme at Full Council in February.

Variances

7.7 The majority of the variances on the capital programme are due to delays in delivery as a result of Covid and it is proposed that these funds, totalling £36.828m, be carried forward and the programme rephased to reflect when expenditure is likely to be incurred. For now, funds that need to be carried forward into the next financial year have been identified and more work will be undertaken to establish whether any of this will fall into future years. The outcome of this work will be reported to Cabinet in January 20201 when the Quarter 3 monitoring is produced.

7.8 Some variances have however emerged and approval is sought to meet the additional costs as follows:

- expenditure on Kay Street Bridge which is currently forecast to exceed the budget provision by £0.675m due to additional construction costs as a result of unforeseen issues when the building work was commissioned. In order to fund this, it is proposed that DfT monies included in the 2020/21 be reallocated for this purpose.

- tendered costs for Angouleme Way/Market Street and Wash Lane/M66 Jnc2) are £175k higher than anticipated. To fund this it is proposed that some of the funding within the Growth Deal 2 scheme allocated to the Prestwich High Street Scheme be reallocated for this purpose.

- Given the significant slippage on the capital programme it is not envisaged that this reallocation of funding to address emerging issues will have a significant impact on the wider programme.

Financing

7.9 As well as approving the revised spending in the capital programme, the council must also ensure it has sufficient funds available to meet its capital payments in each financial year. The table below shows how the planned and forecast capital expenditure is to be financed.

Table 17

Financing of the 2020/21 Capital Programme as at 30 September 2020	
	£m
Revised Capital Programme as at Q1	86.562
New Schemes to be added	4.028
Revised Capital Programme	90.590
Funded By:	
External Funding and Contributions	41.416
Use of Capital Receipts	1.389
Revenue	14.675
Prudential Borrowing	33.110
TOTAL	**90.590**

7.10 The Capital Programme will continue to be monitored closely for the remainder of the year. New Capital Gateway processes have been developed and are being introduced in

November 2020. These processes will embed effective monitoring and reporting arrangements. It is envisaged that the new gateway process will ensure that:

- schemes are prioritised and presented to members for consideration at appropriate times during the year
- schemes are a strategic fit with corporate priorities
- adequate resources are identified at the start of the process to ensure sufficient capacity is available to deliver the projects within anticipated timescales
- effective monitoring is carried out so that any slippage or delays can be considered and reported
- effective project management practices are embedded for all projects

7.11 A review and update of the council's capital strategy is underway and will be concluded during 2020/21 for consideration and approval by Cabinet and Full Council. This is particularly important in light of the work on the Bury2030 strategy and will ensure that the capital strategy is aligned to the future outcomes and objectives of the council.

Risks

7.12 Storm Ciara has resulted in some residual damage caused by flooding, the extent of which has only become clear over recent months. Independent assessment of the damage has been carried out and it is anticipated that a total of £6.4m will be needed to carry out the work required. Given the significant financial cost the Council is seeking assistance through the government's Bellwin scheme.

7.13 The Bellwin Scheme is a scheme made available to Local Authorities to provide emergency financial assistance to meet uninsured costs incurred with the aftermath of an emergency in their area. At the time of the storm, the scheme was not made available to the Council as it was not deemed to have reached the threshold. Discussions with MHCLG have established that a claim may be accepted and funding made available. This is currently being progressed. In the event of a claim not being successful, the cost will fall to the Council and will need to be considered as part of the overall capital programme for the current and future financial years.

8 TREASURY MANAGEMENT MID-YEAR REVIEW

8.1 The Treasury Management mid-year review report is attached at Appendix 4. To comply with the CIPFA Code and the Council's Treasury Management Strategy, the Council is required to report on its treasury management activity throughout the year. The repot sets out the latest economic impact and shows the Council's performance against the agreed prudential indicators.

8.2 There are no performance issues and the Council is operating within its financial limits and boundaries as set out in the strategy.

9 FUTURE YEARS

9.1 The impact of COVID-19 is having a significant impact on the council's financial positon and its ability to deliver capital schemes within the anticipated timescales. With Covid Wave 2 and further restrictions being imposed it is expected that further financial pressures will be felt and that these will impact not only in the current financial year but in future financial years. A continuing process of updating the MTFS will ensure that any new or increase in trends will be identified quickly so that remedial action can be taken.

9.2 The ability to forecast with any great accuracy continue to be more difficult now than at any point previously. Not only is the length and the extent of the Covid a huge risk but the

uncertainty around future funding caused by a delayed Comprehensive Spending Review (CSR) and a one year settlement rather than the anticipated 3 year settlement adds further risk and complication. Reliance on scenario planning and reviewing and updating future plans as developments and trends emerge will be a feature of budget planning for some time to come.

9.3 The council is currently refreshing its MTFS and is in the process of identifying options that will manage the financial gap in future years. Delivery of these is essential to ensure longer term sustainability. In the short term, the need to protect reserves as much as possible to help mitigate against the significant financial challenges anticipated, in particular over the next 2 financial years, is recommended.

Community impact / Contribution to the Bury 2030 Strategy

Delivery of the Bury 2030 strategy is dependent pong resources being available. The delivery of the strategy may be impacted by changes in funding and spending.

Equality Impact and considerations:

24. *Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:*

A public authority must, in the exercise of its functions, have due regard to the need to -

(a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

(b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

(c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

25. *The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services*.

Assessment of Risk:

The following risks apply to the decision:

Risk / opportunity	Mitigation
There are significant risks in the financial position both in the current and future financial years. Financial sustainability is critical and the report sets out areas of concern that need to be addressed. Delays in delivering projects within the capital programme provide an opportunity to review projects and align to the changing position that has	Regular monitoring and reporting ensures that any changes in the financial position are quickly identified and action can be taken to manage he overall position. The longer term medium financial strategy takes accounts of any in-year changes in funding and demand and ensures the Council has a longer term view for future

arisen due to Covid and to ensure that projects align to the Bury 2030 strategy.	years.

Consultation:

There are no consultation requirements arising from this report.

Legal Implications:

Local authorities must make proper arrangement for the administration of their financial affairs and produce a balanced, robust budget for forthcoming years. This should be consistent with the Council's work plans and strategies and any identified budget gap. This report sets out the current anticipated position and the impact in terms of revenue and capital, in particular of the impact of Covid 19. This will assist Cabinet in formulating proposals to submit to Council in 2021, for the Council budget and council tax calculations for 2021/22.

Financial Implications:

The financial implications are set out in the report. The continuation of the Covid pandemic has impacted significantly on both the revenue and capital budgets across the whole of the Council and needs to be carefully monitored. The in-year position will be reflected in an updated medium term financial strategy and will inform the budget setting process for the 2021/22 financial year.

Report Author and Contact Details:

Lisa Kitto

Interim Director of Financial Transformation (S151 Officer)

Background papers:

The Council's Financial Position as at June 2020

Revenue Budget 2020/21 and Medium Term Financial Strategy 2020/21 – 2024/25

Capital Strategy and Capital Programme 2021 – 2022/23

Treasury Management Strategy and Prudential Indicators 2020/21

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning

Analysis of Grants Received 2020/21 as a result of COVID -19			
Description	**Amount (£m)**	**Additional Costs**	**Detail**
COVID–19 Tranche 1	5.364	No additional costs. This grant was received in 2019/20 and is un-ringfenced and is available to support the Council to meet additional costs and loss of income as a result of COVID-19.	£1.1m of the total allocation of £5.364m was utilised within the 19/20 financial year. The balance will be utilised to offset additional costs / income losses across all services. The grant is being monitored and reflected in the forecast position of the non-service specific budget.
COVID-19 Tranche 2	5.253	No additional costs. This grant is un-ringfenced and is available to support the Council to meet additional costs and loss of income as a result of COVID-19.	The grant will be utilised to offset additional costs / income losses across all services. The grant is being monitored and reflected in the forecast position of the non-service specific budget.
COVID-19 Tranche 3	1.699	No additional costs. This grant is un-ringfenced and is available to support the Council to meet additional costs and loss of income as a result of COVID-19.	The grant will be utilised to offset additional costs / income losses across all services. The grant is being monitored and reflected in the forecast position of the non-service specific budget.
Hardship Relief Fund	1.880	Criteria on how this should be allocated was provided by government. Majority to be used to fund £150 credit on council tax bills to working age residents eligible for local council tax support scheme. Remainder allocated to hardship and welfare schemes.	Currently held within the Collection Fund as most of the costs will be incurred within the fund.
Infection Control Tranche 1	2.396	New Costs will be incurred. Monitoring assumes that the grant will be offset fully by new additional costs.	All of the grant received has been allocated to care home and other organisations as specified in the grant criteria.

Infection Control Tranche 2	1.934	New Costs will be incurred. Monitoring assumes that the grant will be offset fully by new additional costs.	
Re-Opening High Streets	0.169	New costs will be incurred. Monitoring assumes that the grant will be offset fully by new additional costs.	This grant will be paid in arrears on qualifying expenditure.
Test and Trace	1.084	New Costs. Monitoring assumes that the grant will be offset fully by new additional costs.	Additional costs will be reflected within the OCO department
DEFRA Food and Essentials Hardship Grant	0.229	Monitoring assumes that new costs will be incurred.	
New Burdens (Revenues and benefits) for the administration of the business rates grants.	0.170	New costs to support the administration of grants to businesses and increase in welfare and benefit claimants.	Decision made and funding used to increase capacity in the revenues and benefits team.
Test and Trace Enhanced Support	0.150	Monitoring assumes that new costs will be incurred.	Report being prepared
COVID Marshall Funding	0.104	Monitoring assumes that new costs will be incurred.	Report being prepared
Self Isolation Grant	0.171	Grant payments to eligible claimants who are self-isolating	Decision made. Scheme is operating in line with national guidance.
Business Rates Grants	42.920	Grant payments of £10k and £25k to eligible business and funding for a discretionary scheme.	The scheme is now closed.
TOTAL	**63.523**		

Further announcements of funding to support local authorities who have suffered income losses have been announced. Of the additional £1bn funding announced, Bury will receive £3.324m and it is expected that up to a further £1.9m compensation grant for losses on sales, fees and charges will be received. The Council is also assuming £4.8m grant funding made available to CCGs to cover health related costs.

Analysis of Grants Received 2020/21 by schools as a result of COVID -19			
Description	**Amount (£m)**	**Additional Costs**	**Detail**
Wellbeing for Education Grant	0.030	Allocated to Schools	Non-ringfenced grant to better equip education settings to support wellbeing and psychological recovery as they return to full time education.
Covid catch-Up Premium	2.367	Allocated to Schools	Additional funding to help children catch up on lost learning and reach expected curriculum levels during the 2020/21 academic year. It should be noted that £0.875m of the funding was received by the council to be passported to academies. Funding will be received in 3 tranches (Autumn, Spring and Summer terms).
Covid Exceptional Cost Re-Imbursement Scheme	2.645	Allocated to Schools	Reimbursement scheme to allow schools to reclaim any exceptional costs incurred during lockdown from March – July 2020 in relation to premises, cleaning and free school meals plus other costs that are subject to DfE scrutiny and validation. Of the funding allocated £0.660m is for academies.
TOTAL	**5.312**		

Appendix 2

Forecast Position on Reserves at 31 March 2021				
	Balance as at 1 April 2020	Planned use of Reserves	In Year Overspend (including future known grants)	Forecast Balance as at 31 March 2021
	£M	£M	£M	
General Reserves	6.989	19.277	(1.700)	24.566
Directorate Risk Reserves	0.992	(0.250)		0.742
Volatility and Fiscal Risk	34.174	(4.000)		30.174
Total Management of Risk Reserves	**42.155**	**15.027**	**(6.931)**	**55.482**
Corporate Priorities	7.794	4.550		12.344
External Funding/Grants	20.794	(14.806)		5.988
Total Earmarked Reserves	**28.588**	**(10.256)**	**0.000**	**18.332**
TOTAL COUNCIL RESERVES	**70.743**	**4.771**	**(1.700)**	**73.814**
School Reserves				
DSG Central Reserve	(20.067)	(4.464)		(24.531)
TOTAL SCHOOL RESERVES	**(20.067)**	**(4.464)**	**0.000**	**(24.531)**
TOTAL NET RESERVES	**50.676**	**0.307**	**(1.700)**	**49.283**

	2020/21 Budget	Slippage Brought Forward	Approved Adjustments	Revised Budget	Actual Expenditure as at 30 September 2020	Forecast Expenditure 2020/21	Proposed Rephasing to future years
	£m	£m	£m	£m	£m	£m	£m
Radcliffe Regeneration:							
Radcliffe Town Centre	0.100	0.000	0.000	0.100	0.000	0.000	0.100
Radcliffe Market Chambers	0.100	0.000	0.000	0.100	0.000	0.000	0.100
Radcliffe Library Refurbishment	0.000	-0.020	0.000	-0.020	-0.008	-0.008	-0.012
Radcliffe Regeneration	0.300	0.000	0.000	0.300	0.000	0.263	0.037
Radcliffe Regeneration Action Plan	0.000	0.231	0.000	0.231	-0.002	-0.002	0.233
Sub Total	***0.500***	***0.211***	***0.000***	***0.711***	***-0.010***	***0.253***	***0.458***
Prestwich Regeneration:							
Public Services Hub	0.050	0.000	0.000	0.050	0.000	0.000	0.050
Strategic Acquisition – Longfield	0.300	0.000	0.000	0.300	0.000	0.000	0.300
Prestwich Urban Village	0.200	0.000	0.000	0.200	-0.008	0.492	-0.292
Sub Total	***0.550***	***0.000***	***0.000***	***0.550***	***-0.008***	***0.492***	***0.058***
Ramsbottom Regeneration:							
Ramsbottom Town Plan	0.200	0.000	0.000	0.200	0.000	0.000	0.200
Upper Floor Development	0.200	0.000	0.000	0.200	0.000	0.000	0.200
Sub Total	**0.400**	**0.000**	**0.000**	**0.400**	**0.000**	**0.000**	**0.400**
Bury Regeneration							
Bury Market	0.050	0.000	0.000	0.050	0.000	0.000	0.050
Bury Business centre	0.050	0.000	0.000	0.050	0.000	0.000	0.050

	2020/21 Budget	Slippage Brought Forward	Approved Adjustments	Revised Budget	Actual Expenditure as at 30 September 2020	Forecast Out Turn	Proposed Rephasing to future years
	£m	£m	£m	£m	£m	£m	£m
Elizabethan Suite Update	0.080	0.000	0.000	0.080	0.000	0.000	0.080
Bury Civic Centre – Phase 1	1.800	0.000	0.000	1.800	0.000	-0.001	1.801
Sub Total	***1.980***	***0.000***	***0.000***	***1.980***	***0.000***	***-0.001***	***1.981***
Bradley Fold Regeneration	0.200	0.000	0.000	0.200	0.000	0.000	0.200
Refurbishment of Bury Market	0.900	-0.008	0.000	0.892	0.000	0.206	0.686
TOTAL - REGENERATION	**4.530**	**0.203**	**0.000**	**4.733**	**-0.018**	**0.950**	**3.783**
Place Shaping/Growth:							
Prestwich	0.000	0.249	0.000	0.249	0.000	0.000	0.249
Radcliffe	0.000	0.420	0.000	0.420	0.000	0.000	0.420
Whitefield	0.000	0.100	0.000	0.100	0.001	0.001	0.099
Place Shaping/Growth Programme	0.000	2.715	0.000	2.715	0.000	0.000	2.715
Other Development Schemes	0.000	0.138	0.000	0.138	0.478	0.450	-0.312
TOTAL – PLACE SHAPING/GROWTH	**0.000**	**3.623**	**0.000**	**3.623**	**0.479**	**0.451**	**3.172**
Sport and Leisure:							
Parks and Green Space Strategy	0.800	0.000	0.000	0.800	0.030	0.439	0.361
Play Area Strategy	0.250	0.000	0.000	0.250	0.001	0.251	-0.001
Outdoor Gyms	0.120	0.000	0.000	0.120	0.000	0.000	0.120
Access, Infrastructure and Quality – Parks	0.300	0.000	0.000	0.300	0.000	0.220	0.080
Grass Pitch Vert Draining	0.010	0.000	0.000	0.010	0.000	0.000	0.010
Leisure Gym Equipment Upgrade	0.500	0.000	0.000	0.500	0.257	0.500	0.000
Bury Athletics Track	0.100	0.000	0.000	0.100	0.000	0.006	0.094
Flood Repair – 3 G Pitch	0.000	0.105	0.511	0.616	0.000	0.052	0.564
3G Pitch – Bury Radcliffe	0.040	0.000	0.000	0.040	0.000	0.000	0.040
3G Pitch at Goshen	0.669	0.000	0.000	0.669	0.000	0.000	0.669

	2020/21 Budget	Slippage Brought Forward	Approved Adjustments	Revised Budget	Actual Expenditure as at 30 September 2020	Forecast Out Turn	Proposed Rephasing to future years
	£m	£m	£m	£m	£m	£m	£m
Sustainable Tennis Strategy	0.180	0.000	0.000	0.180	0.000	0.226	-0.046
Radcliffe FC Facilities	0.170	0.000	0.000	0.170	0.000	0.000	0.170
Match Fund Football Grants	0.150	0.000	0.000	0.150	0.000	0.000	0.150
Non Turf Cricket Pitch	0.072	0.000	0.000	0.072	0.000	0.000	0.072
Flood Repair and Defence	0.000	0.568	0.000	0.568	0.385	0.395	0.172
Environmental Works	0.000	0.084	0.000	0.084	0.003	0.078	0.005
Parks	0.000	0.142	0.000	0.142	0.000	0.137	0.005
TOTAL – SPORT AND LEISURE	**3.361**	**0.898**	**0.511**	**4.770**	**0.677**	**2.305**	**2.465**
Operational Fleet::							
Vehicle Replacement Strategy	6.760	0.000	0.000	6.760	0.000	4.000	2.760
Grounds Maintenance Equipment	0.240	0.000	0.000	0.240	0.017	0.070	0.170
TOTAL – OPERATIONAL FLEET	**7.000**	**0.000**	**0.000**	**7.000**	**0.017**	**4.070**	**2.930**
ICT:							
ICT Projects	5.015	0.869	0.000	5.884	1.106	2.100	3.784
Improving Information Management	0.000	0.057	0.000	0.057	0.000	0.000	0.057
GM Full Fibre Project	0.000	0.469	0.000	0.469	0.468	0.468	0.001
TOTAL – ICT	**5.015**	**1.395**	**0.000**	**6.410**	**1.574**	**2.568**	**3.843**
Highways:							
Highways Investment Strategy – Tranche 2	4.000	0.000	0.000	4.000	0.000	4.000	0.000
Cycling and Walking Routes – Mayors Challenge	3.000	0.102	0.000	3.102	0.025	0.035	3.067
Growth Deal	0.711	0.000	0.000	0.711	0.000	0.000	0.711
Mobile Speed Signs	0.035	0.000	0.000	0.035	0.000	0.000	0.035

	2020/21 Budget	Slippage Brought Forward	Approved Adjustments	Revised Budget	Actual Expenditure as at 30 September 2020	Forecast Out Turn	Proposed Rephasing to future years
	£m	£m	£m	£m	£m	£m	£m
Full Fibre Infrastructure	0.520	0.000	0.000	0.520	0.000	0.000	0.520
Weather Station and Road Surface Temperature Sensors	0.030	0.000	0.000	0.030	0.000	0.030	0.000
Street Lighting	2.000	-0.239	0.000	1.761	0.029	1.289	0.473
Traffic Calming and improvement	0.517	0.281	0.000	0.798	0.119	0.239	0.559
Traffic Management Schemes	0.000	0.127	0.000	0.127	0.000	0.075	0.052
Public Rights of Way	0.000	0.058	0.000	0.058	0.000	0.005	0.053
Highways Planned Maintenance	0.000	2.640	0.049	2.689	1.026	2.689	0.000
Pothole Fund	0.000	0.000	1.523	1.523	0.000	1.156	0.367
Bridges	0.000	0.050	0.000	0.050	0.022	0.052	-0.002
TOTAL – HIGHWAYS	**10.813**	**3.019**	**1.572**	**15.404**	**1.221**	**9.570**	**5.835**
Children and Young People (including Schools):							
NDS Modernisation	6.995	1.121	1.742	9.858	1.110	4.026	5.832
DFE Formula Capital	0.327	0.555	0.008	0.890	0.253	0.353	0.537
Targeted Capital Funds	0.000	-0.130	0.000	-0.130	-0.131	-0.131	0.001
Special Provision Grant	0.000	0.320	0.195	0.515	0.078	0.494	0.022
Radcliffe School	0.378	0.000	0.000	0.378	0.000	0.000	0.378
Condition Related Schemes – Schools	0.500	0.000	0.000	0.500	0.000	0.000	0.500
Schools Sustainability Schemes	0.250	0.000	0.000	0.250	0.000	0.000	0.250
TOTAL – CHILDREN AND YOUNG PEOPLE	**8.450**	**1.866**	**1.945**	**12.261**	**1.309**	**4.741**	**7.520**
Estate Management – Investment Estate:							
Demolition of Former Fire Station – Bury	0.300	0.000	0.000	0.300	0.000	0.000	0.300

	2020/21 Budget	Slippage Brought Forward	Approved Adjustments	Revised Budget	Actual Expenditure as at 30 September 2020	Forecast Out Turn	Proposed Rephasing to future years
	£m	£m	£m	£m	£m	£m	£m
177 & 179 The Rock	0.005	0.000	0.000	0.005	0.000	0.000	0.005
Portland and Chesham industrial Estate	0.010	0.000	0.000	0.010	0.000	0.000	0.010
Former Prezzo, Lytham	0.055	0.000	0.000	0.055	0.000	0.000	0.055
Black Manor Street	0.050	0.000	0.000	0.050	0.000	0.000	0.050
Tile Street	0.050	0.000	0.000	0.050	0.000	0.000	0.050
St Mary's Place	0.030	0.000	0.000	0.030	0.000	0.000	0.030
TOTAL – ESTATE MANAGEMENT INVESTMENT ESTATE	**0.500**	**0.000**	**0.000**	**0.500**	**0.000**	**0.000**	**0.500**
Estate Management - Corporate Landlord:							
Fernhill Gypsy and Traveller Site	0.360	0.000	0.000	0.360	0.000	0.000	0.360
Bradley Fold Welfare Facilities	0.200	0.000	0.000	0.200	0.123	0.205	-0.005
Bradley Fold Depot – Essential Maintenance	0.220	0.000	0.000	0.220	0.000	0.220	0.000
Leisure Health and Safety Improvements	0.188	0.000	0.000	0.188	0.000	0.120	0.068
Leisure Health and Safety Improvements 19/20	0.181	0.000	0.000	0.181	0.000	0.003	0.178
LED Lighting Installation	0.011	0.000	0.000	0.011	0.000	0.051	-0.040
Seedfield – Health and Safety	0.025	0.000	0.000	0.025	0.000	0.000	0.025
Bury Cemetery Upgrade of Welfare Facilities	0.025	0.000	0.000	0.025	0.000	0.010	0.015
Hoyles park Pavilion Demolition and Clarence Park Skateboard Park removal	0.040	0.000	0.000	0.040	0.000	0.000	0.040
TOTAL – ESTATE MANAGEMENT CORPORATE LANDLORD	**1.250**	**0.000**	**0.000**	**1.250**	**0.123**	**0.610**	**0.640**
One Commissioning Organisation:							
Older People	0.588	-0.204	0.000	0.384	0.080	0.079	0.305
Disabled Facilities Grant	0.855	0.597	0.000	1.452	0.179	0.179	1.274

	2020/21 Budget	Slippage Brought Forward	Approved Adjustments	Revised Budget	Actual Expenditure as at 30 September 2020	Forecast Out Turn	Proposed Rephasing to future years
	£m	£m	£m	£m	£m	£m	£m
Neighbourhood Working	0.000	0.242	0.000	0.242	0.014	0.014	0.228
Planning – Other Schemes	0.065	0.012	0.000	0.077	0.000	0.012	0.065
Other Development Schemes	0.027	0.000	0.000	0.027	0.000	0.000	0.027
Environmental Works	0.067	0.000	0.000	0.067	0.000	0.000	0.067
TOTAL – COMMUNITIES AND WELLBEING	**1.602**	**0.647**	**0.000**	**2.249**	**0.272**	**0.283**	**1.966**
Electric Vehicle Trials	0.075	0.000	0.000	0.075	0.000	0.000	0.075
Housing – HRA	9.280	3.406	0.000	12.686	0.171	9.592	3.094
HRA – Disabled Facilities Adaptations	0.550	0.166	0.000	0.716	0.000	0.609	0.107
Empty Property Strategy	0.000	0.273	0.000	0.273	0.000	0.000	0.273
Next Steps Accommodation Programme	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Housing Development	0.000	1.000	0.000	1.000	0.921	1.100	-0.100
TOTAL – HOUSING	**9.905**	**4.845**	**0.000**	**14.750**	**1.091**	**11.301**	**3.448**
Climate Change:							
Community Climate Capital Fund	0.600	0.000	0.000	0.600	0.000	0.007	0.593
Climate Change Resilience Fund	0.200	0.000	0.000	0.200	0.000	0.060	0.140
Electric Charging Points	0.040	0.000	0.000	0.040	0.000	0.000	0.040
Glysophate Alternative Equipment	0.050	0.000	0.000	0.050	0.000	0.050	0.000
Waste Management	0.000	0.014	0.000	0.014	0.000	0.069	-0.055
Fly-Tipping	0.060	0.000	0.000	0.060	0.000	0.052	0.008
TOTAL – CLIMATE CHANGE	**0.950**	**0.014**	**0.000**	**0.964**	**0.000**	**0.238**	**0.726**
Strategic Airport Investment	0.000	1.863	1.863	3.726	3.726	3.726	0.000
Strategic Airport Investment	0.000	0.000	12.950	12.950	9.677	12.950	0.000
TOTAL – STRATEGIC INVESTMENT	**0.000**	**1.863**	**14.813**	**16.676**	**13.403**	**16.676**	**0.000**
TOTAL	**53.376**	**18.373**	**18.841**	**90.590**	**20.148**	**53.763**	**36.828**

Appendix 4

Treasury Management Mid-Year Review 2020/21

1.0 BACKGROUND

1.1 In December 2017, the Chartered Institute of Public Finance and Accountancy, (CIPFA), issued revised Prudential and Treasury Management Codes. As from 2020/21, all authorities have been required to prepare a Capital Strategy which is to provide the following:-

- A high-level overview of how capital expenditure, capital financing and treasury management activity contribute to the provision of services,
- An overview of how the associated risk is managed,
- The implications for future financial sustainability.

A report setting out our Capital Strategy will be taken to Council before 31st March 2021.

1.2 The Council operates a balanced budget, which broadly means that cash raised during the year will meet cash expenditure. Part of the treasury management operations ensure this cash flow is adequately planned, with surplus monies being invested in low risk counterparties, providing adequate liquidity initially before considering optimising investment return.

1.3 The second main function of the treasury management service is the funding of the Council's capital plans. These capital plans provide a guide to the borrowing need of the Council, essentially the longer term cash flow planning to ensure that the Council can meet its capital spending obligations. This management of longer term cash may involve arranging long or short term loans, or using longer term cash flow surpluses, and on occasion any debt previously drawn may be restructured to meet Council risk or cost objectives.

1.4 Accordingly, treasury management is defined as:- "The management of the local authority's borrowing, investments and cash flows, its banking, money market and capital market transactions; the effective control of the risks associated with those activities; and the pursuit of optimum performance consistent with those risks".

1.5 This report has been written in accordance with the requirements of the Chartered Institute of Public Finance and Accountancy's (CIPFA) Code of Practice on Treasury Management (revised 2017). The primary requirements of the Code are as follows:

1. Creation and maintenance of a Treasury Management Policy Statement which sets out the policies and objectives of the Council's treasury management activities.
2. Creation and maintenance of Treasury Management Practices which set out the manner in which the Council will seek to achieve those policies and objectives.
3. Receipt by the full council of an annual Treasury Management Strategy Statement - including the Annual Investment Strategy and Minimum Revenue Provision Policy - for the year ahead, a **Mid-year Review Report** and an Annual Report (stewardship report) covering activities during the previous year.
4. Delegation by the Council of responsibilities for implementing and monitoring treasury management policies and practices and for the execution and administration of treasury management decisions.
5. Delegation by the Council of the role of scrutiny of treasury management strategy and policies to a specific named body. For this Council the delegated body is: Overview & Scrutiny Committee.

1.6 This mid-year report has been prepared in compliance with CIPFA's Code of Practice on Treasury Management, and covers the following:

An economic update for the 2020/21 financial year to 30 September 2020;
A review of the Treasury Management Strategy Statement and Annual Investment Strategy;
The Council's capital expenditure, as set out in the Capital Strategy, and prudential indicators;
A review of the Council's investment portfolio for 2020/21
A review of the Council's borrowing strategy for 2020/21
A review of any debt rescheduling undertaken during 2020/21
A review of compliance with Treasury and Prudential Limits for 2020/21

1.7 This report fulfils the requirement to produce a mid-year review.

2.0 ECONOMIC UP-DATE (from Treasury Advisors)

2.1 Economic Performance to date

2.1.1 The Bank of England's Monetary Policy Committee kept Bank Rate unchanged on 6th August. It also kept unchanged the level of quantitative easing at £745bn.

The fall in **GDP** in the first half of 2020 was revised from 28% to 23% (subsequently revised to -21.8%). This is still one of the largest falls in output of any developed nation. However, it is only to be expected as the UK economy is heavily skewed towards consumer-facing services – an area which was particularly vulnerable to being damaged by lockdown. The peak in the **unemployment rate** was revised down from 9% in Q2 to 7½% by Q4 2020.

2.1.2 It was forecast that there would be excess demand in the economy by Q3 2022 causing CPI **inflation** to rise above the 2% target in Q3 2022, (based on market interest rate expectations for a further loosening in policy). Nevertheless, even if the Bank were to leave policy unchanged, inflation was still projected to be above 2% in 2023.

2.1.3 In conclusion, the MPC acknowledged that the "medium-term projections were a less informative guide than usual" and the minutes had multiple references to **downside risks,** which were judged to persist both in the short and medium term. In addition, Brexit uncertainties ahead of the year-end deadline are likely to be a drag on recovery.

2.2 Interest rate Forecasts and Outlook

2.2.1 The Council's treasury advisor, Link Asset Services, has provided the following forecast on 11th August 2020.

Link Group Interest Rate View 11.8.20										
	Dec-20	Mar-21	Jun-21	Sep-21	Dec-21	Mar-22	Jun-22	Sep-22	Dec-22	Mar-23
Bank Rate View	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
3 month average earnings	0.05	0.05	0.05	0.05	0.05	-	-	-	-	-
6 month average earnings	0.10	0.10	0.10	0.10	0.10	-	-	-	-	-
12 month average earnings	0.15	0.15	0.15	0.15	0.15	-	-	-	-	-
5yr PWLB Rate	1.90	2.00	2.00	2.00	2.00	2.00	2.10	2.10	2.10	2.10
10yr PWLB Rate	2.10	2.10	2.10	2.10	2.20	2.20	2.20	2.30	2.30	2.30
25yr PWLB Rate	2.50	2.50	2.50	2.60	2.60	2.60	2.70	2.70	2.70	2.70
50yr PWLB Rate	2.30	2.30	2.30	2.40	2.40	2.40	2.50	2.50	2.50	2.50

The coronavirus outbreak has done huge economic damage to the UK and economies around the world. After the Bank of England took emergency action in March to cut Bank

Rate to first 0.25%, and then to 0.10%, it left Bank Rate unchanged at its meeting on 6th August (and the subsequent September meeting), although some forecasters had suggested that a cut into negative territory could happen. However, the Governor of the Bank of England has made it clear that he currently thinks that such a move would do more damage than good and that more quantitative easing is the favoured tool if further action becomes necessary. As shown in the forecast table above, no increase in Bank Rate is expected within the forecast horizon ending on 31st March 2023 as economic recovery is expected to be only gradual and, therefore, prolonged.

2.2.2 The overall balance of risks to economic growth in the UK is probably relatively even, but is subject to major uncertainty due to the virus. There is relatively little UK domestic risk of increases or decreases in Bank Rate and significant changes in shorter term PWLB rates. The Bank of England has effectively ruled out the use of negative interest rates in the near term and increases in Bank Rate are likely to be some years away given the underlying economic expectations. However, it is always possible that safe haven flows, due to unexpected domestic developments and those in other major economies, could impact gilt yields, (and so PWLB rates), in the UK.

3.0 TREASURY MANAGEMENT STRATEGY STATEMENT AND ANNUAL INVESTMENT STRATEGY UP-DATE

3.1 The Treasury Management Strategy Statement (TMSS) for 2020/21 was approved by the Council on 26 February 2020.

3.2 There are no policy changes to the TMSS; the details in this report update the position in the light of the updated economic position and budgetary changes already approved.

4.0 THE COUNCIL'S CAPITAL POSITION (PRUDENTIAL INDICATORS)

This part of the report is structured to update:

- The Council's capital expenditure plans;
- How these plans are being financed;
- The impact of the changes in the capital expenditure plans on the prudential indicators and the underlying need to borrow; and
- Compliance with the limits in place for borrowing activity.

4.1 Prudential Indicator for Capital Expenditure

This table shows the revised estimates for capital expenditure and the changes since the capital programme was agreed at the Budget

Capital Expenditure	2020/21 Original Estimate £m	2020/21 Revised Estimate £m
Non-HRA	43.546	75.915
HRA	9.830	14.675
Total	**53.376**	**90.590**

The increase of the revised estimate over the original estimate is due to slippage from 2019/20 of £18.373m with approved in year adjustments of £18.841m.

4.2 Changes to the Financing of the Capital Programme

The table below shows the main strategy elements of the capital expenditure plans. The borrowing requirement shown will increase the underlying indebtedness of the Council by way of the Capital Financing Requirement (CFR), although this will be reduced in part by revenue charges for the repayment of debt (the Minimum Revenue Provision). This direct borrowing need may also be supplemented by maturing debt and other treasury requirements.

Capital Expenditure	2020/21 Original Estimate £m	2020/21 Revised Estimate £m
Total capital expenditure	**53,376**	**90,590**
Financed by:		
Capital receipts	**609**	**1,389**
Capital grants	**14,978**	**41,416**
Revenue	**9,830**	**14,675**
Total financing	**25,417**	**57,480**
Borrowing requirement	**27,959**	**33,110**

4.3 Changes to the Prudential Indicators for the Capital Financing Requirement, External Debt and the Operational Boundary

The table shows the CFR, which is the underlying external need to incur borrowing for a capital purpose. It also shows the expected debt position over the period, which is termed the Operational Boundary.

	2020/21 Original Estimate £m	2020/21 Revised Estimate £m
Prudential Indicator - Capital Financing Requirement		
CFR – non HRA	168.481	169.866
CFR – HRA existing	40.531	40.531
Housing Reform Settlement	78.253	78.253
Total CFR	**287.266**	**288.651**

Prudential Indicator - External Debt / the Operational Boundary		
Borrowing	269.300	298.700
Other long term liabilities	5.000	5.000
Total	**274.300**	**303.700**

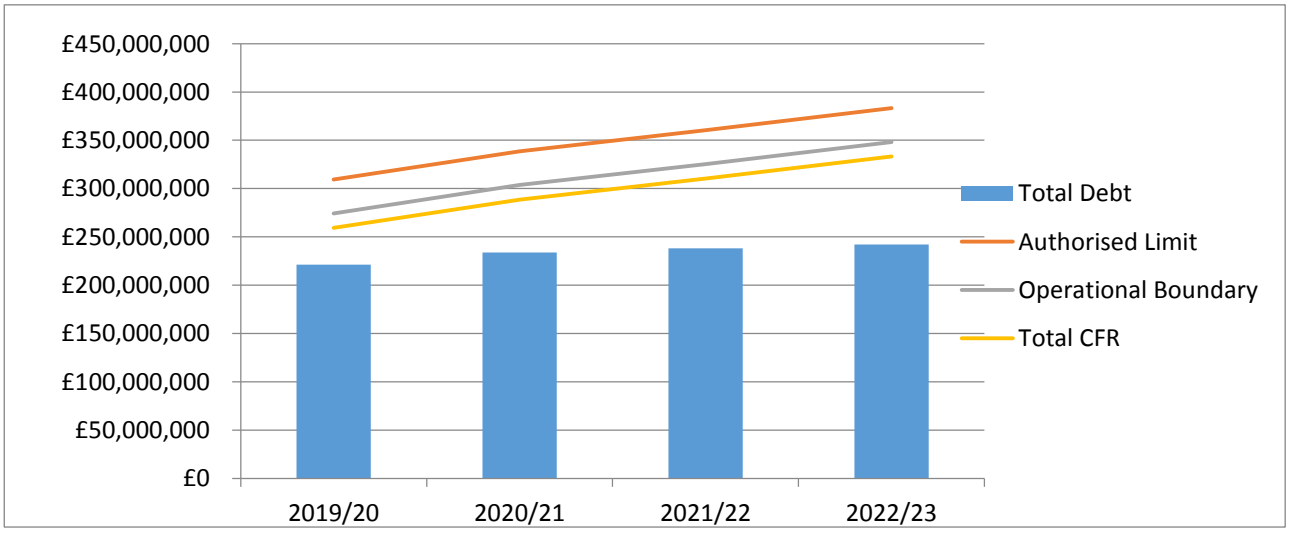
4.4 Limits to Borrowing Activity

4.4.1 The first key control over the treasury activity is a prudential indicator to ensure that over the medium term, net borrowing (borrowings less investments) will only be for a capital purpose. Gross external borrowing should not, except in the short term, exceed the total of CFR in the preceding year plus the estimates of any additional CFR for 2019/20 and next two financial years. This allows some flexibility for limited early borrowing for future years. The Council has approved a policy for borrowing in advance of need which will be adhered to if this proves prudent.

4.4.2 A further prudential indicator controls the overall level of borrowing. This is the Authorised Limit which represents the limit beyond which borrowing is prohibited, and needs to be set and revised by Members. It reflects the level of borrowing which, while not desired, could be afforded in the short term, but is not sustainable in the longer term. It is the expected maximum borrowing need with some headroom for unexpected movements. This is the statutory limit determined under section 3 (1) of the Local Government Act 2003.

Authorised Limit for External Debt	2020/21 Original Indicator £m	2020/21 Revised Indicator £m
Borrowing	304.300	333.700
Other long term liabilities	5.000	5.000
Total	**309.300**	**338.700**

4.4.3 The chart below shows the projected trend of the Council's Prudential Indicators.



5 INVESTMENT PORTFOLIO 2020/21

5.1 The Treasury Management Strategy Statement (TMSS) for 2020/21, which includes the Annual Investment Strategy, was approved by the Council on 26th February 2020. In accordance with the CIPFA Treasury Management Code of Practice, it sets out the Council's investment priorities as being:

- Security of capital
- Liquidity
- Yield

The Council will aim to achieve the optimum return (yield) on its investments commensurate with proper levels of security and liquidity and with the Council's risk appetite. In the current economic climate it is considered appropriate to keep investments short term to cover cash flow needs, but also to seek out value available in periods up to 12 months with high credit rated financial institutions, using the Link suggested creditworthiness approach, including a minimum sovereign credit rating and Credit Default Swap (CDS) overlay information.

5.2 As shown by the interest rate forecasts in section 2, it is now impossible to earn the level of interest rates commonly seen in previous decades as all investment rates are barely above zero now that Bank Rate is at 0.10%, while some entities, including more recently the Debt Management Account Deposit Facility (DMADF), are offering negative rates of return in some shorter time periods. Given this risk environment and the fact that increases in Bank Rate are unlikely to occur before the end of the current forecast horizon of 31st March 2023, investment returns are expected to remain low.

5.3 The Council held £27.7m of investments as at 30 September 2020 (£29.4m at 31 March 2020) and the investment portfolio yield for the first six months of the year is 0.14% against a 3 month benchmark of 0.05%.

The investments held as at 30 September 2020 were:-

Type of Investment	£ m
Call Investments (Cash equivalents)	27.7
Fixed Investments (Short term investments)	0.0
Total	**27.7**

5.4 The Director Of Financial Transformation confirms that the approved limits within the Annual Investment Strategy were not breached during the first six months of 2020/21.

5.5 The Council's budgeted investment return for 2020/21 is £0.1m, and performance for the year to date is in line with the budget.

5.6 The Cabinet have approved a "Property Investment Strategy" which aims to increase investment income by investing in property rather than investing with financial institutions where returns are low at present. Additional borrowing may need to be undertaken to finance property acquisitions; each investment will be subject to a robust business case and also non-financial factors (e.g. ethical stance) will be considered.

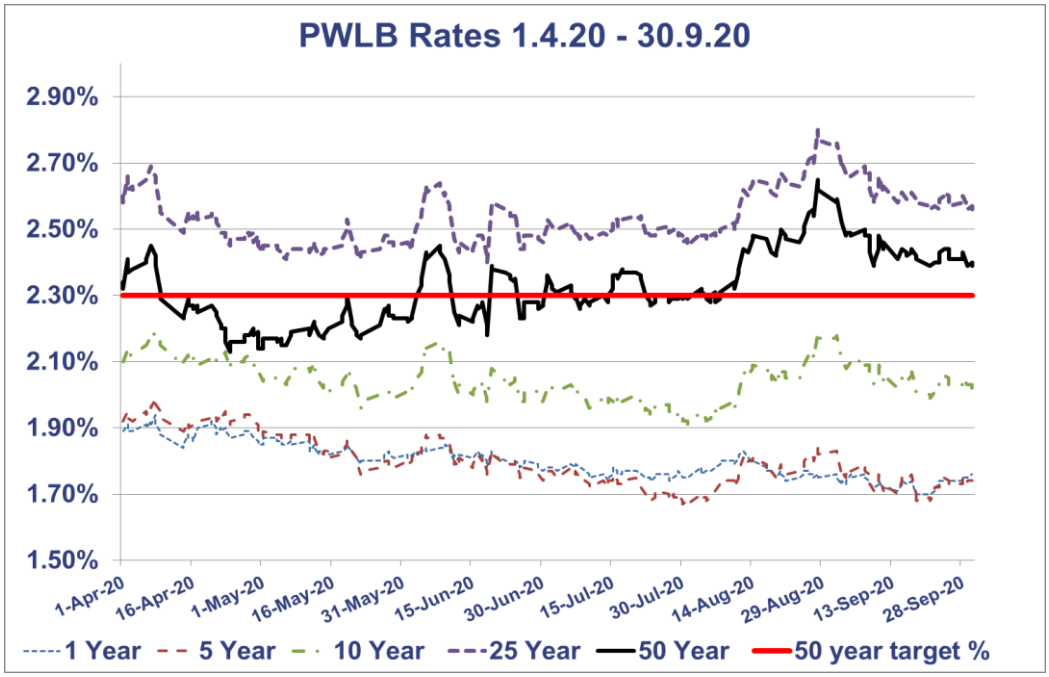
6.0 BORROWING

6.1 The Council's capital financing requirement (CFR) for 2020/21 is £288.7m. The CFR denotes the Council's underlying need to borrow for capital purposes. If the CFR is positive the Council may borrow from the PWLB or the market (external borrowing) or from internal balances on a temporary basis (internal borrowing). The balance of external and internal borrowing is generally driven by market conditions. The table below shows the Council has borrowings of £207.2m and has utilised £81.4m of cash flow funds in lieu of borrowing. This is a prudent and cost effective approach in the current economic climate but will require ongoing monitoring in the event that upside risk to gilt yields prevail.

		1st April 2020			30 September 2020		
		Principal		Avg.	Principal		Avg.
		£M	£M	Rate	£M	£M	Rate
Fixed rate funding							
	PWLB Bury	134.071			134.102		
	PWLB Airport	11.828			11.828		
	Market Bury	49.272	195.171		51.300	197.230	
Variable rate funding							
	PWLB Bury	0			0		
	Market Bury	0	0		0	0	
Temporary Loans / Bonds		21.003	21.003		10.003	10.003	
Total Debt			**216.174**	**3.70%**		**207.233**	**3.70%**
Capital Financing Requirement			**259.304**			**288.651**	
Over/ (under) borrowing			**(43.130)**			**(81.418)**	
Total Investments			**29.410**	**0.62%**		**27.660**	**0.14%**
Net Debt			**186.764**			**179.573**	

6.2 External borrowing of £2.3m has been undertaken from the market during the first 6 months of 2020/21. 1 loan was taken to take advantage of low interest rates. Additional external borrowing will be required during the remainder of this financial year.

6.3 The graph below shows the movement in PWLB certainty rates for the first six months of the year to 30.09.20.



	1 Year	5 Year	10 Year	25 Year	50 Year
Low	1.70%	1.67%	1.91%	2.40%	2.13%
Date	18/09/2020	30/07/2020	31/07/2020	18/06/2020	24/04/2020
High	1.94%	1.99%	2.19%	2.80%	2.65%
Date	08/04/2020	08/04/2020	08/04/2020	28/08/2020	28/08/2020
Average	1.80%	1.80%	2.04%	2.54%	2.33%

7.0 DEBT RESCHEDULING

7.1 Debt rescheduling opportunities have been very limited in the current economic climate given the consequent structure of interest rates, and following the increase in the margin added to gilt yields which has impacted PWLB new borrowing rates since October 2010. No debt rescheduling was undertaken during the first six months of 2020/21.

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NHS
Bury
Clinical Commissioning Group

Meeting: Finance, Contracting and Procurement Committee

Meeting Date	15 October 2020	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Month 6 Finance Report		
Presented By	Mike Woodhead, Joint CFO		
Author	Carol Shannon-Jarvis & Simon O'Hare, Associate CFOs		
Clinical Lead	N/A		

Executive Summary

As stated in previous reports, in response to the COVID-19 pandemic a national top down command and control framework has been put in place by NHS England. As part of this there is a financial regime for the first six months of 2020/21 covering the period from 1st April to 31st September in which the CCG has received a baseline allocation based on the month 11 2019/20 position uplifted for inflation.

In addition to this, based upon expenditure to month 5, the CCG has received a retrospective allocation of £6.3m to contribute to COVID related and business as usual expenditure. This is to support the CCG in the national intention to achieve a balanced position for the first 6 months of 2020/21. Alongside this the £8.2m planned non recurrent surplus draw down has also been received. All of this led to a break-even position at month 5.

At month 6 the CCG is reporting a month 6 overspend of £1.3m against an allocation of £176.8m. Within this position, in addition to business as usual expenditure, the CCG has incurred £7.6m of expenditure related to the COVID-19 pandemic. This overspend is split £1.2m COVID-19 (£0.3m from month 5) and £0.1m Business As Usual. As in previous months, it is expected that a retrospective allocation will be received by the CCG to ensure a breakeven position.

A separate paper is on the agenda to discuss the allocations published for months 7 -12 and the impact of this upon the CCG.

Recommendations

It is recommended that the Finance, Contracting and Procurement Committee:

- Receive the report for information.
- Note the continuation of the current financial arrangements into August and September with a new regime to be in place from October.
- Note the month 6 overspend of £1.3m against notified allocation
- Note the COVID related expenditure of £7.6m at month 6
- Note the expectation of retrospective allocations to enable the CCG to report a breakeven position at month 6.

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:	
GBAF	

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 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's risk register?	Yes	☐	No	☐	N/A	☒

Month 6 Finance Report

1. Introduction

1.1. This report provides an update on the current financial regime put in place for the CCG and an analysis of the financial position at month 6.

2. 2020/21 Financial Framework 1st April to 30th September

2.1. In March 2020 the CCG submitted a draft budget plan to NHS England based on a month 9 forecast recurrent outturn position adjusted for pressures including inflation and growth, investments and savings plans. The draft plan showed a deficit of £11m after expected delivery of a £9m QIPP plan. Subsequent to this the planning round was suspended and a national top down command and control framework was put in place in response to the COVID 19 pandemic. In light of this on the 24th April 2020 the Governing Body approved the draft plan as an interim budget for 2020/21.

2.2. Late in March, CCG's were notified of a number of changes to the contracting and payment process. All NHS providers were moved to stipulated block payments for the first four months of 2020/21 as notified by NHSE England based on month 9 agreement of balances figures uplifted for inflation. All other NHS provider to CCG invoicing was suspended. Independent sector hospital capacity was centrally block purchased by NHS England. Payments to other healthcare providers essential to the COVID response were guaranteed at least in line with amounts received in 2019/20. Those not essential to the response were directed to other forms of government support.

2.3. In May CCG allocations were issued for the first four months of the year from the 1st April to the 31st July and new financial framework described. In July NHS England informed CCG's that the current financial arrangements would continue into August and September with a new financial regime to be in place for the second half of the year. CCG allocations have been published for months 7 -12 and the impact of these is discussed in a separate paper.

2.4. As per the financial framework for the first six months of the year the CCG has received a notified baseline allocation of £166.9m. In addition to this the CCG has received the full planned non-recurrent historic surplus drawdown of £8.2m (with £4.1m shown to month 6) and £5.8m retro adjustment allocation for COVID related costs and business as usual variances to month 5. This brings the CCG allocation for the first six months of the year to £176.8m with an anticipated allocation of £1.3m for month 6 allowing the CCG to achieve a breakeven position.

3. Financial Position at month 6

3.1. The table below shows the reported financial position against allocation at month 6.

Month 6 Year To Date	Allocation £'000	Business as Usual £'000	COVID £'000	Total Actual £'000	Variance £'000
Acute Services (ISFE)	85,012	84,274	84	84,358	(654)
Mental Health Services (ISFE)	17,568	17,680	160	17,840	272
Community Health Services (ISFE)	18,109	16,072	2,378	18,450	341
Continuing Care Services (ISFE)	10,863	8,162	3,320	11,482	619
Primary Care Services (ISFE)	21,959	20,808	1,452	22,260	301
within which Prescribing	*16,971*	17,062	*0*	17,062	*91*
Primary Care Co-Commissioning (ISFE)	14,171	14,228	0	14,228	57
Other Programme Services (ISFE)	7,228	7,378	186	7,564	336
Total Commissioning Services	**174,910**	**168,602**	**7,580**	**176,182**	**1,272**
Running Costs (ISFE)	1,905	1,905	0	1,905	0
Total CCG Net Expenditure	**176,815**	**170,507**	**7,580**	**178,087**	**1,272**

3.2. At month 6 the CCG is reporting an overspend of £1.3m against an allocation of £176.8m. Of this £1.2m relates to COVID expenditure (£0.3m from month 5) and £0.1m on business as usual expenditure.

3.3. The key over and underspends in business as usual (BAU) areas are:

- Acute services are £0.7m underspent in month 6, primarily due to receiving allocation for expenditure not being incurred by the CCG following the central purchasing of independent sector bed capacity.
- Mental Health services are £0.3m overspent as a result of both an increase in the number of high cost mental health placements, complexity of patients.
- Community Services are £0.3m underspent due to COVID related costs
- Primary Care is £0.3m overspent as a result of actual prescribing spend for April to July being higher than forecast. This is after the inclusion of pressures for non-cheaper stock options (NCSO) and category M drugs.
- Delegated co-commissioning is £0.06m overspent following the receipt of GP claims for backdated claims and locum fees.
- Other programme spend is £0.3m underspent due to a delay in planned investments.

3.4. At month 6 the CCG reported £7.6m of expenditure on COVID related costs broken down in the table below.

CCG COVID Expenditure Analysis to month 6	Expenditure £'000
Remote management of patients	949
Hospital Discharge Programme	3,970
National Procurement Areas	308
After Care and Support Costs	1,113
Remote working for non-patient activities	192
Other Covid-19	1,049
Total CCG Net Expenditure	**7,581**

3.5. The largest area of expenditure is £4.0m for the hospital discharge programme of which £2.9m relates to local authority costs mainly with care homes. Other key areas of spend are £0.9m on the remote management of patients, £1.1m on After Care and Support Costs, £0.6m for COVID management services and community swabbing and £0.4m on GP IT.

3.6. In line with national guidance and allocation received to date covering COVID expenditure to month 4. It is expected that the balance of the full cost of the COVID response to month 5 and 6 will be met through additional allocation in month 7.

4. Overall 2020/21 financial position

4.1. At the start of the year the forecast position was an £11m deficit after delivery of a £9m QIPP programme. The current financial position follows the receipt of £5.8m retro top-up and £8.2m drawdown of historic surplus. Whilst this takes the CCG a lot closer to breakeven reporting an overspend of £1.3m the CCG is reliant on additional allocations to ensure a breakeven position for the first 6 months of 2020/21.

4.2. The assurance that the CCG will receive further allocation adjustments for all reasonable expenditure to allow delivery of a breakeven position for the period April to September reduces the immediate financial risk to the CCG. However the prescribed value of provider payments, restriction on investment, inability to work on QIPP plans and likely recurrent impacts of the COVID response means the longer term risk to the CCG cannot yet be understood.

4.3. Work is ongoing both within the OCO and with partners across the locality to ensure a financially sustainable system recovery to the pandemic ensuring that any beneficial financial impact of pathway changes and improvements made are embedded in the longer term.

4.4. An assessment of the impact of the month 7 - 12 allocations is covered in a separate paper.

5. Actions Required

The Finance, Contracting and Procurement committee is required to:

- Note the current financial arrangements to September with a new regime to be

in place from October.

- Note the month 6 overspend of £1.3m against notified allocation
- Note the COVID related expenditure of £7.6m at month 6.
- Note the expectation of retrospective allocations to enable the CCG to report a breakeven position at month 6.

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October 2020

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Receive
Item No	7.1	**Confidential / Freedom of Information Status**	No
Title	Integrated Commissioning Fund Quarter 2		
Presented By	Mr M Woodhead, Joint CFO, Bury Council & NHS Bury CCG		
Author	Carol Shannon-Jarvis, Associate CFO		
Clinical Lead	n/a		
Council Lead	Mr M Woodhead, Joint CFO, Bury Council & NHS Bury CCG		

Executive Summary

This report provides an update on the ICF budget for 2020/21 and forecast outturn for 20/21 at quarter 2.

The command and control regime implemented in the NHS means the CCG only received formal notification of allocation of budget for the year in November. The second half of 2020/21 sees an end to the financial regime whereby the CCG received retrospective allocations for all over/underspends to ensure achievement of a breakeven position. The CCG must, as in previous years, manage within a notified allocation for the remainder of the year. The CCG has been notified of a total allocation of £349.7m with a further £1.3m outstanding retrospective allocation expected in November. That allocation has been largely based on 2019/20 expenditure run rates for Half 1 and forecasts for Half 2.

This revised CCG allocation results in a total ICF expenditure budget of £501m split between the 3 elements of the fund as:

- pooled budget £323m
- aligned budget £139m
- In-view budget £38m

Further allocations are expected to cover costs not currently included within the CCG baseline for Half 2 including the Hospital Discharge Scheme for which estimates are £6m.

The CCG allocation includes receipt of £8.2m historic surplus which has enabled the CCG to make the additional £10.5m allocation to the pooled budget committed to last year. In turn, the council contribution to the pooled budget has been reduced by £10.5m in 2020/21.

At month 6, the ICF is forecasting an overspend of 6.9m. There is a £1.6m overspend on services held within the section 75 pooled budget, £5.3m overspend on aligned services and breakeven position on in-view services. The key overspends are driven by COVID related expenditure, loss of income across council services and delays in the achievement of savings. In the pooled budget, £1.9m of the forecast overspend is due to loss of income from

wellness leisure facilities in the council.
Recommendations
It is recommended that the Strategic Commissioning Board: • Accept the newly notified CCG budget for 20/21 and its allocation to the ICF • Note the ICF forecast financial position at month 6 of £6.9m overspend and the assumptions on which it is based. • Note the financial risks to Bury.

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
Achievement of in-year financial balance and financial sustainability over medium term.	

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	Yes	☐	No	☐	N/A	☒

Implications						
User Implications?						
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?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /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.		

Integrated Commissioning Fund View Quarter 2

1. Introduction

1.1. This report provides a summary view of the financial position of the Bury Integrated Commissioning Fund (ICF) for quarter 2. More detailed organisational reports with full departmental variance analysis have been presented to the appropriate Council and CCG committees and are attached as appendices to this report.

1.2. The ICF brings together the financial resources of the CCG and Council into a single fund enabling the Strategic Commissioning Board (SCB) to make decisions and recommendations (subject to reserved matters) based on the full picture of CCG and Council finances. The ICF is comprised of 3 budgets: a section 75 pooled budget for which the SCB has delegated decision making powers, an aligned budget for which the SCB can make recommendations but decision making powers remain with the originating statutory body and an in-view budget which impact the CCG and council but decisions are made by bodies other than the partners.

2. ICF Budget

2.1. Since the opening budget, the command and control regime implemented in the NHS means the CCG only received formal notification of allocation of budget for the year in November. The second half of 2020/21 sees an end to the financial regime whereby the CCG received retrospective allocations for all over/underspends to ensure achievement of a breakeven position. The CCG must, as in previous years, manage within a notified allocation for the remainder of the year. The CCG has been notified of a total allocation of £349.7m with a further £1.3m outstanding retrospective allocation expected in November. That allocation has been largely based on 2019/20 expenditure run rates for Half 1 and forecasts for Half 2.

2.2. The CCG notified allocation includes £8.2m draw down of historic surplus which has allowed the CCG to fulfil the £10.5m additional allocation commitment to the pooled budget in 20/21 made last year. In turn, the council has been able to reduce its contribution to the pooled budget by £10.5m. The CCG allocation also includes:

- £5.8m of retrospective allocation to compensate for:
  - the impact of COVID; and
  - variances in business as usual spend for the first 5 months of the year
- £8.8m additional support towards the achievement of a breakeven plan in the second half of the year.

2.3. Further allocations are expected over the coming months to cover costs not currently included within the baseline for Half 2, including the Hospital Discharge Scheme for which estimated costs and funding are £6m. As these allocations are received, they will be varied into the ICF pooled, aligned and in-view budgets to match the relevant expenditure.

2.4. The CCG plan reflects the ambition to achieve community, primary care and mental

health investment standards in 2020/21. Specifically, investments have been agreed with Pennine Care NHSFT and our voluntary sector providers to ensure the CCG achieves the Mental Health Investment Scheme (MHIS) annual target of £34.1m. Also within the plans are QIPP schemes totalling £0.9m (0.5% of allocation) which are already implemented and on track for full delivery.

2.5. For Council led services, the total net ICF budget remains at £164.8m with grant income received in year offset by matching expenditure.

3. ICF Financial Performance

3.1 At month 6, the ICF is forecasting an overspend of 6.9m. Based on current mapping of budgets and income, there is a £1.6m overspend on services held within the section 75 pooled budget, £5.3m overspend on aligned services and breakeven position on in-view services. This forecast position assumes the CCG will receive retrospective allocations for variances to budget including COVID expenditure to month 6 as have been received in previous months allowing the CCG to breakeven to month 6 and that expenditure for months 7 to 12 will be as per plan. To note, as required in the month 7 to 12 planning guidance, the CCG forecast does not include costs for the hospital discharge programme, independent sector activity and other costs which the CCG expects will be matched through claims against other funding streams. The plan, as instructed by NHSEI, also does not take account of the current second wave of COIVD-19.

Service area	20/21 Budget £'000	20/21 Forecast Outturn £'000	20/21 Variance £'000
CCG Pool Contribution	(220,283)	(220,283)	0
LA Pool Contribution	(103,002)	(92,502)	10,500
CCG Pool Additional Contribution	0	(10,500)	(10,500)
LA Pool Additional Contribution	0	0	0
Total Pool Contribution	**(323,285)**	**(323,285)**	**0**
Acute Health Services	83,396	83,396	0
Community Services	34,891	34,891	0
Mental Health Services	36,089	36,089	0
Primary Care Services	43,233	43,233	0
Adult Social Care Operations	7,616	7,108	(509)
Care in the Community	39,640	39,387	(253)
Public Health	10,435	10,433	(2)
Other OCO Services	21,775	21,818	43
Childrens Social Care	6,513	7,052	540
Other Childrens Services	5,991	5,948	(43)
Other CCG Services	22,674	22,674	0
Other Council Services	11,032	12,897	1,865
Total Pool Expenditure	**323,285**	**324,926**	**1,641**
Section 75 Pooled Budget	**0**	**1,641**	**1,641**
CCG Aligned Contribution	(77,644)	(77,644)	0
LA Aligned Contribution	(61,845)	(61,845)	0
Total Aligned Contribution	**(139,489)**	**(139,489)**	**0**
Acute Health Services	76,725	76,725	0
Childrens & Young Peoples	29,275	30,019	744
Operations	15,136	21,045	5,909
Other CCG Services	919	919	0
Other Council Services	17,434	16,072	(1,362)
Total Aligned Expenditure	**139,489**	**144,779**	**5,290**
Aligned Budget	**0**	**5,290**	**5,290**
CCG In View Contribution	(38,441)	(38,441)	0
LA In View Contribution	0	0	0
Total In View Contribution	**(38,441)**	**(38,441)**	**0**
Delegated Co-Commissioning Budgets	28,354	28,354	0
Other CCG Services	10,088	10,088	0
Other Council Services	0	0	0
Total In View Expenditure	**38,441**	**38,441**	**0**
In-View Budget	**0**	**0**	**0**
CCG Total Contribution	(336,368)	(346,868)	(10,500)
LA Total Contribution	(164,847)	(154,347)	10,500
Total Contribution	**(501,215)**	**(501,215)**	**0**
CCG Expenditure	336,368	336,368	0
LA Expenditure	164,847	171,778	6,931
Total Expenditure	**501,215**	**508,146**	**6,931**
Bury Integrated Commissioning Fund Total	**0**	**6,931**	**6,931**

3.2 The key overspends in the ICF are driven by COVID related expenditure, loss of income across council services and delays in the achievement of savings. In the pooled budget £1.9m of the forecast overspend is due to loss of income from wellness leisure facilities in the council.

3.3 COVID-19 CCG related funding claims for quarter 1 and 2 are:

CCG COVID Expenditure Analysis to month 6	Expenditure £'000
Remote management of patients	949
Hospital Discharge Programme	3,970
National Procurement Areas	308
After Care and Support Costs	1,113
Remote working for non-patient activities	192
Other Covid-19	1,049
Total CCG Net Expenditure	**7,581**

3.4 The council and CCG have worked together closely to optimise NHS funding for the locality, including council access to more than £2.2m of NHS funding streams for the first half of the year related to the Hospital Discharge Programme. All CCG COVID funding received to date is included within the pooled element of the ICF.

3.5 The council tracker of COVID related grant income is shown below. Of this £1.1m was utilised within the 19/20 financial year. In 20/21 £2.4m for infection control is reflected within the pooled budget forecast with the balance in the aligned budget.

Council COVID Grants	£'000
Tranche 1, 2 & 3 un-ringfenced	12,316
Hardship relief fund & DEFRA food hardship	2,117
Infection Control	4,330
Re-Opening High Streets	169
Test and Trace	1,230
New Burdens	170
COVID Marshall	104
Self Isolation	171
Business Rates Grants	42,920
Total	**63,527**

4 Financial Risk

4.1 In the current uncertain environment of COVID there are a number of financial risks SCB should be aware of.

4.2 Firstly, the CCG has only received formal confirmation of allocations relating to baseline spend for the period October to March. There is a risk that the CCG will not receive the funding it needs to cover the continuation of COVID related schemes, wave 2 costs and any additional demands placed on the CCG and Council for the remainder of the year. However, there are indications that reasonable costs in line with guidance will be reimbursed so the immediate risk is limited.

4.3 As part of the NHS financial reset all funding allocations have been reviewed and transformation funding has ceased. There is a risk that, due to delays in the achievement of deflection savings, there are services needing to be recurrently funded without realizable savings to cover the costs. LCO colleagues are working on revised programme phasing. Strong evaluation processes will be essential in determining if/how to continue transformation programmes.

4.4 In the command and control response to COVID, the decision on the introduction of a number of services which benefit the Bury population have been taken at a Greater Manchester, regional or national system level. These costs have been reimbursed to providers or leading organisations under the current regime and there is a risk that Bury will be required to pick up any on-going costs without receiving additional funding. The risk in the longer term will require the input of commissioners and finance colleagues to ensure only those services of benefit and value for money continue and any costs are mitigated by reductions elsewhere in service spend. Work is being done by the Financial Advisory Committee of GMHSCP to understand the system-wide run-rates and investment commitments, alongside predicted funding levels.

4.5 There is a risk that the CCG and health care providers are expected to achieve significant improvements in performance targets for the second half of the year, despite service capacity decreasing. There is a risk that the expectation of localities will be extremely challenging.

4.6 Under the terms agreed for the ICF, financial risk will be managed in the following ways:

1) Where underspends occur, to ensure overall financial balance underspends from one fund can be used to offset financial risk in another.
2) The section 75 pooled budget agreement allows additional contributions to the pool to be made by a party, matched by equivalent additional contributions by the other party in a subsequent year.
3) A 50:50 risk share agreement between the partners each contributing 50% of a budget overspend.

5 Budget Changes

5.1 Since the opening budget, the command and control regime implemented in the NHS means the CCG has only received formal notification of allocation of budget for the year in the last month. Based on run rates during 19/20 and during the pandemic months 1 to 6 the baseline allocation received for 20/21 is £335.7m. In addition, the CCG has received allocations of £8.2m draw down of historic surplus and expects a

total of £7.1m in COVID and business as usual support for months 1 to 6 bringing the total CCG allocation for 20/21 to £351m. Further allocations are expected over the coming months to cover costs not currently included within the baseline for months 7 to 12 including the Hospital Discharge Scheme for which estimates are £6m.

5.2 For Council led services, the net budget remains unchanged with additional grants received in year matched by forecast expenditure.

6 Actions Required

6.1 The SCB is asked to:

- Accept the newly notified CCG budget for 20/21 and its allocation to the ICF
- Note the ICF forecast financial position at month 6 of £6.9m overspend and the assumptions on which it is based.
- Note the financial risks to Bury.

Carol Shannon-Jarvis
Associate CFO
Carol.Shannon-Jarvis@nhs.net
November 2020

Appendices: Organisation Month 6 reports

Cabinet November 2020 - The Councils Finance Report.pdf

AI 5 Month 6

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Consider
Item No	7.2	**Confidential / Freedom of Information Status**	No
Title	Council 2021/22 Budget Setting		
Presented By	L Kitto		
Author	L Kitto		
Clinical Lead	n/a		
Council Lead	Cllr O'Brien		

Executive Summary

The attached paper was presented to Cabinet on 24 November 2020, prior to the government's latest Spending Review announcements, and was slated to come to SCB to inform a system wide discussion about the potential impact of savings proposals across the health and care system and to inform a debate about prioritization of OCO/system spending. That discussion also needs to take account of emergent guidance on the revised NHS financial framework, alongside the anticipated CCG financial position, savings programmes and GM system architecture for the new year.

The council has been working to develop a medium-term financial strategy to address its financial gap (estimated at £50m over the next two years, prior to the Spending Review announcements). The focus of the adult social care savings plans has been to accelerate the themes of transformation already identified in the locality plan and considered as part of the health and care recovery transformation programme. The attached paper gives an overview of the scale of the financial challenge faced by the Council as a whole, including adult social care.

The attached paper shows a savings target of c£21m over the next two years and, although some of the announcements in the Spending Review will go some way to mitigating that pressure (at least in the short term), the scale of the challenge will still be considerable.

Further detailed savings and spending prioritization proposals will be presented to SCB early in the New Year.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receive the report
- Consider the implications of savings proposals on the wider system
- Consider how to prioritize system spending in the context of the significant financial challenges and uncertainty facing the council and NHS organisations

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.
Financial sustainability risks	

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?						

Implications						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /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.		

Classification Open	Item No.

Meeting:	**CABINET**
Meeting date:	**24 November 2020**
Title of report:	**Setting the 2021/22 Budget**
Report by:	**Leader of the Council and Cabinet Member for Finance and Growth**
Decision Type:	**Key Decision**
Ward(s) to which report relates	**All**

Executive Summary

1 INTRODUCTION

1.1 This year the context in which financial planning is being undertaken is perhaps the most complex and difficult of recent times. When the Council's 2020/21 budget was set uncertainties around Government policy and funding through the Comprehensive Spending Review, Local Government Finance Settlement, the Fairer Funding Review, the Business Rates Retention Review and potentially other major reforms existed. Whilst a challenging situation in it's own right, this was without the emergence and impact of the Covid-19 pandemic, which will continue to have a significant financial impact on our own finances and on the wider economic position of our borough and our region, for some time to come.

1.2 The economic reality is fast changing and challenging and the extent of how long this will last cannot be predicted with any great certainty but will inevitably bring additional pressures in demand for the services provided by the Council and our partners. The significant financial impact of Covid-19 cannot be underestimated and as the economic impact of Wave 1 is still unfolding the potential for an even greater impact of Wave 2 and beyond is one which the Council needs to consider and plan for. In response to this, the Council has developed a six month plan for living with Covid as part of a two year corporate plan that is recommended for approval elsewhere on the agenda.

1.3 Over recent months the Council has been reviewing and reporting on its financial position and in October 2020 Cabinet received a financial planning document and financial framework within which its 2021/22 budget would be developed and which would form the basis of the budget for future years. In providing a framework, it was recognised that there were still some significant uncertainties, particularly with the funding assumptions for future years which remain unknown largely due to the delay in the Comprehensive Spending Review, the outcome of which is not likely to be known until early to mid-December. What is known is that whatever the outcome of the CSR, the Council is likely to be facing a significant financial challenge going forward and processes need to be put in place to be able to deal with this now in order to meet our statutory requirements around budget setting.

1.4 In October 2020, the Council launched a public consultation on the Bury 2030 strategy and it is essential that are budget planning aligns to the vision and priorities set out in the strategy. The priorities are organised around the five themes of the local industrial strategy:

- **Healthy People:** We want to improve health and well-being by working with communities and residents to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life.
- **Thriving, green Places:** All six towns should be thriving and sustainable and by 2030 we will have delivered key regeneration opportunities within our town centres. Everyone will be living in a high-quality carbon-neutral environment by 2038.
- **Co-designed Ideas:** We will routinely harness the voices and creativity of all our residents in developing future plans; celebrate the diversity of our community and offer an 'opportunity guarantee' for everyone who wants to develop through volunteering or needs specific support to get back to playing a fulfilling role in the community.
- **Future-proofed Infrastructure:** All people and businesses in the Borough will have access to modern well-managed infrastructure including excellent housing, transport and superfast broadband as part of a new 'digital first' norm.
- **Inclusive Business Growth:** Our Borough will have a thriving local economy which will be recovered from the impacts of Covid-19 and from which all residents can benefit through a first-class all-age skills offer, high quality local jobs and targeted support for people experiencing hardship, including those who are working.

1.5 Underpinning the strategy is a commitment to internal transformation, the objectives for which include:

- the need to drive internal improvements across core key functions within the partnership such as organisation strategy; programme delivery and IT/Digital infrastructure;
- a requirement to develop the internal capabilities to deliver vision of Bury 2030 outcomes;
- public service reform to support more integrated working practice and enhanced partnership working in order to reduce demand.

1.6 It is within this context that the Council's approach to setting the 2020/21 budget has been developed. Over recent months the Executive Team has been involved in detailed discussions on how the Council's budget may be reshaped and transformed to deliver the services and outcomes that we need but within a reduced cost and funding envelope. The outcome of this work forms the basis for the rest of the report. The One Commission Organisation and Pooled Budget with Bury CCG has been central to the work on budget options and to our single response to Covid. The largest proportion of savings proposed so far in the budget process are with the Health and Social Care partnership as set out in section 5 of this report.

Recommendations

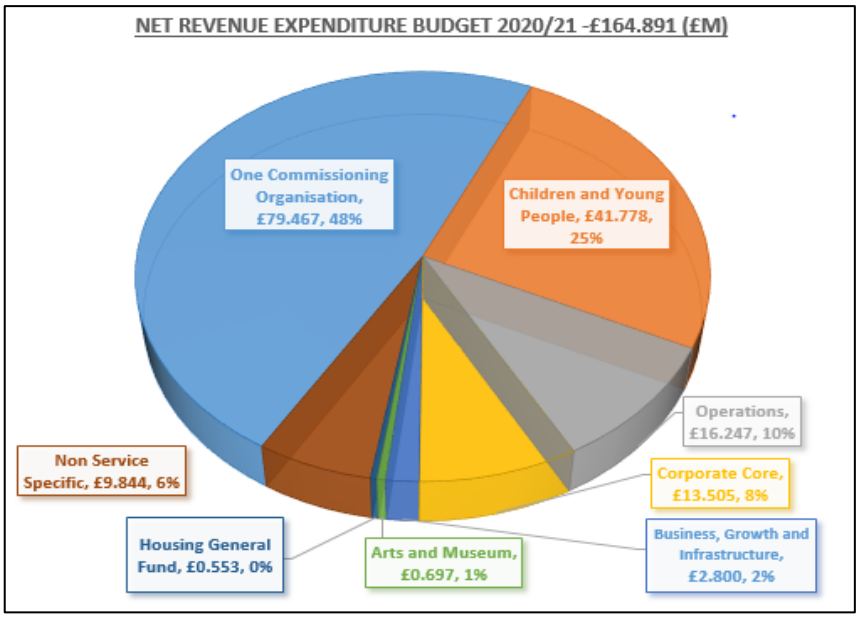
To:

- **Approve the 2021/22 to 2024/25 medium term financial and budget strategy including the savings proposals for the purposes of a conversation with the public, key stakeholders and staff to inform the final budget proposals to Full Council in February and that these proposals will be presented to the Overview and Scrutiny Committee as part of the process;**
- **Note the significant uncertainty in funding and that the MTFS will be updated and reviewed in light of the announcements anticipated in December 2020;**
- **Note the budget gap of £64.093m over the 4 years of which £31.243m relates to 2021/22 prior to any proposed savings and the proposed use of reserves;**
- **Note the residual gap of £15.280m over the 4 year period should all savings proposals and use of reserves be ultimately accepted and that a gap of £4.194m remains by the end of the second year of the strategy (2022/23) and that further work is underway to identify further options;**
- **Note the planned work on transformation and that a saving of £5m, the key themes of which are described in the report, are expected to generate savings of £5m to contribute towards the savings target;**
- **Note the projected position on the Council's reserves and the intention to bring forward proposals to generate one-off income that can be utilised to supplement reserves and reduce the 'run rate', i.e. capital receipts;**
- **Note the further work underway on the Council's capital programme and to prioritise projects that can deliver better outcomes and reduce the revenue funding requirements;**
- **Note that the initial proposals as a conversation prompt will be considered by the Strategic Commissioning Board in December alongside emergent clarity on the CCG financial position for 2021/22 and in the context of the commitment to the pooled budget for health and care between the Council and the CCG.**

2 FINANCIAL CONTEXT AND BACKGROUND

2.1 The Council's 2020/21 budget was set to remove ongoing reliance on short term and one-off reserves funding, 'rebalance' budgets to where the funding was needed, remove historic savings targets that were unachievable and these were replaced with savings options that had been robustly challenged and were considered achievable at that time. At the same time the Council's reserves were starting to be replenished and funding to support the wider transformation of the Council was available. The 2020/21 financial year, whilst challenging, was considered to be deliverable. This unfortunately is no longer the reality.

2.2 In understanding the budget proposals it is useful to understand the financial envelope within which the Council operates. The net controllable budget for the Council (excluding schools) is £164.891m and the allocation of the budget across the services is set out below:



2.3 Since 2010 the Government has reduced the funding for Local Government as part of its efforts to reduce the fiscal deficit and has been the longest sustained squeeze on public spending on record.

2.4 Alongside reductions in funding, Local Authorities have had to deal with growth in demand for key services, most notably adults and children's social care and this demand is expected to continue. Other pressures have also been faced including higher national insurance contributions, inflationary pressures on goods and services, the apprentice levy and the National Living Wage.

2.5 The cost to the Council of the Covid-19 pandemic and the expected ongoing financial pressures have also added to the savings requirement for 2021/22 and beyond.

2.6 On 21 July 2020 the Chancellor announced a Comprehensive Spending Review (CSR) for the autumn which was to inform government departmental totals. The consultation period has now ended and the outcome is awaited. Due to the unprecedented uncertainty it is now known that a one year only settlement will be announced. The Spending Review is expected 'in the last weeks of November with the CSR two to three weeks later'. This means that the outcome of the CSR is unlikely to be known until mid-December and at that point a further review of the Council's financial position will be needed to inform the final budget proposals in February.

2.7 The Council is however unable to wait until the funding allocations are known and planning assumptions have been updated and refreshed. This work will ~~will~~ continue throughout the remainder of the year until the budget is set in February 2021. The outcome of the refresh has:

- Determined the likely levels of resources available over the medium term;
- Determined the level of spending priority commitments arising from the Covid-19 recovery plan and the Council's ambitions over the medium term;
- Developed and considered options to deliver budget reductions that can be evaluated alongside spending priorities.

Updated Resource Forecast

An updated position on forecast resources is set out in the table below:

Revised Resources Forecast – November 2020						
	2021/22			2022/23	2023/24	2024/25
	Original	Revised Nov	Net Reduction / (Increase)	Net Reduction / (Increase)	Net Reduction / (Increase)	Net Reduction / (Increase)
	£m	£m	£m	£m	£m	£m
Total Resource Forecast	167.446	160.435	7.008	4.397	1.269	(0.764)
Analysis:						
Improved Better Care Fund	7.405	7.405	0.000	0.000	0.000	0.000
Social Care Grant	1.395	1.395	0.000	0.000	0.000	0.000
New Homes Bonus	0.235	0.235	0.000	0.000	0.000	0.000
Social Care £1bn	3.375	3.375	0.000	0.000	0.000	0.000
NHS Funding/Contribution	0.400	0.000	0.400	0.400	0.400	0.400
Independent Living Fund	0.291	0.291	0.000	0.000	0.000	0.000
LCTS Admin Grant	0.230	0.230	0.000	0.000	0.000	0.000
Housing Benefit Admin Grant	0.520	0.520	0.000	0.000	0.000	0.000
Sub Total	**13.851**	**13.451**	**0.400**	**0.400**	**0.400**	**0.400**
Council Tax	90.747	87.987	2.760	0.559	(1.766)	(3.368)
Business Rates	62.846	58.997	3.848	3.439	2.635	2.205
Sub Total	**153.593**	**146.9841**	**6.609**	**3.997**	**0.869**	**(1.164)**
TOTAL	**167.446**	**160.435**	**7.009**	**4.397**	**1.269**	**(0.764)**

2.8 The calculation of resources assumes:

- **Continuation of grants at 2020/21 levels –** There is currently no information on the level of grants for 2021/22 and future years and therefore it has been assumed that these will continue at existing levels;
- **Council tax increase of 2% per annum –** This is subject to political decision making however was included in the MTFS when it was set in February 2020. A 1% change in council tax is equivalent to £0.8m;
- **Collection Rates for council tax and business rates –** This is currently an extremely volatile situation and continues to be significantly impacted by Covid-19 and the wider economic impact on our residents and businesses. Currently a reduction in council tax collection from the previously assumed 96.5% to 94.5% has been reflected in the figures (this reflects an improvement in the last two months of the current financial year). Similar assumptions have been made on business rates though there is a risk that these are artificially high and are being masked by the additional S31 grants received from the government;

- **Council Tax Growth –** A review of empty properties and current growth has identified £1.257m that can be built into the baseline for 2021/22. In addition to this, a further 1% in the council tax growth has been assumed generating a further anticipated £3.294m over the subsequent financial years. This has now been built into the base;
- **Rephasing of 2020/21 collection fund deficit over 3 financial years –** The final accounting regulations have now been released however councils have been advised that they can phase the 2020/21 impact over 3 financial years. For Bury this is £1.976m applied equally over the 3 years. This is the new cost for Bury after taking account of S31 grants (£26m) that were made available to local authorities in 2020/21 to cover the cost of the business rates holiday for eligible businesses in the retail, hospitality and leisure sectors.

Refresh of Savings Plan

2.9 When the 2020/21 budget was set in February 2020 a total of £4.162m savings were reflected in the budget. Some of these savings were expected to increase over the next financial years increasing to £4.629m in 2021/22 and £4.964m in 2022/23. In July, Cabinet agreed that where savings were not considered deliverable, alternative efficiencies should be identified where possible. Some alternative areas of efficiency have been identified and approved by Cabinet as replacements for those that are not achievable. Two savings have however emerged as unachievable:

- Corporate Landlord (£0.585m). Savings on the corporate landlord model are not currently deliverable as initially anticipated however work on the one public estate, the corporate facilities management function, the consolidation of the council's properties and a move towards agile working as part of the wider transformation programme will deliver savings. It is proposed that savings will be generated in future years to offset this proposal trough a reduction in the Council's estate, creation of public service hubs and sharing of premises with partners;
- Architects Service (£0.525m). Savings on staff have been reflected in previous budget rounds however the associated income loss has not been addressed which has created an undeliverable pressure on the service.

It is proposed that these be added back into the forecast.

Update and Refresh of Demand Assumptions

2.10 Some demand assumptions had already been reflected in the MTFS when the 2020/21 budget was set however an assessment of current demand trends and other known factors suggest that a further £11.684m in ongoing costs is required over the next 4 years of which £9.725m is required in the first two financial years. The impact of Covid-19 has been reflected in demand and is a key driver for a higher than anticipated increase particularly in the early years of the strategy. Of the £3.188m demand pressures in 2020/21, £1.980m is Covid-19 related (adults social care, looked after children placements, home to school transport and legal costs), the remainder reflecting changes in demand/demographics etc.

A summary is set out in the table below and a full analysis at Appendix A.

Analysis of Cost Pressures Reflected in the MTFS				
	2021/22	2022/23	2023/24	2024/25
	£m	£m	£m	£m
Previously Agreed Costs	*1.115*	*0.000*	*0.000*	*0.000*
Pay Award	*0.250*	*0.000*	*0.000*	*0.000*
Inflation	*0.239*	*0.613*	*0.591*	*0.658*
Demand	3.188	0.324	0.398	0.312
DSG Related Costs	2.295	0.000	0.000	0.000
Fall Out of Time Limited Funding	0.600	0.000	0.000	0.000
Undeliverable Savings from previous years	1.110	0.000	0.000	0.000
TOTAL	**8.798**	**0.937**	**0.989**	**0.970**

2.11 In addition to reviewing demand, a review of income assumptions has also been carried out:

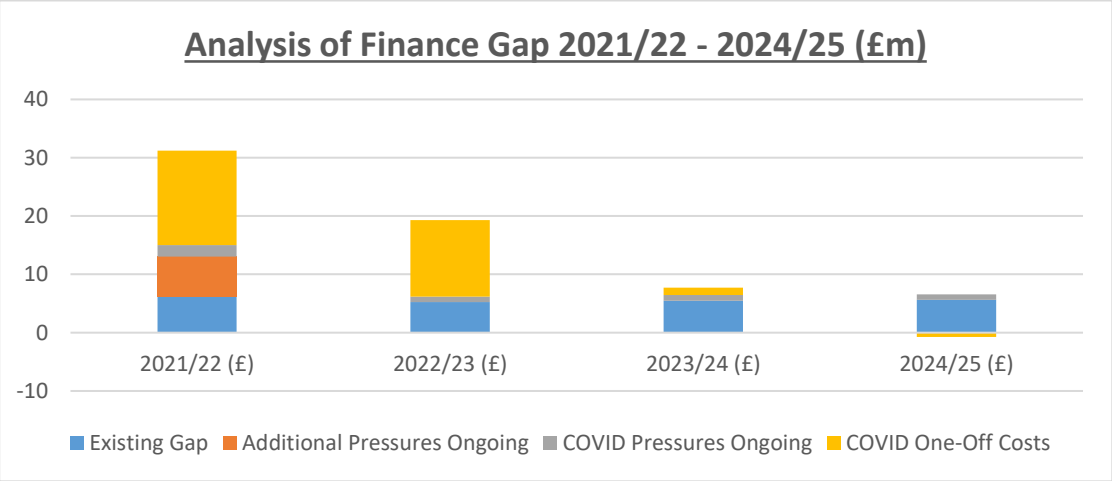
- The Council has a strategic investment in the Manchester Airport Group and has budgeted income within the financial strategy of £5.9m. In line with the principles of the mid-range scenario it has been assumed that the dividend will not be paid in the 2021/22 and 2022/23 financial years after which it will recover in full;
- The Council has previously provided strategic investment loans to Manchester Airport the interest payment for which is received in twice yearly instalments. These loan repayments are not forecast to be payable in the 2021/22 and 2022/23 financial years and it is therefore considered prudent that provision for these be made in the Council's strategy equivalent to £2.256m per annum;
- It has also been assumed that some of the income losses relating to car parking, leisure etc. will not recover to current budget levels for the same period of time. Both of these are shown as one-off losses to be met from reserves as they are directly related to Covid-19.

3 REVISED POSITION

3.1 The table below sets out the revised position in light of the MTFS update and is split between those costs that are deemed to be one-off and those that are deemed to be ongoing.

Updated MTFS Position November 2020				
	2021/22	2022/23	2023/24	2024/25
	£m	£m	£m	£m
Original Gap (Ongoing)	6.203	5.269	5.472	5.616
Additional Cost Pressures (Ongoing)	8.798	0.937	0.989	0.970
Annual Revised Gap (Ongoing)	**15.001**	**6.206**	**6.461**	**6.586**
Cumulative Revised Gap (Ongoing)	**15.001**	**21.207**	**27.668**	**34.254**
One-Off Funding Shortfall	7.009	4.397	1.269	(0.763)
Income Loss	9.233	8.694	0.000	0.000
Annual Short Term Funding Shortfall	**16.242**	**13.091**	**1.269**	**(0.763)**
Cumulative Short Term Funding Shortfall	**16.242**	**29.333**	**30.602**	**29.839**
Annual Gap (One-Off and Ongoing)	**31.243**	**19.297**	**7.730**	**5.823**
Cumulative Gap (One-Off and Ongoing)		**50.540**	**58.270**	**64.093**

3.2 In total £64.093m of savings are forecast to be required over the next 4 financial years which is an improvement on the previously forecast position largely due to improved forecast position on the collection fund and council tax base.



4 MANAGING THE GAP

4.1 To manage the gap, Cabinet agreed that this would be a combination of reserves, budget reductions and efficiencies through transformation. Based on the current position, it is not unrealistic to assume that the one-off losses can be met from one-off reserves and the remainder through budget reductions and transformation. In the broadest terms this means that £34.2m of savings are required on an ongoing basis over the next 4 years, of which £21.2m is required in the first two financial years. The call on reserves over the 4 years is forecast to be £29.9m of which £29.3m is required in the first two financial years.

4.2 Bury's reserves have been historically low however a review of the collection fund in the last financial year, and a commitment to make planned contributions to general reserves, was an opportunity to see reserves grow in the short term. Due to the position outlines above the call on reserves is now likely to be significant and must be reviewed as an integral as part of budget monitoring and through the development of the strategy. With this in mind the focus of the savings delivery plans is on the first two financial years in order to demonstrate financial sustainability and resilience in the longer term.

4.3 The options developed to date are set out below and are summarised at Appendix B. In total these total £6.437m in 2021/22 increasing to £13.974m in 2023/24. The proposed options include:

Children and Young People (£1.125m)

4.4 Wider transformation of the children and young people's service is envisaged and to support this a further diagnostic piece of work which will commence towards the end of the year to consider what opportunities may be available in the future. This piece of work will focus on a whole system analysis to ensure that practice in family support and prevention is robust in all areas of service delivery and is front loaded to ensure that the best evidence based interventions are available at the earliest opportunity without unnecessary reference to referral and thresholds. Avoiding escalation to costly care options, particularly out of borough placements, is the most effective way to reduce spending. The analysis will provide modelling and close monitoring of the relationship between early help in the form of locality, and settings based family work in close alignment with all locality based delivery partners and reduction in the need for statutory

intervention. This is in line with the neighbourhood model of the public service integration proposed in the Bury 2030 strategy. The analysis will provide for a challenging comprehensive narrative to be developed and shared, which will raise expectations for families from their Council, their schools and their health services, particularly in respect of inclusivity, co-production and family self-efficacy. This requires a whole system focus on some agreed principles and ways of working, including focusing money where it has most impact, ensuring most work with families is undertaken in community settings, empowering communities to act to prevent escalation to statutory services and reducing dependency on costly and sometimes ineffective provision. It requires helping people to receive and exit statutory services when needed as rapidly as possible.

4.5 The Council has made a good start on this journey with its commitment to Early Help and locality based working and has made some progress in reducing the number of school placements in out of borough Independent Non Maintained Sector. Additionally, the Council is engaging with the Department of Education who are working with local authorities with significant deficit balances on their Dedicated Schools Grant. The opportunity to consider the relationship between funding and expenditure will be explored at the time. In the meantime, the Council continues to manage its relationship with increasingly autonomous schools, maintaining a focus on its statutory and strategic role in promoting high quality education, skills and training and ensuring that the needs of the most vulnerable children and those with additional needs are met.

4.6 The Children & Young People Directorate will work on joint strategies such as the All Age Learning Disabilities Strategy referenced below, making sure that opportunities to work as a whole system are maximised.

One Commissioning Organisation

Transformation and Innovative Commissioning - All Age Disability Integration (£3m)

4.7 Our vision for Learning Disabilities (LD) services in Bury is an all age service, which would remove the need for transitions providing one smooth pathway for customers. To do this we will work differently recognising peoples strengths, ensuring all care is outcome focused, so all customers are aware that it's individual first not their disability. It is recognised that current practice to support people through the transitions process could be better therefore we are focussing on transitions planning, in particular those young people transitioning to adult's services in the coming 24 months.

4.8 We will focus on those transitioning from Children and Young Peoples services at an earlier age, ideally 13/14 years, this will enable more appropriate support of the individual and their family to be put in place. This will better manage expectations of the transitions process and potential reduction in support packages preventing less upset and chaos for those involved.

4.9 We need to prevent out of borough placements where possible, therefore we will work collaboratively with partners to improve our local offer i.e. education, housing, respite thus allowing individuals to remain part of their community and improve equity for all Bury customers. Achieving this will realise savings in reduction in care package values relevant to aspired outcomes that are more suitable, encourage independence, choice and control for our young adults.

Adult Social Care Personalisation and Transformation (£2m)

4.10 We will be moving from our traditional approach of social care assessment and support planning to a more personised approach, recognising the strength of our residents and

ensuring community, family and carer support options are fully explored before providing additional support. The support provided will focus on how we enable the person to achieve their outcomes rather than providing or doing it for or to them. There is extensive research to show working this way delivers outcomes for people and reduces demand. Alongside the transformation and savings work the Principal Social Worker in Bury will lead a programme of workforce development that will bring about:

- Strength and asset based approach
- Ethnographic thinking
- Personalised conversations
- New quality assurance framework
- Providing social care with the tools and information to work differently

Development of Assistive Technology (£0.500m)

4.11 Assistive Technologies is a range of equipment designed to prompt and assist people with everyday activities which have become difficult. They support people to stay safe and independent in their own home for as long as possible. Often called personalised technology because it is not about the technology, but the people and how providers can enhance lives. Solutions include anything from telecare equipment and environmental controls, to mobile technology and communication aids. The gadgets and equipment selected will meet someone's daily needs, whether at home, out and about in the community or at work.

4.12 A review of other local authorities has highlighted opportunities that not only deliver better outcomes for people and services but also significant savings. The initial findings suggest the amount of savings is dependent on a number of factors, willingness to invest to save, dedicated leadership/ team, innovation to continually develop, buy in from health and social care staff and an appetite to mainstream Assistive Tech across Social Care.

Improved Housing Options for people with disabilities (£0.1m)

4.13 The links between housing and social have never been more important and these are set out in the draft Housing Strategy approved by Cabinet for consultation on 14 October 2020. It is our intention to better utilise properties available, ensure they are of good quality, value for money, fit for purpose for the intended client groups and used in the best way possible. To achieve this involves improving existing stock and exploring new ways to develop local specialist housing options.

To enable us to achieve this we need to;

- Increase our shared lives scheme to deal with increased demand for the service that will come from a range of customers including reducing those in supported living.
- Develop the aspirational 'own front door' concept of a number of individual self-contained units as currently many people live in accommodation with shared facilities i.e. kitchens, bathrooms. With onsite support available 24/7, the costs of sharing support arrangement will realised savings and provide better quality of life for customers.
- Reconfigure and/or realign current specialist housing stock to reduce increasing voids costs to the council and providers. Develop connections between housing and social care system to provide improved accommodation options in borough.
- Reduce number of high cost out of borough placements through increasing adequate local accommodation opportunities.

- Decommission empty properties/spaces that have financial implications and work with providers to better use their available stock to prevent (where possible) market destabilisation.

Effective and Innovative Commissioning (£3.387m)

4.14 The focus of high quality, effective and innovative commissioning is on people, health and wellbeing, achieving good outcomes with using evidence, local knowledge, skills and resources to best effect. This means working in partnership across the health and social care system to promote health and wellbeing and prevent, as far as is possible, the need for health and social care.

4.15 Every person using health and social care services deserves the highest quality care and support, and the maximum opportunity to influence how that support is arranged and managed. Effective commissioning plays a central role in driving up quality, enabling people to meaningfully direct their own care, facilitating integrated service delivery and making effective use of available resources.

4.16 Commissioning is the Councils cyclical activity to assess the needs of the local population for care and support services, then designing, delivering, monitoring and evaluating those services to ensure person-centred and outcomes-focused delivery. In addition, good commissioning ensures a vibrant, diverse and sustainable market to deliver positive outcomes for people and communities, actively encouraging and promoting investment and innovation in the market in partnership care providers.

4.17 A number of areas have been prioritised to consider and test our approach to deliver effective and innovative commissioning:-

- Increased contribution from health into the pooled budget,
- More effective and efficient payment of Care at Home,
- Continuation of the work in respect of effective Market management in borough
- More effective management of personal budgets

4.18 The proposals in adult social care are with the grain of transformation programmes articulated in the Locality plan for health and care 2019-2024 which highlighted the potential of a health and care system wide gap in funding of £86m of which £27m was identified as associated with in scope local authority services. The implementation of the proposals will be managed as part of the health and care recovery and transformation programme and specifically the community programme of work.

Packages of Care Reviews (£3.462m)

4.19 Extensive research shows there are better outcomes for people when done ‘with’ the person rather than ‘to’ or ‘for’ the person. Alongside the transformation Bury is leading a programme of workforce development that will bring about:

- Strength and asset based approach
- Ethnographic thinking
- Personalised conversations
- New quality assurance framework
- Providing social care with the tools and information to work differently

4.20 This workforce development will ultimately lead to behavioural change of the social care workforce that overtime will reduce the reliance on traditional care.

4.21 Service delivery will continue with a different vision and new ways of working, considering alternative options for people, in most cases better options. This may result in some packages of care being reduced following a review process. In these instances best interest outcomes will be considered whilst ensuring statutory requirements are met. This work is not focused on removing support irrationally, rather considering alternative options that may not have been available at the point of assessment due to new ways of transformational working.

Operations

Civic Venues (£0.132m)

4.22 The Council operates a number of civic venues some of which operate at a loss and are also in need of significant investment in future years. Closure of the venues is proposed and will generate an ongoing saving as well as avoid the cost of future capital investment.

Waste Review and Vehicle Rationalisation (£0.237m)

4.23 This will involve continuation of the vehicle rationalisation programme, optimising waste collection rounds and street cleansing litter rounds as well as looking at opportunities to increase household waste recycling rates beyond 60% through:

- A comprehensive, sustained communications campaign which would require recruitment of additional staff and ongoing engagement with residents.
- Potential to enforce recycling, involving the issue of fines to residents who do not put 'the right stuff in the right bin'.
- Collection of a wider range of recyclables e.g. plastic pots, tubs and trays; textiles; batteries; small Waste Electrical and Electronic Equipment.
- Promotion of home composting, with an offer of subsidised compost bins to residents.

Dimming of Street Lights (£0.030m)

4.24 A street lighting column replacement programme is already underway in Bury. As a result of this programme, approximately 3,500 street lighting columns across Bury will be equipped with energy efficient LED lanterns which are able to be dimmed.

4.25 It is proposed to dim these lanterns between 00:00hrs and 06:00hrs, which will realise a reduction in carbon output and energy consumption in the region of 80 tonnes and £40,000 per annum respectively, therefore supporting a lower carbon economy, greater resilience to climate change and cleaner growth.

4.26 The proposed dimmed lighting levels will remain in line with the current British Standard Specification whilst providing adequate levels of lighting on the highway. It is important to note that the public will notice very little change in lighting quality from street lights being dimmed. A number of pilots have already taken place across Bury, with no negative feedback being received.

4.27 If implemented, the changes will enable the Council to reduce light pollution, and ~~it's~~its negative effects on residents' sleep patterns, certain nocturnal animals, plant species and people's enjoyment of the night sky.

5 TRANSFORMATION

5.1 When the Council's budget for 2020/21 was set in February 2020, the need for transformation was central to the strategy going forward and, in recognition of this, a fund of £5.8m was created to support transformation with the expectation that long term savings would be delivered. In managing the gap, it is proposed that a total of £5m be delivered through transformation in the first two financial years and the fund will be used to provide capacity to drive the agenda forward and make long term change .

5.2 Transformation projects will be pursued that improve service outcomes and can deliver efficiency savings as well. Initial areas of focus are set out below:

Transformation Workstream	Proposed savings option
Leadership	**Agile Working model** – improvement in staff productivity and reduction in Council owned and occupied buildings and operating costs
Process	A council **Customer service** strategy - channel shift opportunity to extend the Council's reach to communities and secure economies of scale by streamlining all customer contact into a coherent corporate function
	A joint **business support** review to establish a modern and cost effective service which reduces cost through: • Simplified and standardised support process, enabled by MS Teams collaborative tools • An expectation of user self-service through digital capabilities via i-Trent and MS Teams and corporate behaviours such as open diaries • An agile working model which removes the need to arrange and manage meeting rooms • Paperless meetings without the need for printing, postage and filing
Workforce	**Management** efficiencies within the Council through consistent and efficient spans of management control and organisational hierarchy

5.3 The options above are expected to make a significant contribution to the £5m target but more options are likely to be required to balance the budget over the next two years. Work is underway to engage a partner to lead a piece of "Design and Discovery" analysis, as follows:

- Assess the Council's costs, resources and delivery arrangements against sector best practice generally and public sector reform in particular. Deliverables from the initial discovery phase during this financial year will be required as follows:
  - A future operating model proposed based on strength based, community first principles.
  - Cost and use of resources analysis using benchmarks from across local government and other appropriate comparators.
  - Financial modelling using a range of techniques to reassess current allocation.
  - Proposal of a series of further potential budget options to reduce costs and maintain / improve outcomes.

5.4 As part of the Council's relationship with Microsoft a piece of digital design and discovery analysis is also underway, without additional cost, to assess systems requirements and opportunity across the strands of:

- Executive priorities, with reference to the Bury 2030 Strategy and Corporate Plan.
- Customer services, related to the specific budget option proposed.
- Data expectations and potential.

5.5 The output of this analysis will be advice on the digital journey including an indication of timescale and business-case based investment requirements.

5.6 In developing the transformation plan, it is essential that the rigour and the governance is in place to ensure that the plan remains on track and that overall cost of the business is reduced. To enable this to happen, a Delivery Unit was established in the September 2020 Cabinet report, comprised of a small team of programme and project managers which operate within the Corporate Core but work organisation-wide to establish and deliver all budget options and corporate transformation activity as a single programme of work. This Unit will create:

- an overarching programme plan for all transformation activity including all corporate budget savings options;
- a consistent delivery methodology;
- regular update reports to Members;
- corporate "check and challenge" of proposed options to ensure a consistent approach to such issues as stakeholder consultation;
- risk management and the use of resources to ensure, for example, that savings in one part of the organisation do not create costs in another.

5.7 The Delivery Unit will be directed by the Corporate Core Leadership team, specifically the Deputy Chief Executive (Corporate Core); the Executive Director Financial Transformation and the Chief Information Officer, supported by wider members of the Corporate Core Management Team. The Transformation Strategy will be included within the Leader's portfolio and regular updates provided to Cabinet.

6 OVERALL POSITION

6.1 The table below sets out the position taking into account the options and shows that overall there is a shortfall of £15.280m over the 4 year period with a gap outstanding of £4.194m at the end of the first two years which is the area of focus.

Updated MTFS Position November 2020				
	2021/22	2022/23	2023/24	2024/25
	£m	£m	£m	£m
Annual Revised Gap (Ongoing)	15.001	6.206	6.461	6.586
Annual Short Term Funding Shortfall	16.242	13.091	1.269	(0.763)
Total Shortfall	31.243	19.297	7.730	5.823
Planned Use of Reserves	(16.242)	(13.091)	(1.269)	0.763
Proposed Budget Options	(6.437)	(5.576)	(1.961)	0.000
Transformation	(1.500)	(3.500)	0.000	0.000
Remaining Gap	7.064	(2.870)	4.500	6.586
Cumulative Gap	7.064	4.194	8.694	15.280

6.2 Clearly there is still some more progress to be made and the Executive Team is currently looking at other options that can be used to bridge the gap. The outcome of this work will

be reported in subsequent reports to Cabinet. Phasing of savings between the first two financial years is challenging due to the lead in time for some savings to be delivered. As it stands, the gap in 2021/22 is £7.064m and if not addressed would fall to reserves which will place greater pressure on the reserves position which, as previously recognised, is an integral and critical strand to the overall strategy and long term sustainability of the Council.

7 RESERVES

7.1 As part of the budget setting process, the Council's S151 statutory officer is required to assess the adequacy of the Council's reserves in light of risks both known and unknown at that time. If it is the S151's opinion that that reserves are not adequate and are below an adequate level to reflect the risks and therefore the setting of a balanced budget was at risk then further statutory responsibilities under S114 of the Local Government Finance Act exist and a formal report to Council would have to be issued.

7.2 The Ministry of Housing, Communities and Local Government (MHCLG) are liaising with all local authorities to identify those at risk of a S114 and to establish what exceptional support could be given. Based on what is known, Bury's reserves remain adequate for the 2021/22 financial year although it is recognised that the situation will need to be carefully monitored during the year and as part of the development of the 2022/23 budget and beyond.

7.3 To illustrate this further, the forecast position on the Council's reserves is set out in the table below and assumes that all ongoing savings will be identified and delivered:

Forecast Position on Reserves - Assumes all ongoing savings delivered				
	2019/20	2020/21	2021/22	2022/23
General Reserves	6.989	24.566	15.911	10.407
Corporate Reserves	7.794	7.544	7.294	7.044
Transformation Reserve	0.000	4.800	2.300	0.000
Directorate Reserves	0.992	0.742	0.492	0.242
Fiscal and Risk Management Reserves	34.174	30.174	22.074	13.974
External/Grant Funded Reserves	17.522	2.716	1.216	0.000
Capital Reserves	3.272	3.272	0.000	0.000
Sub Total	**70.743**	**73.814**	**49.287**	**31.667**
DSG Reserve	(20.067)	(24.531)	(24.231)	(22.431)
TOTAL FORECAST RESERVES	**50.676**	**49.283**	**25.056**	**9.236**

7.4 The DSG reserve deficit is significant and, in line with the current legislation, is offset against the Council's reserves. It is anticipated that a statutory override will be announced shortly to remove the link between the DSG deficit and the Council's reserves however until this is issued the reserve is shown as part of the overall position on reserves.

7.5 It is clear that the impact in the first two financial years of the financial strategy, 2021/22 and 2022/23, is significant and this has to be the immediate focus for planning purposes in order to ensure financial sustainability and resilience in future years.

7.6 Clearly to be financially resilient and sustainable the Council needs to deliver significant savings in the short and medium term. It is a statutory requirement that councils are able to deliver a balanced budget each financial year and based on the current information this

may not be possible beyond the 2022/23 financial year or earlier if ongoing cashable savings are not delivered.

7.7 Building back reserves through one-off monies, including capital receipts, are currently being developed which, if successful, will reduce the run rate' on reserves and contribute to the longer term sustainability. Proposals on how these may be achieved will be presented to Cabinet for consideration in due course.

8 CHALLENGE AND SCRUTINY

8.1 A challenge and scrutiny process has been built into the MTFS development and will include:

- Enhanced scrutiny and assessment of spending/savings proposals for consideration. This will be carried out by the Executive Team;
- Independent evidence will be used to challenge the extent of savings including cost comparisons, commerciality and the financial viability of services and benchmarking information;
- Opportunity for scrutiny through the Council's Overview and Scrutiny process.

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8.2 An outline timetable is set out below.

Budget Setting Timetable		
Consideration of Savings Options	November	Cabinet
Capital Programme Update	November	Cabinet
Quarter 2 Monitoring Position	November	Cabinet
Budget Scrutiny	November	Scrutiny
Capital Programme Proposals	January	Cabinet
Final Proposals for Consideration	January	Cabinet
Budget Scrutiny	January	Scrutiny
Budget Finalised and set	February	Council

8.3 A key programme of change and delivery will emerge from the approach outlined and it is essential that capacity is available to fully support the process. Project management support will be secured in order to ensure the plans are properly defined, are on track and that escalations are made when necessary. These costs will be met from the transformation fund and from the corporate capacity budget that was reflected in the 2020/21 budget on an ongoing basis.

8.4 Challenge and scrutiny on the proposals and implementation will also need to be considered in the operation of the pooled budget between council and CCG recognising both opportunities for shared investment in demand reduction, and unintended financial consequences of service reductions being seen as additional costs to the pool.

8 Risks and Opportunities

9.1 There still remain significant risks within the budget including the potential changes to the funding for Clinical Commissioning Groups and future funding arrangements. The financial regime in which Bury Clinical Commissioning Group operates is subject to clarification in national guidance. This guidance is still awaited.

9.2 There is also significant risks of changes in the funding settlement from government, the fact that a one year only settlement will be received and therefore make longer term planning more difficult. Other risks include the wider economic impact on our communities

that could see demand for services increase and income collection, particularly council tax and business rates, reduce and the loss of income from the airport as a result of Covid-19.

9.3 Other risks and opportunities are set out later in the report and reflect on potential changes to assumptions made in the model relating to pay awards, inflation, borrowing costs etc. are set out below:

Sensitivity Analysis Risks and Opportunities		
		£m
Fair Funding and Review of Business Rates	+/- 1% change	0.600
Council Tax	+/1 1% change	0.800
Pay Inflation	+/- 1% change	1.000
Price Inflation	+/- 1% change	0.500
Capital Financing Borrowing	£5m of investment	0.400

9.4 Any delay in the delivery of savings will place greater pressure on reserves and the profiling of savings to ensure more can be brought forward for the first year of the strategy needs to be considered as a mitigating action.

9.5 The opportunity to leverage long term savings through better utilisation and prioritisation of the capital programme is being reviewed alongside the development of the capital programme for 2021/22 onwards.

9.6 The pace at which change within the organisation can happen is also a risk and plans will need to be developed to ensure there are the skills in place and that any emerging issues are quickly identified and mitigations put in place.

10 Recommendations

10.1 Cabinet is asked to:

- Approve the 2021/22 to 2024/25 medium term financial and budget strategy including the savings proposals for the purposes of a conversation with the public, key stakeholders and staff to inform the final budget proposals to Full Council in February and that these proposals will be presented to the Overview and Scrutiny Committee as part of the process;
- Note the significant uncertainty in funding and that the MTFS will be updated and reviewed in light of the announcements anticipated in December 2020;
- Note the budget gap of £64.093m over the 4 years of which £31.243m relates to 2021/22 prior to any proposed savings and the proposed use of reserves;
- Note the residual gap of £15.280m over the 4 year period should all savings proposals and use of reserves be ultimately accepted and that a gap of £4.194m remains by the end of the second year of the strategy (2022/23) and that further work is underway to identify further options;
- Note the planned work on transformation and that a saving of £5m, the key themes of which are described in the report, are expected to generate savings of £5m to contribute towards the savings target;
- Note the projected position on the Council's reserves and the intention to bring forward proposals to generate one-off income that can be utilised to supplement reserves and reduce the 'run rate', i.e. capital receipts;
- Note the further work underway on the Council's capital programme and to prioritise projects that can deliver better outcomes and reduce the revenue funding requirements;

- Note that the initial proposals as a conversation prompt will be considered by the Strategic Commissioning Board in December alongside emergent clarity on the CCG financial position for 2021/22 and in the context of the commitment to the pooled budget for health and care between the Council and the CCG.

Community impact

There are no community impacts arising from this report at this stage. As the budget process continues, the impacts on our communities will be considered and reported.

Equality Impact and considerations:

24. *Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:*

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

    (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

    (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

25. *The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services*.

Assessment of Risk:

The following risks apply to the decision:

Risk / opportunity	**Mitigation**
The proposed strategy is intended to reflect the known financial position and to reflect emerging changes in funding and costs over the next 4 years to enable the Council to understand its financial position and long term financial resilience and sustainability.	The development and refresh of the medium term financial strategy ensures the Council has an up to date position and assessment of its finances and has an overarching strategy for delivering and managing the funding gap.

Consultation:

The Council is legally required to consult on service changes or reductions. Some options, which are clearly indicated, will therefore require a period of formal consultation. Others will not diminish overall levels of provision and therefore do not require community consultation.

As a matter of good practice the Council is entering into a period of structured conversation with the community about the financial position and plans to mitigate it. The conversation is an inextricable part of the 2030 strategy and therefore the consultation materials already published include the opportunity to feedback about use of resources. The community will be reminded of this process next week when the cabinet report is considered. All staff will be briefed on proposals being put forward this week, when papers are published.

The budget conversation will continue until January 2020 when a final report will be presented to the Cabinet including key messages of feedback and the CSR position from government. At this stage final decisions will be taken about the basis of budget proposals to be taken to full council for agreement.

A period of 30 days formal consultation will be allowed before any decisions are taken for those options that involve statutory service change and are legally subject to this requirement.

The Strategic Commissioning Board will consider both the Council proposals and the emergent national context for the Clinical Commissioning Group and ensure that the issue of interdependence are identified and considered.

Legal Implications:

The Local Government Finance Act 1992 (LGFA 1992) requires the Council to set a balanced budget, including the level of the Council tax. This means the income from all sources must meet the proposed expenditure. Best estimates must be employed to identify all anticipated expenditure and resources.

The approval of the Council's budget and Council Tax, and the adoption of a final strategy for the control of the Council's borrowing or capital expenditure are matters reserved, by law, to full Council. However, the Cabinet has responsibility for preparing, revising and submitting to Council estimates of the various amounts which must be aggregated in making the calculations required in order to set the budget and the Council tax; and may make recommendations on the borrowing and capital expenditure strategy. This Report is an important step in ensuring the Cabinet are able to provide these estimate before February 2021.

Local authorities must decide every year how much income they are going to raise from Council Tax. This decision must be based on a budget that sets out estimates of what the Council plans to spend on services. As the Council Tax must be set at the start of the financial year and cannot

be increased during the year, consideration must be given to risks and uncertainties, and allowances made in funds for contingencies and reserves as outlined in the Report.

The Local Government Act 2003 establishes a system to regulate the capital expenditure and borrowing of the Council. The heart of the prudential borrowing system is the duty imposed upon authorities to determine and keep under review how much money they can afford to borrow. This Report will assist in that regard.

Financial Implications:

The proposed approach will support the Council in its statutory duty to deliver a balanced budget for the 2021/22 financial year. The report sets out some options for managing the financial gap or future years and proposed use of reserves to support the strategy on a one-off basis to assist with the impact of Covid. Failure to act will mean that that the Council's long term financial sustainability and resilience will be at risk.

Report Author and Contact Details:

Lisa Kitto
Interim Director of Financial Transformation

Background papers:

Revenue Budget 2020/21 and Medium Term Financial Strategy 2020/21 – 2024/25

Approach to developing the Medium Term Financial Strategy 2020/21 – 2024/25

The Council's Financial Position 2020/21 – As at 30 June 2020

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning
MTFS	Medium Term Financial Strategy
CSR	Comprehensive Spending Review
DSG	Dedicated Schools Grant
MHCLG	Ministry for Housing, Communities and Local Government
DFE	Department for Education

Appendix A

Analysis of Cost Pressures Reflected in the MTFS				
	2021/22	2022/23	2023/24	2024/25
	£m	£m	£m	£m
Previously Agreed				
Employee Assistance Programme	0.015	0.000	0.000	0.000
Borrowing Costs – Strategic Investments	1.100	0.000	0.000	0.000
Sub Total	***1.115***	***0.000***	***0.000***	***0.000***
Pay				
Pay Award 2020/21Catch Up (2.75%)	0.250	0.000	0.000	0.000
Sub Total	***0.250***	***0.000***	***0.000***	***0.000***
Inflation				
Residential Care Living Wage Adjustment	-0.135	0.024	0.028	0.032
External Foster Placements	0.006	0.046	0.051	0.055
Fostering, Adoption and Leaving Care Allowances	-0.058	0.030	0.031	0.035
Support Packages and Direct Payments (CYP)	-0.022	0.002	0.002	0.001
Premature Retirement Costs (CYP)	-0.018	-0.013	-0.012	-0.014
Community Care Contract	0.219	0.205	0.175	0.162
Residential Care	0.247	0.319	0.315	0.387
Sub Total	***0.239***	***0.613***	***0.591***	***0.658***
Demand				
External Legal provision (CYP)	0.150	0.000	0.000	0.000
Home to School Transport	0.441	0.000	0.000	0.000
Increase in Looked After Children	0.452	0.000	0.000	0.000
Care in the Community – Covid Increase	0.937	0.000	0.000	0.000
Transition from Children's Services	0.259	0.324	0.398	0.312
Winter Maintenance	0.082	0.000	0.000	0.000
Legal Services	0.150	0.000	0.000	0.000
New Homes Bonus Adjustment	0.597	0.000	0.000	0.000
Moderations	0.120	0.000	0.000	0.000
Sub Total	**3.188**	**0.324**	**0.398**	**0.312**
Costs Previously Funded from DSG				
SEN Team	0.255	0.000	0.000	0.000
16-19 Team	0.056	0.000	0.000	0.000
LAC Education (Virtual Headteacher)	0.200	0.000	0.000	0.000
Connexions Bury	0.315	0.000	0.000	0.000
Youth Service general	0.234	0.000	0.000	0.000
Oasis Team (Early Help)	0.495	0.000	0.000	0.000
CAMHS	0.233	0.000	0.000	0.000
Victoria Family Centre	0.507	0.000	0.000	0.000
Sub Total	**2.295**	**0.000**	**0.000**	**0.000**
Fall out of Time Limited Funding				
Reablement	0.600	0.000	0.000	0.000
Sub Total	**0.600**	**0.000**	**0.000**	**0.000**
Unachievable Savings				
Corporate Landlord Model	0.585	0.000	0.000	0.000
Architects Review	0.525	0.000	0.000	0.000
Sub Total	**1.110**	**0.000**	**0.000**	**0.000**
TOTAL	**8.798**	**0.937**	**0.989**	**0.970**

Appendix B

Analysis of Budget Options (2021/22 – 2045/25)					
Directorate	**Description**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
		£m	**£m**	**£m**	**£m**
Children and Young People	Deletion of vacancies	0.694	(0.309)	0.000	0.000
Children and Young People	Contract Reviews	0.120	0.000	0.000	0.000
Children and Young People	Review of Placements	0.300	0.120	0.000	0.000
Children and Young People	Review of Children's centres	0.100	0.100	0.000	0.100
	Sub Total	***1.214***	***(0.089)***	***0.000***	***0.000***
One Commissioning Organisation	Innovative Commissioning	1.050	1.750	0.200	0.000
One Commissioning Organisation	Personalisation and Transformation	0.000	1.000	1.000	0.000
One Commissioning Organisation	Development of Assistive Technology	0.000	0.500	0.000	0.000
One Commissioning Organisation	Improved Housing Options	0.000	0.050	0.050	0.000
One Commissioning Organisation	Effective and Innovative Commissioning	2.987	0.300	0.100	0.000
One Commissioning Organisation	Review of Care Packages	0.797	2.055	0.611	0.000
	Sub Total	***4.834***	***5.655***	***1.961***	***0.000***
Operations	Closure of Civic Venues	0.132	0.000	0.000	0.000
Operations	Review of Waste Services/Fleet Rationalisation	0.237	0.000	0.000	0.000
Operations	Street Light Dimming	0.020	0.010	0.000	0.000
	Sub Total	***0.389***	***0.010***	***0.000***	***0.000***
TOTAL BUDGET OPTIONS		**6.437**	**5.576**	**1.961**	**0.000**

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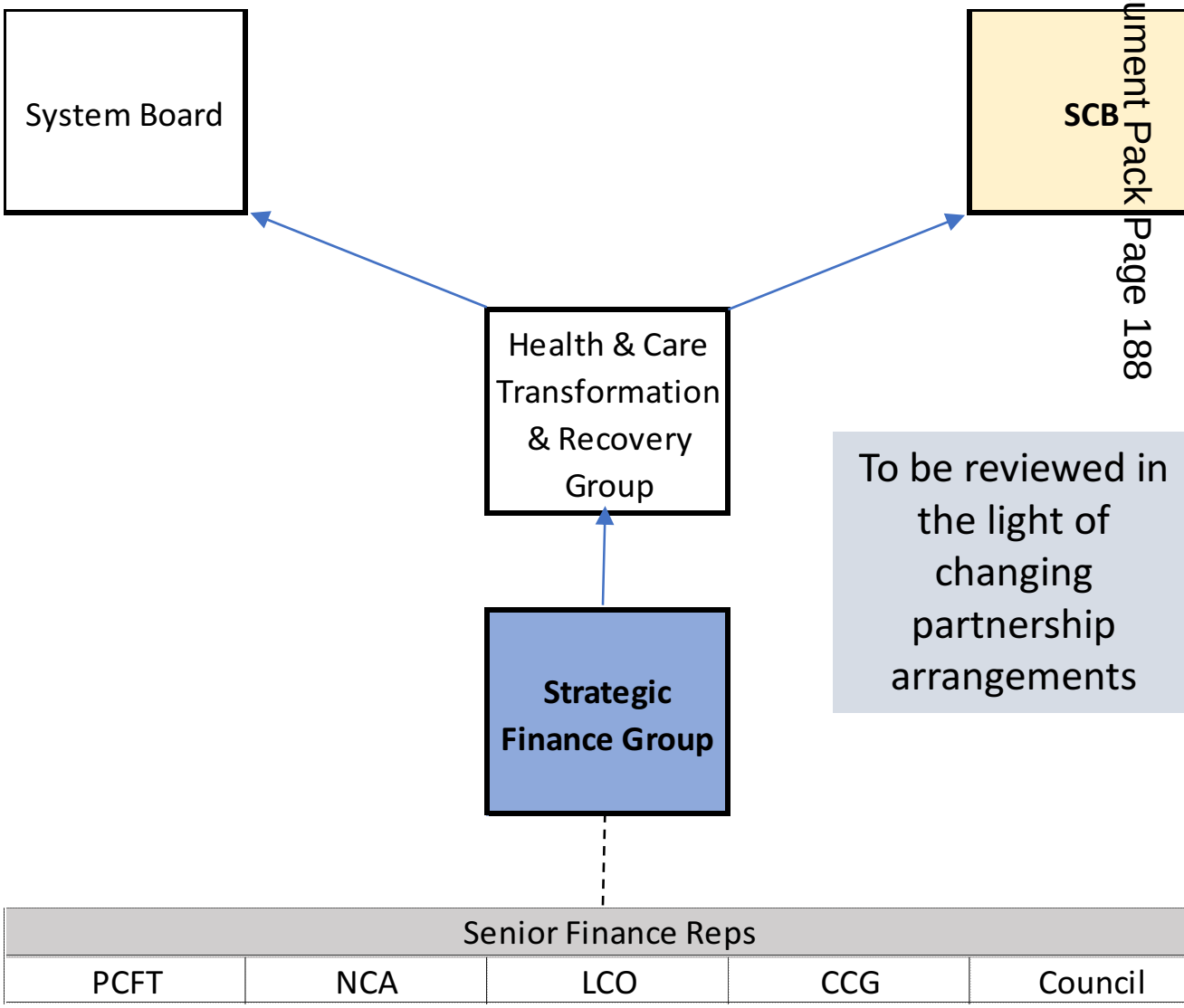
Strategic Finance Update

SCB 7th December 2020

Principles

- Clinical & political engagement and leadership
- Co-production & collaboration
- System view
  - One pot
  - Shared objectives
  - Shared risks and benefits
  - Single reporting
  - Max benefits/min harm (e.g. no cost shunting)
- Transparency
- Check, challenge & hold to account



To be reviewed in the light of changing partnership arrangements

ICF Categories 20/21

All CCG healthcare allowed per legislation
- Community Services
- Mental Health
- Learning Disabilities
- Acute non-surgical services
- Continuing Healthcare
- Intermediate Care
- Primary Care (prescribing & LES)

Transformation and Better Care Fund
Adult Social Care
Care in the Community
Public Health
All health and care related children's services
CCG staffing budgets
Council commissioning staff budgets

Pooled, £323m

Cannot be pooled:
- Acute surgery
- Director of Adult Social Care
- Services related to the M
- Adoption & fostering
- Accommodation of children
- Charging of accommodation and recovery of client costs.

Could be pooled but recommend for alignment:
- Reserves
- All Council directorates outsi
- Adult Social Care, Children's Social Care and Public Health (excludes DSG and HRA)

Aligned, £139m

- GP Core Contract
- Emergency Ambulance Servic
- Central Drugs

In-View, £38m

Budget Outlook

Integrated Care Fund

Council

- Savings target next 2 years £21m (prior to Spending Review)
- Driven by relative underfunding, ↑ demand, ↑ costs and ↓ income
- Limited non-recurrent reserves
- Risks from more COVID waves, Brexit and recession

CCG

- Underlying deficit c£17m next year (prior to system reset)
- Driven by relative underfunding,↑ demand, ↑ costs and ↓ NHS productivity
- No reserves
- Risks from more COVID waves, Brexit and recession
- Uncertainty re system redesign, funding and financial frameworks

- Both significantly challenged
- Uncertainty = major risk across the system
- Interdependent so need to work together to optimise system finances

Latest OCO Savings and Efficiency Plans

Programme	Area	Org	Programme Lead	2021/22 Saving Target (£'000)	2022/23 Saving Target (£'000)	2023/24 Saving Target (£'000)	Total All years	System Risk	System Risk Narrative
Urgent Care	All	CCG	Lindsey Darley	TBC	TBC	TBC	**TBC**	Y	System risk is around reduced income to acute dep contracting model or more work in PC, Community is TBC as waiting finalised contracting guidance and from acute colleagues to model impact of activity r costs and income.
Planned Care	All	CCG	Leah Robins	£851	£1,562	£0	**£2,413**	N	Additional work in PC and Community were factore business cases.
Community	Adult Social Care	LA	Julie Gonda	£4,834	£5,655	£1,961	**£12,450**	Y	System risk is increased costs to CCG as a result of s potential increased use of crisis services as a result service availability or time spent and mental health impacts of technology and reduced physical contac residents / clients.
Community	New LD	LA / CCG	Will Blandamer	TBC	TBC	TBC	**TBC**	Y	This is an OCO wide piece of work that is currently i phase but due to the inter related nature of the wo to cost changes for all partners.
Community	CHC	CCG	Catherine Jackson	£500	£500	£0	**£1,000**	Y	Reviewing CCG packages of care may lead to identi costs are attributable elsewhere in the system.
Community	Prescribing & High Cost Drugs	CCG	Salina Calligan	£803	£750	£0	**£1,553**	N	All schemes are either gain share where benefit is acute.
Community	Transformation Fund	LA / CCG	Lindsey Darley	£559	£0	£0	**£559**	Y	£559k is only Residential Care, other amounts are b urgent care reductions and so are TBC. System risk reduced income to acute dependent on contracting more work in PC, Community or VCFA. Value is TBC finalised contracting guidance and work needed fro colleagues to model impact of activity reductions o income.
Childrens	All	LA		TBC	TBC	TBC	**TBC**	TBC	Awaiting latest position.
Mental Health	All	CCG	Julie Gonda	TBC	TBC	TBC	**TBC**	N	CMHT review unlikely to propose any reduced inco and High Cost placement review will look to repatr where possible and this would not have a negative impact upon partners.
				£7,547	**£8,467**	**£1,961**	**£17,975**		

Process/ Timeline

Plus: public & stakeholder engagement and consultation, OSC, Health OSC, HWB, Exec Team, System Board Health & Care Recovery and Transformation Group, GM forums, etc

Spending Review 1/2

General Points

- 1 year instead of 3 (for revenue)
- Not as harsh as some feared - some positive news
- Devil in the detail
- Doesn't close the existing financial gaps and challenges in the public sector

Local Government & Social Care

- Core spending power to increase by 4.5% (mostly CT flexibilities)
- Revenue Support Grant to be increased in line with inflation
- £3b to help LAs deal with pressures of C-19, incl additional spend & compensation for lost CT & BR & other income
- LAs also have access to >£1b funding for social care - £300m new grant funding + £700m-£800m possible from 3% social care precept, subject to political decisions
- Existing LA grants maintained in 21/22, e.g. the additional £1b Soc Care funding announced in last year's SR, the £2.1b iBCF, Disable Facilities Grant, etc
- Extra money for homelessness & rough sleeping
- Lower than originally planned increases in NLW
- £4b levelling up fund (local infrastructure investment)

***Estimated* Impact on Bury Council MTFS**

- 1% precept = c£0.8m, so could generate **up to £2.4m** subject to political decision
- c**£1m** additional grants (targeted at Social Care)
- Freeze on pay c**£2m**
- Lower than planned increase in NLW c**£1m**
- One-off C-19 funding c**£5m**

Spending Review 2/2

Overall Health Budget

- *Ignoring C-19 funds & costs*, no big change from existing 5-year deal to 23/24 for NHS LTP
- = NHS gets £6.6b cash increase (revenue) to £147.1b in 21/22

Direct COVID-19

- £50b for health & care in 20/21 in direct response to C-19 (Test & Trace, mass screening, vaccine procurement, PPE, use of Independent Sector, & Infection Control measures, etc)
- >£20b already earmarked for 21/22, incl £3b NHS "recovery package" for 21/22 (non-recurrent: £1b for WL backlogs, £0.5m for MH + £1.5b for other existing pressures from C e.g. lower productivity due to IPC). Further C-19 funding will be agreed early in 2021.

NHS Capital

- An increase in national capital funding from £8.2b to £11.1b in 20/21 in response to C-19 (then falls to £9.4b in 21/22)

NHS workforce

- Disappointing in terms of limited cash boost to HEE. Public sector pay freezes not applyin "front line" staff, but not sure what likely uplifts will look like or whether they'll be backed with any extra funding (or will need to come from Dept savings)

Public Health

- Disappointing that PH gets virtually no mention at all in the 122 page document
- Simply says the PH grant will be maintained - not sure whether in cash terms or real term

Agenda Item 8

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Consider
Item No	08	**Confidential / Freedom of Information Status**	No
Title	Strategic Commissioning Board Risk Register		
Presented By	Lynne Ridsdale, Deputy Chief Executive		
Author	-		
Clinical Lead	-		
Council 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.

At this time, the CCG and Council are working to separate Risk Management Strategies and therefore the risks presented on separate registers. This reflects the position reported to the Council's Audit Committee on 30 July 2020 and CCG Audit Committee in September 2020, which outlined that whilst there that whilst the Council had committed to integrating its approach to risk management with the CCG, in order to operate a common approach to the definition of risks to partnership delivery, a review had found that the Council's approach to risk management was perhaps not mature enough to add value to a partnership approach.

It was therefore proposed and agreed that both organisations would revert to its own management of risk, but through alignment of the Council framework to be comparable to the CCG to enable read-across and a common assessment of shared risks to the work of the Strategic Commissioning Board.

Annex 1 : CCG Risk Register Report

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

- Urgent Care System - Re-design (level 16)
- 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 10); and
- Lack of effective engagement with communities (level 10).

Reviews have been completed against all 4 risks and will be presented for consideration by the CCG's Audit Committee on 04 December 2020 and thereafter presented to the Governing Body in January 2021.

The Strategic Commissioning Board is advised that there has been a reduction in the level of risk for 3 of the 4 risks, with the remaining risk remaining static since the last presentation of the report.

Annex 2 : Council Risk Register Report
The Council's full risk registers are attached for information and this report sets out those risks that are within purview of the Strategic Commissioning Board for oversight:

- Failure to ensure adequate safeguarding Vulnerable Adults arrangements are in place (level 10); and
- Non-delivery of Health and Care Recovery Programme (Level 20)

Recommendations

It is recommended that the Strategic Commissioning Board:

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

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:	No
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?	The report reflects risks identified to delivery of the Health & well-Being Strategy					

Implications						
How do proposals align with Locality Plan?	The report reflects risks identified to delivery of the Locality Plan					
How do proposals align with the Commissioning Strategy?	The report reflects risks identified to delivery 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?	Through the effective management of risk associated with delivery programmes identified to support wider commissioning and delivery agenda, improved outcomes will be delivered.					
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?	None					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
This is a report on risks associated with delivery of work programmes and does not required an EA.						
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**

Annex 1 : Strategic Commissioning Board Risk Register Report - CCG

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 **04 November 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 - CCG

3.1 There are currently four CCG 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_1.1 Lack of effective engagement with communities**

3.4 The risk review in November 2020 resulted in no change to the risk score of 15, against a target level of 10 to be achieved by March 2021.

3.5 Although good progress has been made this risk will remain at this level whilst public engagement picks up significant pace as there is a requirement to systematically ensure the public (patient and resident) voice is included as part of the organisations Recovery and Transformation Programme.

3.6 The role of the Health and Wellbeing Board has now been refreshed and the ambition is to focus on developing the population health system to address health inequalities within the Borough.

3.7 A revised performance and outcomes framework is now in place, however reporting in to the Health and Wellbeing Board has yet to be finalised.

3.8 Work continues to ensure the Bury 2030 Strategy and the Corporate Plan reflects the particular contribution of the OCO and to ensure alignment across strategies the Locality Plan objectives have now been incorporated within the Bury 2030 Strategy.

Risks that have reduced in score

3.9 During the reporting period **3** risks have reduced in score.

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

3.10 The latest review has seen the risk reduce further from a level 15 to its target level of 10.

3.11 As the 2030 vision continues to improve through collaborative and mature working across the CCG, Council and Partners this has resulted in the likelihood score being reduced from a level 3 (possible) to a level 2 (unlikely).

3.12 The November risk review confirmed that an Assistant Director has been appointed who will lead on Public Service Reform alongside recasting of the Health and Wellbeing Board who will focus on developing the population health system to address health inequalities within the borough. In addition, work continues to develop the Council and CCG's Corporate Plan.

3.13 On-going public engagement continues. The latest iteration of the Bury 2030 Strategy was launched on the 31st October 2020 and is subject to an 8-week public consultation period ending December 2020.

3.14 In line with CCG process, a watching brief will be maintained and as a strategic risk, this will remain on the GBAF whilst all outstanding actions are finalised and the year-end rationalisation process concluded.

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

3.15 The latest review has seen the risk reduce further from a level 15 to its target level of level 10.

3.16 As previously reported, 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 3 (possible) to a level 2 (unlikely). In addition, monthly Clinical Director meetings have been established to ensure there is clinical leadership focus regarding business and transformation plans.

3.17 To ensure continued development, engagement and staff involvement, monthly staff meetings have been scheduled with the Executive Director and Management Team. Furthermore, joint OCO and LCO meetings remain in place to ensure a shared perspective is captured as part of the Recovery and Transformation Plan.

3.18 In line with process this strategic risk will remain on the GBAF whilst outstanding actions are finalised and the year-end rationalisation process concluded.

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

3.19 The latest review has seen the risk reduce from a level 20 to a level 16, against a target level of 12 to be achieved by March 2021.

3.20 Although the CCG needs to understand the implications of COVID-19 in respect to the Urgent Care Re-design, the risk owner considered that the risk could be reduced at this time. The likelihood of 5 (almost certain) has been reduced to 4 (likely) and is primarily due to the on-going development of the urgent care redesign model which is emerging at a reasonable pace and although some gaps remain, theses are being addressed through mitigating actions.

3.21 Arrangements to support the redesign of urgent care are in place, with the Primary Care Networks (PCNs) and Neighbourhood Teams working in collaboration, although it should be noted that these remain in development however continue to mature at a satisfactory pace.

3.22 The proposed model for Intermediate Care (IMC) although subject to consideration of the Radcliffe Regeneration Plan is currently open to public consultation. Following the consultation, recommendations for implementation will be presented to the Strategic Commissioning Board in December 2020.

3.23 As previously reported, discussions remain underway with the LCO to implement the IMC model; however, this is still subject to further dialogue regarding the form and function of the LCO. Updates will be reported through future risk reviews.

Risks that have increased in score

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

Risks that have reached their target level

3.25 During the reporting period **2** risks have reached their target score.

- GB2021_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health
- GB2021_PR_4.1 Assuring decisions are influenced by all staff including clinicians

Risks recommended for closure

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

New Risks

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

Risks that have not been reviewed in the reporting period

3.28 During the reporting period **0** risks have not yet been reviewed.

4 Risk Summary

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

	Nov	Nov %
Total Risks on Report	**4**	
New Risks	0	
Risks reduced since last report	3	75.0%
Risks increased since last report	0	0.0%
Risk that have reached target level	2	50.0%
Low Risks (1-3)	0	0.0%
Medium Risks (4-6)	0	0.0%
High Risks (8-12)	2	50.0%
Significant Risks (15-25)	2	50.0%
Risks reviewed in this period (November 2020)	4	100.0%
Risks yet to be reviewed (August 2020)	0	0.0%
Risks to be reviewed for next report (January 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.

Lynne Byers
Interim Risk Manager
November 2020

Appendix A: Strategic Commissioning Board Risk Register: CCG 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	**02-Nov-2020**	16	12	↓	**Jan-2021**
GBAF	GB2021_PR_1.1	Lack of effective engagement with communities	28-Nov-2016	20	**02-Nov-2020**	15	10	–	**Jan-2020**
GBAF	GB2021_PR_2.1	Lack of effective working with key partners which influence the wider determinants of health	14-Aug-2019	20	**02-Nov-2020**	10	10	↓	**Jan-2021**
GBAF	GB2021_PR_4.1	Assuring decisions are influenced by all staff including clinicians	29-Nov-2016	20	**02-Nov-2020**	10	10	↓	**Jan-2021**

Appendix B: : Strategic Commissioning Board : CCG 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 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, then the improvements across the wider economy will not materialise, impacting upon patient experience and CCG reputation	**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	02-Nov-2020	4	**4**	16	**Jan-2021**	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 **5. Understanding the impact of the covid** **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	**Arrangements to support the redesign of urgent care are in place, with the Primary Care Networks (PCNs) and Neighbourhood Teams working in collaboration, although it should be noted that these remain in development however are maturing well**	90%		In Progress
1.3f Bury System Board and Strategic Commissioning Board to receive and agree proposals of IMC	**31-Jan-2021**	Will Blandamer	**The SCB received the proposed IMC model in October 2020, this model although subject to consideration of the Radcliffe Regeneration Plan is now subject to public consultation, following consultation recommendations for implementation will be presented to the SCB in December 2020**	**90%**		In Progress
1.3i Discussions commenced to hand over implementation of new model when agreed to the LCO	**31-Mar-2021**	Will Blandamer	**Subject to further discussions regarding form and function of the LCO**	20%		In Progress

Risk Code & Title	GB2021_PR_1.1 Lack of effective engagement with communities				
Risk Statement	1.1 - Because of a lack of effective engagement with communities there is a risk that the public will not access preventative services and make lifestyle changes which supports good health and quality of life	**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
28-Nov-2016	5	4	20	02-Nov-2020	5	3	15	**Jan-2020**	5	2	10	31-Mar-2021

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Patient Cabinet reports to the Governing Body 2. Lay Member for PPI voting member on the Governing Body and Primary Care Commissioning Committee 3. Healthwatch attend PCCC 4. NHSE PPI indicator assessment (an external assessment of the CCG's website/annual reports etc.) 5. Annual 360 Stakeholder Survey 6. New Strategic Commissioning Board in place October 2019	1. Close working with Public Health to co-ordinate joint working and messages 2. Communications and Engagement Strategy for CCG activity 3. Patient Cabinet in place to promote active engagement and public voice 4. Self-care has an increased focus in the refreshed locality plan 2017 5. Beginning to mobilise locality plan e.g. integrated neighbourhood teams. 6. Neighbourhood engagement models under development 7. Joint Comms & Engagement Team in place. **8. Inclusion of the objectives of the Locality Plan within the Bury 2030 Strategy**	**Gap(s) in controls**: 1. Engagement Strategy related to the locality plan not yet in place 2. Slow pace in respect of the implementation required to deliver the transformation programme **Gap(s) in assurances:** 1. Unable to monitor the strategy as currently being developed

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
1.1d Scrutiny of the health and wellbeing of the local population to be built in to regular reporting	31-Mar-2021	Will Blandamer	**Role of the Health and Wellbeing Board refreshed. Revised performance and outcomes framework in place (reporting yet to be reviewed).**	60%		In Progress
1.1g Ensuring the work on Bury 2030 Strategy and the Operating Plan reflects the particular contribution of the OCO	**31-Mar-2021**	Will Blandamer	**Fully participated in the development of the Bury 2030 Strategy and Operating Plan**	**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	**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	02-Nov-2020	5	**2**	10	**Jan-2021**	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. Refresh of Locality Plan completed emphasising the importance of wider Public Sector Reform on improving health and reducing health in-equalities **3. The Northern Care Alliance (NCA) is the anchor organisation for commissioning social value** (e.g. inclusion of social value goals in Provider contracts, support environmental sustainability etc) **4. Council and CCG Operating Plan under development - timeline December 2020**	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	**The latest iteration of the Bury 2030 strategy was launched on the 31/10/2020 and is subject to an 8 week consultation period ending Dec 2020**	**70%**		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	02-Nov-2020	5	**2**	10	**Jan-2021**	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 **10. Weekly Primary Care Webinar**	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. 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. 5. **OCO** Senior Team restructure now 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	**Monthly staff meetings in place - Executive Director and Management Team**	**70%**		In Progress
4.1e Strengthening relations between the OCO and LCO	31-Mar-2021	Will Blandamer	**Joint meetings routinely held. Shared perspective in to the Recovery and Transformation Plan**	**80%**		In Progress

Annex 2 - Strategic Commissioning Board Risk Register Report - CCG

1.0 Introduction

1.1 This report is presented to the Strategic Commissioning Board and reflects those risks that have the potential to impact on delivery of the agreed strategic objectives and work programme of the Strategic Commissioning Board

2.0 Background

2.1 As previously notified to the Strategic Commissioning Board and reported to the Council's Audit Committee, it was intended to progress a single joint strategy for the management of risk across the partnership of the CCG and Council.

2.2 An independent review found that the Council's approach to risk management was perhaps not mature enough to add value to a partnership approach at this time and therefore it was therefore proposed and agreed that both organisations would revert to its own management of risk, but through alignment of the Council framework to be comparable to the CCG to enable read-across and a common assessment of shared risks to the work of the Strategic Commissioning Board.

2.3 As part of this common approach the attached revised Corporate Risk Register now incorporates the corporate risks to managed by OCO and Health & Wellbeing colleagues.

2.4 This register is the output in a wider review of all corporate, directorate and operational risk registers, which is underway and in addition to the population of the registers, also considers awareness and understanding, training and development and monitoring and reporting.

2.5 It is supported by a detailed timetable and action plan and is on target to be fully integrated by December 2020. Progress against the agreed timetable is summarised in Section 2.0 below and overleaf.

3. Strategic Commissioning Board Risk Register – Council

3.1 Two specific risks are highlighted to the Strategic Commissioning Board in respect to their direct relevance to the business of the Committee, as attached to this report, however for completeness and following review by the Audit Committee, the Corporate Risk Register, CCMT and Finance and Budget risk registers are also attached for information given the relevance of these.

3.2 The risks are presented as at October 2020.

4 Recommendations

4.1 The Strategic Commissioning Board is asked to:

- Receive the Strategic Commissioning Board Risk Register - Council;
- Review the information presented;
- Provide a Strategic Commissioning Board opinion on the risks reported and any reflections for future development; and
- Note the full Corporate Risk Register and supporting CCMT, Finance and Budget risk registers.

Annex 2 : Strategic Commissioning Board Risk Register Report - Council

Corporate Risk Register

Risk Register Completed:
Date of Revision:

						Gross score				Current score				Target score		
Priority / Objective	Risk No.	Owner	Risk	Cause	Effect	Likelihood	Impact	Total Score = L*I	Current Mitigating Controls	Likelihood	Impact	Total Score = L*I	Planned Risk Actions	Likelihood	Impact	Total Score = L*I
Health & Wellbeing Efficiency & Effectiveness		WB	**Failure to ensure adequate safeguarding Vulnerable Adults arrangements are in place**	Demand for services exceeding its capacity and capability. Failure to commission safe care for vulnerbale adults and the elderly. Limited available budget	Risk of poor outcomes for vulnerbale residents. Failure of Council to meet statutory duty	3	5	15	Safeguaring Vulnerable Adults Board Internal management controls, training, development, and professional support Good quality commissioning arrangements and standards with providers Financial monitoring Recovery and Transformation programme	2	5	10	Good quality maket management and provider engagement arrangements	2	4	8
Health & Wellbeing Efficiency & Effectiveness		WB	**Non Delivery of Health and Care Recovery Programme**	Covid Pandemic Budget Restrictions in NHS and Council Growth in demand from demography and Covid 19 Effect Financial and Structural Uncertainty in NHS	Failure to transform services and realising required cost savings Sub optimal outcomes for residents	5	5	25	Routine monioiring and oversight of all aspects of the programme. Close financial review of delivery of savings and outcomes. Reporting to System Board and Strategic Commisiosning Board and Health Scrutiny Committee.	4	5	20	Working closely with CCG and GM Health and Social Care Partnership	5	3	15

Corporate Risk Register

Risk Register Completed:
Date of Revision: October 2020

Bury COUNCIL

						Gross score				Current score				Target score			
Priority / Objective	**Risk No.**	**Owner**	**Risk**	**Cause**	**Effect**	**Likelihood**	**Impact**	**Total Score = L*I**	**Current Mitigating Controls**	**Likelihood**	**Impact**	**Total Score = L*I**	**Planned Risk Actions**	**Likelihood**	**Impact**	**Total Score = L*I**	
Health & Well-being	**1**	**GL**	**Covid-19 Global Pandemic Second Wave**	Social Distancing and other preventative measures not used or not effective Increase in localised cases due to mass gatherings	New lockdown measures, potentially localised Support/response planning commenced for most vulnerable Significant pressure on Public Health and NHS Excess deaths	5	5	**25**	• Partnership working with CCG, AGMA • Experience and planning for first outbreak and lockdown • Lessons learned evaluation • Regular liaison with Public Health England • Social Distancing including face covering guidance • Business Continuity Planning/Review/Update	4	5	**20**	• Review current mitigating controls • Follow PHE guidance • Keep under review	3	5	**15**
	2	**GL**	**Council liability for the death of an employee or member of the public**	Failure to implement appropriate health & safety measures Failure to manage effectively manage	Senior officers held accountable and potentially imprisoned Significant reputational damage Financial redress	4	5	**20**	• Health & Safety Policies •Regular maintenance and inspection scheduling	4	4	**16**	• Review of current facilities management procedures in light of recent Town Hall maintenance issues •Regular maintenance and inspection scheduling	3	4	**12**
Value for Money	**3**	**LK**	**Section 151 Officer compelled to issue a Section 114 Notice**	Failure to set a balanced budget Poor financial management and governance Running down reserves	Moratorium on non-essential spend Reputation damage Potential government intervention	4	5	**20**	• Constitution/Schemes of Delegation **• Budget Risk Register developed and subject to regular monitoring** • Financial Management and reporting and refresh MTFS • Internal and External Audit	3	5	**15**	• Review current mitigating controls • Keep under review	3	5	**15**
	4	**LK**	**Council forced to step in/rescue one of its Companies (e.g. Six Town Housing)**	Commercial Failure Poor financial management and governance	Council takes services back 'in-house' Council accepts company liabilities	4	4	**16**	• Appropriate management and operational structures • Financial Management and operational reporting • Budget Risk Register developed and subject to regular monitoring • Internal and External Audit	2	4	**8**	• Regular review of KPIs and Financial Performance • Internal Audit Reviews	2	3	**6**
Health & Well-being	**5**	**KD**	**Council implicated in the death or serious injury of a child or vulnerable adult**	Safeguarding measures not in place or not observed	Individuals held accountable and/or prosecuted Significant reputational damage Government intervention	5	5	**25**	• Appropriate safeguarding measures, processes and procedures • Regular monitoring and supervision • Unannounced monitoring and inspection	4	5	**20**	• Regular monitoring and supervision • Mock inspection	3	5	**15**
Efficiency & Effectiveness	**6**	**LR**	**Serious data breach**	Failure to follow GDPR provisions Failure to follow Council's own data management policies Negligent or unlawful use of data	Individuals' identity/location compromised Reputational Damage ICO Review and/or fine	5	5	**25**	• GDPR and Data Management Policy • Document retention and disposal policy • GDPR/Data Training & Development • Fair Use Notices	4	4	**16**	• Regular training and development • Regular review and updates to policies and procedures • Internal Audit review subject to risk assessment	3	3	**9**
Legal and Governance	**7**	**JW**	**Monitoring Officer compelled to issue governance notice**	Failure to comply with legislative requirements and acting unlawfully	Reputational Damage	4	5	20	Council's rules and procedures observed Effective involvement of the Monitoring Officer Council Constitution Defined Scheme of Delegation and Codes of Practice	4	4	16	Proper training and development Regular updates of policies and procedures	3	4	12

						Gross score				Current score				Target score		
Priority / Objective	**Risk No.**	**Owner**	**Risk**	**Cause**	**Effect**	**Likelihood**	**Impact**	**Total Score = L*I**	**Current Mitigating Controls**	**Likelihood**	**Impact**	**Total Score = L*I**	**Planned Risk Actions**	**Likelihood**	**Impact**	**Total Score = L*I**
	8	**JW**	**Serious legal findings against council**	Court, tribunal or inquiry decisions resulting in significant adverse outcomes	Reputational Damage	4	5	20	~~Defined Scheme of Delegation and Codes of Practice~~ Major decisions approved by members	4	4	16		3	4	12
Investment in Bury	**9**	**PL**	**No Deal Brexit**	Failure of the UK Government to negotiate an acceptable trade agreement with the EU	Economic Uncertainty Failure to attract inward investment Economic targets for Bury missed Timescales for recovery lengthened	3	4	**12**	• EU withdrawal Bill passed • Monitoring of negotiation of future trade agreement developments with the EU	3	2	**6**	• Regular review of progress and respond accordingly	2	2	**4**
Value for money	**10**	**DB**	**Significant income losses in Departmental Services (i.e. Civics, Market, Car Parking)**	Covid Pandemic Systemic Budget Reductions Lack of investment over decades	Future uncertainty for Services Increased ongoing subsidy	5	5	**25**	Budget saving proposals re: future viability	5	5	**25**	Planned Cabinet reports	5	3	**15**
Value for money **Legal and Governance**	**11**	**DB**	**Property Infrastructure Standards - Corporate Risks**	Lack of investment over decades Failure to comply with legal / statutory requirements	Buildings in significant disrepair - emergency repairs required Compliance concerns Risk to workforce	5	5	**25**	Recruitment to Head of Corporate Landlord underway Corporate Landlord Board established Development of Corporate Landlord Model Repairs being undertaken	5	4	**20**	Full compliance system Procurement of Concerto system Full procurement exercise for FM contracts Future rationalisation plans	3	4	**12**
Efficiency & Effectiveness	**12**	**DB**	**Carbon Neutrality / Climate Agenda**	Global Climate Agenda Bury Climate Manifesto - 2030 targets	Targets for Bury missed Impact on the public Efficiencies not made	4	4	**16**	Climate Strategy being produced Recruitment to Climate Team	3	4	**12**	Climate action plan Long term walking / cycling initiatives Infrastructure projects	3	2	**6**
Efficiency & Effectiveness **Value for money** **Investment in Bury**	**13**	**DB**	**Provision of Leisure Services**	Covid Pandemic Systemic Budget Reductions Lack of investment over decades	Future uncertainty for Services Increased ongoing subsidy	5	5	**25**	Leisure Recovery Plan Future regeneration options Budget saving proposals re: future viability	5	5	**25**	Working collaboratively with BGI re: Regeneration Planned Cabinet reports	5	3	**15**
Efficiency & Effectiveness	**14**	**WB**	**Failure to ensure adequate safeguarding Vulnerable Adults arrangements are in place**	Demand for services exceeding its capacit y and capability. Failure to commission safe care for vulnerbale adults and the elderly. Limited available budget	Risk of poor outcomes for vulnerbale residents. Failure of Council to meet statutory duty	3	7	**14**	Safeguaring Vulnerable Adults Board Internal management controls, training, development, and professional support Good quality commissioning arrangements and standards with providers Financial monitoring Recovery and Transformation programme	2	5	**10**	Good quality maket management and provider engagement arrangements	3	4	**12**
Efficiency & Effectiveness	**15**	**WB**	**Non Delivery of Health and Care Recovery Programme**	Covid Pandemic Budget Restrictions in NHS and Council Growth in demand from demography and Covid 19 Effect Financial and Structural Uncertainty in NHS	Failure to transform services and realising required cost savings Sub optimal outcomes for residents	5	5	**25**	Routine monioiring and oversight of all aspects of the programme. Close financial review of delivery of savings and outcomes. Reporting to System Board and Strategic Commisiosning Board and Health Scrutiny Committee.	5	5	**25**	Working closely with CCG and GM Health and Social Care Partnership	5	3	**15**

						Gross score				Current score				Target score		
Priority / Objective	Risk No.	Owner	Risk	Cause	Effect	Likelihood	Impact	Total Score = L*I	Current Mitigating Controls	Likelihood	Impact	Total Score = L*I	Planned Risk Actions	Likelihood	Impact	Total Score = L*I
Financial Resilience	1	MW	Impact of CCG funding Framework impacts adversely on council finar	Hospital Discharge Schemes Cease due to funding Financial Strategy does not reflect all short term fur CCG Funding Strategy Changes	Increased gap Further budget reductions	3	4	12	CCG Funding Updates	3	4	12	Updates received and refecetd in MTFS	2	4	8
	3	LK	DSG Defitict increases significantly	Demand increases Accountability for funing not accurately reflected In School costs re met from reserve	DfE warning and intervntion Budget reductions	4	4	16	Medium Term Financial Strateg Updated Monthly Monitoring Escalation to Executive Team and Members	4	4	16	DFE Recovery Plan Submitted DFE Engagement Review of Expenditure and Rebaselining	3	4	12
	4	LK	Capital Schemes not dlivered in line with programme	Inaccurate financial reporting and profiling of exper effective gateway processes not in place Capacity for project delivery not fully specidfeied.	Significant slippage Repttaional risk Schemes not delivered	4	4	16	Cpaital Programme Approved Annually Quarterly Monitoring	4	4	16	Revbaseline of capital programme Capital Gateway prcesses Established	3	4	12
	5	LK	Statutory Polices are out of date and not compliant with legislation	Specialist expertise not available Lack of Training	Adverse external audit Best Value Qualificatiom	3	4	12	Specialist advice sought Training of permanent staff	3	3	9	New Capital Stragey being developed New treasury Management Strategy being develo	2	3	6
	6	LK	Financial Resilience and Sustainability not acheved	Significant increase in demand fro services Ineffective S75/partnership Arrangements Traded Services lose income and do not cover cost	S114 Notice Issued Adverse External Audit Governemnt intervention	4	4	16	Reserves Strategy Monthly monitoring Budget Startegy Principles	4	4	16	Review of S75	3	4	12

CCMT Risk Register

Risk Register Completed: 30/10/2020
Date of Revision: 30/10/2020

Bury COUNCIL

						Gross score				Current score				Target score		
Priority / Objective	Risk No.	Owner	Risk	Cause	Effect	Likelihood	Impact	Total Score = L*I	Current Mitigating Controls	Likelihood	Impact	Total Score = L*I	Planned Risk Actions	Likelihood	Impact	Total Score = L*I
ICT / Digital	1	KW	**Failure of infrastructure**	Outdated systems; hardware failure; lack of availability of support or maintenance due to staffing shortages or products being out of licence / support contracts	Loss of functionality and reduction in productivity; Impact on customer and user experience	3	5	15	●Infrastructure replacement programme ●extended support purchase for older servers	3	5	15	● Infrastructure replacement programme to be rolled out / completed ●Migration to cloud storage / back-up	2	5	10
	2	KW	**Failure of applications and / or software programmes**	Outdated systems; hardware failure; lack of availability of support or maintenance due to staffing shortages or products being out of licence / support contracts	Loss of functionality and reduction in productivity; Impact on customer and user experience	3	4	12	●system back-up strategy in place	3	4	12	●Cloud migration plan in design phase for software and applications	2	1	2
	3	KW	**Failure of TH Data Centre**	External damage e.g. fire, flood, electric supply failure	Potential data breach if records lost on permanent basis; loss of productivity due to quality of connection to back-up data centre	3	5	15	●Data management strategy in place re. backups; ●Textile Hall back up data centre	3	5	15	●cloud migration plan to move data into Azure ● relocatation of data centre;	2	5	10
		KW	**Failure to delivery new Digital Strategy**	lack of resources e.g. funding, staff or delivery partner (e.g. GMSS)	Inability to achieve ambition for new ways of working and improved customer and staff experience; inability to deliver data management and business intelligence model required for improved decision making and performance management	3	4	12	●Placement of Digital strategy in Transformation programme to ensure visibility and deliverability ●SLA with GMSS	3	4	12	●Review of resources across Council and CCG IT/Digital functions	2	4	8
		KW	**Cyber attack**	External threat to data and systems	Potential loss of data resulting in significant data breach; potential significant loss of functionality if systems were damaged or shut down	3	5	15	●Training and updated Cyber Essentials Toolkit in place. ●PCN accreditation renewed annually	3	5	15	●Further training and investment in cyber security to be progressed ● PSN accreditation of the Council ●Cyber Essentials accreditation for Council and CCG to be achieved	2	4	8
Elections		MC	**Failure to deliver an efficient Election 2021**	insufficient capacity (shortage of staff / standby resource) to meet increased business (due to covid) and customer demands; lack of robustness of ICT support; ability of printers to meet high postal vote demands	Legal challenge/reputational damage/people unable to vote - do not get vote needed / printers cannot meet increased high volume of demand for postal votes	3	5	15	●National (Government and Electoral Commission), regional (AGMA and GM Elections Managers) and local guidance ●Elections Project Board in place with agreed delivery plan ●Lessons Learned (from previous election) action plan delivered ●Approved printers as part of AGMA consortium	2	5	10	● Review current mitigating controls ● Follow PHE / EC / AGAM / Government guidelines ● Monthly update and agreed action at Elections Project Board. ● Early preparation and planning already commenced. ● Develop network of internal back up staff.	1	5	5
		MC	**Ability to deliver the Canvass 2020.**	Covid preventing use of personal canvassers new procedure introduced nationally electorate apathy	reputation integrity of register	3	4	12	● Process in place and applied consistently ● Mechanisms to secure contact with remaining non-responders agreed ● Baseline register in place following December 2019 General Election	3	3	9	● Follow EC and Government guidance ● Follow best practice ● Follow PHE guidance	2	1	2
		MC	**Adverse impact on resources (people and money)**	National changes in respect to the central land charges database and central scanning of files by HMLR	Loss of income potential redundancies / redeployment / role redesign	5	3	15	● Integrated Elections / Land registry Team	5	3	9	● Review need for land charges posts and impact on Elections if loss of staff due to shared role/support provided.	3	3	9
Land Charges		MC	**Failure to allow / action searches**	Covid restrictions temporarily closed down service preventing personal searches to be undertaken	Legal challenge from failure to deliver service reputational damage increased pressure on staff resources loss of income	5	3	15	● Revised processes in place enabling searches to be carried out by staff	5	3	15	● Review current mitigating controls. ● Follow PHE guidance. ● Look to safe return of personal searchers, taking into account all safety precautions.	5	2	10
Legal		JW	**Failure to provide an effective and timely legal service**	Reduction/loss of service due to absence from covid or other illness, lack of capacity due to increase is instructions and/or lack of capability due to new/novel matters	not meeting statutory Court dates / staffing/ failure in ICT; Error in law and legal advice.	3	5	15	●Deployment of other team members ●Links with counsel & other local authorities ●Continuing professional development and training, review of capacity and workloads with team and client departments	3	5	15	●Review business continuity plan, staffing levels, workloads and capacity monthly	2	5	10

						Gross score				Current score				Target score		
Priority / Objective	**Risk No.**	**Owner**	**Risk**	**Cause**	**Effect**	**Likelihood**	**Impact**	**Total Score = L*I**	**Current Mitigating Controls**	**Likelihood**	**Impact**	**Total Score = L*I**	**Planned Risk Actions**	**Likelihood**	**Impact**	**Total Score = L*I**
Registrars		**HK**	**Failure to provide an effective and timely BMD service**	Reduction/loss of service due to absence from covid or other illness, increase in customer demand above capacity levels local restrictions (Possible suspension of Births, Marriages and Citizenship ceremonies by Government.)	Unable to meet legislative requirement creation of backlogs, increased complaints from customer, elected members and GRO	4	3	12	●BCP arrangements in place ●Mutual Aid with other localities ●processes in place which reflect Covid safe delivery	3	3	9	●BCM to be reviewed monthly or following changes in PHE / Covid Guidance	2	3	6
Transformation		**KW**	**Partnership**	Insufficient buy-in to Bury 2030 to enable partnership priorities to be delivered. Lack of resource across the Team Bury partnership to support delivery of Bury 2030.	Outcomes would not be achieved; new ways of working not implemented; demand management targets would not be met resulting in high costs	3	4	12	●Consultation and engagement programme for Bury 2030	3	4	12	●Engagement on consultation to be progressed ●performance framework to be co-designed ●delivery plan to be developed KPIs to be agreed	2	3	6
	4	**KW**	**Failure to introduce new neighbourhood model**	Work programme of public service reform insufficient to generate commitment to implement neighbourhood model; unable to deliver constituent parts of the NM e.g. data warehouse; MDT integrated working	Limited ability to implement commitment in Bury 2030 to public service reform; impact on the potential for re-shaping demand and achieving improved outcomes	3	4	12	●Strategic resource in place ●Investment approved for addition resource (in AD PSR) ●Community Hub model approved ●VCFA and community sector aligned	3	4	12	●Appoint of new posts to support development and implementation of Neighbourhood Model. ●Work with GMCA to share best practice and obtain advice and support on implementation.	2	3	6
Service Delivery	**5**	**KW**	**Failure to deliver Inclusion Strategy**	Lack of expertise or resources to support deliver of the work programme and culture change required to implement action plan and policy commitments	Negative impact on workforce moral and community trust; lack of engagement from communities in the co-design and delivery of Bury 2030; breach of statutory duties; increased health inequalities; poor decision making	3	4	12	●Inclusion integrated into Bury 2030 and Corporate Plan	3	4	12	●Inclusion Strategy to be approved ●Listening events to be implemented ●Action plan to be delivered ●recruitment to key posts to support programme delivery ●reporting scheduled to be prepared	2	3	6
Governance	**6**	**JW / JW**	**Failure to deliver effective governance and decision making**	Reduction/loss of service due to absence from covid or other illness, Instability of Governance arrangements/lack of understanding of delegations/ process/ constitution/ incorrect recording of decisions	Judicial challenge / inability to deliver / reputational damage / financial impact	3	5	15	●constitution and governance arrangements in place ●guidance on decision making and supporting decision record templates ●JET Pre-Governance process to review all agenda	3	5	15	refreshed Constitution to be approved and implements Training programme to be implemented governance arrangements to be revised	2	5	10
	7	**LF/ JW**	**failure to meet the requirements of data protection legislation and good information governance practice**	Polices out f date/staff capability due to lack of training/lack of staff	Judicial / or ICO challenge / inability to deliver / reputational damage / financial impact due to fine or compensation	5	5	25	●DPO/IG Lead oversight of processes ●DSPT 2019/20 submission ●Policies	4	5	20	●IG strategy to be developed ●IG processes to be mapped ●IG resources to be identified ●comprehensive training programme to be implemented ●IG policies and Procedures to be reviewed ●DPST 2020/21 requirements to be assessed	2	5	10
Value for Money	**8**	**SJ**	**Contracts with external suppliers fail to deliver best value for money**	Inadequate procurement processes Supplier failures Poor contract management Impact of Covid-19 - supplier failure, increased lead-times, increased costs Impact of Brexit - supplier failure, increased lead-times, increased costs	Increased pressure on budgets resulting in cuts to services and jobs	4	4	16	● Contract Procedure Rules ● Professional Support via Strategic Procurement Team ● Contracts Register	3	4	12	● Review and revise Procurement Operating Model and CPR ● Develop corporate approach to improve contract management	1	4	4
Legal Compliance	**9**	**SJ**	**Failure to follow procurement rules or use approved contracts**	insufficient capacity and skills/knowledge of relevant procedures insufficient Capacity of Strategic Procurement Team	Legal Challenge Impact on service delivery Reputational impact	3	4	12	● CPR & Procurement guidance ● Professional Support via Strategic Procurement Team	2	4	8	● Review current mitigating controls ● Keep under review	1	4	4
HR	**10**	**SB**	**Breakdown of Employee Relations**	Inability to reach agreement over budget savings options due to perceived negative impact upon the workforce	industrial action, which may include strike. Low levels of staff engagement and performance. Poor levels of recruitment and staff retention. Reputational damage.	4	4	16	●Agreed TU Consultation Framework, comprising DJCC & CJCC meetings and regular TU/Management meetings ●Good existing relationship between the Council and Trade Unions. ●Regular employee communications.	3	4	12	●Review existing processesfor consultation and agreement ●Refresh voluntary exit schemes.	2	4	8

						Gross score				Current score				Target score		
Priority / Objective	Risk No.	Owner	Risk	Cause	Effect	Likelihood	Impact	Total Score = L*I	Current Mitigating Controls	Likelihood	Impact	Total Score = L*I	Planned Risk Actions	Likelihood	Impact	Total Score = L*I
HR	10	SB	**Lack of relevant skills, knowledge and experience across the organisation**	Inadequate appraisal and talent management arrangements Lack of workforce planning failure to invest in employee development Unexpected change in skills requirement due to unanticipated change to working practices	Ineffective workforce and low levels of performance. Inability to meet service demands. Increased costs through buying in skills and knowledge to achieve aims.	4	4	16	●Annual Appraisal policy ●Mandatory Training ●Apprenticeship Leadership Programme	2	3	12	●New leadership, structures and staffing arrangements to be finalised ●People Strategy, including organisational development plan to be developed ●System to support improved performance management data to be enhanced (investment) ●appraisal policy to be refreshed	3	3	9
Communications	**11**	**KJ**	**Loss of trust and confidence in the council to deliver services**	Worsening public perception of council. Lack of understating about what the council does Instant perceptions via social media High profile policy and strategy development wit significant reputation risks - GMSF, CAZ, MLS Performance not meeting expectations	Impact on our value by residents and businesses	5	4	20	●Vision and strategy set out in Bury 2030 (under consultation) ●Clear emergency response and business continuityarrangements in place to effectively react in the event of a crisis ●Agreed Comms and engagement management for high profile policy development ●Relationships with Media to effectively manage Coucnil reputation	3	4	12	●Communication and engagement strategy to be approved ●Review and revise comms and engagement plans ●develop Brand and ensure consistently linked to services ●internal communications channels to be improved ●Expectations of public to be managed particularly via social media and other online	2	4	8
Engagement	**12**	**KJ**	**Consultations not delivered to required standard**	Unable to use usual channels and processes because of Covid restrictions in meeting people A number of high profile consultations due this Autumn	Bias towards digital and online methods Open to legal challenge on basis of Gunning Principles Unable to effectively make decisions Reputational impact	5	4	20	●Clear comms and engagement plan for each of the Autumn consultations ●EIAs completed for GMSF, CAZ and MLS consultations ●Availability of alternative provision to digital ●Statement of Community Involvement for GMSF revised	3	4	12	Consultation Feedback kept under review Comms and Engagement Strategy to be refreshed	2	4	8
Housing Needs & Options	**13**	**PC**	**Failure to meet Homelessness Statutory Function & Delivery**	●Increasing pressures on the service that impacts (reduces) capacity across the service ●Increase in homelessness - stat and non stat provision ●Lift on ban on evictions will result in further increases of homeless cases, pressures on the service and temp accommodation.	● Unable to meet statutory requirements as per Homelessness & HRA legislation. ●Legal challenge with potential judicial reviews resulting in increased legal costs and reputation damage	4	5	20	● HRA adhered to ● Robust processes and operating procedures in place ●CBL system suspended ●Direct Let priority.	3	5	15	● Review structure of team / service ● Framework of regular monitoring and KPI reviews to be developed ● external funding opportunities to be maximised	2	5	10
	14	**PC**	**Insufficient resources (staffing) to meet increased responsibilities / pressures on service**	● Changing ways of working due to Covid ● increasing demand on the service ● Increasing expectations for rough sleepers	● Non compliance with current Govt directives for rough sleepers ● impact on staff well-being	4	5	20	● BCM in place supported by Agile and Flexible Team ● Additional resource secured through BCM ● Greater partnership working aligned to Emergency 10 point plan for RS's - enabler role. ● Service delivery models adapted to Covid	3	5	15	● Channel shift services through IT solutions and software, telephone options to create capacity and smarter working. ● Comprehensive staff development and progression programme to be implemented ● undertake Service review and restructure	2	5	10
	15	**PC**	**Available provision unable to meet local demand for rough sleeper / homeless service**	●Increase in rough sleepers locally, regionally and nationally due to numerous factors ●Gov'ts 'Everyone in' directive requires provision of emergency accommodation with support to reduce the risk of Covid infection.	● Greater pressure on current services ● Increases in temp accommodation provision needed. ● Demand & Lack of engagement by the cohort to provide support and help into sustained accommodation. ● Lack of emergency and sustainable move on properties. ● adverse impact on the Councils ability to respond to statutory duty ● Compounds demand for move on properties	5	4	20	● funding to continue with ABEN approved for phase 3 provision ● NSAP revenue funding approved ● Stepping Stones emergency provision extended with support until 31/3/21 ● Rough sleeper outreach provision funded ● Arrangements agreed with GM Housing First initiative ● multi agency panel in place to assist and support rough sleepers ● Created ● MHCLG NSAP capital & revenue bid approved ● Robust links to the Councils supported accommodation provision	3	4	12	●Identify future funding opportunities to sustain / increase resources - NSAP phase 2 (2021/22) & ABEN phase 4 ●Develop Bury Homeless Partnership ●Affordable social housing to be included within New Housing Strategy ●Submit future robust bid for RSi funding and outreach provision to continue for 2021/22 ●Maximise opportunities to influence local, regional and central Govt in relation to funding ●Progress, develop business case and build homeless hub for emergency & interim accommodation.	2	4	8

						Gross score				Current score				Target score		
Priority / Objective	Risk No.	Owner	Risk	Cause	Effect	Likelihood	Impact	Total Score = L*I	Current Mitigating Controls	Likelihood	Impact	Total Score = L*I	Planned Risk Actions	Likelihood	Impact	Total Score = L*I
	16	PC	**Lack of sustainable permanent accommodation to meet Homelessness and housing register demands.**	● Lack of investment and strategy to recognise and address the lack of social and affordable housing needs ● Historical Govt approach to social housing generally with RTB and home ownership approach has restricted growth and opportunities for social housing. ● Reduced availability of affordable and social housing through existing stock ● Increased demand for affordable and social housing	● Increase in housing register demands and priority need ● Blockages in temporary accommodation for both single and families ● Challenges to meet the statutory duties around timescales in temp accommodation ● Councils ability to discharge homeless duty ● Demand and supply misalignment	4	5	20	● Developing PRS to engage better with PRS landlords ● Strategic Group established with remit to develop PRS engagement ● Help to rent scheme in place ● insurance product offered as prevention tool. ● Proactive intervention / team in place ● Partnership working with STH ● Nomination agreements with RSL's / HA's	4	4	16	● New Housing Strategy to be developed ● Allocations policy / housing options to be reviewed ● Common housing register to be developed ● funding opportunities with the new affordable homes programme to be identified ● HRA opportunities and capital receipt rule changes to be reviewed ● PRS and landlord offer to be further developed ● ELA options for Bury to be developed	3	4	12
Adult Learning	17	JK	**Inability to operate service effectively and deliver GMCA and ESFA contracts**	Failure of ICT infrastructure	Inability to submit data to GMCA/ESFA and therefore breach of contract Inability to enrol learners Impact on learners due to lack of digital teaching resources Increase in staff workload due to lack of MIS in place and requirement to complete all information on paper Restricted ability for most staff to work from home	3	5	15	●Business Continuity Plan in place ●Teaching platform hosted in the Cloud to allow learners where possible to continue learning ●Classroom based teaching still possible	2	5	10	●Review current mitigating controls Learners provided with laptops to support learning	1	5	5
	18	JK	**the Bury ALS Centre building becomes unfit for purpose and unable to meet required minimum standard**s	Lack of clarity / contract for existing facilities management arrangements Lack of building maintenance programme Significant ongoing issues with building including toilets, blockages, drains	Impact on staff who are tasked to deal with overburdensome building maintenance with little support Lack of knowledge to oversee works carried out Increased pressure on budget due to maintenance costs and frequent, repeated, expenditure in certain areas Potential temporary closure of building due to lack of facilities being available Loss of delivery if building closed Impact on learners and staff Reputational Impact	3	5	15	●facilities management contract in place ●Processes to sign-off repairs in place and followed (Careful monitoring of essential repairs and maintenance and checking where possible the quality of the work carried out so as not to incur addition cost)	2	5	10	●Exploration of where Adult Learning Service sits with One Public Estate in the long term ●Follow up results of exercise completed by People too on improving the efficiency and compliance levels of the Bury Estate ●Move to online learning where possible ●Work with Facilities Management Group to determine the position of Adult Learning Centre	1	5	5
Community Hubs	19	NP	**unable to resource Community Hubs to meet local demand in response to national requirements / changes around shielding**	staff returned to substantive posts volunteers have gone back to work as furlough has ended	unable to deliver national requirement	5	5	25	●Redeployed staffing resources into Community Hubs ●Network of Community / NHS Volunteers	3	5	15	review business continuity plans use of government funding to quickly employ Reed agency staff advertise for volunteers and approach national voluntary organisations negotiate a scheme with NHS Volunteers for Bury	2	5	10
	20	NP	**contact centre unable to meet demand of CEVs seeking to register for supermarket delivery slots**	change in delivery model of contact / support with full delegation to LAs and national call centre closed	long queues at contact centre high rate of abandoned calls up to 2000 residents anxious and more vulnerable additional pressure on Contact centre staff	3	5	15	●Redeployment of staff from core roles to support contact cent	3	5	15	mobilise hub staff, redeploy staff into contact centre, review P3 services, recruit more staff with shielding or T3 funding boost capacity in contact centre to register people by phone, persuade people to do telephone shopping at Morrisons or Sainsbury's	2	5	10

						Gross score				Current score				Target score		
Priority / Objective	**Risk No.**	**Owner**	**Risk**	**Cause**	**Effect**	**Likelihood**	**Impact**	**Total Score = L*I**	**Current Mitigating Controls**	**Likelihood**	**Impact**	**Total Score = L*I**	**Planned Risk Actions**	**Likelihood**	**Impact**	**Total Score = L*I**
	21	NP	**Increased demand on Community Hubs to provided support with supermarket shopping (up to 2000 residents)**	CEVs do not have external networks CEVs do not register for supermarket delivery slots CEVs do not have ICT access at home CEVs do not have plastic payment methods	would need to mobilise 100s of volunteers to go shopping for 2000 people and wont have enough volunteers up to 2000 residents anxious and more vulnerable	4	5	20	●Contact Centre receiving calls and supporting registration	4	5	20	●digital helpers to be recruited ●funding to place kit and connectivity into people's homes to be secured ●recruit more volunteers	2	5	10
HR	22	LR	**Failure of itrent system**	Failure to switch from on premise to host environment before on premise systems fall out of support from Midland HR due to lack of resource, insufficient testing time and failure to develop suitable hosted environment within the timeframe	Unable to access staff records and undertake HR functions effectively. Unable to update UNIT 4 with payment and year end information.	4	5	20	●Project Board meetings in place ●External consultant[appointed to review implementation plan.	3	5	15	●Appointment of independent Project Management and technical support to oversee transition to hosted environment	1	5	5

Finance Service Risk Register

Risk Register Completed: 30/10/2020
Date of Revision: 30/10/2020

						Gross score				Current score				Target score		
Priority / Objective	**Risk No.**	**Owner**	**Risk**	**Cause**	**Effect**	**Likelihood**	**Impact**	**Total Score = L*I**	**Current Mitigating Controls**	**Likelihood**	**Impact**	**Total Score = L*I**	**Planned Risk Actions**	**Likelihood**	**Impact**	**Total Score = L*I**
Accountancy			**Treasury Management/Cash Flow**	Inadequate levels of cash in the bank.	Paymens cannot be made.	4	5	20	cash flow projections updated weekly/daily. On calall cash/borrowing.	3	5	15	Staff training. Resilience in place.	3	5	15
Revenues and Benefits		**ID**	**Council Tax and Business rates letters not issued.**	Invoices not issued. System failure. Loss of staff.	Loss of Income. Financial resilience of the Council affected. More budget redcutions maty be required.	4	5	20	External provider for councill tax billing. Resilience part of contract. Investment in current systems and snure upgrades are actioned. In house technical expertise.	3	5	15	Upgrades up to date. Systems roadmap being developed.	3	5	15
			Debt Recovery not in place.	Remiders not issued. No debt recovery or enforecement	Loss of income. Increased debt profile. More budget reductions may be required.	4	5	20	External provider for councill tax billing. Resilience part of contract. Investment in current systems and snure upgrades are actioned. In house technical expertise.	3	5	15	Upgrades up to date. Systems roadmap being developed.	3	6	18
			Inability to provide benefit and welfare advice and support.	Loss of staff with specialist knowledge. Increased demand as a result of Covid.	Residents not accessing supoort they eed. Increase in arrears on coucil tax.	3	4	12	Use of Civica On demand. Contract with Citizen's dvice Bureau.	3	4	12	Staff reviews. Performance monitoring	3	3	9
Pay Services		**RF**	**Failure to pay people and suppliers**	Breakdown in systems. Loss of staff due to sickness	Staff and suppliers not paid. Financial hardship and Reputational rsks.	5	3	15	• Revised processes in place enabling searches to be carried out by staff	5	3	15	• Review current mitigating controls.	5	2	10
Audit		**JS**	**Failure to provide an effective internal audit service.**	Wealk governance and control environment across the council, financial loss, reputation of the Council, qualified accounts from the external auditors.	Qualifie Accounts. Incidences of fraud.	4	5	20	•Deployment of other team members •Risk based approach to audit planning and regular reporting to the audit committee and executive Tam •Continuing professional development and training, review of capacity and workloads with team and client departments	3	5	15	•Revew of proceses and practices. Specialist suport as part of the service improvement plan.	2	5	10
Insurance		**EH**	**Failure to establish adequate Insurance arrangements for the Council and all its functions**	Tender / Renewal exercise not completed in a timely manner	Reputation of Risk Exposure to financial losses	5	5	25	Insurance Brokers support activity Insurance Officers are experienced Insurance Tender completed Completion of the 20/21 annual renewal	2	5	10	Reminder to all managers to make Insurance team aware of any changes which would affect the Councils insurance. Build increased resilience within the team by involving staff in tender and renewal exercise	2	3	6
		EH	**Negligence claims against the Council**	Lack of Department Inspection Poor workmanship Defective Premises Change of staff	Financial impact on budgets Reputation damage Increase of Insurance Premiums Legal costs	5	4	20	Request for Departmental reports along with inspection reports, Risk Assessments etc. Advise the need for a system of inspection with the relevant documentation to assist in the defending of claims . Staff training	3	3	9	Continue dialog with departments on the need for Inspections and documentation to assist in defending claims. Department training	2	2	4
		EH	**Property uninsured or under insured**	Not informed of changes and cannot update insurance programme accordingly Inadequate property values	Financial impact on budgets Reputation damage Increase of Insurance Premiums	4	4	16	Notices from Property Services re addition or deletion of properties not always received	3	4	12	Reminder to managers to make Insurance team aware of any changes made as soon as possible. Updated property Insurance valuations needed	2	3	6

		EH	**Breach of Data Protection Act Claims**	Failure to follow GDPR provision Failure to follow Council's own data protection policies	Individuals identity / location compromised Reputation damage ICO review and / or fine Increase of Insurance Premiums	5	5	25	GDPR and Data Management Policy Document retention and disposal policy GDPR/Data training & Development	3	4	12	Regular review and updates to policies and procedures. Reminder to Schools and Departments on strong passwords and sensitivity of data.	2	3	6
		EH	**Covid 19 Negligence Claims**	Failure to comply with relevant Government Guidelines. Failure to have adequate Risk Assessments in place with the relevant documentation	Financial impact on budgets Reputation damage Increase of Insurance Premiums	5	5	25	Advice to follow Government guidelines with documented Risk Assessments and training.	4	5	20	Continued advice on Training/Risk assessments and the need for documentation.	3	5	15
Value for Money		LK	**Contracts with external suppliers fail to deliver best value for money**	Inadequate procurement processes Supplier failures	Increased pressure on budgets resulting in cuts to services and jobs	4	4	16	• Contract Procedure Rules • Professional Support via Strategic Procurement Team • Contracts Register	3	4	12	• Training on Procurement Rules • Develop approach to improve contract management	1	4	4
				Poor contract management													
				Impact of Covid-19 - supplier failure, increased lead-times, increased costs													
				Impact of Brexit - supplier failure, increased lead-times, increased costs													

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Approve
Item No	10	**Confidential / Freedom of Information Status**	No
Title	Supervised Consumption – proposed changes		
Presented By	Lesley Jones – Director of Public Health		
Author	Jon Hobday - Consultant in Public Health		
Clinical Lead	Dr Daniel Cooke		
Council Lead	Cllr Andrea Simpson Chair of the Health and Wellbeing Board		

Executive Summary

A key element of supporting individuals with substance misuse is the provision of supervised consumption (of opiate substation medication) through pharmacies. As a result of COVID supervised consumption has changed from mostly daily to almost exclusively weekly pickups of medications.

Pharmacies who receive payments for supervised consumption have been supported through these changes which have resulted in significantly reduced activity and income. Pharmacies have received average pay for the months of April to June based on national guidance.

It is proposed we continue to fund pharmacies on average monthly payments based on historical supervised consumption data until 31st December 2020. Then from the 1st January 2021 fund supervised consumption on an activity basis in line with Greater Manchester (GM).

This will result in significant savings to Bury Council, and will reduce existing budget pressures within the substance misuse budget by approximately £20,250 for 20/21, and £40,500 annually after that.

It is also proposed that going forward supervised consumption would continue to adhere to NICE guidance. This would mean all new service users are placed on daily supervised consumption for the first 12 weeks, then if and when it is safe to do so, seek to progress service users on to less frequent medication picks ups as part of their recovery.

In addition this will align with the GM approach.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Agree to continue to pay the average of the previous 6 months spend on supervised

consumption to pharmacies until the 31st December 2020 – after which agree to fund supervised consumption on an activity only basis from January 1st 2021.

- Agree to continue to deliver supervised consumption in line with NICE guidance (https://www.nice.org.uk/guidance/ta114/chapter/1-Guidance), so all new service users go on to daily supervised consumption for the first 12 weeks, then if and when it is safe to do so, seek to progress service users on to less frequent medication picks ups as part of their recovery.

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 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?	Health and Wellbeing is a priority within the LP					
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	This will potentially reduce the need for daily					

Implications						
health inequalities?	travel to pharmacies for some service users and potentially open up job / life opportunities to those with substance misuse issues who currently have to attend pharmacies on a daily basis.					
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?	None at this stage					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /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**
	01/10/2020	

Supervised Consumption

1. Introduction and Background

1.1 A key element of supporting individuals with substance misuse is the provision of supervised consumption through pharmacies. Supervised consumption is when individuals who are opioid dependent regularly attend pharmacies to receive opioid substitution medication (usually methadone or buprenorphine). This is an important service provided by pharmacies to target misuse of illicit substances and prevent withdrawal symptoms and reduce risk to the patient. Before deciding to prescribe, a full assessment of the patient will be undertaken by the clinician in combination with the substance misuse service. A care plan will then be put in place and agreed with the patient and they will be assigned to a pharmacy.

1.2 Since the start of the lock down in March 2020 daily supervised consumption rates have fallen dramatically. This is a result of service users complying with social distancing, shielding and isolation and in response to availability of this service in community pharmacies and new working practices. This has been achieved predominantly through reduced daily supervised consumption in a move to weekly pickups of medication (to avoid face to face contacts). As part of the transition safe boxes (to store medications) and naloxone (a drug to be used in the event of overdose) have been issued as part of the adapted response to ensure safety.

1.3 There were initial concerns that providing weekly medications rather than providing daily doses may have additional risks i.e. service users may use all the drugs at one time increasing the risk of overdose and Drug Related Deaths (DRDs). As part of the new way of working the drug related incidents have been monitored closely through the number of DRD's. A summary of the numbers of DRD's for Bury residents is outlined in table 1 below

Table 1.

Number of deaths per month 2020		
April	=	12
May	=	15
June	=	7
July	=	20
August	=	9
Total	=	**63**
Number of deaths per month 2019		
April	=	12
May	=	13
June	=	11
July	=	15
August	=	8
Total	=	**59**

(Provided by from Greater Manchester Mental Health Trust (GMMH), October 2020).

As can be seen in table 1 apart from an increase in July (which following further investigating appears to be an anomaly with no clear reason) there seems to be no significant change in numbers of DRDs over the whole period (63 in 2020 Vs 59 in 2019). This small increase over the period is in line with usual year to year variation.

1.4 As part of the adapted working practices the substance misuse service have been monitoring physical and psychological impacts on service users. To date there has been no ongoing negative implications to patient outcomes as a result of the change in practices and the situation continues to be reviewed on an ongoing basis. Case workers have continued to engage with service users to get insight into their experience over this period. A summary of feedback obtained from case workers and service users is outlined below in figure 1.

Fig 1. Case worker and service user feedback

FW's client expressed to him that he was nervous when he first went on weekly pick up with no supervision, But in no time at all he started to feel as though he had been given some responsibility, which in turn made him feel more invested in his recovery. He still remains unsupervised and on weekly pick up's as things have gone so well for him regarding his treatment.

RB's client was changed from daily supervised to weekly pickups he struggled, he was abstinent but having cravings and occasionally took some of the following day's methadone to manage the cravings. He asked to go back to daily pickups, which we did, we also increased his daily dose to help with the cravings. He reported feeling much more stable afterwards.

Most of the service users on my caseload much prefer weekly pickups and although some missed pickups (3+ days) there don't seem to be as many as there were when everyone was on daily.

EW's service user commented: "it's a lot easier, I can't walk it up there every day anymore. I get so out of breath it's not funny. Still not touched the brown and only had 4 white this month. Not bad for me".

Another EW's service user feedback: "It's made it a lot easier by not going out as much and I can concentrate on keeping safe"

AF, AOT feedback: The majority of clients I have spoken to prefer weekly dispense and feel able to store their medication safely and take it as prescribed but a couple of clients preferred daily pick up as it was 'a reason to leave the house' and motivation to get up that day.

(Greater Manchester Mental Health Trust, November 2020)

1.5 As part of understanding any potential wider implications, Greater Manchester Police (GMP) were engaged to identify whether the increased number of individuals on weekly medication pickups had resulted in any increase in drug related offences. Following an analysis conducted by GMP they confirmed that locally in Bury the data had not shown any increase in drug related crime or drug related deaths and anecdotally intelligence officers have not seen any increases in the sale of methadone.

1.6 In addition wider conversations have taken place with both the local and regional Local Pharmacy Committees (LPCs). The key concerns from the committees were a lack of engagement in the decisions to changing patients from daily supervised consumption to weekly pickups and where to report concerns should they have them. This feedback was provided to Bury's substance misuse provider GMMH. They have committed to work with pharmacies to provide the opportunities for engagement around treatment decisions. In addition they are looking in to developing a direct line for pharmacies to the service for them to feedback any concerns without having to go through the main service number.

1.7 Prior to COVID Bury council spent approximately £54,000 per year on supervised consumption with community pharmacies. Since COVID the amount of supervised consumption has reduced by around 75% across Greater Manchester. On this basis projected savings to Bury Council would be in the region of £40,500 per year. This money could be used to offset other pressures within the substance misuse budget including the substantial increase in medication costs over the last 18 months.

1.8 The implications for this new way of working are

- Substantially less service users accessing daily supervised consumption in the long term
- Pharmacies who get paid for supervised consumption will potentially see a significant reduction in their incomes from supervised consumption.
- Significant savings to councils who pay pharmacies for supervised consumption as part of the local substance misuse offer

1.9 In line with the national guidance - to ensure the business continuity of local pharmacies a decision was made to pay the equivalent of the average of our supervised consumption spend for October 2019 to March 2020, in May 2020 the equivalent of the average of our supervised consumption spend for November 2019 to April 2020 and in June the average of our supervised consumption spend for December to May. This has meant that to date local pharmacies have not seen an impact on their income. The proposal is that we continue to fund pharmacies based on the average spend until December 31st 2020, after which we would fund on an activity basis.

2 Associated Risks

2.1 There is a potential risk for an increase in drug related deaths due to increased amounts of medication being provided at visits (As demonstrated in table 1 this has not been the case)

2.2 The potential risk that some pharmacists may be heavily dependent on the income of supervised consumption and the business may become destablised as a loss of income (this is much more relevant for the smaller pharmacies).

3 Recommendations

3.1 In line with Greater Manchester approach to addressing this issue it is recommended

Bury agree to continue to pay the average of the previous 6 months spend on supervised consumption to pharmacies until the 31st December 2020 – after which agree to fund supervised consumption on an activity only basis from January 1st 2021.
.

3.2 Agree to continue to deliver supervised consumption in line with NICE guidance (https://www.nice.org.uk/guidance/ta114/chapter/1-Guidance), so all new service users go on to daily supervised consumption for the first 12 weeks, then if and when it is safe to do so, seek to progress service users on to less frequent medication picks ups as part of their recovery.

4 Actions Required

4.1 Agree to continue to pay the average of the previous 6 months spend on supervised consumption to pharmacies until the 31st December 2020 – after which agree to fund supervised consumption on an activity only basis from January 1st 2021.

4.2 Agree to continue to deliver supervised consumption in line with NICE guidance, so all new service users go on to daily supervised consumption for the first 12 weeks, then if and when it is safe to do so, seek to progress service users on to less frequent medication picks ups as part of their recovery.

First name Surname – Jon Hobday
Job Title – Consultant in Public Health
Email address – j.hobday@bury.gov.uk
Month and Year September 2020

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Agenda Item 11

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Approve
Item No	11	**Confidential / Freedom of Information Status**	No
Title	LCO Business Case for the Further Development of the Urgent Treatment Centre (UTC)		
Presented By	Will Blandamer, Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG		
Author	Samantha Merridale, Interim Programme Lead – Bury Urgent Care Programme		
Clinical Lead	___		
Council Lead	____		

Executive Summary

The purpose of this paper is to present an outline business case describing the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury. The business case also gives a summary position of the required capital development with respect to changes to the estates requirements to provide the capacity for increased patient demand and deliver safe waiting and clinical treatment areas with respect to infection prevention and control.

The Business Case has been discussed and supported via the LCO Governance structures which has included discussions at the Urgent Care Programme Board and LCO Board.

The CCG Finance, Contracting & Procurement Committee considered the Business Case at its meeting on the 19th November 2020 and the recommendations are included within the relevant section of this report.

Recommendations

The Strategic Commissioning Board are asked to: -

(i) Support the outline business case which describes the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury in the context of the recommendations made by the CCG Finance, Contracting & Procurement Committee on the 19th November 2020 which: -

- Recognised the reprovision of current UTC and WIC contractual income into the new operational model and that moving to operational delivery is dependant on the development of the capital business case and estates model.
- Recognised that current funding requirements may change subject to longer term decisions regarding mental health and digital funding streams

- Recognised the delivery of the operational model will be phased in line with development of suitable estate.
- Recognised that work will move to focus on developing a full business case for the UTC to appraise the capital options
- Remained open-minded about option 4 as being the preferred option and it was a credible option however they said there were a number of next steps required before they could fully support this option at this stage which were detailed as above
- Agreed with the recommendation that the green car service is commissioned recurrently to help deliver the new urgent care pathways at a cost of £219,700

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 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?	See attached report.					
How do proposals align with Locality Plan?	See attached report.					
How do proposals align with the Commissioning Strategy?	See attached report.					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒

Implications						
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?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /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**
Finance, Contracting and Procurement Committee		

BURY LOCAL CARE ORGANISATION
Improving lives in Bury

Title: **FGH Urgent Treatment Centre – Business Case**

Report of: **Samantha Merridale**

Report to: **Bury LCO Board**

Date: **18 November 2020**

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1. Background and Purpose

The purpose of this paper is to present an outline business case describing the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury. The business case also gives a summary position of the required capital development with respect to changes to the estates requirements to provide the capacity for increased patient demand and deliver safe waiting and clinical treatment areas with respect to infection prevention and control.

One of the key deliverables within the Bury Urgent Care strategy includes the redesign of urgent care at Fairfield General Hospital including building a brand-new purpose-built urgent care facility, and implementation of pre-ED triaging/streaming as part of the GMUEC by appointment model. The ability to be able to triage / stream patients away from the front door, by deflecting them into other more appropriate clinical pathways (e.g primary and community care) has been tested in a number of different localities, including Bury, using an experienced Band 7 ENP, and it is confidently assumed that the introduction of this, combined with the introduction of NHS 111 First to encourage patients to "call before you go" will deflect around 18,000 patients away from the front door. From a total figure of c.58,060 self-presenters to Bury ED each year, this leaves around c.40,060 patients to be managed onsite through a variety of different pathways, with an estimated 30,000 to be treated in the new Urgent Treatment Centre, which is an increase from the current patient throughput of around 17,000 annually.

This paper describes the potential options for the development of the existing staff model to deliver clinically safe treatment for the 30,000 patients described above. Option 4, which will deliver the increased level of demand within the proposed operating model, and which will achieve the standards described in both the national UTC specification and the requirements of Greater Manchester Urgent Care by Appointment, is our preferred option.

In order to deliver the increased patient demand through the proposed operating model, the existing estates infrastructure will require some redesign to expand the physical environment and reduce clinical risk associated with infection prevention and control, and the safe treatment of vulnerable patients. This paper gives a summary position in terms of those requirements with outline, estimated capital costs. This will be developed into a full business case.

2. Green car

The Green Car scheme was set up in 2016 to help address several well documented interrelated urgent care system pressures which impact on the system being able to provide people with the right care at

the right time and in the right place. Primarily the scheme was designed to help reduce failure demand and support more patients to remain at home by:

• Reducing unnecessary conveyance of people to A&E; and

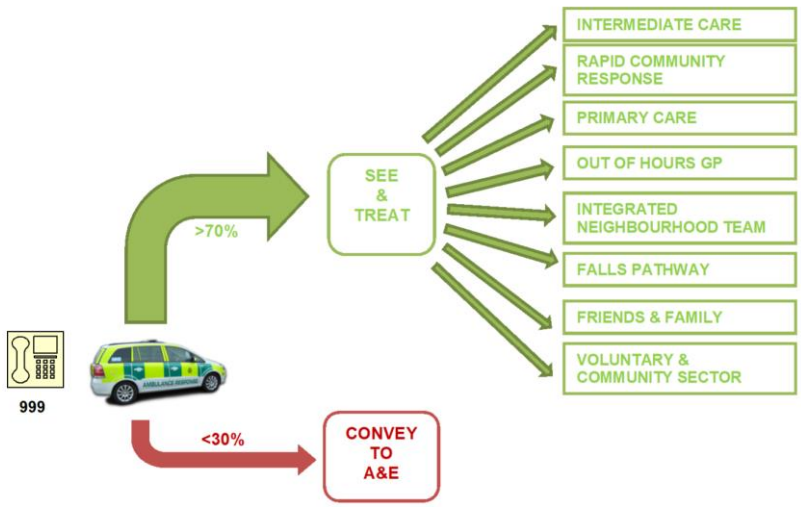
• Reducing unnecessary emergency admissions.

It has achieved this through the deployment of experienced community paramedics who respond to certain categories of 999 calls to provide a 'see and treat' response avoiding the need for transfer to A&E. Key to the success of the model is the high level of awareness and integration with the full range of primary and community health services in Bury with the ability of the paramedics to efficiently link the person they attend with appropriate services that can respond to their health, but also social care needs.

Key Outcomes

- A reduction in ambulance conveyance to A&E compared with a standard ambulance attendance.
- A reduction in non-elective admission compared with a similar cohort of patients receiving a standard ambulance response.
- More patients are supported to remain at home through referral and liaison with wider community-based health and social care services.
- A reduction in repeat 999 calls by identified frequent callers engaged with by the Green Car service.

NWAS monitoring and evaluation has demonstrated a see and treat response of around 70% for all patients attended by the Green Car paramedic. This compares with a see and treat rate of about 20% for a routine ambulance response. Evaluation suggests this is because of the Green Car paramedic's knowledge of local services and pathways enables a far higher proportion of patients to be supported at home through referral and linking in with other local services such as Rapid Response, local GPs, District Nursing etc. The majority of patients attended have been frail elderly patients and in a significant proportion of cases if these patients were conveyed to A&E there is a high likelihood of admission to ACU or on to the medical wards.



Activity Deflections

The table below shows the activity for the Green Care between April 2019 and December 2019. It shows that the see and treat response for the Green Car is 77%, which is higher than forecasted.

	Apr-19	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Number of incidents attended	159	202	194	212	200	191	218	194	204	1774
Total 18_19	66	78	88	70	165	157	171	176	173	
Number of incidents treated at home	118	165	155	162	158	150	172	141	148	1369
Number of 'other' incidents not conveyed to A+E			14	21	15	12	14	18	14	
% Non-Conveyance 19_20	74%	82%	87%	86%	87%	85%	85%	82%	79%	77%
% Non-Conveyance 18_19	71%	86%	70%	77%	79%	83%	77%	82%	83%	79%

It shows a total of 1,774 referrals, of which 1,369 were seen and treated at home. Pro Rata for 12 months this would be 1,825 patients. Assuming these patients would have been admitted after a A&E attendance would demonstrate a saving of £1.9m if this activity was costed at PbR with average cost of £1,052.

The current cost of the service is £219,700. During 2020, the service has been suspended at certain times due to NWAS current resourcing pressures particularly in relation to staff self-isolating. Therefore, the activity reviewed is for 2019.

3. Recommendations

The Board is asked to:

a) Support the recommendation of the Urgent Care Programme Board that Option 4 of the UTC staffing model is the preferred option as the re-defined operating model for the Bury UTC to deliver the increased patient demand.
b) Note the reprovision of current UTC and WIC contractual income into the new operational model and that moving to operational delivery is dependant on the development of the capital business case and estates model.
c) Recognise that current funding requirements may change subject to longer term decisions regarding mental health and digital funding streams.
d) Recognise that delivery of the operational model will be phased in line with development of suitable estate.
e) Recognise that work will now move to focus on developing a full business case for the UTC to appraise the capital options.
f) The **Green Car** has been funded non recurrently for the last 5 years. It has demonstrated the activity deflection from A&E and NEL admissions and established links with primary care, rapid response and other community health services. It is recommended the service is commissioned recurrently to help deliver the new urgent care pathways at a cost of £219,700.

Samantha Merridale

Interim Programme Lead – Bury Urgent Care Programme

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Outline Business Case

Urgent Treatment Centre
Fairfield General Hospital

PART 1: Workforce/staffing and IM&T requirements
PART 2: Estates / capital requirements

FINAL

V2.2

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Version control:

Version	Author	Changes	Date
1.0	SM	Initial draft version produced	5th September 2020
1.1	SM	Options considered	23rd September 2020
1.2	SM	Further development of costs and options	30th September 2020
1.3	SM/MW	Finance breakdown	8th October 2020
1.4	SM/MW/CR	Staffing profiling	15TH October 2020
1.5	SM	Summary paper to LCO Board	15th October 2020
1.6	SM/MW/CR	Finance and capital options	23rd October 2020
1.7	SM	Final draft for initial circulation	2nd November 2020
1.8	SM / MDB	Revised costings IM&T	3rd November 2020
1.9	SM/MW	Capital costs added	11th November 2020
2.0	SM/MW	IM&T update – final circulation	11th November 2020
2.1	MW	Portering costs added and financial assumptions	12th November 2020
2.2	MDB/MW	IM&T revisions and finance update	13th November 2020

Table of contents:

1. Executive summary

1.1 Purpose

The purpose of this paper is to present an outline business case describing the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury. The business case also gives a summary position of the required capital development with respect to changes to the estates requirements to provide the capacity for increased patient demand and deliver safe waiting and clinical treatment areas with respect to infection prevention and control.

1.2 Context

The NHS Long Term Plan published in 2019 outlined the NHS's ambitious commitment to continue the transformation of urgent and emergency care services. Over the next 10 years, NHS organisations will work together to ensure that patients get the right care, in the right place, at the time. One of the key objectives within the delivery of urgent and emergency care services was to confirm that by December 2019 each area should have an Urgent Treatment Centre, delivered to the standards set out in the national specification which had been published in 2017.

The Bury response to Urgent Treatment Centre review and implementation culminated in a system-wide review of urgent care provision in totality in Bury at the beginning of 2020, with a public consultation as to how this should be delivered locally, which included a review of the Walk in Centre provision. A local urgent care strategy was produced with the outputs of the review, along with a Programme Charter.

One of the key deliverables within the strategy includes the redesign of urgent care at Fairfield General Hospital including building a brand-new purpose-built urgent care facility, and implementation of pre-ED triaging/streaming as part of the GMUEC by appointment model. The ability to be able to triage / stream patients away from the front door, by deflecting them into other more appropriate clinical pathways (e.g primary and community care) has been tested in a number of different localities, including Bury, using an experienced Band 7 ENP, and it is confidently assumed that the introduction of this, combined with the introduction of NHS 111 First to encourage patients to "call before you go" will deflect around 18,000 patients away from the front door. From a total figure of c.58,060 self presenters to Bury ED each year, this leaves around c.40,060 patients to be managed onsite through a variety of different pathways, with an estimated 30,000 to be treated in the new Urgent Treatment Centre, which is an increase from the current patient throughput of around 17,000 annually.

1.3 IM&T Requirements

In order to achieve the national standards around UTC implementation and also facilitate the introduction of the NHS 111 First and pre-ED Streaming models, we will need to upgrade the IM&T infrastructure in the UTC. This is part of the NCA wider strategy and will mirror what has been agreed for the Rochdale Infirmary UTC. Using the same blueprint for the redesign as Rochdale will enable us to save costs as project management time does not need to be replicated.

1.4 Financial context

The operational planning process for 2020-21 was suspended in March 2020 to allow the system to prepare for the COVID pandemic. Temporary financial arrangements were put into place. These gave NHS providers a guaranteed a fixed minimum level of income.

As such the business case sets out the financial envelope for the Urgent Care Review based on the current contractual income for Moorgate Walk in Centre and The Urgent Treatment Centre as opposed to income from a tariff based system for A&E attendances and NEL admissions.

The contractual income for Moorgate WIC and UTC is £469k and £1,322k respectively. It is anticipated there will be further funding for additional Mental Health resource of £261k and Recurrent funding for Pre Ed Triage of £225k. This gives a total financial envelope of £2,277k.

This paper sets out options for reinvestment of this funding to support the GM Urgent Care pathways and commission a Pre Ed Triage and new model for UTC with additional MH capacity.

1.5 Options appraisal – workforce requirements

This paper describes the potential options for the development of the existing staff model to deliver clinically safe treatment for the 30,000 patients described above. Option 4, which will deliver the increased level of demand within the proposed operating model, and which will achieve the standards described in both the national UTC specification and the requirements of Greater Manchester Urgent Care by Appointment, is our preferred option.

1.6 Estates / capital requirements

In order to deliver the increased patient demand through the proposed operating model, the existing estates infrastructure will require some redesign to expand the physical environment and reduce clinical risk associated with infection prevention and control, and the safe treatment of vulnerable patients. This paper gives a summary position in terms of those requirements with outline capital costs. This will be developed into a full business case.

1.7 Summary of capital cost implications

A forecast cost of the capital works have been provided by NCA at £5,384 per m2. The capital build required has estimated Gross Internal Floor Area (GIFA) of approx. **700m2** – subject to space planning /schedule of accommodation checks.

Based on the above an estimated cost applying the 700m2 GIFA x £5,384/m2 = **£3,768,800**

This is based current information available reflects an **estimated cost** at this stage.

2. National context

The NHS Long Term Plan published in January 2019 outlined the NHS's ambitious commitment to continue the transformation of urgent and emergency care services. Over the next 10 years, NHS organisations will work together to ensure that patients get the right care, in the right place, at the time. In the short term, translating this vision into reality means:

- Promoting a 24/7 urgent care service, accessible via NHS 111, which can refer directly to more appointments in Urgent Treatment Centres (UTCs), general practice (in and out of core hours), and other community services (pharmacy etc.);
- Continuing to stream patients to the most appropriate service at the front door of emergency departments to ensure patients are managed by the correct service;
- Working with ambulance and out-of-hospital services to safely reduce the number of patients who call 999 and don't need to be taken to A&E;
- Maximising the number of patients who can be treated without being admitted to hospital overnight via same day emergency care, resulting in a better experience for patients and reducing pressure on inpatient beds;
- Working closely with primary and community care services to ensure an integrated, responsive healthcare service helping people stay well longer and receive preventative or primary treatment before it becomes an emergency;
- Focusing efforts to reduce length of stay for all patients and paying particular attention to why patients are remaining in hospital for longer than 21 days, improving patient flow and reducing the risk of harm by providing care in the most clinically appropriate setting.

Moving into the medium term the NHS vision for transforming care asks that local urgent and emergency care services increasingly operate as an integrated network of community and hospital-based care, hand in hand with primary care services. By working as part of this extended network, services can collectively reduce pressure on emergency departments, ambulance services, and general practice. To do this the NHS nationally and locally will keep working with systems across the country to enhance the Clinical Assessment Service so that it is a central element of the out of hospital approach.

2.1 Urgent Treatment Centres

In July 2017, NHS England published the National Service Specification for the implementation of Urgent Treatment Centres. From the outset of the review of urgent treatment services in the NHS, patients and the public reported a confusing mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service. Within and between these services, there is a confusing variation in opening times, in the types of staff present and what diagnostics may be available.

The core standards for Urgent Treatment Centres therefore aimed to establish as much commonality as possible, and the original aim was to have UTCs fully operational by December 2019.

Reduced attendance at, and conveyance to, A&E are expected as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. Attendances at urgent treatment centres will count towards the four hour access and waiting times standard.

2.2 Alignment with primary care and other urgent care services

The guidance set out the key functions of the urgent care system:

- guide the patient to the correct level of care and treatment.
- provide clarity as to which services are provided where, along with providing pathways to access these services reliably 24/7.

NHS 111 should be that guiding service for most urgent care needs, in addition to provision of treatment through the clinical assessment service.

Wherever a patient contacts the health care system they will have consistent access to all services and will, if necessary, be referred on to necessary services through a process of direct booking whenever possible. Urgent treatment centres will operate as part of a networked model of urgent care, with referral pathways into emergency departments and specialist services as required. Commissioners should make sure that all services form part of ambulance services referral pathways as an alternative to conveyance to A&E where appropriate.

2.3 Principles and standards for Urgent Treatment Centres

Urgent treatment centres (UTCs) are described as being community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as “Type 3 and Type 4 A&E Departments”.

Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will be beneficial in providing an effective and integrated service. There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.

The full set of standards from the 2017 national specification are detailed in Appendix 1, however it is recognised that the national context has changed significantly since this was published, (particularly due to the COVID-19 pandemic) and thus certain elements have been considered locally and interpreted for a more appropriate level of provision, particularly around meeting infection prevention and control standards.

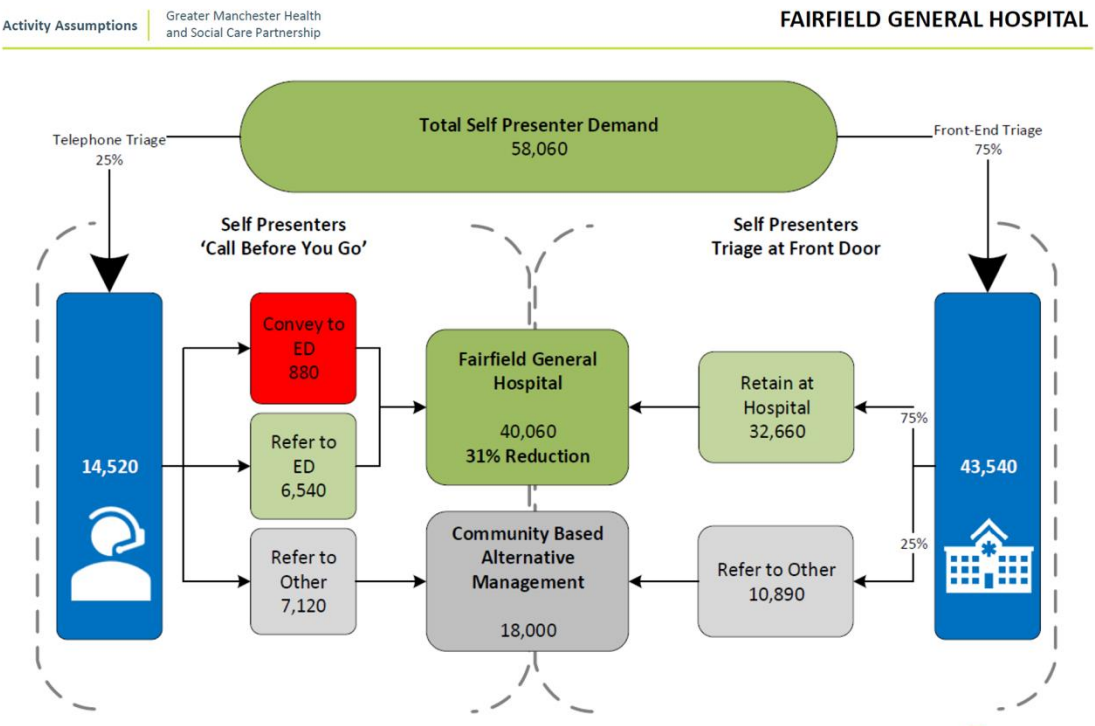
3. Regional Context – Greater Manchester Urgent Care by Appointment

Within the Greater Manchester Urgent Care Strategy there are 5 workstreams to support urgent care as a system. While the proposal is to develop a GM-level model, the emphasis is on locality-developed service models based on the needs of patients, supported and connected by digital solutions where possible. UEC by appointment was further developed in the Spring of 2020, following the COVID-19 escalation, to actively support deflection of patients, where clinically appropriate, away from front door ED/acute sites, to maintain safe social distancing and infection prevention / control.

UEC by appointment assumes a minimum of 25% of self-presenting patients to be deflected to other community based alternative service such as specific specialities, primary care or community services, to be achieved either through "Call before you Go" (NHS 111 First) or pre-ED triage and streaming. This pre-ED based CAS will ensure patients are diverted to the most clinically appropriate setting, connecting patients with local clinicians or services quickly by eliminating non-value adding steps or delays.

The local Bury implementation model for GM UEC by appointment, with anticipated patient volumes, is pictured below:

Figure 1: GM UEC by appointment demand and deflection – Fairfield General Hospital



GM will work with localities to measure and evaluate work programmes to ensure pathways deliver the intended outcomes.

The workstreams will be monitored and evaluated to support commissioning decisions.

4. Local Context – Bury Urgent Care

4.1 The case for change

The local response to Urgent Treatment Centre review and implementation culminated in a system-wide review of urgent care provision in totality in Bury at the beginning of 2020, with a public consultation as to how this should be delivered locally, which included a review of the Walk in Centre provision. A local urgent care strategy was produced with the outputs of the review, along with a Programme Charter (Appendix 2).

There are multiple factors influencing the development of an urgent care system. As a result, the urgent care system in Bury represents a model that has evolved over time rather than one which has been bespoke planned for the locality. Over time services may evolved this way for many reasons including:

- Locally identified need
- Nationally mandated developments
- Ad hoc services rolled over pending wider system change
- System pressures
- National and local drive to integrate services
- Political influences both at a local and national level
- National incidents (i.e. Pandemic)
- Technological advancements
- Finance available
- Changing societal expectations.

Over recent years Bury CCG, with system partners, has been reforming the way urgent care services are delivered across Bury. Many of the changes have been triggered for reasons listed above and include:

- Redesign of Extended Working Hours
- Development of GP Quality Scheme which has increased GP access
- Development of Community Wound Care Services
- Commissioning of NHS111
- Enhancement of Ambulatory Care on acute sites
- Establishment of a Local Care Alliance (LCA) bringing local providers together
- Scaling down of Walk-In Centre Service due to reducing attendances levels
- Expansion of the NWAS Green Car Scheme
- Establishment of NHS Digital
- Increasing use of Pharmacists locally and nationally
- Development of Local Integrated Clinical Hub and GM CAS
- Development of Integrated Neighbourhood Teams
- Emerging Development of Primary Care Networks
- Development of Urgent Treatment Centre at FGH.

This evolutionary approach has left Bury with a range of first-class services however too many of them operate in isolation and do not seamlessly interlink with each other to create a single approach. As a result, the Bury urgent care system could be described as:

- Complicated for patients to navigate
- Complicated for professionals to understand
- Generates high levels of duplication across the system
- Provides too many access points
- Delivers differing responses in differing settings
- Does not recognise the ability of Primary Care influence behaviours
- Does not always ensure patients see the right person, in the right place at the right time
- Does not maximize the potential efficiencies in the system
- Does not lend itself towards an integrated approach
- Does not maximise the opportunities for cross referrals and electronic booking
- Operates using differing IT platforms which do not always talk to each other.

The current urgent treatment centre, based within the ED at Fairfield General Hospital, is small and currently delivers around 17,000 patient episodes / year. The department is often overcrowded. The current issues around infection prevention and control due to the COVID-19 pandemic means that if there are any more than 8 patients awaiting treatment, the waiting area is dangerously overcrowded and unsafe. The children's waiting and treatment area has had to be given over to a 'hot area' to treat COVID-19 positive patients, which means that children have to wait and be treated in the same clinical area as adults. The front door itself consists of a very small foyer which is not fit for purpose.

Additionally, there is limited capacity for assessment and treatment of patients who attend with mental health conditions, and the reduction in community-based capacity in both Bury and Rochdale means that there is now a serious gap in provision for patients with mental health. This is being addressed by means of a separate business case, however assumptions on capacity and demand are being included as part of the overall UTC business case as the staff mix will need to include on site mental health practitioners.

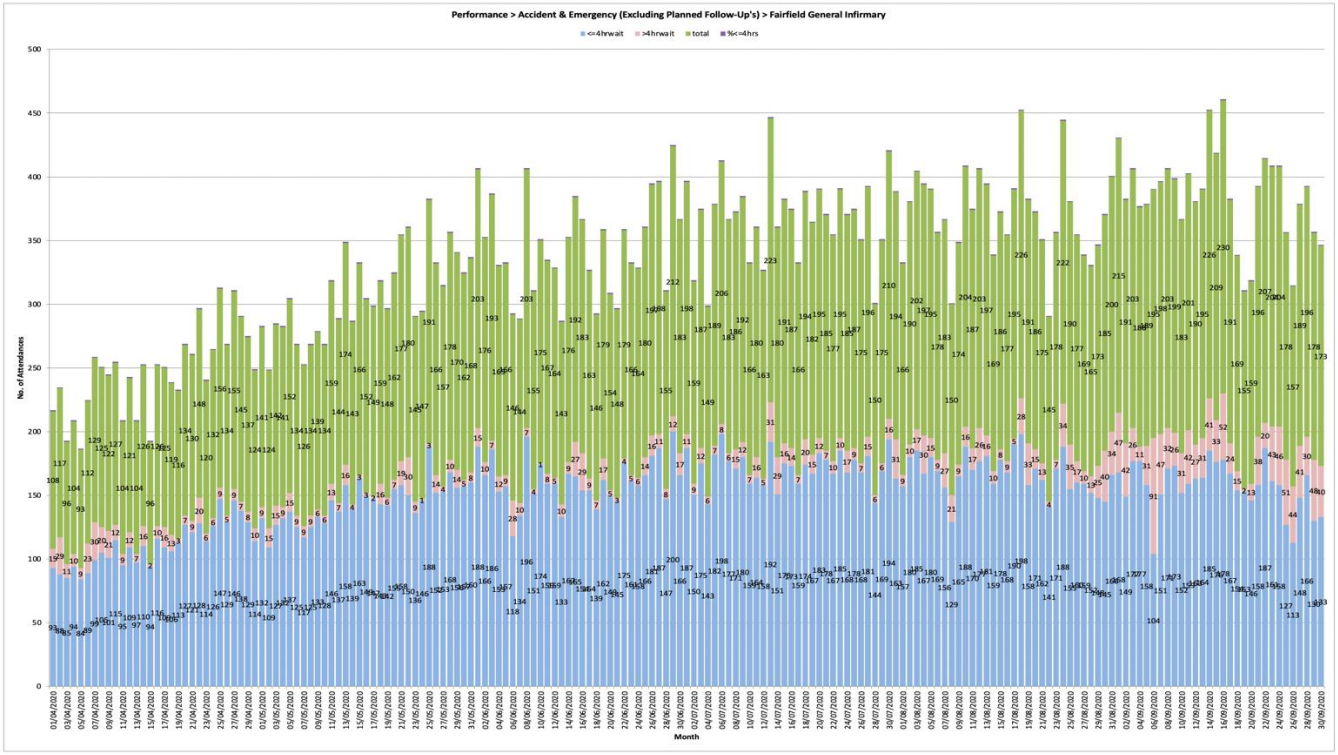
Up until the onset of the COVID-19 pandemic in March this year a Walk in Centre facility had also operated out of the Moorgate site in Bury. To maintain safe social distancing and IPC measures this was closed and the staffing transferred to the UTC. In addition, the provision of a GP within the UTC was also reviewed and ceased.

The IM&T system, Symphony, currently does not allow for direct booking, which means that one of the standards within the national service specification, i.e. the ability to offer patients a booked appointment within a UTC, cannot currently be delivered. IM&T requirements therefore also form part of the business case, and this is part of the wider IM&T strategy for the NCA.

4.2 Activity and demand analysis

Following an initial fall in self presenting activity to ED caused by the COVID-19 pandemic (which was mirrored in all EDs nationally) we have seen a steep rise in attendances throughout Q2, and this has directly impacted on our ability to achieve our 95% 4-hour target. The following chart (Figure 3) shows activity from 1st April 2020 to mid September 2020 clearly shows this, and the worsening position around the 4 hour waits:

Figure 2: Total ED activity and 4 hour performance – 1/4/20 – 30/9/20



5.0 Proposed Operating Model

Transforming hospital urgent care represents one of the critical elements of the new IUCS for Bury.

Workstream 1 describes the redesign and blend of several services into a single Urgent Treatment Centre service offer, based at the Fairfield General Hospital site. This does not mean simply making all current services available 24/7. Within the UTC, we will blend and redesign:

- Moorgate WIC (NCA)
- Bury Out of Hours (BARDOC)
- Bury UTC, currently in the main body of the hospital (NCA and partners)
- ED Minors Service (NCA)
- ED Mental Health Services (PCNHSFT)

A working group consisting of stakeholders from Fairfield Hospital, Bury LCO, Bury OCO, BARDOC, primary care, Pennine Care and community teams have met weekly since late July to fully evaluate the current activity and demand and determine what the future operating model of the new Bury UTC needs to be. This was within the context of delivering the GM UEC by appointment model and having sufficient space to be able to deliver pre-ED triaging/streaming. In addition, we have also considered the requirements of additional capacity to assess and treat patients presenting with mental health conditions.

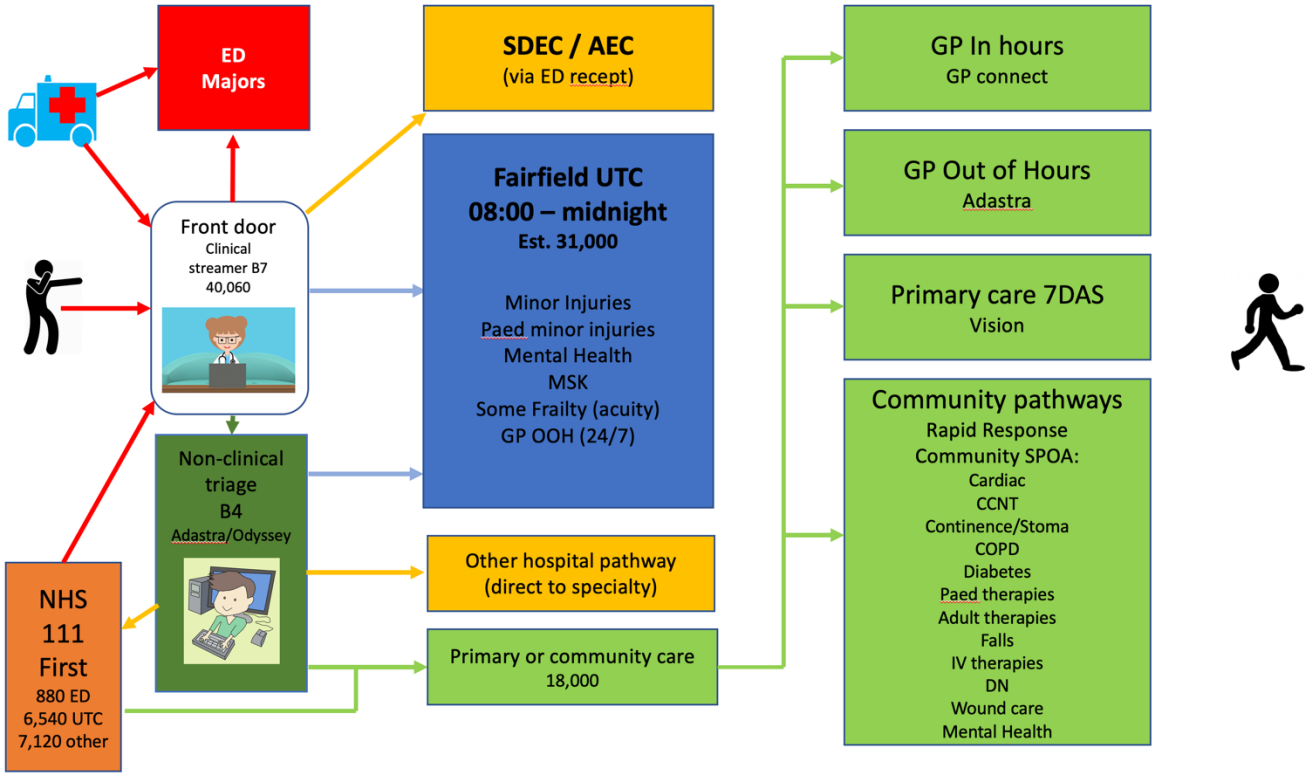
We have had full support from a comms and engagement subgroup which is supporting this workstream, and also from the Bury Urgent Care Clinical Reference Group which is overseeing the clinical governance of this work.

The Bury Urgent Treatment Centre will:

- Operate under a single operational leadership
- Provide a blended staff model across a 24/7 period and will redesign how services are delivered into one place.
- Encompass the services currently delivered by Bury WIC with an assumed reduction in wound care provision as a result of further LCO led work on the wound care service pathway, and the ability to deflect patients back into community-based pathways.
- Deliver GP out of hours service to national required standards. Face to face consultations will be moved from the Folds Suit at FGH to the new build and will be delivered using a blended staffing model as appropriate.
- BARDOC's wider out of hours service offering telephone advice, GM CAS and other support services will be redesigned.
- The current ED minors service will be moved from the main building into the new build and will be delivered using a blended staffing model as appropriate.
- The current Mental Health Service delivered in ED will be further reviewed and redesigned to fit into the new UTC model.
- The new UTC will help to reduce flow into the ED department allowing for it to be redesigned. The ED department and the UTC will be separately staffed and thus operate as two individual units; however we will have the ability to flex staffing arrangements during times of surge;
- The new service will receive electronic appointments from local and national stakeholders as per the current UTC guidance.

The following model (Figure 3) represents the combined operating process of NHS111 First – which will have the ability to offer booked appointments into the UTC – and a pre-ED triaging / streaming function, which will be a combination of both FTF clinical streaming, using a B7 Extended Nurse Practitioner, and the Adastra / Odyssey algorithm, using a Band 4 non-clinical triager. An assumed activity level of 31,000 patients per year has been derived following a 25% reduction in activity away from front door through the pre-ED triaging function, and the ability to transfer patients into alternative pathways such as SDEC/AEC, mental health, or ED majors should this be required.

Figure 3: Proposed operating model – Fairfield Urgent Treatment Centre



5.1 Hours of operation

The UTC will be operational 08:00 – 12 midnight, 7 days / week. In addition, GP OOH will also be present on site, accessible through a booking process, making a 24/7 service offer.

5.2 Pathways to be offered

- Minor injuries (adults and children)
- Mental health
- Musculoskeletal presentations
- Some frailty dependent on acuity
- GP out of hours services

5.3 Demand and case mix

Detailed evaluation of the case-mix of self-presenting patients arriving between 08:00 and 0:00 has shown that around 42% (23,000) of cases are minor injuries (including children) and are thus very suitable for a UTC pathway.

We have also seen a sharp rise (30%) in the number of mental health conditions (3,500) presenting at ED, and thus the operating model for the UTC proposes mental health practitioners being part of that team, with the ability to receive patients who have arrived at the front door with mental health conditions.

We have allowed for a small volume of other presentations (3,000) (e.g. frailty, MSK etc) and thus are estimating therefore we will treat around 29,500 patients / year in the UTC between the hours of 08:00 and 0:00.

Of the remaining 9,000 self presenting patients who are not suitable for UTC, these will be sent directly to same day emergency care (SDEC) / ambulatory care, or diverted into ED majors as appropriate, and as demonstrated in Figure 2 above.

5.4 Deflections from pre-ED triaging and NHS 111 Call Before You Go

We have made an initial assumption, based on work done by GM, that we would be able to deflect around 25% (10,800) of self presenting patients back out into primary or community care. The outputs of the two tests of change held in early October 2020 (see below) have confirmed that this is accurate, however the majority of the deflections were back into primary care, with little community based activity deemed to be appropriate. The average deflection rate across the two days was 26%. Combined with the activity deflected via the NHS 111 “Call before you go” this equates to a total of 18,000 patients who can be seen in an alternative to an acute setting.

We are considering the options for provision of additional capacity in a primary care setting to take the deflected activity, and this will be part of the options appraisal in this business case.

5.5 Tests of change

We have so far held a number of “tests of change” to test our proposals specifically around deflections away from the front door. These have consisted of evaluating the presenting complaint of all self-presenting patients and assessing whether they could have been deflected into community-based pathways, mental health or MSK. We have also tested the concept of “Go Home, we Will See you Later” whereby the patient was offered a booked appointment to return to UTC when it was less pressured.

The outputs of these tests were variable; and demonstrated that it was in a large part due to the skill of the person doing the evaluation as to whether the patient was deemed suitable.

Additionally, we have done two tests of change using an experienced ENP doing face-to-face streaming to actively deflect patients away from the front door. The results of these are as follows:

5.5.5 Outputs of the FTF tests of change held in October:

1st Test of Change – Tuesday 6th October 2020 (face to face clinical streaming)

- 92 self presenting patients assessed
- Total deflections (actual and potential) – 25 (27%)

Actual:

- 14 deflected to Bury primary care (11 in hours to 'duty doctor' and 5 OOH
- 1 patient sent home with advice
- 1 to HMR CMS

Potential:

- 5 would have been suitable for HMR primary care if available
- 2 suitable for MH (no capacity to refer)
- 2 dental patients
- Ambulance arrivals also assessed by the clinical streamer – none suitable for deflection
- Rapid Response took a further two patients from majors.

2nd Test of Change – Monday 12th October (face to face clinical streaming)

- 84 self presenting patients assessed
- Total deflections possible (actual and potential) – 20 (24%).

Actual:

- 1 to Bury primary care duty doctor
- 1 to BARDOC OOH
- 1 to HMR CMS

Potential:

- 7 HMR GP
- 2 Bury MSK
- 1 Bury Wound care
- 1 Bury Mental Health
- 2 Bolton GP
- 1 Middlesborough GP
- 1 Oldham GP
- 1 Bury GP referred to ED without Face to Face appointment from care home, painful hip (could have been referred straight to x-ray or had a FTF assessment as patient was weightbearing).

3rd Test of Change – Saturday 24th October (face to face clinical streaming)

- XX self presenting patients assessed (awaiting figure from FGH)
- Total deflections possible (actual and potential) – 17

Actual:

- 12 in total redirected, including 3 to CMS

Potential:

- 3 requiring wound care had to be seen by ED as no suitable alternative
- 1 x patient rejected due to apparently lack of equipment (speculum) at Rochdale HMR
- 1 x dental pain no access to dentist (booked up)

The outputs of these front door tests of change have confirmed our assumptions around the number of patients who can be deflected safely away into more appropriate pathways, and we are currently in the process of commissioning additional primary care based capacity to be able to accept these patients in both Bury and Rochdale. A total of 30/ day (F-F) additional primary care slots will be available in Rochdale (20 minor illness at Whitehall Street and 10 minor injury at the Rochdale Infirmary UTC) and up to 40 / day (M-F) in Bury in the Moorgate Centre (minor illness). Patients deflected out of core hours or at the weekend will be seen in Extended Working Hours or Out of Hours services.

5.6 Implementation of Pre-ED Streaming / non-clinical triaging

We will be implementing pre-ED streaming, using a clinical nurse streamer, from Friday 6th November 2020. Additional in-hours primary care / GP cover will be provided in Bury on a temporary basis to allow us to further evaluate the potential deflections and also to complete necessary upgrades to the Vision software in General Practice to allow for direct booking. GPs have now agreed to accept 1 patient per site per day from deflections from the front door; and this is in addition to the 1:500 slots ring fenced for referrals from NHS 111/ GM CAS.

Additional primary care cover has also been provided in HMR.

Following the implementation of the Adastra software into the front door, to allow direct booking into ED/UTC and also giving access to the Odyssey clinical triaging system, we will be able to also commence non-clinical triaging. It is envisaged that we will run a hybrid model of non-clinical triaging in less busy times, and clinical streaming at peak times to maximise efficiency and prevent a backlog of patients at the front door.

5.7 Implementation of NHS 111 First "Call before you Go".

This is a nationally mandated initiative and will be rolled out across Greater Manchester localities during November 2020. Following installation of Adastra licences into our ED we will be able to accept patients from the GMCAS, who have called NHS 111 prior to attending ED, and who can be directly booked into slots to manage flow. Having the ability to provide bookable slots into the UTC is one of the requirements of the National UTC Specification, and this will be implemented in Bury no later than 1st December 2020.

6.0 IM&T Requirements

The following paper is an extract from a paper which was written to support the upgrade to IM&T for the Rochdale UTC. It is expected that the IM&T upgrades to Fairfield UTC will mirror that of Rochdale; thus this is presented as an illustration of the likely order of costs and the technical requirements. This has yet to be ratified by the Bury Digital Board and we need to further clarify any additional costs with respect to project management. The annual hosting, licensing and support costs can be shared with HMR @ 50% and this is detailed below.

6.1 Summary

The purpose of the document is to highlight the options and recommendation for a clinical system to be procured and implemented at Rochdale UTC and Fairfield General Hospital UTC to meet NHSE UTC mandated standards (See Appendix 1).

The two systems that have been appraised (via both vendor demo and demo in use clinically) are EMIS and Adastra, these are the only systems that meet the 10 Must have/Critical requirements. However, further evaluation shows that EMIS is the only possible solution, and this is therefore costed in section 6.2 below.

UTC Requirements v1.0.docx

6.2 IM&T Costs

6.2.1 Software, set up and licensing

Year	Item (Excl VAT)	£
1	Database, set up on own instance, deployment, training (one off cost) Annual hosting, licensing and support (no of licences) @ 50% of total **TOTAL**	16,395 36,900 **53,295**
2	Annual hosting, licensing , links to SPINE, Pathology, Manchester triage, ECDS and support for 20 Licences	36,088
3	Annual hosting, licensing , links to SPINE, Pathology, Manchester triage, ECDS and support for 20 Licences	36,088
	Total (3 year cost)	**125,470**

6.2.2 Internal Costs

Project resource (Excl VAT)	Duration	£
Project Manager/ Specialist/Tech Support/ Information	<3 months	36,000
Total		**36,000**
BAU resource		
System Specialist Band 5 PAT	Part Time	20,000

Service desk 1st Line Support PAT	Part Time	10,000
Total		**30,000**

6.2.3 IM&T summary costs:

	Year 1	Year 2	Year 3
Software, setup and licensing/hosting	**53,295**	36,088	36,088
Project management	36,000	-	-
BAU resource (Part time)	30,000	30,000	30,000
TOTAL	**119,295**	**60,088**	**60,088**

6.3 Recommendation

Although both vendors meet the Must have/Critical requirements, reflecting on the cost and additional benefits of the EMIS system the recommendation is EMIS. This has been agreed by the contributors to this document.

6.4 Timescales

The NCA are currently deploying the EMIS tracker in HMR and hence have a PM ready to extend deployment to the Bury site, thus reducing normal time to deploy to circa 3 months, as long as the projects dovetail into each other.

6.5 Site issues

There may be additional networking costs associated with the UTC being situated on a new site; although at this stage until the capital / estates case is made in more detail, this is not quantified – however it needs highlighting as a potential risk to delivery.

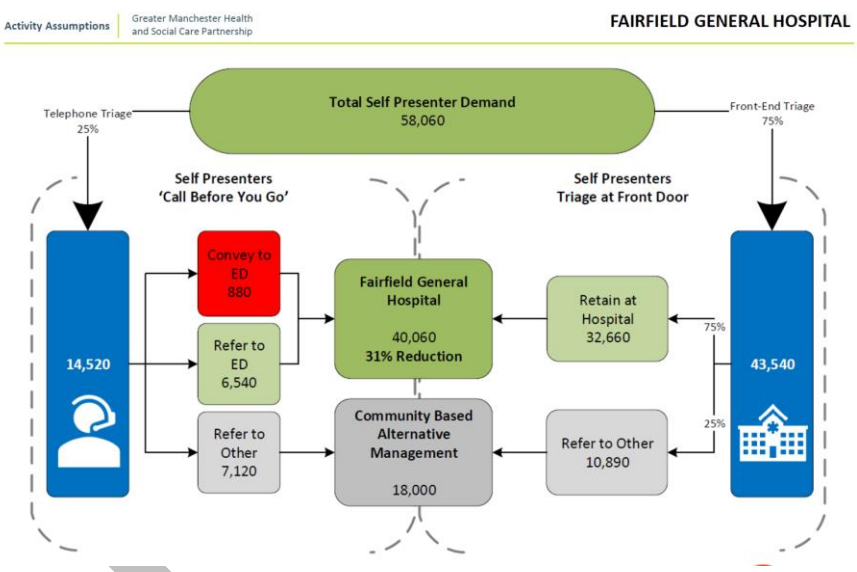
7. Financial context – staffing requirements

7.1 2020-21 Financial Framework

The operational planning process for 2020-21 was suspended in March 2020 to allow the system to prepare for the COVID pandemic. Temporary financial arrangements were put into place. These gave NHS providers a guaranteed a minimum level of income in a block amount. The national block contracts have been in place since 1st April to 30th September. From 1st October budget allocations were awarded to Integrated Care Partnerships (ICPs) and for Greater Manchester ICP there is a reported £120m gap in CCG and providers plans and the current budget available.

7.2 Activity deflections

As provider contracts are fixed, there is no cashable savings in the short term. The focus of this review therefore has been on A&E activity and how this is deflected away from the front door of FGH by using Moorgate and UTC contracted income differently. It is a site based review focusing on activity at FGH rather than activity by CCG. The diagram below shows the activity assumptions for the review.



Within this business case, there are planned forecasted A&E deflections from three sources:

1. Call before you go model
2. Pre Ed Triage
3. Increase activity through UTC

7.3 Current Contracted Activity

The current contracted activity for Moorgate Walk in Centre and Urgent Treatments Centre is as follows:

Service	Provider	Contracted Amount
Moorgate WIC	NCA	£469,190
Urgent Treatment Centre	NCA, BARDOC, GP Fed	£1,322,103
Total		**£1,791,293**

7.4 Current Operating Model

Bury Walk in Centres were stood down at the start of the pandemic. Staff at Moorgate WIC were redeployed to work in A&E and UTC. One Band 7 was redeployed to work as a clinical streamer at the A&E front door at FGH.

The GP element of the UTC was also stood down in April 2020 during the height of the pandemic and resources was prioritised elsewhere in the system. The current operating model is summarised below:

2020-21	RATE	WTE	TOTAL
PRE ED TRIAGE			
Band 7 Clinial Streamer	Redeployed WIC	1	£ 54,230
TOTAL PRE ED TRIAGE		**1**	**£ 54,230**
PAHT			
ANP	B8a	2.64	£ 188,729
ENP	B7	2.64	£ 161,092
Reception	B2	2.76	£ 78,624
Porter	B2	1	£ 26,520
Additional			
ANP/Mid Doctor	B8a	1.63	311,042
HCA	B3	2.13	72,111
Diagnostics			£ 318,240
Consumables [2]			£ 48,000
Drug costs [3]			£ 16,000
Estates			£ 125,623
TOTAL URGENT CARE CENTRE			**£ 1,345,982**
Total			**£ 1,400,212**

Additional costs were incurred by NCA to staff UTC during the pandemic. As the future model and commissioning arrangements of the UTC, staff were employed at agency rates.

7.5 Stranded Costs

Stranded costs are incurred when expenditure cannot be avoided after termination of service contract. In this scenario, all costs have been redeployed to other services areas or reused in the new service model. Therefore, no stranded costs have been included in the future model.

7.6 Financial Options

The summary below shows 4 options for the urgent care pathways with associated deflected activity and costs.

	Option 1 - Current Operating Model		Option 2 - Streaming with no Primary Care & Mental Health		Option 3 - Streaming with Primary Care & Mental Health		Option 4 - Revised UTC Offer Streaming with Primary Care & Mental Health	
	Activity deflected to community	Cost	Activity deflected to community	Cost	Activity deflected to community	Cost	Activity deflected to community	Cost
Pre Ed Triage		£ 54,230		£ 311,298		£ 311,298		£ 311,298
Additional out of hospital capacity		£ -	6,024	£ 75,000	6,024	£ 75,000	6,024	£ 75,000
Additional Primary Care capacity					3,893	£ -	3,893	£ -
Additional Mental Health capacity					973	£ 260,715	973	£ 260,715
UTC Offer	17,000	£ 1,345,982	17,000	£ 1,345,982	17,000	£ 1,345,982	26,000	£ 1,539,281
Total Costs	**17,000**	**£ 1,400,212**	**23,024**	**£ 1,732,279**	**27,890**	**£ 1,992,994**	**36,890**	**£ 2,186,294**

7.6.1 Option 1 – Do Nothing as per Current Operating Model

This assumes no changes to the current operating model and no additional deflections.

7.6.2 Option 2 – Pre Ed streaming with no Primary Care & MH deflections

This model assumes the following staffing mix for the Pre Ed Triage

Hours	B7 Clinical Streamer	B4 Non Clinical streamer
8am-10am	1.00wte	1.00wte
10am – 4pm	2.00wte	
4pm-10pm	1.00wte	1.00wte

The forecasted activity deflected is 6,024 based on the average test of change at FGH. The forecasted split by CCG is:

Bury CCG	4217
HMR CCG	1807

7.6.3 Option 3 – Pre Ed Streaming with Primary Care and MH deflections

Primary care referrals will be deflected to a duty doctor model in the short term until contractual changes can be made to accept deflections from A&E into the Quality in Primary Care contract. The Duty doctor model will run 12-4pm Monday –Friday from Moorgate. The cost of this model is £112,320.

The proposed model for mental health is as follows and is to be considered at SCB on the 6th November:

Urgent and emergency care by appointment (per locality)	WTE	12 months
Team Manager	0.40	20,703
MH Practitioner	4.00	166,878
Admin	1.00	25,007
Non Pay		15,629
Estate Contribution		nil
Corporate clinical delivery support costs and Surplus		32,498
CQUIN		
Total		**260,717**

IT setup costs (Non recurrent)	**12,958**

The forecasted MH activity from A&E is 3,500 per annum. This includes 973 deferred from Pre Ed Triage. The options on how the delivery of MH activity is to be considered at SCB on 6th November.

7.6.4 Option 4 – Increased UTC offer

The revised UTC model is open from 8am to midnight. There were 3,000 attendances per annum outside of these hours. These attendances will be offered an appointment the following day. Assume 50% will take up these appointments.
The revised forecast UTC activity is as follows

42% minor injury/MSK	23,000	(63 per day)
Mental Health	3500	(9 per day)
Other	3000	(8 per day)
Total	**29,500**	**81 per day**

Current UTC activity is recorded in Symphony as Type 1 activity. By definition UTC activity is recorded as Type 3. Other A&E minor injury activity and it is the intention that all activity in the new model will be recorded as type 3. Therefore, the increased UTC activity has been included in the scope of this business case as it is an increase deflection from Type 1 A&E activity.

UTC activity in 2019-20 was 17,000. The new model forecasts an increase of 9,000 attendances deflected from Type 1 A&E activity per annum with a revised staffing model.

As posts will be permanently recruited to and no agency costs will be incurred, the additional cost of the new model is £133k more than the current operating model.

A further £60k is included recurrently for IM&T costs with the set costs of EMIS included non recurrently.

7.6.5 Preferred Option

The preferred option is option 4. This has a total deflection of 36,890 from Type 1 A&E activity of which 19,890 is new deflections over and above the 17,000 current UTC activity.

The 19,890 additional activity has come from Pre ED Triage 10,890 and 9,000 additional activity flowing through UTC.

The total cost of this option is £2,186,294 with additional contingency of £90,714.
The costs to run this service from November 2020 to March 2021 5 months is £1,060,009 which includes non recurrent expenditure for IT and recruitment and a contingency of £32,953.

Option 4	£	1,060,009	£	2,186,294
Contingency	£	32,953	£	90,714
Total	**£**	**1,092,961**	**£**	**2,277,008**

The preferred option will be funded as follows:

Funding Source	**2020-21 5 months**	**2021-22**
Moorgate WIC	£195,496	£469,190
UTC	£550,876	£1,322,103
GM – CCGs	£225,000	£225,000
GM – Providers	£0	
MH CQUIN/MHIS	£121,589	£260,715
Total	**£1,092,961**	**£2,277,008**

7.7 Assumptions

The following assumptions have been taken into consideration when calculating the funding available:

- £225k made available for Pre ED triage for 6 months in 2020-21 will be made available recurrently.
- Estates charges for Moorgate WIC have been consumed by other services and therefore no VOID costs will be incurred.
- Community capacity made available is sufficient to absorb deflected activity
- Duty Doctor arrangement will not be needed in 2021-22
- Digital costs for Pre Ed streaming has been funded outside the scope of this business case.

8.0 PART TWO: Capital and Estates requirements

This section will be further developed as the case for the capital and estates development is progressed within NCA with detailed costings and an options appraisal, however the purpose of this brief summary is to outline the physical requirements for delivering the enhanced UTC model as described in Part 1 of this paper.

8.1 Current position

The current UTC is delivered from within a shared space with the ED and outpatients department. The waiting area is small, and in line with IPC policies, can seat no more than 8 patients. There is only 1 small area suitable for streaming (either non-clinical or clinical) and, given the need to create a separate area for COVID-positive patients, there is no dedicated area for either paediatric patients, or those presenting with mental health conditions. This creates an element of risk, both from an IPC perspective, and also with respect to vulnerable patients.

8.2 Anticipated requirements

The following table represents the estate requirements for the new UTC, should capital monies be available to develop the estate:

UTC Building

Area	In use	Room Size	No of Rooms
Clinical Streaming Area	08:00 to 22:00	Large sized triage/clinic room	1
Pre ED Triage Non Clinical Area	08:00 to 22:00	Large enough for 4 people	2
Reception	08:00 to 08:00	Room for 3 staff members	1
Waiting Room	08:00 to 08:00	20 people socially distanced	1
Treatment rooms	08:00 to 00:00	Standard size	2
Plaster room	08:00 to 00:00	Standard sized clinic room	1
Clinical Rooms	08:00 to 00:00	Standard sized clinic room	4
Office space	08:00 to 00:00	2 people each office	2
Mental Health	08:00 to 00:00	Rooms need to meet Mental Health Guidelines	2
GP OOH Rooms	18:30 to 08:00 08:00 to 08:00 w/e	Standard sized clinic/GP room	2
Staff Room	08:00 to 08:00	To fit 4 to 5 people socially distanced	1
Staff Kitchen	08:00 to 08:00	Standard - could be incorporated into the staff room above	1
Domestic Room	08:00 to 08:00	Standard size	1
Sluice	08:00 to 08:00	Standard size	1
Toilets	08:00 to 08:00	Patient, staff and disabled	3

8.3 Capital costs

The capital team at PAHT have costed the above in line with a standard algorithm as follows:

The below is based upon a cost /m2 basis for new build accommodation and we have assumed the following

				£/m2	
a	Works Costs			3,000	
b	Contingency	15%		450	
				3,450	
c	Fees	15%		518	
				3,968	
d	VAT @ 20%			794	
e	Reclaimable VAT on Fees		100%	- 104	
f	Reclaimable VAT on Works, say			TBC	
g	Equipment, say	15%		518	
h	VAT on equipment			104	
				5,279	
j	Optimism Bias @ say	2%		106	
				5,384	/m2

8.4 Exclusions and notes

Please note the above excludes

1) Abnormal ground conditions
2) Additional costs arising from contaminated ground
3) De-watering / lowering of the site water table
4) Demolition of existing structures / buildings
5) Land purchase costs
6) Legal fees
7) Diversion of existing services
8) Inflation beyond 4th quarter 2020
9) Framework procurement fees
10) VAT reclaim on the works costs – subject to advice from the Trusts VAT assessor
11) Fixed Furniture and Fittings/ Equipment

Looking at the accommodation listed this may require an estimated Gross Internal Floor Area (GIFA) of approx. **700m2** – subject to space planning /schedule of accommodation checks

8.5 Estimated cost

Based on the above an estimated cost applying the 700m2 GIFA x £5,384/m2 = **£3,768,800**

We can provide more detailed information once we have more firm information available but based on what we have at present the above reflects an **estimated cost** at this stage

APPENDICES:

Appendix 1: - National Standards for Urgent Treatment Centres.

https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

Saving lives, Improving lives

NHS
Salford Care Organisation
Northern Care Alliance NHS Group

Requirements Document

Rochdale UTC clinical system

Document Properties

Property	Value
Produced by	Sarah Kierans
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Contributors

Name	Role
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Approval

This document requires the following approvals:

Name	Title	Date of Issue	Version
Dr Stephen Gerrard	SRO and Divisional Clinical Director, Rochdale UTC	07/07/20	1.0
Tanveer Kausser	Urgent Care Commissioning Manager – HMR CCG	07/07/20	1.0

Glossary of terms

Term/Acronym	Definition
UTC	Urgent Treatment Centre
NCA	Northern Care Alliance
111	NHS 111 Service
HMR	Heywood, Middleton, Rochdale
ECDS	Emergency Care Data Set
PEM	Post Event Messaging
EOL	End of Life
CP-IS	Child Protection – Information Sharing
GM IDCR	Greater Manchester Integrated Digital Care Record

1. Introduction

The purpose of this document is to detail the requirements of a project's software or system requirements so that Digital Technical Services can accurately assess the impact of this system, create any system diagrams, assess impact on other systems, estimate time, and provide costs.

Complete this document in collaboration with the vendor. Provide as much information as possible.

2. Solution Requirements

The solution will need to be able to interface with the following systems:

Microsoft Office	☐
G2 Digital Dictation	☐
Medisec	☐
SCM (EPR)	☐
Patient Flow	☐
Patient Centre	☐
PAS	☐
Windip	☐
TheatreMan	☐
SCR/Spine	☒

Telepath	☐
CRIS	☐
PACS	☐
Integra	☐
Symphony	☐
ERS	☐
Graphnet	☒
Community EMIS	☐
SystmOne	
EMIS GP systems	☒

Assessment of Requirements

Rochdale UTC clinical system requirements are assessed and given a score using the prioritisation technique MoSCoW, which has been used to reach a common understanding amongst stakeholders on the importance of each of their functional requirements.

Vendors need to meet all the MUST have/Critical Priority requirements.

Acronym		Description	Priority Level
M	MUST have this	Requirements labelled as ***Must have*** are critical to the current delivery time box in order for it to be a success. It is a requirement that has to be satisfied for the final solution to be acceptable.	**Critical**
S	SHOULD have this	Requirements labelled as ***Should have*** are important requirement that should be included if possible within the delivery time frame. Workarounds may be available for such requirements and they are not usually considered as time-critical or must-haves.	**High**
C	COULD have this	Requirements labelled as ***Could have*** are desirable or nice-to-have requirement (time and resources permitting) but the solution will still be accepted if the functionality is not included.	**Medium**
W	Won't have this	Requirements labelled as ***Won't have*** represent a requirements that stakeholders want to have, but seen as less critical as such, will not be implemented in the current delivery time box or not appropriate at that time. However, they can be considered for inclusion in the future	**Low**

Ref	Requirement Description	MoSCoW Level	Priority Level
UTC1	Enable 111 service to directly book appointments into the UTC system	Must	Critical
UTC2	Ability to extract and submit all the mandated ECDS	Must	Critical
UTC3	Allows electronic prescribing	Must	Critical
UTC4	Allows UTC to view HMR GP clinical record	Must	Critical
UTC5	Ability to send a PEM or electronic discharge summary to GP	Must	Critical
UTC6	Allows UTC to access EOL information	Must	Critical
UTC7	Allows UTC to access Mental Health information	Must	Critical
UTC8	Allows UTC to access CP-IS	Must	Critical
UTC9	Enable UTC service to directly book appointments into HMR GP clinical systems	Must	Critical
UTC10	Able to interface with and send data to the GM IDCR (Graphnet)	Must	Critical
UTC11	Electronic prescribing allows patients to collect prescription from any pharmacy (not just nominated one)	Could	Medium
UTC12	Order comms – ability to request pathology and radiology from the system	Could	Medium
UTC13	Ability to receive pathology and radiology results into the system	Could	Medium
UTC14	Tasks/flags sent to GP with actions required from the discharge summary	Could	Medium
UTC15	Ability to host system on existing NCA or HMR infrastructure/platform with vendor	Could	Medium

H. Timescales

Timescales	
What are the proposed timescales?	UTC mandated standards from NHSE are that the above critical digital requirements are met by 31/08/20.

NHS
Bury
Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Consider
Item No.	12	**Confidential**	No
Title	Consideration of future arrangements for the provision of Community Health Care Services		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning Julie Gonda, Director of Community Commissioning		
Author	Julie Gonda, Director of Community Commissioning		
Clinical Lead	Howard Hughes		

Executive Summary

This paper sets out the background to how the current provision of community services came into being and summarises the considerable work which has taken place to develop strong local collaborative provider working across the sector.

It introduces the current contract which enables the community services to be delivered through the Northern Care Alliance and makes the case for the critical time currently required in order to develop a confidence to specify and commission the community services for the future.

This paper makes a recommendation to continue the current service model for a further year, being supported through an award of an interim contract for 12 months.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Support the proposal to award a further interim contract for a period of 12 months from 1 July 2021 to 20 June 2022, with a potential for a further 12 month extension. Enacting any extension beyond June 2022 would be brought back to SCB for approval;
- Agree that the interim contract should take the form of a direct award to the Northern Care Alliance in line with the current arrangements in place;
- Authorise for the publishing of a Contract Award Notice through OJEU to ensure lawful compliance in regard to market transparency.

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 for 2020/21	☒
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:	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☒	No	☐	N/A	☐
If yes, please give details below:						
The EIA has been completed and signed off.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Finance Contracting & Procurement Committee	19/11/2020	The Committee supported the paper, but requested that any further extension beyond June 2022 is re-presented to the Committee for sign off.

1. Purpose

This paper sets out the background to how the current provision of community services came into being and summarises the considerable work which has taken place to develop strong local collaborative provider working across the sector.

It introduces the current contract which enables the community services to be delivered through the Northern Care Alliance and makes the case for the critical time currently required in order to develop a confidence to specify and commission the community services for the future.

This paper makes a recommendation to continue the current service model for a further year, being supported through an award of an interim contract for 12 months.

Informal discussions around the approach outlined within the paper have taken place with NHSE and NHS Shared Services.

2. Background

In 2010, national policy for Transforming Community Health Services stressed the need for the externalisation of community health services from commissioning bodies, with the aim of separating PCT commissioning from the provision of services. This had to be achieved by April 2011. The options permitted at the time nationally included consideration of vertical integration with acute trusts, as well as horizontal integration with other NHS providers.

Whilst most areas separated out community health services to become stand-alone contracts, the North East Sector (of Greater Manchester) PCTs, made up of Bury, HMR and Oldham, took the joint decision to transfer these services to Pennine Care NHS Foundation Trust (PCFT), formed in 2002 as a mental health trust, and the transfer was completed by April 2011. The PCTs believed that this would allow community health services to retain autonomy and reflect their unique local focus, whilst focussing on transformation of care pathways to support delivery of local care outside hospitals rather than concentrating on a new organisational form. Community health services were subsequently hosted by PCFT until July 2019, at which point, they were transferred to the acute care provider in Bury, the Northern Care Alliance (NCA).

3. Development of the Bury Local Care Organisation (LCO) to date

During the time that PCFT hosted community health services, place based integration of health and care services within Bury was being driven forward.

In February 2015, NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement with the government to take charge of health and social care spending and decisions in the city region. The development of Local Care Organisations as instruments of care delivery became the heart this pioneering approach, bringing together NHS community health providers, mental health providers, primary care and social care.

The Bury Locality Plan (2017) and Locality Plan Refresh (2019) set out Bury's approach to

population health being at the heart of our communities, with targeted, integrated, asset based health and care provision at a neighbourhood level for those who need it. The ambition was to enable people to get joined up, quality care closer to home, as well as helping them stay out of hospital and manage their own wellbeing.

The plan described the need for community health services to be integrated with other community based services to maximise the benefits delivered to Bury people. Key to the delivery of this vision was the establishment of the Local Care Organisation (LCO), a partnership of providers which has been in place since September 2017.

The LCO has played a significant role in respect of whole system leadership to organise and deliver care locally to people in Bury acting as a single provider voice, which works in collaboration to deliver effective integrated health and social care services. Its members are made up the major health and care providers in Bury:

BARDOC
Bury Council - Adult Social Care Operational Services
The GP Federation
Northern Care Alliance – Bury Care Organisation
Pennine Care Foundation Trust
Persona Care & Support
The Voluntary, Community & Faith Alliance (VCFA)

The agreed priorities for the LCO for the past three years have been focussed on:

- establishing the five Integrated Neighbourhood Teams, with core teams made up of GPs, community nurses and social workers, working together to deliver joined up care to people on a neighbourhood footprint serving between 30,000 – 50,000 people;

- driving the transformation and expansion of Intermediate Care, to be more home based and establish a fully integrated health and care model, made up of teams with community health services and social care operational services;

- developing palliative and end of life care across the health and care system, with a real focus on an out of hospital approach for support.

At the time of writing, the further strengthening of integrated care delivery led by the LCO is beginning to show some real evidence of success on how a difference is being made to people's lives. This means that we are beginning to grow an evidence base to demonstrate how, in future, health, voluntary, and social care partners should work even more closely together to deliver the right care at the right time and in the right place for Bury residents.

The recent consideration of the LCO Programme Board to move towards a lead provider model, whilst now on pause due to the resurgence of Covid 19 in our community, remains a significant aspiration, to be revisited during 2021. The agreement of all partners that form should follow function means that whilst partnership governance will remain as is for now, partnership relationships can be strengthened and developed to become even more robust in the interim.

Whilst living with and beyond Covid19, we look forward to accelerating working in partnership to further integrate services and ensure that local people are cared for and supported by integrated teams of professionals in their own homes or local communities, led by the Bury LCO.

4. Transfer of Community Health Services in 2019

As stated above, community health services were hosted by PCFT until July 2019, working within the collaborative arrangements of the LCO. The further transfer of services arose from a change in direction for PCFT. In December 2018, the Trust announced its strategic intent, via a Board Paper entitled 'Trust Strategy 2019-22: Maximising Potential, to concentrate its business solely on the delivery of mental health and wellbeing services.

In January 2019, in order to ensure the safe ongoing delivery of community health services, the Finance Procurement and Contracting Committee of NHS Bury CCG recommended to the Governing Body to support a waiver to a procurement process. Again, this was in line with the other NES CCGs. A number of factors were considered as part of the decision making process, but the overriding rationale was clearly the need to continue to operate community health services within the framework of the developing LCO to support effective integration and service transformation of health and care services for the people of Bury.

The CCG then wrote to the LCO Board inviting them to consider which partner was the most appropriate to act as a host provider for community health services for a period of two years, which would involve becoming the new employer of the community service staff and becoming responsible for service delivery and performance.

The LCO Board made the decision against a set of assessment criteria and the Northern Care Alliance (with Salford Royal Foundation Trust as the legal entity) was confirmed as the preferred interim provider of community health services for Bury and the other NES areas.

On 1 July 2019 community health services transferred to Salford Royal Foundation Trust, a significant transfer, which supported the continuing integration of services within Local Care Organisations.

5. Current position - value and scope of current services, impact of Covid19

The services transferred continue to operate under the arrangements established in July 2019. The range of services currently within scope of this contract are listed in Appendix 1 of this report, they are very diverse and cover both children's and adult services.

For Bury, the opening value of the current contract for community health services would have been £19.2m for 2020/21 in respect of these core services, notwithstanding different financial arrangements or payments made due to either Transformation funding or funding received as a result of managing the Covid pandemic.

Much work has been undertaken by the Northern Care Alliance in improving core quality of services and reviewing and strengthening clinical governance since July 2019, with clinical reporting now established within NCA arrangements. At the end of January 2020, a new Managing Director of Community Health Services was appointed by the NCA to lead effective transformation of services, with a focus on place-based delivery and working into the LCO management team, alongside the Assistant Director of Social Care and Director of Transformation & Delivery, reporting to the Chief Officer of the Bury LCO.

Work on integrated clinical pathways, especially those which have undergone transformation such as Intermediate Tier services, where therapy delivery at home had

been identified as lacking, has demonstrated the clinical value of delivering services on a place-based basis, with integration across the system where possible, to ensure an improved patient journey.

However, due to the Covid pandemic, since March 2020, services have been operating differently, with some services stood down in line with Covid-19 national guidance, others operating differently under NCA business continuity arrangements, with re-deployment of clinical staff to areas of pressure; the NCA are, at the time of writing, outlining plans to respond to the second wave of Covid, incorporating the learning from the first wave. Details of how this will impact community health services moving forward are awaited, as of the beginning of November 2020.

6. Current position - drivers for integration

Community health services are central to plans for the future of the health and care system. The NHS's long-term plan (January 2019) reaffirmed the NHS commitment to the integration of health and care, and the shift towards a population health approach. It set out ambitions to 'boost "out-of-hospital" care, and finally dissolve the historic divide between primary and community health services'. It also committed to increasing the share of the NHS budget going to community and primary care services.

The ambition to deliver more and better health services in the community is not new, and ensuring they are delivered in an integrated way means better services for patients with a number of real advantages:

- more possibilities for person-centred rather than condition focussed care
- genuine integration of primary care and community health care delivery
- reduced numbers of professionals going into someone's home
- care delivered closer to or within someone's home through the neighbourhood delivery model.

In Bury, we have been working on our programme of health and care transformation for 3 years now, and there is still much to do. The Covid pandemic has brought a different dynamic to this work, and has shown the value of the reform work previously done, in genuine cross system working as part of the response for people in Bury.

Looking forward, place based integration and person centred reform continue to be the mainstays of our transformation programme; key to this is the delivery of services on a neighbourhood footprint. The Bury 2030 strategy sets out how wider public service support will be delivered in neighbourhoods, building on the success of health and care delivery in this way.

The health and care integrated teams are therefore a key component of future neighbourhood delivery, working together to deliver joined up services, supporting people with chronic, long term physical and mental health conditions; they will actively case manage the most complex cases, and focus on early intervention and prevention and the avoidance of unplanned care. This will support people even with complex conditions, to be in control of their care and their lives and enable them to live well at home.

7. Procurement considerations

The current interim provider arrangements regarding the transfer of community health services to NCA are due to end on 30 June 2021, which is the end of the 2 year agreement originally put in place. This two year period was agreed on the basis of local arrangements becoming more mature during that time, with each locality in the NES identifying its own long term approach and organisational form. This would have meant that there would be clarity around what exactly should be commissioned moving forward.

If the current service provision is to continue, the CCG will is unable to further extend the existing contract, but will need to establish a new contract. Given the nature and value of the contract, there will be application of the prevailing procurement regulatory framework.

Whilst the normal expected strategy would be for the CCG to assess the appropriateness of market testing these services, , there are a number of issues that require further consideration before the CCG can gain a confidence as to what community services are to be commissioned and how this should best be put into place. The considerations set out within the next section below point to the need for the CCG to create additional time before having a confidence to commit to a longer term contractual solution which might be expected to be secured through market testing.

8. Considerations to inform an optimal contractual solution

8.1. Covid pandemic and transformation

Firstly, from both a commissioner and service delivery point of view, we cannot ignore the Covid pandemic. Given the impact on health and care services, it has to be a significant factor in determining how and when community health services are put out to tender. Since mid-March 2020, services have been operating very differently from usual, often under direct guidance from the DHSC, to ensure that support to people in respect of Covid is delivered consistently across the whole of England. This means that effectively, the NCA only had 8 months (from July 2019 to March 2020) of the 24 months originally planned to work through transformation and integration with partners in Bury. As indicated above, things may soon change again, due to business continuity arrangements in respect of the second wave of Covid.

By default therefore, the transformation journey of community health services in Bury has, to a significant extent, been paused and consequently substantially delayed as a result of the Covid pandemic. The clarity of what is needed from the health and care system from community health services has therefore not yet been worked through, due to the need to prioritise Covid arrangements. In reality, both commissioner and provider services have lacked the capacity to simultaneously manage the pandemic and review services to the extent required to inform a confidence to commission the services which will be fit for purpose for the future.

8.2. Data

In addition, health trusts are currently exempt, under NHS Covid guidance, from having to undertake data reporting at this time; therefore the metrics needed to evidence what improvements, changes and future outcomes would be required within a Bury health and

care system would need are not currently in place.

8.3. Financial considerations

The financial arrangements in respect of the current contract have been revised in line with national requirements put in place as a result of the Covid pandemic, which are block funded arrangements for 2020/21. For 2021/22 there is to date no indication as to what NHS planning guidance will require in respect of funding arrangements at this point. This uncertainty needs to be addressed before we can commission a longer term service solution.

Withdrawal of services from the NCA may also cause financial uncertainly for the Trust as an organisation.

8.4. Workforce considerations

Staff within all health and care services have been going the extra mile in supporting Bury residents with Covid for the past 9 months. This is set to continue for the unforeseeable future as the UK deals with the second wave of Covid through the Autumn and into Winter, with significant system pressures already evident.

This same staff group within Community Health Services, who have only recently undergone the transfer into the NCA from PCFT at the same time as working through the Covid pandemic, will benefit from a continuation of the existing service provision whilst the CCG works with system providers to define the future service model for Bury.

8.5. Commissioning outcomes

It is recognised that the CCG has several critical commissioning outcomes to achieve through the provision of community health services, including:

- Ensuring all available investment contributes to the system bottom line and overall system sustainability
- Development of integrated care pathways across acute, community and primary care – achieving optimal “efficiencies” for both the system, and also for patients and how they are supported
- Supporting integration of the local provider landscape.

For Bury, place based delivery of health and care services underpins the future direction of delivering safe, effective and sustainable services in the future; this direction has been clearly articulated in the Bury Locality Plan (2017), the Locality Plan Refresh (2019) and more recently as part of the Bury 2030 Strategy which considers wider public service reform, with health and care within it.

In order to assure effective system working, the alignment of acute and community health services and the ability to transfer better between services will become more significant as transformation progresses and integrated delivery becomes the norm. Such an approach may therefore strengthened through retaining services within the NCA at this time.

9. Conclusions and proposal

To summarise, the delivery of services on a neighbourhood footprint is fundamental to transforming health and care services to become sustainable for the future.

There is significant uncertainty at this time in respect of both future operational and financial requirements in respect of community health services, due to Covid and future planning requirements of the NHS.

Capacity of both the CCG and provider services should be considered, and recognition given to the benefit of ensuring that these currently stretched resources are not distracted from continuing to deliver optimal outcomes for Bury residents at this time.

There is clear benefit from maintaining continuity of current services within the structure of the Northern Care Alliance at this time: to ensure continuity for staff and patients, to avoid uncertainty, to minimise risk of ineffective or unsafe delivery of care and to ensure leadership of the ongoing development of the Bury LCO. In addition, an extension to current arrangements would ensure robust planning can be undertaken to formulate the long term future requirements of these services.

Given the issues described above it is considered that the most appropriate way to progress is to continue with the current contractual arrangements to allow sufficient time to explore and document these future requirements, and create the blueprint for future community health service in Bury.

To support this continuation, it is proposed that the CCG establishes an interim contract with the Northern Care Alliance to secure the ongoing delivery of community health services in its current form. This interim basis should be for a period of 12 months from the expiry of the current arrangements, with a reservation of rights for this to be extended for up to a further 12 months if needed, given that the longer term impacts of Covid are not yet known.

10. Next steps

The CCG recognises its lawful obligations to ensure a transparency with the provider market in regard to this contract decision. Publishing a Contract Award Notice (CAN) through the Official Journal of the European Union (OJEU), detailing the rationale for re-establishing current contractual arrangements through this interim contract will fulfil this requirement. There is recognition that whilst the CCG assesses the necessity of this interim contract at this time, there is potential for the market to question and potentially seek to challenge this decision. As such a *standstill* period of at least 30 days will be allowed between notifying the market and entering into this new contract with the NCA in order to flush out any such potential market response.

11. Recommendations

It is recommended that the Strategic Commissioning Board:

- Support the proposal to award a further interim contract for a period of 12 months from 1 July 2021 to 30 June 2022, with a potential for a further 12 month extension.

Enacting any extension beyond June 2022 would be brought back to SCB for approval;

- To agree that the interim contract should take the form of a direct award to the Northern Care Alliance in line with the current arrangements in place
- To authorise for the publishing of a Contract Award Notice through OJEU to ensure lawful compliance in regard to market transparency.

End
Julie Gonda
10 November 2020
V1.2

Appendix 1 – List of Services commissioned within the block contract for Community Health Services

Adult Speech & Language Therapy
Adults Occupational Therapy
Audiology
Community Eye Service
Community Nursing
Continence and Stoma
Trial Without Catheter (TWOC)
Community Cardiac
Community IV Therapy
Dietetics
Physiotherapy
Posture and Mobility
Respiratory Team / COPD
Bealey Community Hospital
Discharge Liaison
Early Discharge Team/Neuro Rehab/Stroke Team
Community Equipment Store
Rapid Response / Crisis Response
Children's Community Nursing Team
Children's Occupational Therapy
Children's Speech & Language Therapy
Special School Nursing
Bury Walk-in Centre
Prestwich Walk-in-Centre
Safeguarding/ LAC
Specialist Palliative Care
Resettlement
Special School (A002)
Paediatric Physiotherapy Service
Neuro Rehab (A019)
Woundcare and Lymphoedema
Podiatry
VAC Therapy

Bury Clinical Commissioning Group

Equality 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:	Julie Gonda (Director of Community Commissioning)
2	Directorate/ Corporate Area	Commissioning
3	Head of or Director (as appropriate):	Will Blandamer (Exec Director of Community Commissioning)
4	Who is the EA for?	NHS Bury CCG
4.1	Name of Other organisation if appropriate	Northern Care Alliance
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.	In respect of community health services commissioned by the CCG, a direct award of a contract for 1 year (with a possible 12 month further extension if absolutely required).
6	Why is it needed? Please give a brief description of the activity.	It is considered that the most appropriate way to progress is to continue with the current contractual arrangements to allow sufficient time to explore and document future commissioning requirements, in light of transformation leading to integrated health and care delivery.
7	What are the intended outcomes of the activity?	It is intended that a full procurement is undertaken so that transformed services can be delivered from July 2022. In order to do this, much work needs to be undertaken around the commissioning outcomes in respect of community services, namely: overall system sustainability, further developing integrated services to deliver better outcomes for patients and achieving optimal efficiencies.

8	Date of completion of analysis (and date of implementation if different). Please explain any difference	Date of completion of EIA: 12/11/2020 Implementation date: July 2021
9	Who does it affect?	All patients accessing community health care services

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	Yes	All patients would have equal access to services through referral mechanisms already agreed. Not subject to change through this piece of work, but possibly through transformation programmes, for which separate EIA would be undertaken.
	To advance equality of opportunity between people who share a protected characteristic and those who do not.	Yes	All community practitioners should provide care of a consistent standard, based on clinical need of the individual. This in essence should allow equality of opportunity between people who share a protected characteristic and those who do not.
	To foster good relations between people who share a protected characteristic and those who do not	Yes	Ensure where people are referred to services they are treated in agreed and safe time scales

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	Yes		All age groups will be accessing services based in the community
	Disability	Yes		Ensure where people are referred to services they are treated within in agreed and safe time scales
	Gender	Yes		

	Pregnancy or maternity	Yes		Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales All patients should have services delivered in an accessible, compassionate and safe way.
	Race	Yes		
	Religion and belief	Yes		
	Sexual Orientation	Yes		
	Other vulnerable group	Yes		
	Marriage or Civil Partnership	Yes		
	Gender Reassignment	Yes		
	Human Rights **(refer to Appendix 1 and 2)**	Yes		
	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.			

	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**
11.1	**Are there any information gaps, and if so how do you plan to address them**	No
	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?	No significant impact at this time, given that services are expected to continue as they currently operate
	What recommendations are in place to mitigate any negative effects identified in 10.1?	None
	What opportunities have been identified for the activity to add value by advancing equality and/or foster good relations?	Neighbourhood delivery of community health services should support the delivery of services based on needs within the particular

		neighbourhood, especially through Integrated Neighbourhood Teams for health and care. Improved staff and team morale for a team that can respond in a timely manner, and ensure effective outcomes for the individuals treated.
	What steps are to be taken now in relation to the implementation of the activity?	The intention is to review all services during the timeframe of the one year extension, to ensure that long term planning for Community Health Services is fit for purpose for the future.
	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.	
The proposed extension is for 12 months and it is anticipated that learning through service reviews, in order to shape the future service specification, would be in-depth, robust and outcomes focussed. In the meantime, ongoing monitoring, in line with national requirements, will continue.		

Protected Group	**Explanation**
Race	There is currently no data in relation to Race collected nationally for this service. JSNA data for Bury CCG: According to the 2001 Census, 93.9% of Bury's population is white with 'White British' representing 90.7% (compared to 87% nationally). The remaining 6.1% is made up of ethnic communities with the largest group being Pakistani at 3% of the population. Indians are the second largest group representing 1.4% of the population. The largest concentration of non-white residents is in East Ward where ethnic groups make up over 20% of residents. The Census however was produced in 2001 recent estimates (2006) suggest that the white population has fallen to 87.9% (compared to 84% nationally), with the largest proportional increase being in the Bangladeshi community. This data shows a decreasing white population and a substantial increase in the Asian heritage community although it has to be considered that the Pakistani community is predominantly young (with 65% of the population aged under 30) and that many of the migrant workers settling in Bury may not be represented. Local Area Profile (Rochdale) 2011 for HMR CCG: Population Profile Rochdale (HMR CCG) 2011 vast majority of people in Rochdale Borough are from a White British ethnic background, equivalent to 83.5% of the total population. People of a Pakistani background make up the largest minority ethnic group, with 17,200 people (8.3%). A significant proportion of the Bangladeshi, Pakistani and Mixed ethnic groups are aged between 0-15 years old. In comparison to the White British ethnic group, the minority ethnic groups have a much younger age structure, with fewer older people (Irish and White Other are the exceptions).

<table>
<tr><td></td><td>The 2011 Census revealed that in Rochdale Borough 166,481 people identify as White British which makes up 78.6% of the local population. The largest ethnic minority group is Pakistani which makes up 10.5% of the local population (22,265), and the second largest is Bangladeshi with 2.1% of the population (4,342). Source: 2011 Census.</td></tr>
<tr><td>Disability</td><td>Data from Bury BC gives a comparator between residents who are disabled compared to their non-disabled neighbours:

<table>
<tr><th>Area</th><th>All people in thousands</th><th>disabled based on the DDA definition</th><th>work-limiting disabled</th></tr>
<tr><td>Bury</td><td>12.7%</td><td>4.8%</td><td>2.9%</td></tr>
<tr><td>ONS da</td><td></td><td></td><td></td></tr>
</table>

Data from Rochdale Borough (HMR CCG) indicates:

The number of Rochdale Borough residents reporting a long-term health condition or disability is 44,359 (21%). Source: 2011 Census</td></tr>
<tr><td>Gender</td><td>Bury CCG:
In the 2011 census the population of Bury was 185,060 and is made up of approximately 51% females and 49% males.
HMR CCG:
According to the 2015 Mid-Year Estimates there are slightly more women than men in the Rochdale borough; with approximately 108,841 people identifying as female compared with 105,354 of the local population identifying as male.</td></tr>
<tr><td>Gender Reassignment</td><td>At present, there is no official estimate of the trans population. The England/Wales Census and Scottish Census have not asked if people identify as trans…" Equality and Human Rights Commission.
The GIRES (2009) report on Gender Variance in the UK estimated that around 20 in every 100, 000 people had sought medical care for gender variance. Using 15+ ONBS data of current list size of 163,013 (ONS 2015-16) the Gender Reassignment figure for Bury would be approximately 33 Bury Residents and 34 Residents in HMR CCG.</td></tr>
<tr><td>Age</td><td>BURY CCG:
The Bury population can be split by the following c ategories(JSNA 2015):
<table>
<tr><th>Year</th><th>0-4</th><th>5-15</th><th>16-24</th><th>25-44</th><th>45-64</th><th>65+</th><th>85+</th></tr>
<tr><td>2015</td><td>12,430</td><td>25,630</td><td>18,910</td><td>48,100</td><td>49,420</td><td>33,410</td><td>3,950</td></tr>
</table>
JNSA for Bury CCG:

Bury has an estimated resident population of 182,600 (ONS 2009 mid year population estimates) but a registered (with a Bury general practice) population of 194,350 as at 31st March 2010. The resident population of Bury is expected to increase to 193,000 by 2022 (5.5% increase) mainly due to more births than deaths. By 2022, the number of people aged under 25 years old is expected to increase by only 2,600 so that their proportion of the population will decrease by 4%, whereas there will be 9,000 more people aged over 65 (29% higher proportion of the population) with 2,000 more people aged over 85 (54% higher</td></tr>
</table>

	proportion of the population).
Sexual Orientation	In 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015. The population who identified as LGB in 2015 were most likely to be single, never married or civil partnered, at 68.2%. In 2015, the majority (93.7%) of the UK population identified themselves as heterosexual or straight, with 1.7% identifying as LGB, the remainder either identifying as "other", "don't know" or refusing to respond. Young adults (16 to 24 year olds) 3.3% are more likely to identify as LGB compared with older age groups, and a higher proportion of males identify as LGB than females. Of those they were most likely to be single, never married or civil partnered, at 68.2%. There are no accurate statistics available regarding the profile of the lesbian, gay and bisexual (LGB) population either in the UK as a whole. Sexuality is not incorporated into the census or other official statistics. It's acknowledged that approximately 6-10% of any given population will be LGB. *Source: MYE 2015 and Stonewall*
Religion or Belief	Bury CCG: 88.9% of people living in Bury were born in England. Other top answers for country of birth were 1.9% Pakistan, 1.2% Scotland, 1.0% Ireland, 0.6% Wales, 0.5% Northern Ireland, 0.4% India, 0.3% Iran, 0.2% Hong Kong , 0.2% South Africa. 95.1% of people living in Bury speak English. The other top languages spoken are 0.9% Urdu, 0.8% Polish, 0.7% Panjabi, 0.2% Persian/Farsi, 0.2% Pashto, 0.2% Arabic, 0.1% All other Chinese, 0.1% Italian, 0.1% French. Religion is given as The religious make up of Bury is 62.7% Christian, 18.2% No religion, 6.1% Muslim, 5.6% Jewish, 0.4% Hindu, 0.2% Buddhist, 0.2% Sikh. 11,069 people did not state a religion. 476 people identified as a Jedi Knight and 42 people said they believe in Heavy Metal.
Pregnancy and Maternity	Public Health England March 16 Child Health Profile gives a live birth figure for Bury (2014) as 2,329. Children and young people under the age of 20 years make up 24.9% of the population of Bury. 23.6% of school children are from a minority ethnic group. The health and wellbeing of children in Bury is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is better than the England average with 17.1% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average. Children in Bury have better than average levels of obesity: 7.8% of children aged 4-5 years and 17.2% of children aged 10-11 years are classified as obese. There were 295 children in care at 31 March 2015, which equates to a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.

Married/ Civil Partnership	Bury CCG: 46.6% of people are married, 11.5% cohabit with a member of the opposite sex, 0.8% live with a partner of the same sex, 24.3% are single and have never married or been in a registered same sex partnership, 9.4% are separated or divorced. There are 10,162 widowed people living in Bury.
Other Groups: Asylum Seekers Travellers Military Veteran Carers	Asylum Seekers/ Refugees - **Asylum seeker:** a person who enters a country to claim asylum (under the *1951 UN Convention and its 1967 Protocol*).2 Individuals undergo the asylum process to have their claim assessed. **Refugee:** "… *a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country*...". (5) Refugee status, or temporary 'leave to remain' (sometimes granted on humanitarian grounds) is awarded by the Home Secretary and affords the same welfare rights as other UK citizens. Entitlement to health and social care for asylum seekers and refugees is complex and dependent on their stage in the asylum process. Rules on entitlement are also subject to review and up to date advice should therefore be sought (see also footnote). However, there are some principles that generally apply: • necessary or urgent medical treatment should never be denied to any person, regardless of whether or not they are resident in the UK, or are able to pay in advance; • for life-threatening conditions and for the purpose of preventing any conditions from becoming life-threatening the appropriate treatment is normally given regardless of ability to pay; • maternity services should always be classed as 'immediately necessary treatment Whilst many asylum seekers do arrive in the UK in relatively good physical health, health problems can rapidly develop whilst they are in the UK.7 Reasons for this include: • difficulty in accessing healthcare services; • lack of awareness of entitlement; • problems in registering and accessing primary and community healthcare services, particularly if their claim has been refused; • language barriers. However, some asylum seekers can have increased health needs relative to other migrants. There are several reasons for this: • a number have faced imprisonment, torture or rape prior to migration, and will bear the physical and psychological consequences of this; • many may have come from areas where healthcare provision is already poor or has collapsed; • some may have come from refugee camps where nutrition and sanitation has been poor so, placing them at risk of malnourishment and communicable diseases; • the journey to the UK can have effects on individuals through the extremes of temperatures, length of the journey, overcrowded transport and stress of leaving their country of origin; • health needs of asylum seekers can be significantly worsened (and even start to develop in the UK) because of the loss of family and friends' support, social isolation,

	loss of status, culture shock, uncertainty, racism, hostility (eg. from the local population), housing difficulties, poverty and loss of choice and control. Travelers - The literature specific to the Gypsy and Traveller population indicates that, as a group, their health overall is poorer than that of the general population and poorer than that of non-Travellers living in socially deprived areas (Parry *et al*., 2004; Parry *et al*., 2007). They have poor health expectations and make limited use of health care provision (Van Cleemput *et al*., 2007; Parry *et al*., 2007). Van Cleemput *et al*. (2007) refer to many Gypsies and Travellers sense of fatalism with regard to treatable health conditions and low expectations of enjoying good health (particularly as they age). They also mention the commonly held belief that professionals are unable to significantly improve patients health status and may in fact diminish resilience by imparting bad news, such as a diagnosis of cancer. The impact of such beliefs is a heightened suspicion of health professionals and a reluctance to attend for screening or preventative treatment. The report by Parry *et al*. (2004), entitled *The Health Status of Gypsies and Travellers in England*, shows that both men and women often experience chronic ill health, frequently suffering from more than one condition; that carers experience a high level of stress; and that secrecy about depression keeps it hidden and increases the burden on both the individual and the family as they try to manage. Many Gypsies and Travellers face high levels of bereavement, which is also a precipitating factor of depression. Poor psychological health is often found in the context of multiple difficulties, such as discrimination, racism and harassment, as well as frequent evictions and the instability caused by this. Military Veterans A veteran is someone who has served in the armed forces for at least one day. There are around 2.6 million veterans in the UK as a Regular or Reservist or Merchant Navy serving in an active theatre of war. Estimates for the Bury population by the British Legion are 12,000-14,000 Veterans currently resident within the Borough. This figure does not include the Spouses or close family members of those who have served who may have specific needs due to service life. Taken as a whole, the ex-Service population, which has been estimated at around 3.8 million for England, has comparable health to the general population. The current generation of UK military personnel (serving and ex-serving) have higher rates of heavy drinking than the general population. However, this difference may attenuate with age. The most common mental health problems for ex-Service personnel are alcohol problems, depression and anxiety disorders. In terms of the prevalence of mental disorders, ex-Service personnel are like their still-serving counterparts and broadly like the general population. Military personnel with mental health problems are more likely to leave over a given period than those without such problems and are at increased risk for adverse outcomes in post service life. The minority who leave the military with psychiatric problems are at increased risk of social exclusion and on-going ill health. The British Legion 2012 gave estimates of the Military Veteran population of circa 12,000 (Bury) and 14,000 (HMR). Carers The role of the carer is especially important when the person who receives care (the care recipient) is unable to live independently without the carer's help. A young carer is a child or young person under the age of 18, carrying out significant caring tasks and assuming a level of responsibility for another person that normally would be undertaken by an adult.

	Underpinning the caring role may be life-long love and friendship, together with an acceptance of the duty to provide care. Carers can derive satisfaction and a sense of well-being from their caring role, receive love and affection from the care recipient, gain a sense of achievement from developing personal attributes of patience and tolerance, and gain satisfaction from meeting cultural or religious expectations (Cassell *et al*, 2003). Caring responsibilities may arise at any time in life. Carers may have to adapt and change their daily routine for work and social life, perhaps incurring personal and financial costs. They may become isolated from other members of their family, friends and work colleagues. In an ageing population, family members are expected to undertake complex care tasks, often at great cost to their own well-being and health (Schulz & Matire, 2004). The role of carer can be demanding and difficult, irrespective of whether the care recipient has a mental disorder, learning disability or a physical disability, either separately or combined. A survey of over 1000 carers in contact with carers' organisations found that just less than 50% believed that their health was adversely affected by their caring role (Cheffings, 2003). Mental health problems included stress and tension (38%), anxiety (27%) and depression (28%). Physical health problems included back injury (20%) and hypertension (10%). Back injury was associated with caring for individuals with physical disabilities. Similar figures were found in a survey by Carers UK (2002), in which the most frequently experienced negative emotions in carers were: feelings of being mentally and emotionally drained (70%), physically drained (61%), frustration (61%), sadness for the care recipient (56%), anger (41%), loneliness (46%), guilt (38%) and disturbed sleep (57%). Carers who are more vulnerable to health problems are women, elderly or very young people, those with pre-existing poor physical health, carers with arduous duties and those with few social contacts or support. Carers may attribute symptoms of an illness to their work as a carer and fail to recognise the onset of an illness. In Bury alone, we currently know of 3,320 adult carers but we acknowledge that there may be many more who do not receive any support to undertake their caring role (6). References (1) Gender, age, society, culture, and the patient's perspective inthe functional gastrointestinal disorders." *Gastroenterology* (April 2006): 130-35. Web. 17 July 2007 (2) Epidemiology, demographic characteristics and prognostic predictors of ulcerative colitis." *World J Gastroenterol* (2014): 20-28. Web. 17 July 2017. (3) Matthews, Z. (2008). *The health of gypsies and travellers in the UK*. London: Race Equality Foundation. (4) Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, C. (2004) *The Health Status of Gypsies and Travellers in England*, Sheffield, University of Sheffield. (5) The Health Needs of Asylum Seekers , Briefing Paper, The Faculty of Public Health (May 2008) (6) Bury Adult Carers Strategy Caring for Carers 2013-18

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Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2019	**Action**	Approve
Item No	13	**Confidential / Freedom of Information Status**	No
Title	LCO Service and Infrastructure Costs		
Presented By	M Woodhead and W Blandamer		
Author	M Woodhead		
Clinical Lead	n/a		
Council Lead	Cllr O'Brien		

Executive Summary

Bury LCO lead several transformation schemes on behalf of the Health and Care system. The "Transformation Fund and LCO Management Costs 2021/22 Onwards" paper (Appendix 1) sets out a position regarding those transformation schemes and related management costs. The funding source for these schemes is at risk. However, these services are considered critical to the health and care system and the LCO has requested that the OCO support a decision to give staff contractual security to:

- prevent a hemorrhaging of staff on temporary contracts resulting in operational difficulties; and
- maintain and build upon demonstrable system benefits delivered by the schemes.

There are financial risks to continuing the schemes (i.e. the potential for unfunded recurrent costs). These risks cannot be fully resolved or mitigated before the end of January 2021 at the very earliest. However, there are also significant financial and operational risks to terminating the schemes (loss of financial and quality benefits, knock-on impact across the wider system and transformation programme, etc.)

A commitment is therefore required, at risk – with that risk to be managed and mitigated by all system partners over the ensuing months in line with the principles of integrated working and system-wide collaboration.

Recommendations

SCB is asked to:

- note the contents of this report and the risks and benefits of each option;
- support option 3, recognising the financial risk that this entails for the OCO and the wider system

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.
Financial sustainability risks	

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?	The proposals are in line with the transformational objectives and schemes laid out in the Bury Locality Plan					
How do proposals align with the Commissioning Strategy?	As above					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	The transformation schemes referred to in this paper help to address health inequalities, as discussed in the Bury Locality Plan					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact	Yes	☒	No	☐	N/A	☐

Implications						
Assessment required?						
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Impact assessments will only be required if option 1 (terminating schemes) is chosen.						
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.		

LCO Service and Infrastructure Costs

1. Introduction

1.1. The “Transformation Fund and LCO Management Costs 2021/22 Onwards” paper (Appendix 1) was produced by LCO colleagues and sets out a position regarding LCO-run transformation schemes and related management costs.

1.2. The funding source for these schemes is at risk. However, these services are considered critical to the health and care system and the LCO has requested that the OCO support a decision to give staff contractual security to:

- prevent a haemorrhaging of staff on temporary contracts resulting in operational difficulties; and
- maintain and build upon demonstrable system benefits delivered by the schemes.

2. Background

2.1. Bury locality was awarded £19.5m of NHS transformation funding in 2016 to help deliver the ambitions of the Bury Locality plan. Funding was allocated to a programme of transformational schemes, recognising the costs of:

- enabling and setting up schemes; and
- double running some services for a period to take account of the time lag for benefits to be realised

2.2. Transformation funding was given non-recurrently and was due to run out in Bury by September 2021. By that point, the locality partners would need to evaluate schemes and decide on whether to:

- continue the schemes because they were shown to be self-financing (in terms of being cash releasing or cost avoidance);
- revise the schemes but continue, on the basis that the schemes could become self-financing with modifications; or
- end the schemes.

2.3. The COVID-19 pandemic has impacted transformation schemes in several ways. The work of key transformation schemes has been significantly slowed during the initial phases of the COVID-19 response. At the same time, the NHS funding regime has been dramatically changed and transformation funding ceased. It is not yet clear whether Bury’s remaining transformation funds will be made available in 2021/22, but the CCG has secured equivalent funding for the remainder of 2020/21.

2.4. The risk around the future of transformation funding, alongside the unavoidable delays in progressing the schemes during the pandemic and the knock-on effect on evaluation timescales, means there is now an urgent need to make decisions on staff contracts if the locality is to maintain the teams listed in the following table:

Scheme	Staffing Model Est WTE	Total LCO Funding requirement £
Rapid Response	28.50	1,621,000
Integrated Neighbourhoods	20.20	1,170,000
Intermediate Care	39.00	1,589,000
Falls	5.50	213,992
Palliative Care	3.60	187,763
Business Support	8.50	435,675
Management	4.70	446,361
Total LCO and PMO Costs	**13.20**	**882,036**
Total	**110.00**	**5,663,791**

Note: the business support and management teams above have been subjected to a £0.3m reduction versus original 2020/21 plans.

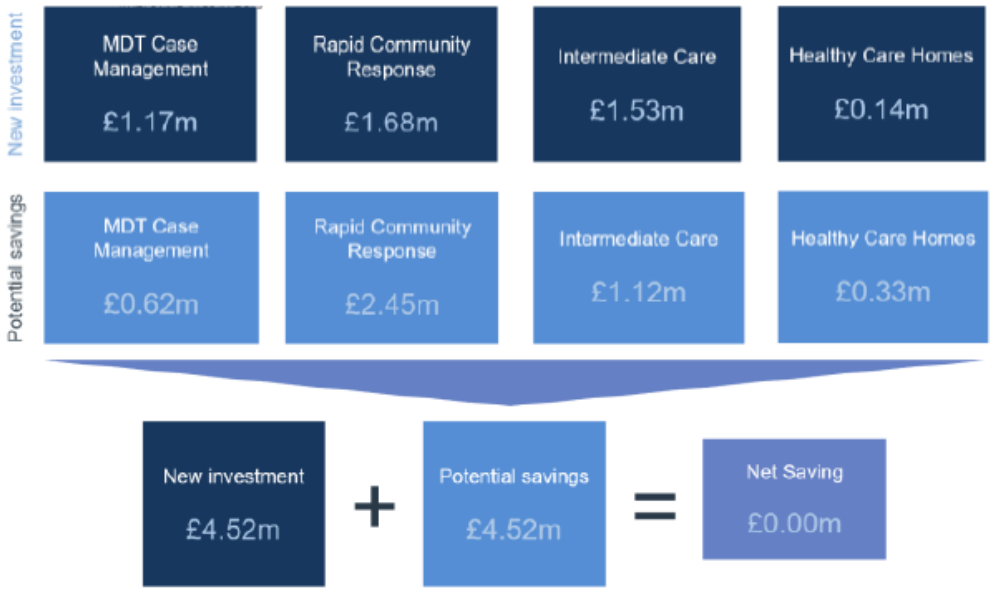
3. Benefits and Options

3.1. Appendix 1 includes details of the current and projected benefits of the 3 main schemes. Financial benefits mainly relate to avoidance and reductions of A&E attendances, non-elective hospital admissions, and residential care placements. It is very difficult to accurately measure and allocate benefits to specific schemes because there is a high level of inter-dependency across the whole transformation programme and, of course, wider system initiatives also deliver benefits in the same areas. However, LCO monitoring data indicates that the original plan, shown in the figure 1, in on course to be bettered.

3.2. The paper at Appendix 1 has been considered at both the LCO Management Board and the CCG Finance, Contracting and Procurement Committee in the last 2 weeks. The paper considers 3 options:

- Option 1: terminate schemes
- Option 2: continue schemes and extend staff contracts by 12 months
- Option 3: continue schemes and put staff on substantive contracts

Figure 1:



3.3. The LCO Management Board and the CCG Finance, Contracting and Procurement Committee both supported Option 3. The rationale for that support was:

- these transformation schemes are critical to the objectives and ambitions laid out in the Locality Plan and Bury 2030, therefore option 1 (terminate the schemes) is not supported;
- there is evidence that they are on track to deliver significant system benefits;
- given the evidence that we already have, it is highly unlikely that any of the schemes would be terminated on evaluation – they are far more likely to be refined/revised;
- there is little to gain from option 2, i.e. extending staff contracts by 12 months, during which most of them would accrue permanent employment rights in any case.

4. Risk Exposure and Mitigations

4.1. Around £5.2m of the £5.7m costs are staff costs, the remainder being non-pay costs. The contracts for those staff currently sit with the NCA (£3.5m), Bury Council (£1.1m) and the GP Federation (£0.3m) and other organisations (£0.3m).

4.2. Neither the LCO or OCO partners have an identified budget or source of funding for these staff from 1 April 2021 if Transformation Funding isn't reinstated. Benefits delivered to date have already been reflected in current OCO budgets.

4.3. Ending the schemes reduces recurrent costs and avoids increasing potential redundancy liabilities. However, this would have a significant impact upon urgent care, adult social care, primary care, intermediate care and other community services and would:

- impact on achievement of targets around A&E, hospital admissions and residential care placements, resulting in increased costs elsewhere in the system

- reduce the quality of patient/service user care
- risk reputational damage to the locality
- result in a loss of staff knowledge and expertise to the Bury system
- result in 39 w.t.e. staff needing to be either redeployed or made redundant

4.4. Continuing the schemes and the staff beyond 1 April increases potential redundancy costs (if at some point schemes are ended/downsized) and requires a source of funding. However, it also:

- maintains and builds on current system benefits including substantial financial savings and cost avoidance;
- maintains and builds on current standards of patient care and developed pathways;
- provides permanency to staff and the system and increases likelihood of knowledge and expertise remaining within the Bury Health and Social Care system;
- continues the schemes supporting urgent care, adult social care, primary care, intermediate care and other community services;
- maintains system commitment to these priority schemes in line with Bury Locality Plan and Bury 2030.

4.5. There is unlikely to be any certainty around the availability of Transformation Funding or the scope and quantum of CCG funding until the end of January (and possibly longer). If SCB supports the recommendation of the LCO Board and the CCG Finance, Contracting and Procurement Committee, i.e. to go with Option 3 and continue schemes with staff on substantive contracts, this means the OCO agreeing to carry some system risk, along with LCO partners, until funding options are clarified at the end of the current financial year. If any risks materialise, potential mitigations will include:

- finding additional savings in other services (through a prioritisation process);
- using savings if/where transformation benefits exceed current plans;
- finding alternative funding sources;
- absorbing costs elsewhere in the system (e.g. by transferring skilled staff to other services).

4.6. The extent to which risk materialises as part of an OCO overspend in the Integrated Care Fund, the CCG and Bury Council would agree to share that impact equally. This is in line with the system wide approach to Health and Care and the Integrated Care Fund arrangements.

5. Recommendation

5.1. SCB is asked to:

- note the contents of this report and the risks and benefits of each option;
- support option 3, recognising the financial risk that this entails for the OCO and the wider system.

Mike Woodhead
Joint CFO
3 December 2020

NHS
Bury
Clinical Commissioning Group

Meeting: Finance, Contracting and Procurement Committee			
Meeting Date	19 November 2020	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Transformation Fund & LCO Management Costs 2021/22 onwards		
Presented By	Simon O'Hare, Interim Deputy CFO		
Author	Simon O'Hare, Interim Deputy CFO Mui Wan, Associate Director of Finance, Bury LCO Caroline Beirne, Associate Director of Workforce, Bury LCO		
Clinical Lead			

Executive Summary

Bury locality had £19.5m of transformation funding approved in 2016 to deliver the ambitions of the locality plan. In 2020/21 there are 3 primary remaining schemes:

- Integrated Neighbourhood Teams
- Rapid Response; and
- Intermediate care

These have been formally recognised by senior system leaders as a key priority, alongside LCO management costs, Falls and Palliative Care. Within original Locality financial plans, this funding ceases in September 2021. However, during the pandemic Transformation Funding has ceased and staff resources have been redeployed. This had resulted in slippage to the implementation and evaluation of schemes and risks to the ongoing stability and funding of priority services.

This paper gives an overview of the benefits these transformation schemes have brought, options for the future and the benefits and risks associated with these options.

The current annual cost of the schemes being considered is £4.78m and the LCO management costs are £0.88m, giving a total funding requirement of £5.66m. The staff associated with this are employed in a variety of ways, these being secondment, fixed term contract and permanent contract; the majority being employed via secondment. Staff employed on a fixed term or secondment basis for more than 2 years have the same rights as permanent staff with regard to redundancy and this is significant in considering the future options for the service.

The options for the future are:

1. Do not continue the schemes
2. Extend for 12 months
3. Make all post permanent

The benefits and disbenefits of each option are discussed within the paper.

The preferred option from both LCO and OCO partners is option 3 to fund the schemes and

LCO management costs recurrently, to mainstream these services and prevent destabilisation at this crucial time. If doing so creates a system financial pressure, then cost reductions would need to be sought in other services. Regarding management costs, there is no capacity within existing substantive structures to absorb this workload.
Recommendations
The Finance, Contracting and Procurement Committee is asked to: • Note the contents of this report, options and recommendation • Recommend a preferred option to both System Board and Strategic Commissioning Board.

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:	
GBAF	

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 an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact	Yes	☐	No	☐	N/A	☒

Assessment required?						
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	☒

Transformation Fund and LCO Management Costs 2021/22 onwards

1.0 Introduction

Bury locality had £19.5m of transformation funding approved in 2016 to deliver the ambitions of the locality plan. In 2020/21 there are 3 primary remaining schemes, Integrated Neighbourhood Teams, Rapid Response and Intermediate care, which have been agreed on a number of occasions by senior system leaders as a key priority, alongside LCO management costs, Falls and Palliative Care. Within original financial plans, this funding ceases in September 2021. This paper gives an overview of the benefits these schemes have brought, options for the future and the benefits and risks associated with these options.

2.0 Background

Under the Greater Manchester Devolution agenda, Bury Locality, along with all other GM localities, was allocated monies to spend on transformational change in line with the aims and ambitions of the locality plan, initially developed in 2016. The Locality (via the CCG) was allocated £19.5m and this was prioritised to be spent on developing enhanced community services, reducing urgent care activity and costs and trialing small scale community and public health interventions.

In September 2019, due to delays in mobilisation, a system wide re-prioritisation process took place which made decisions to extend funding for Integrated Neighbourhood Teams, Rapid Response and Intermediate Care, alongside the LCO management costs, falls and palliative care. This was done to give these services 24 months funding to deliver their anticipated outcomes. Within this timescale, an evaluation process was built in, with assessment and decision making in March 2021, allowing 6 months' notice to be given (if deemed appropriate) for contracts ending in September 2021.

3.0 Evidence Base

3.1 The field of integrated care is relatively new in research terms, however two studies published this year are relevant in progressing understanding, and also consider long term outcomes.

3.2 The first study is a meta-analysis of the international literature by the International Foundation of Integrated care (Costs and effects of integrated care: a systematic literature review and meta-analysis, Rocks et al, June 2020, EJHE). This analysis is the first collation of the literature to review the findings related to both outcomes, and financial impact. In summary the review found:

- The results indicate that integrated care was associated with lower costs and improved outcomes compared with usual care, especially in studies with a follow-up period over a year
- studies with an extended follow-up period are more likely to capture long-term reductions in cost that may negate and surpass the initial investment in developing and implementing integrated care

3.3 The second study by The Health Foundation entitled The long-term impacts of new care models on hospital use; an evaluation of the integrated care transformation Programme in mid-Nottinghamshire. The study takes place over 6 years and a combination of integration programmes, not dissimilar to Bury. Key points :

• The ICTP programme contained several interventions, which including integrated care teams; a 24/7 care navigation service; a home support service that aimed to bridge the gap between acute and community services; an acute home visiting service; a proactive home care service providing integrated care in a care home setting; the introduction of an ambulatory and emergency care unit; a programme to streamline elective referrals.

• Evaluation considered the overall impact of these interventions over a 6-year period between April 2013 and March 2019..

• In the first 2 years of the programme, rates of A&E visits were higher in Mid-Nottinghamshire than the synthetic control area, by 3.9% in 2013/14 and 5.4% in 2014/15. After 2 years the trends reversed, and by year 6 (2018/19) the Mid-Nottinghamshire population was experiencing 4.3% fewer A&E visits than the synthetic control area. This is equivalent to 14.2 fewer A&E visits per 10,000 people per month.

• Mid-Nottinghamshire also began to see fewer emergency hospital admissions: by the last year of our study there were 6.7 fewer of these per 10,000 people per month in Mid-Nottinghamshire than the synthetic control area (a 6.4% difference). During the last 2 years there was a significant drop in the number of hospital admissions for urgent care sensitive conditions

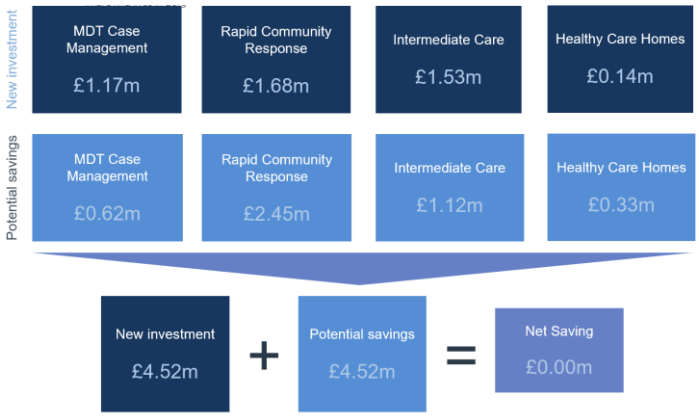
• From the third year, the length of overnight emergency hospital stays was shorter in Mid-Nottinghamshire than the synthetic control area, and the number of 30-day emergency admissions was also lower.

• The evaluation, provides promising evidence that integrated care programmes have the potential to reduce hospital use over the long term, even if there are increases in the shorter term. Our results emphasise the importance of being realistic about how long it will take to see results and that early assessment of impacts risks erroneous conclusions that may lead policymakers to question or abandon potentially effective initiatives.

4.0 Impact of these services

The diagram below shows the original investment agreement for the Programme 6 Transformation Schemes. It recognises that although some schemes do not deliver savings

over above the new investment individually, the combined savings would cover the combined investment.



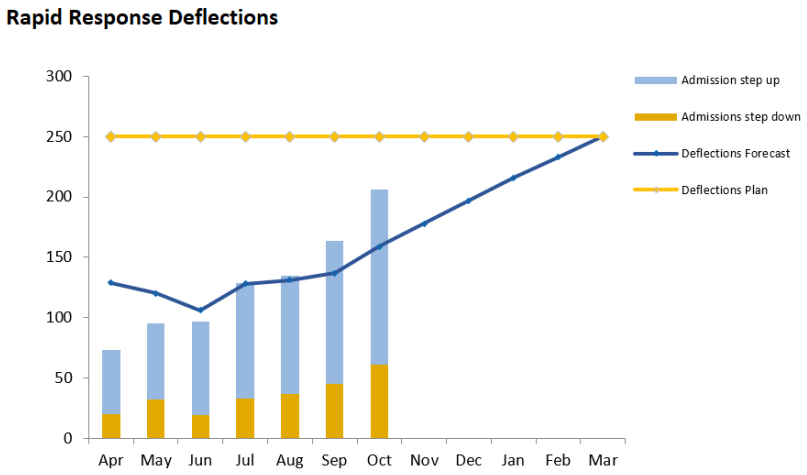
4.1 Rapid Response

The draft methodology for Rapid Response (RR) deflections is summarised below. This shows the link between the additional staff resource to additional capacity and to forecast activity deflections.

Rapid Response
Each assessor (AHP Nurse SW 16wte) to manage 3.5 caseloads
56 per week
2912 per year
242 per month

Rapid Response Deflections
Assume 80% step up which will be a A&E & NEL admission avoided
45 per week
2330 per year
194 per month
£47k per week
£2,451k per year
£204k per month

The forecast expected caseload of the new RR team is 242 per month. 80% of this activity is expected to be stepped up from the community. Had this service not been in place it is expected that these patients would have attended A&E and been admitted for tests.
The graph below shows the trajectory of the capacity being ramped up between April 2020 and March 2021. It is expected that by March 2020, the service will be operating at its full capacity. It also shows the actual activity levels in October of 204 referrals. This is above the forecasted trajectory.



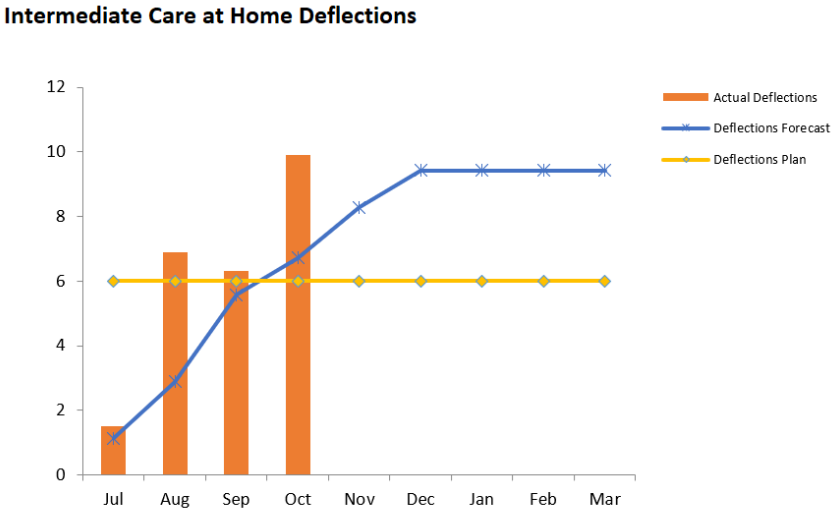
4.2 Intermediate Care

The draft methodology for Intermediate Care deflections is summarised below. This shows the link between the additional staff resource to additional capacity and to forecast activity deflections.

Intermediate Care
Each assessor (AHP Nurse SW 15wte) to manage 6 caseloads
15 per week
780 per year
65 per month

Intermediate Care Deflections
Currently 36% step down. Assume 30% of these would have had a residential care package
1.5 per week — £23k per week
78 per year — £1,170k per year
6.5 per month — £98k per month

The forecast capacity of the Intermediate Care at Home team is 65 patients per month. It assumed that 36% of these patients will be stepped down from acute. A further 30% would have gone straight into a residential care placement had this provision not been in place. Therefore savings from IMC at home is from residential care placements commissioned by Bury MBC.



The graph below shows the trajectory of the capacity being ramped up between July and March 2020. It is expected that by March 2020, the service will be operating at its full capacity. It also shows the actual activity levels in October of 204 referrals. This is above the forecasted trajectory.

4.3 INT

Savings from Active Case Management have been calculated by looking at acute data for patients that have gone through the ACM process. The activity level 12 months prior to the ACM referrals has been compared to the acute data 12 months post ACM referral. The latest data where 274 patients were reviewed is shown below

Neighbourhood	gp_practice_desc	Values PrePost / ACTIVITY TYP / Sum of ACTMON / Pre / AE	EM	Post / AE	EM	Sum of COSTMON / Pre / AE	EM	Post / AE	EM
East	HUNTLEY MOUNT MEDICAL CENTRE	0.75	0.17	1.08	0.33	£79	£417	£157	£1,134
	KNOWSLEY MEDICAL CENTRE	1.33	0.92	1.17	0.92	£220	£2,820	£158	£1,840
	MINDEN FAMILY PRACTICES - DR SAXENA	4.92	2.08	3.08	0.83	£665	£3,167	£462	£1,007
	PEEL GPS	2.58	1.83	1.75	1.00	£422	£5,308	£275	£3,156
	RIBBLESDALE MEDICAL PRACTICE	0.25	0.25	0.08	0.08	£43	£1,187	£14	£961
	ROCK HEALTHCARE LIMITED	10.17	1.67	6.33	1.58	£1,127	£2,941	£839	£5,293
	TOWNSIDE SURGERY	1.92	1.00	1.00	0.50	£300	£2,160	£177	£1,793
	WALMERSLEY ROAD MEDICAL PRACTICE	1.00	0.50	0.08	0.08	£151	£1,302	£14	£327
East Total		**22.92**	**8.42**	**14.58**	**5.33**	**£3,007**	**£19,302**	**£2,097**	**£15,510**
North	RAMSBOTTOM MEDICAL PRACTICE	2.92	0.67	2.50	0.50	£328	£2,398	£307	£1,377
	TOWER FAMILY HEALTHCARE	16.17	8.75	9.00	5.67	£2,332	£17,983	£1,482	£14,394
	WOODBANK SURGERY	0.33	0.42	1.17	0.83	£47	£1,117	£209	£2,726
	GARDEN CITY MEDICAL CENTRE	0.17	0.17	0.17	0.17	£24	£437	£29	£136
North Total		**19.58**	**10.00**	**12.83**	**7.17**	**£2,732**	**£21,934**	**£2,027**	**£18,633**
Prestwich	FAIRFAX GROUP PRACTICE	3.33	1.67	1.00	0.67	£471	£1,667	£189	£1,039
	LONGFIELD MEDICAL PRACTICE	1.67	0.58	2.08	0.58	£231	£928	£306	£316
	ST GABRIEL'S MEDICAL CENTRE	1.58	0.75	1.25	0.92	£239	£2,344	£203	£2,338
	THE BIRCHES MEDICAL CENTRE	0.42	0.08	0.08	0.00	£51	£0	£14	£0
	WHITTAKER LANE MED CENTRE	2.17	0.58	3.67	1.00	£285	£789	£576	£1,325
Prestwich Total		**9.17**	**3.67**	**8.08**	**3.17**	**£1,277**	**£5,727**	**£1,288**	**£5,017**
West	MILE LANE HEALTH CENTRE	5.58	1.33	4.75	1.67	£680	£2,559	£669	£1,806
	MONARCH MEDICAL CENTRE	14.17	1.42	10.25	1.75	£1,381	£1,977	£1,229	£2,103
	RADCLIFFE MEDICAL PRACTICE	9.92	3.08	7.25	2.83	£1,286	£6,840	£1,015	£5,668
	RED BANK GROUP PRACTICE	8.50	4.50	4.25	2.50	£1,127	£10,659	£625	£4,122
West Total		**38.17**	**10.33**	**26.50**	**8.75**	**£4,475**	**£22,035**	**£3,538**	**£13,700**
Whitefield	BLACKFORD HOUSE MEDICAL CENTRE	2.42	1.58	2.08	0.92	£377	£3,316	£337	£1,099
	THE ELMS MEDICAL CENTRE	0.75	0.42	1.50	1.00	£128	£1,368	£254	£4,396
	THE UPLANDS MEDICAL PRACTICE	0.33	0.08	0.50	0.33	£57	£75	£118	£672
	UNSWORTH MEDICAL CENTRE	2.75	0.92	1.67	0.33	£384	£1,076	£199	£546
Whitefield Total		**6.25**	**3.00**	**5.75**	**2.58**	**£946**	**£5,835**	**£908**	**£6,714**
Grand Total		**96.08**	**35.42**	**67.75**	**27.00**	**£12,436**	**£74,834**	**£9,858**	**£59,574**

It shows the A&E and NEL admission activity for patients pre and post ACM and the PbR tariff for this activity. The activity is compared in the summary below. It shows that when the findings are pro rata to 1,000 patients, which is the estimated number of patients going through ACM in one year the savings would be £781k.

	A&E	NEL	Savings £
Reduction in activity per month	28	8	£17,838
Reduction in activity per year	340	101	£214,050
Pro Rata to 1,000 patients	1,241	369	£781,204

5.0 Funding in 2020/21 and 2021/22

In order to secure funding for these teams to September 2020/21, it was agreed that the anticipated savings through reduced emergency admissions and admissions to residential care attributable to these schemes would be used in 2020/21 and 2021/22 to make up a shortfall in funding. The COVID-19 pandemic and the changed financial guidance for 2020/21 and draft guidance for 2021/22 has introduced a block contract arrangement, which means that it is not possible to fund schemes via this reduced activity route.

The emergency CCG funding regime for 2020/21 has been based on historic 2019/20 run-rates and this has been mirrored for providers. Therefore, for 2020/21, the costs of these services are covered within existing funding streams financial plans.

We do not have any confirmation on the NHS funding arrangements for 2021/22 and beyond, aside from a consultation PbR document that suggests the continuation of block arrangements for NHS Trusts in 2021/22. All system colleagues recognise the importance of these schemes for the delivery of a coherent health and social care system and therefore on this basis are committed to funding these schemes in 2021/22 and beyond. In these circumstances, any resultant system-wide financial pressures would need to be made good from savings in other service areas.

6.0 Current costs

The current anticipated costs in 2021/22 of the schemes associated with Transformation fund are shown below. Within this there has been a reduction of £150k in terms of LCO management and business support costs from the costs in 2020/21.

Scheme	Staffing Model Est WTE	Total LCO Funding requirement £
Rapid Response	28.50	1,621,000
Integrated Neighbourhoods	20.20	1,170,000
Intermediate Care	39.00	1,589,000
Falls	5.50	213,992
Palliative Care	3.60	187,763
Business Support	8.50	435,675
Management	4.70	446,361
Total LCO and PMO Costs	**13.20**	**882,036**
Total	**110.00**	**5,663,791**

7.0 Employment risks

The staff employed through the use of transformation funding, are employed in a variety of ways, these being secondment, fixed term contract, permanent contract. The majority are employed through secondment

A secondment has no recognition in employment law and is an agreement between two organisations with one offering their employee as a resource and charging the recipient organisation accordingly. Given this, there is no obligation:

- On the recipient organisation to offer a secondment extension or permanency;
- For the substantive employer to agree to a secondment extension;
- For the individual employee to accept an extension or permanency (unless tenure can be protected).

Whilst a secondment can be beneficial to all parties, this should only be a short term arrangement. For some of the core LCO team, they will have been seconded for upwards of two years by the time the current arrangements cease. Individuals on secondments or fixed term contracts for more than 2 years have the same rights as those with permanent contract, including redundancy rights. This is detailed further in Appendix A.

8.0 Options

There are 3 options for consideration, and these are:

1) Do not continue services past the current agreed end date
2) Continue for 12 months to allow a further evaluation
3) Continue these services permanently and therefore award permanent contracts to staff who deliver these services.

These options are appraised below, detailing the benefits and disbenefits of each option.

8.1 Option 1 – do not continue the service

Financial Breakdown Now		
	WTE	£
Employees who are in fixed term arrangements less than 2 years with no entitlement to redundancy (includes vacancies and those on secondment)	70.71	3,153,011
Employees who will need to be redeployed and are at risk of redundancy	39.19	2,008,780
Non Pay	0	502,000
Total	**110.00**	**5,663,791**

Benefits

- No recurrent costs
- Reduced redundancy risk
- Decision is made and there is surety in the system

Disbenefits

- Significant impact upon urgent care, adult social care, primary care, intermediate care and other community services.
- Likely impact on achievement of targets around A&E and discharge
- Reduction in the quality of patient care
- Reputational damage to the locality
- Loss of staff knowledge and expertise to the Bury system
- 39 WTE of staff will need to be either redeployed or made redundant which could result in significant costs.

8.2 Option 2 – Extend for 12 months

Financial Breakdown in 12 months time		
	WTE	£
Employees who are in fixed term arrangements less than 2 years with no entitlement to redundancy (includes vacancies and those on secondment)	12.70	540,700
Employees who will need to be redeployed and are at risk of redundancy.	97.30	4,621,091
Non Pay	0	502,000
	110.00	**5,663,791**

Benefits

- Continues the schemes supporting urgent care, adult social care, primary care, intermediate care and other community services.

- Allows more time for evaluation and refining of schemes
- Maintains current standards of patient care and developed pathways
- Maintains system commitment to these priority schemes

Disbenefits

- Redundancy cost increased due to extension of fixed term contracts beyond two years.
- Service risk as staff will look to leave due to fixed term nature of contracts
- Loss of knowledge and expertise when staff leave
- Increased recurrent and 2021/22 system costs
- The requirement for redeployment or redundancy risk increases from applying to 39 WTE in option 1 to 97 WTE in option 2 meaning further exposure to risk on significant costs of redundancy.
- There will be a need to negotiate terms of this arrangement with relevant host organisations and seek their approval – which may lead to potential further complications.

8.3 Option 3 – Make all contracts permanent

Recurrent service costs		
	WTE	**£**
Pay	110.00	5,161,791
Non Pay		502,000
	110.00	**5,663,791**

Benefits

- Provides permanency to staff and the system and increases likelihood of knowledge and expertise remaining within the Bury Health and Social Care system.
- Continues the schemes supporting urgent care, adult social care, primary care, intermediate care and other community services.
- Maintains current standards of patient care and developed pathways
- Maintains system commitment to these priority schemes

Disbenefits

- Increased recurrent and 2021/22 system costs
- Redundancy cost increased due to conversion of fixed term contracts to permanent contracts.

9.0 Recommendation

The preferred option from both LCO and OCO partners is option 3 to fund the schemes and LCO management costs recurrently, to mainstream these services and prevent destabilisation at this crucial time. If doing so creates a system financial pressure, then cost reductions would need to be sought in other services. With regard to management costs there is no capacity within existing substantive structures to absorb the workload of transformation and integration activity.

In each case Bury LCO commits to

- regularly review staffing needs to ensure resources are in the right place and were used to best effect
- continually strive to offset the costs by seeking to identify financial benefits arising from changes in patient flow

10.0 Action required

The Finance, Contracting and Procurement Committee is asked to:

- Note the contents of this report, options and recommendation
- Recommend a preferred option to both System Board and Strategic Commissioning Board.

Simon O'Hare
November 2020
Interim Deputy Chief Finance Officer

BURY LOCAL CARE ORGANISATION
Improving lives in Bury

Employment risks – extension of contracts/contract permanency.

The staff employed through the use of transformation funding, are employed in a variety of ways, these being secondment, fixed term contract, permanent contract. The majority are employed through secondment

A secondment has no recognition in employment law and is an agreement between two organisations with one offering their employee as a resource and charging the recipient organisation accordingly. Given this, there is no obligation:

- On the recipient organisation to offer a secondment extension or permanency;
- For the substantive employer to agree to a secondment extension;
- For the individual employee to accept an extension or permanency (unless tenure can be protected).

Whilst a secondment can be beneficial to all parties, this should only be a short term arrangement. For some of the core LCO team, they will have been seconded for upwards of two years by the time the current arrangements cease.

Options available from a HR perspective are:

1. Cease secondments as scheduled on 31st March 2021 which will result in the disbanding of transformation funded teams and their functionality. Whilst the notice period of secondments varies it is suggested that notice to be served by 5th January, 12 weeks prior to contract end. 12 weeks is suggested to enable staff to secure other posts. Critically this creates risk for those staff and organisations, where their substantive posts may no longer be available, albeit re-deployment would apply.
2. Extend secondment arrangements for a further period. Given that there is no obligation on the substantive employer or the employee to agree to this, the result could also lead to the loss of the teams and their functionality. Should employees not agree to continued secondment, recruitment will need to take place based on a 12 month contract, which are difficult to recruit to, and creates instability in currently stable and performing services. Equally there is a risk that whilst 12 months would secure staff for a further time period, this reduces stability of service delivery even further. The current knock on effect of existing secondments impacts on organisations who are undertaking re-structure and are unable to progress due to the nature of temporary funding. This is impacting across three organisations and 5 departments that the LCO is currently aware of.
3. Make permanent the positions for those who are currently on secondment/fixed term contract and continue with the transformation funded schemes. Whilst employers carry the financial risk should the 2021/22 settlement be insufficient, redeployment policies would be invoked and, where appropriate, redundancy may apply. The risk of redundancy is minimal to the system, given the large size of the organisations to whom this applies, predominantly NCA, Bury Council (social care) and PCFT.

It is important to note that each individual circumstance based on current substantive employment terms and conditions will affect ultimate outcome. For specific risks to be identified, there may be a requirement for further breakdown.

Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Information
Item No	14	**Confidential / Freedom of Information Status**	No
Title	Bury System Board Meetings – 16 September 2020 and 21 October 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 16 September 2020 and 21 October 2020.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the Minutes of the Bury System Board Meetings held on 16 September 2020 and 21 October 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 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?						
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?						
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	*N/A*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury System Board	16 September 2020 21 October 2020	Minutes being submitted for ratification

Title	**Minutes of the Bury System Board**
Author	Gillian Cohen, Business Support Manager, Public Health
Version	1.0
Target Audience	Members of the Bury System Board
Date Created	16 September 2020
Date of Issue	
To be Agreed	21 October 2020
Document Status (Draft/Final)	Draft

Document History:

Date	Version	Author	Notes
17.09.20	1.0	Gillian Cohen	Minutes forwarded to Chair for checking
Approved:			
Signature:			

Bury System Board

MINUTES OF MEETING
16th September 2020, 2.00 - 3.30pm Via Teams **Chair –** Cllr Eamonn O' Brien

Members Present:

Cllr Eamonn O' Brien, Leader of the Council (Chair) (EO'B)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Mr Craig Carter, Director of Finance, NCA (CC)
Ms Cathy Fines
Ms Julie Gonda, Interim Executive Director, Communities and Wellbeing
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Dr Kiran Patel, Medical Director, Bury LCO (KP)
Mr Tyrone Roberts,
Dr Jeff Schryer, Chair Bury CCG (Chair) (JS)
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
Ms Sian Wimbury, Deputy Managing Director, PCFT (SW)
Mr Mike Woodhead, CFO, Bury CCG
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)

Others in attendance:

Gillian Cohen – Business Support Manager/PA to DPH, Minute Taker

Apologies

Apologies for absence were received from:

Mr Chris O'Gorman, Independent Chair, LCO Board (CO'G)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)

MEETING NARRATIVE & OUTCOMES

1.	**WELCOME AND APOLOGIES**
	EO'B 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 (19 August 2020) /ACTION LOG**
	The minutes of the previous meeting were agreed and approved as a correct record.
4.	**COVID-19 UPDATE**
	Will Blandamer gave an overview of Bury's current position. With the situation moving at a fast past, at this moment in time Bury are moving into the top 10 area of infections rapidly. Our latest position is 99 positive cases per 100,000 population. The period of time that our numbers are taking to double is reducing, so advice from our public health colleagues is that we are on an upward curve into a 2nd wave. This is replicated across the North West. There is growth in hospitalisation numbers across GM and locally in the Northwest. There is a considerable amount of negative publicity around testing arrangements, in terms of people having problems accessing tests locally. Our walk-in centres have been overwhelmed last week and early this week, however that does appear to have settled down. It has been widely reported that the national testing is having major problems which in turn is causing mass delays locally. There are reports of a large number of residents and school children turning up for a test without having any coronavirus symptoms. Stronger comms needed across all parts of the H&C system to ensure clarity of messages going out. Hard copies as well as electronic versions to clarify the local GM and National arrangements that are in place. Bury is working with colleagues in Salford & Manchester to support the orthodox Jewish community on the forthcoming religious holy days (Jewish new year). Emerging issues to consider as we step up, particularly around shielding. Looking to step up our continuity planning with other partners, as well as looking to stand up our business continuity arrangements around the 2nd wave and the NHS are looking to move to phase 3 working to pre-Covid levels. <u>Comments</u> TR advised that they are looking to align their data triggers at FGH to inform local system interventions.

ID	Type		Owner
A/09/01	**Action**	**To share with partners their triggers for COVID.**	**TR**

5.	RECOVERY & TRANSFORMATION PROGRAMME UPDATE
	The highlight report for the Bury Health and Care Recovery and Transformation Programme had been shared in advance of the meeting, highlighting the breath of this programme of work. The Board discussed that it would be beneficial to choose some of the more challenging aspects and focus on them at a future meeting. Despite COVID, this area of work will be looked at consistently.

ID	Type		Owner
A/09/02	**Action**	**To bring back more specific programme of work to the Board.**	**HH**

6.	STRATEGIC FINANCE UPDATE
	MW provided an update on a report that was produced late yesterday. The key points highlighted were: • There is a full GM Integrated Care System financial plan due out on the 5th October. Individual organisational plans will be signed off on the 22nd October. • There is an expectation that on a national level GM and ICS will break even at the end of the year, with a caveat of £200m, not including the Local Authority. • Need to understand how we access the GM system formulate ICS wide management process. • In terms of contracting and payment guidance, looking at one lead per provider. • As a system, we have not had all our allocations up front, effectively we have been made to break even. From a health point of view, in the first 6 months we have had £50m top up funding. Adrian Roberts and his team are working on the bridge analysis to look at what is driving the gaps. • At a GM capacity meeting, difficult discussions were had in terms of what to stop at a GM level. It was recognised that existing governance arrangements are potentially being pushed beyond their limits. A further meeting is scheduled for 17th September to look at these issues in more depth.

ID	Type		Owner
A/09/03	**Action**	**Once the Finance Advisory Committee have completed their update, MW will share the strategic finance report with the Board.**	**MW**

7.	**DRAFT PHASE 3 SUBMISSION**
	WB referred to the phase 3 COVID-19 planning document that was circulated with the agenda. Guidance has come out for publication of trajectory to bring activity back to pre-COVID levels. Need to prepare for winter pressures whilst being vigilant for a second COVID spike going forward. NCA colleagues have been very positive in exploring and managing actively and improving trajectories. In the first submission made at the end of August, GM were predicting a lower average of containment. Pennine's performance was in accordance with that, towards the lower end. The CCG across the NE sector have been working very closely with Pennine colleagues to get a shared understanding of capacity. We are currently on our second version of the submission and we expect further engagement and challenge from GM; this is a system wide submission rather than just a local version. The Board asked how we can ensure plans are aligned across the whole system around winter pressures and recovery. It was agreed that confidence is required in terms of workforce and financial implications to enable delivery of the proposals. There is a piece of co-production work being undertaken currently looking at these issues. KWJ advised that herself and TR have had discussions at the Urgent Care Delivery group around assumptions of bed escalation in hospitals and bed capacity in the community, to ensure everyone is on the same page over the winter period. JS advised that escalation plans have been shelved for the moment and will be tested shortly to ensure that they are fit for purpose with a second potential COVID wave. JS advised that we need to step back away from recovery and talk about crisis management again. JG commented that emphases needs to be away from hospital beds, as its vitally important that patients return home as quickly as possible, if it is clinically safe to do so. The system needs to be flexed to get people home rather than concentrate solely on the bed issues.
8	**GMHSCP PARTNERSHIP REVIEW**
	WB discussed the review paper that GM Health and Care Partnership is currently undertaking, looking at the way it works and future opportunities within the phase 2 guidance around expectations. This paper was shared via email prior to the meeting. WB highlighted that this paper is a helpful statement of Bury's ambition and obligation to explore all opportunities to do things differently with partners across the NE sector. It is important that we recognise that we are confident in our own ability and ambition for our recovery and transformation programme. This is an opportunity to do things differently in Bury and not wait for GM to move things forward. Steps are being undertaken to ensure we are delivering. The main focus is to build community capacity and capability to support people to feel well and to remain in their own homes.

9	BURY LCO FUTURE FORM & FUNCTION
	KWJ discussed the paper that was circulated with the agenda. This report will help drive and promote the independence and improvement of population health and strengthen the potential for establishing an integrated care system. Following an options appraisal on behalf of the LCO Board, together with an OCO view from JG and WB, it was decided that a lead provider would be the best option. Four expressions of interest have been received from LCO partners: 1. Bardoc 2. Bardoc + Persona 3. Northern Care Alliance 4. VCFSA It was asked to be noted that this will be a collaborative process and not a procurement process to identify a lead provider for the LCO. It was agreed at Board to send a template to all providers who have shown an expression of interest, to ensure they understand the requirements of the lead provider model needed to support the achievements of the LCO. There is a facilitated session scheduled for the 7th October to further discuss with the LCO Board to agree or not that the lead provider model is the preferred option, with the aim of making a final decision by the end of October. It was noted that this was a very helpful piece of work and the right direction of travel to align everything together. WB praised the way the LCO and OCO are working together on this to get the best results for the residents of Bury; this has been achieved with positive conversations with the LCO and providers working together and a shared understanding to achieve the ambitions .

ID	Type		Owner
A/09/04	**Action**	**Further updates to come back to the Bury System Board.**	**KWJ**

10	**BURY 2030 STRATEGY**
	WB discussed the presentation distributed prior to the meeting. WB advised that this was presented at the LCO Board and will be owned by all key partners and the people of Bury to ensure everyone is getting the opportunity to make a contribution. This strategy is progressing at pace; Lynne Ridsdale is in the process of collating revised slides, which will be shared imminently. This will then go out for consultation around November / December time. This strategy cannot be council led; it needs buy in from all system leaders. The LCO are planning a workshop to discuss and drive the strategy forward. There was training for over 100 staff pre-Covid to ensure a solid strength based approach is incorporated in the strategy. Clarity is needed in the strategy in terms of the number of neighbourhoods; it is envisaged that we are moving towards five and this will be clearly set out once it's been agreed.

ID	Type		Owner
A/09/05	**Action**	**To advise WB feedback from the LCO meeting.**	**KWJ**
A/09/06	**Action**	**To circulate latest set of slide from LR for comments.**	**WB**

11	**Closing Matters**
	No further matters were discussed.

Next Meeting	**Date: 21 October 2020, 1.30 – 3.30pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

Title	**Minutes of the Bury System Board** **21 October 2020**
Author	Jill Stott, LCO Governance Manager
Version	1.0
Target Audience	Members of the Bury System Board
Date Created	23 October 2020
Date of Issue	
To be Agreed	19 November 2020
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Date	Version	Author	Notes
23.10.20	1.0	Jill Stott	Draft Minutes submitted to WB for checking
23.10.20	2.0		Amendment by Will Blandamer
23.11.20	3.0		Tyrone Roberts' apologies added
Approved:			
Signature:			.....

Bury System Board

MINUTES OF MEETING
21 October 2020, 2 – 3.50pm 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)
Mr Mike Woodhead, CFO, Bury CCG (MW)
Ms Julie Gonda, Interim Executive Director, Communities and Wellbeing
Mr Chris O'Gorman, Independent Chair, LCO Board
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD) – item 9 onwards
Ms Mui Wan, Associate Director of Finance, Bury LCO (for Mr Craig Carter, Director of Finance, NCA)
M Wan
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 Daniel Cooke, Clinical Director, Bury CCG (DC)
Ms Lesley Jones, Director of Public Health, Bury Council (LJ)
Ms Sheila Durr, Executive Director Children and Young People, Bury Council (SD)

Others in attendance:

Ms Kate Waterhouse, Joint CIO Bury Council & Bury CCG (KW)
Ms Helen Smith, Performance and Intelligence Manager, Bury Council (HS)
Dr Sanjay Kotegaonkar, Clinical Lead IM&T Bury CCG (SK)
Ms Jill Stott, LCO Governance Manager (JMS)
Ms Jane Harris, Cordis Bright (observing)
Ms Caitlin Hogan-Lloyd, Cordis Bright (observing)

Apologies

Apologies for absence were received from:

- Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
- Ms Kath Wynne-Jones, Chief Officer, Bury LCO
- Cllr Eamonn O' Brien, Leader of the Council
- Mr Keith Walker, Executive Director of Operations, PCFT
- Dr Kiran Patel, Medical Director, Bury LCO
- Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
- Mr Craig Carter, Director of Finance, NCA
- Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation

MEETING NARRATIVE & OUTCOMES

1.	**Welcome and Apologies**
	JS welcomed those present to the Bury System Board and the meeting was confirmed as quorate. 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 (16 September 2020)**
	The minutes of the previous meeting were agreed as a correct record.
4.	**Review of Action Log**
	The Action Log was noted, and updates were recorded within the log accordingly.
5.	**Covid-19 Update**

	WB updated System Board on the council's Gold meeting from earlier in the day:
	
	• Increasing numbers of Covid cases across GM and neighbouring localities
	• Significant increase in demand on all services, but particularly on social care, hospital, primary care and community nursing
	• Daily system pressures meeting is now taking place
	• Increased pressure in the system as a result of:
	  ○ Both Covid cases and addressing the backlog of other conditions
	  ○ Flu clinics instigated
	  ○ Staff availability affected by the test and trace system and dependents being sent home from school
	
	WB referred to the effect of the Tier 3 status due to be imposed across GM; he explained that clearer guidance on certain aspects of this is yet to be confirmed, but that the necessary communications on this are being prepared. He noted the potential role of the community hubs in the Tier 3 stage.
	
	LJ alerted the group to the increased number of Covid-related deaths being reported.
	
	Covid and Non-elective activity
	Not discussed.

6	**Recovery and Transformation Programme Update**
	A presentation had previously been shared with Board and HH gave the main highlights from it. He explained that this was part of a more detailed regular update. The background to the work was explained and a report of the delivery status of schemes included. HH reported that Simon O'Hare is working on a finance tracker for schemes. HH gave the main highlights from the programmes and enabler work streams; Estates was noted as a gap and this has been escalated to WB. HH reported on the development of a new Tableau dashboard which will come to this Board and will include finance and activity elements. One of the challenges of part of this work was reported to be capacity of some colleagues to complete the work. JS thanked HH for the work reported on and members were asked for their comments. LJ disagreed with the Population Health programme being reported as red, explaining that there are currently 7 programmes of work under this heading, each with its own plan and led by representatives from across the partnership.

HH and LJ agreed to discuss this in greater detail outside of this meeting.

DC raised the issue of duplication of work, citing an example in UC and MH work streams. He suggested improved communication between programmes of work could address this issue; HH suggested that the Health and Care Recovery Group should be the forum to identify any duplication of work, but asked DC to alert HH or Matt Wright to any areas of concern.

JS suggested that future reporting to the Board should be on an exception basis so that the work of the Health and Care Recovery Group isn't replicated. HH said the plan was to share highlight reports and escalate any issues, but that a more detailed rolling programme of updates for each programme was the intention.

WB reported on the outcomes and performance measures work, which is at an early stage, but has made a positive start. He said the intention will be for reports to come to this Board on a routine basis.

ID	Type		Owner
A/10/01	Action	Outcomes and performance report to come to the November Board	WB

7 Strategic Finance Update

MW shared the latest financial position with the Board:

- Organisational financial submissions are due today
- GM to report a £120m gap for the remainder of the financial year (reduced from £300m after double counting, refinement of forecast costs etc. had been taken into account)
- Split is £103m providers/£17m commissioners
- Concern over potential penalties from the elective incentive scheme
- Bury showing as a break even status
- CCGs will need to address the underlying gap of £20m
- PAHT deficit: £31m
- PCFT deficit: £3m
- LA deficit after quarter 1: £7.5m
- No financial guidance available for 2021/22

From the Financial Advisory Committee MW reported that :

- Funds will be held at a GM level
- £54m due to CCGs
- Covid fund to go directly to providers

MW alerted the Board to the influence on the financial situation of the changing commissioning landscape, but noted that this may give Bury the opportunity for a system-level approach leading to a levelling up of funding.

WB suggested that a block contracting model would impede delivery of transformation as the flow of activity cannot be altered if the flow of money isn't changed. MW agreed that any block contracts would need to be set in a fair way, achieving fair and equitable benefits across the system.

8 Digital Update

KW confirmed that the Digital Charter had been approved via the Health and Care System Recovery Task Group. She listed its 4 main elements:

1. Primary Care
2. Urgent Care

3. Graphnet and shared care records
4. Agile working

KW updated the group on the planned procurement for a GP clinical system, explaining that there is a legal requirement for this to happen as part of a revised framework. Approval on this is needed by the end of December, with implementation planned for 1 April 2021.

KW explained that further details on the procurement process were awaited, but that issues such as choosing one system for all PCNs and the CCG versus practices making individual decisions on the preferred system would need to be considered.

SK highlighted the importance of a system-wide approach to this process, noting that a successful procurement will be central to achieving the goals of the 2030 long-term plan.

AS highlighted the importance of an effective and adaptable system in primary care, and any transition arrangements between one system and another, should that be the case for some practices.

MW emphasised the importance of this piece of work and asked that it be adequately resourced to ensure a successful outcome.

The Board partners agreed to prioritise resource to support engagement in the options appraisal process.

KW reported on the refreshed membership of the Digital Board and the plan to adapt the meeting schedule to allow OCO representatives to attend. She reported that the board was working effectively and that stakeholder events were planned for October and November around the procurement process.

ID	Type		Owner
A/10/02	Action	JS to formally write to System Board partners to seek engagement in the GP clinical system process	JS
ID	**Type**		**Owner**
A/10/03	Action	Update on the GP clinical system process to come back to System Board at the November or December meeting	KW

9 GMHSCP Partnership Review - update

A paper on the outcomes of the first of 4 focus sessions on this topic had been shared with Board. WB updated the group on the main themes:

- Where we are in the journey
- Learning from Covid
- Implications of any reconfiguration, especially on an Integrated Care System (ICS) statutory footing
- Possibility of 1 CCG across GM

WB gave his personal view on current key themes:

- Development of changes to the health and care system (Taking Charge intentions)
- Shift of money and activity into community settings hasn't been totally successful

- Variation in models of governance across the 10 localities
- Scale of ambition for population health has not been secured

WB listed priorities for future focus:

- Population health, addressing inequalities and work on the determinants affecting health and care priorities
- Retain a focus on localities and connectors into communities and neighbourhoods
- Focus on financial flows and governance within localities
- Retain the successful provider collaborations which have taken place, such as mutual aid between hospitals and joint working between the VCFA and community hubs

WB suggested that an objective proposition from all partners was required, demonstrating GM's unique position in having experience of integrated commissioning and provision and in maintaining mature relationships across the locality.

Giving a political perspective on the work AS highlighted some of the challenges ahead:

- Focus on a reduction in health inequalities
- Support for a neighbourhood-level resource
- Need to address GM bureaucracy
- PCNs to have greater involvement
- Focus on innovation
- Politicians to be more involved

From a clinician's perspective JS echoed the above sentiments, noting that 9/10 CCGs wished to retain the current model. He emphasised the importance of clinicians being at the heart of decision-making.

JS questioned whether the system was mature enough to progress changes to the commissioner/provider relationship.

COG gave the LCO's perspective on the proposed changes, noting that the LCO was aware of the potential changes to the commissioning architecture and the connection with progress on the LCO's organisational form. He explained that LCO Board had discussed the topic at its meeting earlier in the day and referred to the LCO's continued work on building and developing relationships and trust across partner organisations. He highlighted the LCO's maturity in promoting successful collaboration across partners, noting specifically the inclusion of OCO colleagues on the LCO Board.

(LJ left the meeting, LD joined the meeting)

HH raised the issue of a focus by NHSE purely on health targets and the effect of this on a health and care system. There was discussion about possible routes of monies through the system via an ICS and the connections between the 10 CCGs and the GMCA.

SJ raised concerns about the lack of influence of local VCFA organisations at a GM level, reporting that he had written to express this concern. From a VCFA perspective he said that a local focus was essential and therefore supported the retention of the 10 CCG model.

	JS endorsed the importance of the VCFA suggesting it should be part of any future collaborative board if a 1-CCG model came into being.
10	**Bury 2030 Strategy – update**
	A 1-page graphic, along with a fuller consultation proposal paper had been shared with Board and WB highlighted the main intentions of the "Let's Do It" 3 components. He explained that a public consultation is planned, to be concluded in December/January time and asked partners to support the engagement process. SH noted the thread of the VCFA's role throughout the document, highlighting the joint working aspect to this piece of work. Via the Teams chat facility COG confirmed that the LCO Board committed at its meeting earlier in the day to engaging fully with the strategy both as a Board and as individual organisations. (MW left the meeting)
11	**Evaluation and GM Workforce Survey**
	A paper had previously been shared with Board and HS joined the meeting to cover the item. She explained that 2 surveys are planned, the GM Wider locality workforce survey and the Bury INT and IMC specific survey (LCO to consider the second). Board agreed that they were happy with the approach in re-running the GM locality workforce survey in November/December. Board agreed to a joint System Board/Health and Care Recovery Group/LCO Board approach to the request for a focus group.
12	**Closing Matters**
	None discussed.

Next Meeting	**Date: 19 November 2020, 10.30 – 12.30, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

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