Strategic Commissioning Board

Agenda	
Date & Time:	12 April 2021, 16.30 -18.30
Venue:	Virtual Meeting via Microsoft Teams
Chair:	Dr J Schryer

Key	A – Approval	R – Recommendation	C – Consideration	I – Information	
Item	**Description**	**Report (Re) Verbal (V)**	**Action**	**Presenter**	**Time**
1.	Welcome, Apologies & Quoracy	V	I	Chair	16.30
2.	Declaration of Interests	Re	C	Chair	16.35
3.	Minutes of the last Meeting and Action Log a) 1 March 2021	Re	A	Chair	16.40
4.	Public Questions	V	C	Chair	16.45
5.	Chief Executive and Accountable Officer Update b) Covid-19 emergency response c) Hospital Discharge arrangements	V	I	Geoff Little	16.50
	Strategy & Policy				
6.	Update on the White Paper/Integrated Care System (ICS) a) The GM ICS discussion - Partnership Executive Board paper b) Update on the developing arrangements c) An update on the work of Carnall Farrar on the North East Sector footprint	V R P R	C C C C	Geoff Little Geoff Little Kath Wynne-Jones Geoff Little	17.00
	Recovery & Transformation				
7.	Update on the Radcliffe SRF	Re	C	Geoff Little/Paul Lakin	17.15
8.	MH Urgent Care by appointment	Re	A	Julie Gonda	17.30
9.	Inclusion Update	Re	I	Lisa Featherstone	17.40

Key	A – Approval	R – Recommendation	C – Consideration	I – Information	
Item	**Description**	**Report (Re) Verbal (V)**	**Action**	**Presenter**	**Time**
Finance /Performance/Risk					
10.1	Finance Quarter 4 report	Re	C	L Kitto/P Crawford/ Cllr O'Brien	
10.2	2021/22 NHS Operational and Financial Planning Guidance	Re	I	Pat Crawford	
10.3	2021/22 ICF Indicative Financial Plan	Re	C	L Kitto/P Crawford/ Cllr O'Brien	17.50
10.4	Council Social Care Provider Fees	Re	A	J Gonda	
10.5	Sustainability of LCO management and clinical costs	Re	I	Kath Wynne-Jones	
11	Next steps for sexual health re-tender	Re to follow	A	Lesley Jones	18.10
12.	Performance Update	Re	C	Kath Wynne-Jones	18.15
Information					
13.	Feedback from Greater Manchester Joint Commissioning Board	V	I	Geoff Little	18.20
14.	Minutes of Meetings a) Bury System Board Minutes: o 16 December 2020 b) Bury System / Transition Board Minutes: o 18 February 2021	Re	I	For information	—
Close					
15.	AOB and Closing Matters	V	I	Chair	18.25

Next Meetings in Public	**Strategic Commissioning Board Meeting (formal):** Monday, 7th June 2021, 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, Email – emma.kennett@nhs.net

Agenda Item 2

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	12 April 2021	**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 12 April 2021; 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
April 2021

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	NHS Heywood, Middleton & Rochdale CCG		X			Employed (substantive) as Quality & Safety Lead	Apr-13	22-Sep-20	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting. To remain on register until 22 March 2021
		Tameside Hospital		X			Seconded to Head of Nursing - Urgent Care	Sep-19	22-Sep-20	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting. To remain on register until 22 March 2021
		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)			X		Senior Clinical Manager	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

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			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	Praxis Real Estate Management LTD, Manchester	X				Director and General Legal Counsel	2011		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.
		PCL (CIP) GP LTD - Nature of Business Asset Management	X				Director	2014		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	2014		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.
		Hanover Law Limited – (changed name from Praxis Law)	X				Director	2018		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.
		The Airfields Residential Management Company Limited	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.
		Praxis Residential Limited	X				Director	Oct-19		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.
		Praxis Group Limited	X				Director	Oct-20		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.
		PCP III Number 2 Limited	X				Director	Mar-21		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		PCP III Number 1 Limited	X				Director	Mar-21		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury Council			X	Indirect	Daughter is an 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			Direct	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		Direct		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		Direct	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			Direct	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			Direct	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			Direct	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.
		RICOCHET project	X			Direct	Taking part in the project application	2021		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.

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Cllr Lucy Smith	Councillor Bury Council	The Christie NHS Foundation Trust			X	Indirect	Spouse / Civic Partner			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Community the Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Socialist Health Association		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		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	Bury Council - Councillior	X			Direct	Councillor	May-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Member of Oldham Health and Well Being Board	X			Direct	Children & Young People Access & Waiting Time	Aug-20	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Member of Greater Manchester Children's Board	X			Indirect	Member	May-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Member of Oldham Health and Well Being Board		X		Direct	Member	Oct-20	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Member of Bury Health and Well Being Board		X		Direct	Member	May-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Chair of Governors, St Lukes Primary School			X	Indirect	Chair	Sep-19	Present	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	Direct	Governor	Apr-18	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Unite the Union		X		Direct	Community Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Health Watch Oldham – Manager	X			Direct	Manager	May-12	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Labour Party		X		Direct	Member	Jun-07	Present	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	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.
Dr Rakesh Thaker	CCG Clinical Director	Knowsley Medical Centre Practice – GP Partner	X					Aug-99	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury GP Federation – Practice is a Shareholder	X					Jun-12	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		BARDOC – Partner to Practice	X					Apr-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury Primary Care Network – Clinical Director	X					Jun-19	Nov-20	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Bury GP Federation – Director	X					Jul-19	Nov-20	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Engine 13 – Medical Director	X					Aug-18	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Thaker Medical Services Ltd - Director	X					Oct-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Rochdale & Bury LMC – Committee member		X				Oct-99	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Manchester District Family Court - Magistrate		X				Apr-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Pat Crawford	Interim Chief Finance Officer						None Declared	10/02/2021	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.

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	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.
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.
Marie Rosenthal	Strategic Advisor - Law & Governance, 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.

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Agenda Item 3

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	12 April 2021	**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 1 March 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the Minutes of the Meeting held on 1 March 2021 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 1 March 2021**
Author	Philippa Braithwaite, Principal Democratic Services Officer, Bury Council
Version	0.1
Target Audience	Strategic Commissioning Board Members / Members of the Public
Date Created	March 2021
Date of Issue	March 2021
To be Agreed	12 April 2021
Document Status (Draft/Final)	Draft
Description	Minutes of the Strategic Commissioning Board on 1 March 2021

Document History:

Date	Version	Author	Notes
	0.1	Philippa Braithwaite	Forwarded to Chair for review.
Approved:			
Signature:			..... **Cllr E O'Brien**

Strategic Commissioning Board Virtual Meeting

MINUTES OF MEETING
Strategic Commissioning Board Virtual Meeting 1 March 2021 16.30 – 17.00 **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 Cultural Economy, 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
Dr Catherine Fines	Clinical Director, NHS Bury CCG
Mr Howard Hughes	Clinical Director, NHS Bury CCG
Cllr David Jones	Cabinet Member Communities & Emergency Planning, Bury Council
Mr David McCann	Lay Member Patient & Public Involvement, NHS Bury CCG
Cllr Alan Quinn	Cabinet Member Environment & Climate Change, Bury Council
Cllr Tahir Rafiq	Cabinet Member Corporate Affairs & HR, Bury Council
Cllr Andrea Simpson	First Deputy Leader, Health & Wellbeing, Bury Council
Cllr Lucy Smith	Cabinet Member Transport & Infrastructure, Bury Council
Dr Rakesh Thaker	Clinal Director, NHS Bury CCG
Mr Chris Wild	Lay Member, NHS Bury CCG
Others in attendance	
Donna Ball	Executive Director of Operations, Bury Council
Philippa Braithwaite	Democratic Services, Bury Council
Pat Crawford	Interim Chief Finance Officer, NHS Bury CCG
Sheila Durr	Executive Director of Children and Young People, Bury Council
Julie Gonda	Director of Community Commissioning, Bury Council
Catherine Jackson	Director of Nursing and Quality Improvement, NHS Bury CCG
Lesley Jones	Director of Public Health, Bury Council
Nicky Parker	Director of Transformation, Bury Council
Lynne Ridsdale	Deputy Chief Executive, Bury Council
Janet Witkowski	Head of Legal Services, Monitoring Officer and Data Protection Officer

Public Members	
Chris Gee	Bury Times

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/03/01	Decision	Noted the information.	

2	Declarations Of Interest
2.1	The Chair reported that the CCG and Council both have statutory responsibilities in relation to the declarations of interest as part of their respective governance arrangements.
2.2	It was reported that the CCG had a statutory requirement to keep, maintain and make publicly available a register of declarations of interest under Section 14O of the National Health Service Act 2006 (as inserted by Section 25 of the Health and Social Care Act 2012). The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.
2.3	The Chair reminded the CCG and Council members of their obligation to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Strategic Commissioning Board.
2.4	Declarations made by members of the Strategic Commissioning Board are listed in the CCG's Register of Interests which is presented under this agenda and is also available from the CCG's Corporate Office or via the CCG website. • **Declarations of interest from today's meeting**
2.5	The Cabinet Member Environment and Climate Change, Bury Council declared a personal interest as his son and daughter are both employed by the NHS and he is a member of the Down's Syndrome Association. It was noted that both these interests were also included on the Declaration of Interest Register.
2.6	• **Declarations of Interest from the previous meeting** There were no declarations of interest from the previous meeting raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/03/02	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 1 February 2021 were agreed as an accurate record.
	• **Action Log**
3.2	There were no updates in relation to the Action Log.

ID	Type	The Strategic Commissioning Board:	Owner
D/03/03	Decision	Approved the minutes of the meeting held on the 1 February 2021	

4	Public Questions		
4.1	There were no public questions raised.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/03/04	Decision	Noted the information.	

5	Persona Contract Extension		
5.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG presented the report which outlined the proposal to renew the contract between Bury Council and Persona Care and Support Limited from 1st April 2021 for a 10-year tenure until 31st March 2031.		
5.2	It was noted that an outcome based 10-year contract will set out the status of existing services provided by Persona and will capture our future ambition to innovate service delivery and meet the changing needs of the partners and customers. The benefit of this approach will give the Council, Persona, and our wider partners a more sustainable commissioning platform on which to develop new and innovative services, sustain a quality and committed workforce and allow opportunities for external funding, broader business development and build on community assets, realising social value, which in turn will benefit the customers and the people of Bury.		
5.3	The contract will also be flexible enough to allow for national policy change which may result in local changes in direction and/or financial restrictions that may be required in response to any such change. The overarching principles in the agreement between partners will minimise any emerging risks and provide reassurance to all parties.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/03/05	Decision	Received the report proposing the renewal of the contract between Bury Council and Persona Care and Support Limited for a period of 10 years commencing on 1st April 2021 and noted that Executive Board approved the proposal on 15th February 2021 and that the report will be presented to Health Scrutiny on 2nd March 2021 and to Cabinet on 24th March 2021.	

6.	Finance update including pooled budget position for Quarter 3
6.1	The Interim Chief Finance Officer, NHS Bury CCG presented the report which provided an update on the Integrated Commissioning Fund budget for 2020/21 and forecast outturn for 20/21 at quarter 3.
6.2	The CCG only received formal notification of allocation of budget for the year in November and for the second half of the year the CCG is only receiving additional allocations for spend deemed “out of envelope”. The CCG has been notified of a total allocation of £352.6m to date with a further £2.3m forecast in allocations to be received before the end of the financial year.
6.3	At month 9, the ICF is forecasting an overspend of £2.3m which reduces to a small underspend of £0.1m following receipt of anticipated CCG allocations. There is a £4.3m overspend on services held within the section 75 pooled budget, £1.9m underspend 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.
6.4	The Board discussed the risks around hospital discharge costs, the funding for which would cease on 31 March, and it was noted that work was underway to understand the impact a reduction of funding and possible mitigations

ID	Type	The Strategic Commissioning Board:	Owner
D/03/06	Decision	Noted the increase to the ICF budget as a result of CCG budget allocations received since the last report to Strategic Commissioning Board for 20/21 and their allocation to the ICF.	
D/03/07	Decision	Noted the ICF forecast financial position at month 9 of breakeven and the assumptions on which it is based.	
D/03/08	Decision	Noted the use of underspends in the aligned fund to address overspends in the pooled fund.	
D/03/09	Decision	Noted the financial risks to Bury.	
D/03/10	Decision	Noted the findings of the annual review not to make any changes to the ICF objectives, responsibilities, risk share and structure for 20/21	
D/03/11	Decision	Noted the planned work on the ICF for 21/22 and report to be produced on the delivery against objectives in 20/21.	

7	Any Other Business and Closing Matters
7.1	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/03/12	Decision	Noted the information.	

Next Meetings in Public	**Strategic Commissioning Board Meetings:** • Monday, 12 April 2021, 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 – March 2021

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

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	
A/02/03	The affordability of a Learning Disability Lead be investigated in line with organisational governance arrangements.	G Little and W Blandamer		March 2021	
A/02/04	A report on the financial trajectory and outcomes and how we measure ourselves against what we set out be brought to a future meeting.	S O'Hare		TBC	

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Agenda Item 6

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Consider
Item No	6a	**Confidential / Freedom of Information Status**	No
Title	GM ICS Development – Paper from GM Partnership Board		
Presented By	Geoff Little – Accountable Officer/Chief Executive		
Author	Will Blandamer – Executive Director Strategic Commissioning		
Clinical Lead	Dr Jeff Schryer		
Council Lead	Cllr Andrea Simpson		

Executive Summary

The attached paper was presented to the GM Health and Care Partnership Executive Board on 23rd March and the GM Health and Care Board on 26th March. It seeks to reset a number of GM wider discussions on the future form and shape of the Greater Manchester Integrated Care System (GM ICS) operational from 1/4/22.

The paper reconfirms important commitments that create the conditions for all 10 districts including Bury to continue with the transformation journey in health and care – integrated, preventative, population health focused, connected to wider public services, VCSE and communities – and also securing transformation of services that of necessity require a GM wide perspective.

There remain a number of important questions for the GM system to resolve in terms of the operating model of the GM ICS. These including 1) the balance of function planning between locality and GM wide 2) the financial flow from GM ICS to localities/providers 3) the governance of the GM ICS 4) the workforce arrangements and the maintenance of skills and capacity in the Bury system.

This paper should be read in the context of the update on the development of the partnership arrangements in Bury, and the work to develop a Northern Care Alliance footprint partnership.

Bury representatives – clinical, political and managerial will continue to work with partners across GM to ensure the conditions are creating to support the next phase of our transformation journey in Bury to secure better outcomes and better population health

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the GM Partnership Paper update for information and comment.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
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 shape of the GM ICS will either help or hinder the delivery of the locality plan ambition and health and wellbeing strategy					
How do proposals align with Locality Plan?	As above					
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 focus of the locality plan, and now the Let's Do It Strategy within which it nests, is to reduce health inequalities as a core objective. The paper describes this maintained intent across GM as part of the GM ICS proposition					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What is the Information Governance/ Access to Information implications?	N/A					

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: Early-stage policy proposal.						
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.		

Draft Paper to PEB 23 March 2021

Developing the GM ICS

Version Control

Version No.	Author	Reason for Change	Date
1.0	M Pritchard	First Draft	7 March 2021
1.1	M Pritchard	Revised draft following meeting of the Working Party	9 March 2021
1.2	M Pritchard	Revised with the comments received	10 March 2021
2.0	M Pritchard	Revised following discussions on 12 March	15 March
2.1	W Heppolette	Additions to incorporate vision & Objectives and appendix	15 March 2021
2.2	M Pritchard	Redraft following Steering Group on 17 March	18 March
2.3	W Heppolette	Additions following Steering Group on 17 March	19 March
2.4	W Heppolette	Incorporating comments from S Price & M Deegan	19 March
2.5	W Heppolette	Incorporating comments from Steering Group members	22 March

1. Purpose of Document

1.1 The purpose of this document is to bring together the progress made in developing the GM ICS, to highlight the key issues and set out the proposed next steps to develop our collective approach to build upon all that has been achieved in our journey so far.

2. Background

2.1 Our Health and Care Devolution deal in 2015 saw Greater Manchester given greater freedom and flexibility over the £6.4bn spent on health and social care services here, to transform how we work with, and for, our population to improve their health and the services we provide.

2.2 Our five year strategic plan was published in early 2016: Taking Charge of our Health and Social Care. Supported by many other more detailed plans, and forming an integral chapter in the city region's blueprint, the Greater Manchester Strategy, this plan has been overseen since April 2016 by a Health and Care Partnership Board, comprising all NHS organisations in GM, all ten councils, GMCA, NHSE and the community and voluntary sector.

2.3 The purpose of this journey of greater freedoms, integration and collaboration has remained to enable us to achieve our collective vision of delivering the greatest and fastest improvement to the health and wellbeing of the people

here, reducing inequalities in a city region which has some of the greatest in the country.

2.4 We have not been alone on this journey. The NHS across England has developed partnerships across local systems and deepened integration through place based working. The development of Sustainability & Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) informed the proposals in NHS England's recent document "Integrating care: Next steps to building strong and effective integrated care systems across England" and the Government's White paper, "Integration and innovation: working together to improve health and social care for all".

2.5 Those national documents intend to solidify and ensure we build on the integration and improved collaboration we, and others, have developed over the past five years. The national objectives for ICSs coincide those we have ourselves prioritised:

- Secure better health and wellbeing for everyone
- Tackle unequal outcomes, experience and access to health and care services
- Enhance productivity and value for money; and
- Support broader social and economic development

2.6 For Greater Manchester therefore, the national proposals can be seen to represent a mid-point in a ten year journey towards integrated health and social care delivered through place based partnerships connected to communities and mature system wide collaboration building on decades of joint working.

3. A Greater Manchester Approach to ICS Development

3.1 It is important that we reflect this history in our approach to developing as an ICS and state those key beliefs that will inform the model we implement:

- Change is done with, not to, people. We want to develop a new relationship between public services and people, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services.
- We adopt an asset-based approach that recognises and builds on what individuals, families and our communities can achieve rather than focusing on what they lack.
- We encourage behaviour change in our communities that builds independence and supports residents to be in control.
- A place-based approach redefines services and puts people, families and communities at their heart
- Improving health requires action on the social determinants alongside the delivery of clinical care. This has guided our pioneering work with the VCSE, our approaches to reducing worklessness and improving school readiness, our efforts to change lives through physical activity as part of GM Moving, our work in tackling homelessness and increasing supported living.

- The opportunity of bringing those contributions together in neighbourhoods with proactive primary care supported through PCNs is at the heart of our model and is delivering now
- We do not believe everything can be delivered in place and have decades of experience in collaborating at scale across Greater Manchester to deliver consistent standards of care. New approaches through the ICS and Provider Collaboratives – such as PCB and PFB which are regarded as nationally leading examples - will strengthen and spread those approaches to reducing variation in access and outcomes.
- We expect to be a place which innovates and ensures our residents benefit quickly from that innovation. We value therefore the strong position of our Universities, healthcare providers and industry base, and using the partnerships between them through Health Innovation Manchester (HInM) to deliver at pace.
- Our entire system understands its contribution to local economic potential and the role individual organisations can make to growth and an inclusive economy.

4. Building on Our Achievements to Date: The Ambition and Purpose of the GM ICS

4.1 In stating those objectives we would confirm our alignment with the national objectives but also emphasize specific opportunities and features within GM which we have developed since devolution. For example the alignment to the Greater Manchester Strategy; the population health potential as the only Marmot City Region with a Mayoral Combined Authority and dedicated Population Health Board to coordinate capacity at the GM level; and the existence of Health Innovation Manchester connected to the Local Industrial Strategy to help the NHS, academic and the GM industry base support broader social and economic development.

Vision

- To improve the health and wellbeing of all the residents of Greater Manchester (GM).

Objectives

- to use social value to tackle the inequalities around us and create lasting benefits for the people of GM, improve the local economy, whilst positively contributing (or at least minimising damage) to the environment;

- To close the health inequalities gap within GM and between GM and the rest of the UK faster;

- To deliver effective & efficient integrated health and social care across GM;

- To continue to redress the balance of care to move it closer to home where possible;

- To strengthen the focus on wellbeing, including greater focus on prevention and population health;
- To ensure equality, diversity and inclusion are reflected in our leadership and guide our priorities and all areas of our work
- To harness the breakthrough opportunities of digital technology for enhancing existing services and crafting novel services to give better outcomes to citizens and improved value for money;
- To secure clinical & financial sustainability across the whole of the health and social care landscape;
- To contribute to growth and connect people to growth and maximise impact from health innovation and digital;
- To further develop our partnership between the NHS, local government, universities and science and knowledge industries for the benefit of the population.

4.2 PEB are asked to confirm that this statement of future ambition and purpose is a good starting point for further engagement with partners and stakeholders in order to build understanding and support for the development of our GM model.

5. **Place-Based Working**

5.1 The next stage of our development will keep and enhance the integration of health, care and wider public services in localities. This place-based approach is central to our local experience, the thrust of the White Paper and an area where we should acknowledge that GM has influenced national thinking.

5.2 Place-based working will remain a cornerstone of integrated local systems. In most localities this has been underpinned by significant pooled budget arrangements to incentivise integration and create greater flexibility in the coordination of care. Whilst the flow of NHS resources will change in the new arrangements, our objective is to retain the scale and scope of place-based pooled budgets. The pooled budgets in localities will be commensurate with the scope of services coordinated and planned at that level.

5.3 As a system, we are absolutely clear that we will ensure that future ways of working will enable to continuation and developments of these arrangements. The section on financial flows later in this document sets out the current thinking on this.

5.4 Our future ways of working in localities will continue to:

- Align local leadership, combining organisational, political and clinical viewpoints

- Agree local strategy for health and care, to deliver the outcomes, performance and financial ambitions
- Use the neighbourhood as the building block for the integration and person centred model of delivery
- Oversee the co-ordination and transformation of local health and care services
- Strategically oversee joint working arrangements including the integration of budgets across NHS and LA partners
- By working in partnership, improve population health and reduce inequalities in a way that has greater impact than the sum of the individual organisations
- Be represented on the GM ICS Partnership Board by the person they locally choose to do so
- Establish place-based governance with a membership defined locally.

5.5 To take this approach to the next stage each locality is working on the transition from current to new forms of working. The development of the GM ICS will therefore be led by localities as well as at GM level. A key issue is ensuring there is agreement on the services where the planning and decision making is in the locality and for which services this makes more sense to do so at a GM level.

6. Provider Collaboratives

6.1 Also central to the White Paper is a reduced emphasis on market mechanisms in the NHS and an enhanced role for providers working together in collaboration at both the Place level and at the ICS level across the NHS and with wider public services.

6.2 GM has pioneered the creation of place-based collaborations which bring together providers of health and care through Local Care Organisations (LCOs) and Integrated Care Partnerships (ICPs). This will further evolve and strengthen as part of place-based working.

6.3 Throughout the pandemic the role of providers collaborating through the GM Hospital Gold Command and Community Co-Ordination Cells, building on the history of joint working in PCB and PFB, and other mechanisms has been critical to our response and enabled support to be provided across GM and mutual aid to be offered to organisations across both the wider North West and the rest of England.

6.4 These will also evolve and strengthen to deliver system wide transformations as an integral part of future GM working.

6.5 Provider Collaboratives will support the vision and objectives shared across the ICS and, specifically:

- Represent providers, including primary care
- Facilitate joint planning and collective decision making

- Support provider development, including PCN development
- Support the identification and tackling of unwarranted variation
- Manage specific transformational programmes

6.6 Provider collaboratives are working through their proposed future delivery programmes. As with place-based working the key issue is ensuring there is agreement on the services where the planning and decision making is in the locality and for which services this makes more sense to do so at a GM level.

7. The GM ICS

7.1 Health and care in Greater Manchester is one system. A system made up of the ten localities and the organisations that work in and across these localities.

7.2 Whatever choices are made about future governance structures and membership the following are critical to making arrangements work:

- Having a common purpose, as outlined above
- A focus on improving population health
- The quality of the relationships between individuals and organisations
- Maintaining trust between partners
- A culture of transparency

7.3 Nationally, the White Paper proposes that ICSs will be made up of two elements – an ICS Partnership Board and an NHS ICS Board - that will work together to deliver the agreed ambition. As part of the Devolution Agreement GM has a single Health and Care Board. Given the degree of connectivity and track record established over many years across GM, we are determined to move forward governance terms in a way that maintains the principle that health and care in GM is one system; a system made up of the ten localities and the organisations that work across these localities. The White Paper descriptions of an ICS Partnership Board and an NHS ICS Board are included as annexe A.

7.4 Our work in shaping our future GM governance, guided by our own experience and any statutory requirements which emerge, will need to be guided by the following design principles in order to ensure connectivity between all parts of the system:

- To ensure that GM continues to operate as one system there will be a common core of political, clinical and organisational leadership in any two Board model
- Any wider Partnership ICS Board provides an opportunity to bring together a “broader church” of partners.
- All parts of our new GM governance will need to be clear in terms of purpose, role and accountability

7.5 Further work and engagement needs to be commissioned to develop these options.

7.6 Further work is also needed to map out how localities, provider collaboratives and the wider GM functions will work together to develop our partnership arrangements.

8. Clinical and Professional Leadership

8.1 The development and inclusion of clinical and professional leadership at strategic, network and operational levels is a critical part of our evolution in GM.

8.2 With the transition from CCGs to ICSs some key parts of the current system will change with the ending of the roles of Clinical Chairs and Governing Body Clinical Leads and uncertainty around how their skillset and expertise will be retained in the new GM ICS at both place level and GM level.

8.3 Other parts will continue to develop with the likely further development of PCN Clinical Directors working collectively in localities and as an integral part of local provider collaboratives, building on their critical role in the delivery of the Covid-19 vaccination programme.

8.4 PCB and PFB will continue to provide reach into clinical leadership and engagement, delivering end to end transformation programmes, building on learning and approaches established in the pandemic.

8.5 Dr Tom Tasker, Chair of the GM Medical Executive is leading on this work with sponsorship from the rest of the GM Medical Executive team which includes Primary Care, Mental Health and Acute Provider medical leads. A group of multi-professional clinical and professional leaders representing a cross section of sectors, organisations and localities in GM have now met for 3 workshops in order to develop the why, what and how clinical and professional leadership will input and work with the emerging GM ICS. Key principles, functions and ways of working have been explored in detail. The group is mindful of the development of clinical and professional leadership arrangements in place and is determined that this work will complement. We anticipate having a draft proposal available shortly which we will seek to engage widely with key stakeholders on before it is finalised.

9. Financial Flows

9.1 How money will move across the system in-line with agreed priorities will be critical to success and system stability. An outline of our current understanding of this is being developed by GM finance leaders, PEB Financial Leadership Group and FAC.

9.2 It is clear that from April 2022 the GM ICS will receive almost all of the NHS funds allocated to GM and be accountable for using these resources to meet national NHS requirements and our GM health and care ambitions. These funds will be deployed in three ways:

- Funds to support GM ICS running costs and programmes of work.

- Funds delegated to support place-based arrangements
- Funds that flow directly to NHS Providers and Primary Care providers

9.3 The actual flow of the funds depends on the agreement achieved as to the agreement of where services are planned and delivered. It is recommended by Finance Directors that the principles of efficiency and effectiveness are considered when making these decisions and that reducing bureaucracy and transactions is a focus. It may be that consideration needs to be given to a short term and medium term set of proposals to ensure the system concentrates on key deliverables in the short term.

9.4 The development of a medium term financial strategy needs to be considered for delivery in 2022/23 as the current system is spending more than the allocation it is receiving, and has done for a number of years.

10. Data and Digital

10.1 As the White Paper makes clear data and digital strategies will have a key role to play in driving innovation, improvement and efficiency.

10.2 Throughout the pandemic a blended team digital and innovation team working on behalf of the GMH&SCP and Health Innovation Manchester responding to the needs of the GM Hospital Gold cell and other mechanisms has made an important contribution to our response and enabled support to be provided across GM. We need to build on this approach through the next stages of our ICS

10.3 There is a strong track record of developing and implementing industrial strategy in GM that has data and digital at its core.

11. Next Steps

11.1 There needs to be a programme of comprehensive engagement with all 10 localities and system leaders (clinical, political, organisational) leading to further refinements of the proposals outlined in this paper aligned to the Parliamentary process. All parties to these discussions are clear that each component of the system is both important and interrelated, so an agreed programme is needed.

11.2 It is proposed that this programme of engagement will focus on the key issues that have emerged from the work so far. A series of engagement events during April will enable a broader group of stakeholders to engage in developing our system thinking on to the next stage. These key issues are:

Theme	Outcome
What Spatial Level to Plan and Decide Services?	Proposals for which functions/services are best placed and developed at place level or at the GM level.
How will NHS Resources be Allocated from 2022/23?	What we know about the funding process for revenue and capital resources and how we ensure the continuation of place-based pooled budgets at the current level
Clinical and Professional Leadership	Proposals for the development and transition of clinical and professional leadership
Locality and GM Working	Options on the way localities will work with the GM ICS in future. Working arrangements for the ICS Partnership Board and an NHS ICS Board

11.3 We recognise the need also to develop the programme approach to support the finalisation of, and transition to, this model. We will establish a representative programme board to oversee each element of the work and deepen system involvement in each.

12. Recommendations:

It is recommended that PEB agree to:

- R1: to confirm that the statement of future ambition and purpose is a good starting point for further engagement with partners and stakeholders in order to build understanding and support for the development of our GM model.

- R2: to support the development of the options set out in 11.2 above by the end of April.

Appendix A (Extract from the White Paper)

6.18 These considerations have led us to the following model:

(a) Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues.

(b) Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to. We will support HWBs and ICSs, including with guidance, to work together closely to complement each other's roles, and to share learning and expertise.

(c) A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local Government and partners e.g. community health providers. We would expect the public name of each ICS NHS Body to reflect its geographical location – for example, NHS Nottinghamshire or NHS North West London.

(d) The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCG's responsibilities in relation to Oversight and Scrutiny Committees. It will not have the power to direct providers, and providers' relationships with CQC will remain unchanged.

(e) Each ICS NHS body will have a unitary board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives. ICSs will also need to ensure they have appropriate clinical advice when making decisions. NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed.

(f) The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:

- developing a plan to address the health needs of the system;
- setting out the strategic direction for the system; and

- explaining the plans for both capital and revenue spending for the NHS bodies in the system

6.19 Discussions with a number of stakeholders including the Local Government Association has led us to the conclusion that there is a strong case for the governance arrangements for an ICS to include an ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS Body. This Partnership would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system. Each ICS NHS Body and local authority would have to have regard to this plan. The Health and Care Partnership will be promoting collaboration and it would not impose arrangements that are binding on either party, given this would cut across existing local authority and NHS accountabilities.

6.20 Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Our intention is to specify that an ICS should set up a Partnership and invite participants, but we do not intend to specify membership or detail functions for the ICS Health and Care Partnership - local areas can appoint members and delegate functions to it as they think appropriate.

6.21 The ICS Health and Care Partnership could also be used by NHS and Local Authority Partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation. We will, working with NHSE and the LGA, also issue guidance to support ICSs in establishing these bodies. This, along with the flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts. We know that this element of flexibility has been of value to the early wave ICSs where there are many (and different) examples of partnership boards and of arrangements at place level. In many cases, partnership boards have served as a way to identify, develop and drive shared priorities and projects between local government and NHS partners.

6.22 Taken together, we think these arrangements provide the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, local authorities and other partners while also strongly encouraging areas to go further in developing joint working and decision-making arrangements that deepen and improve over time in the interests of local people.

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Consider
Item No	6b	**Confidential / Freedom of Information Status**	No
Title	Development of the Bury Health, Care and Well Being Partnership		
Presented By	Kath Wynne Jones		
Author	Will Blandamer		
Clinical Lead	Dr Jeff Schryer		
Council Lead	Cllr Andrea Simpson		

Executive Summary

This paper provides an update on the work to develop the Bury Health, Care and Well Being Partnership arrangements in advance of the establishment of the GM ICS. The paper should be read in conjunction with the paper on the update of the GM ICS development.

The paper reminds the meeting of the objectives of the reform and transformation of the operation of the Bury Health and Care and Well Being system. It provides an update on progress on establishing the previously agreed framework for the system. It provides early consideration of the objectives and membership of the Bury Locality System Board and the Bury Integrated Delivery Collaborative Board, and also describes the developing work of on building the capacity and capability of integrated neighbourhood teams in health and care.

Finally, the paper highlights some outstanding requirements from the GM ICS system in order for the Bury partnership to operate in conditions to be successful.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note the update on the developing arrangements.
- Consider the proposed membership of the Bury System Board and Bury Integrated Delivery Board

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
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?	In line					
How do proposals align with Locality Plan?	The Locality Plan objectives are core to the proposals					
How do proposals align with the Commissioning Strategy?	In line					
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?						
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: Under Development						

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	*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.		

The Bury Health, Care and Well Being Partnership System – from 1/4/22.

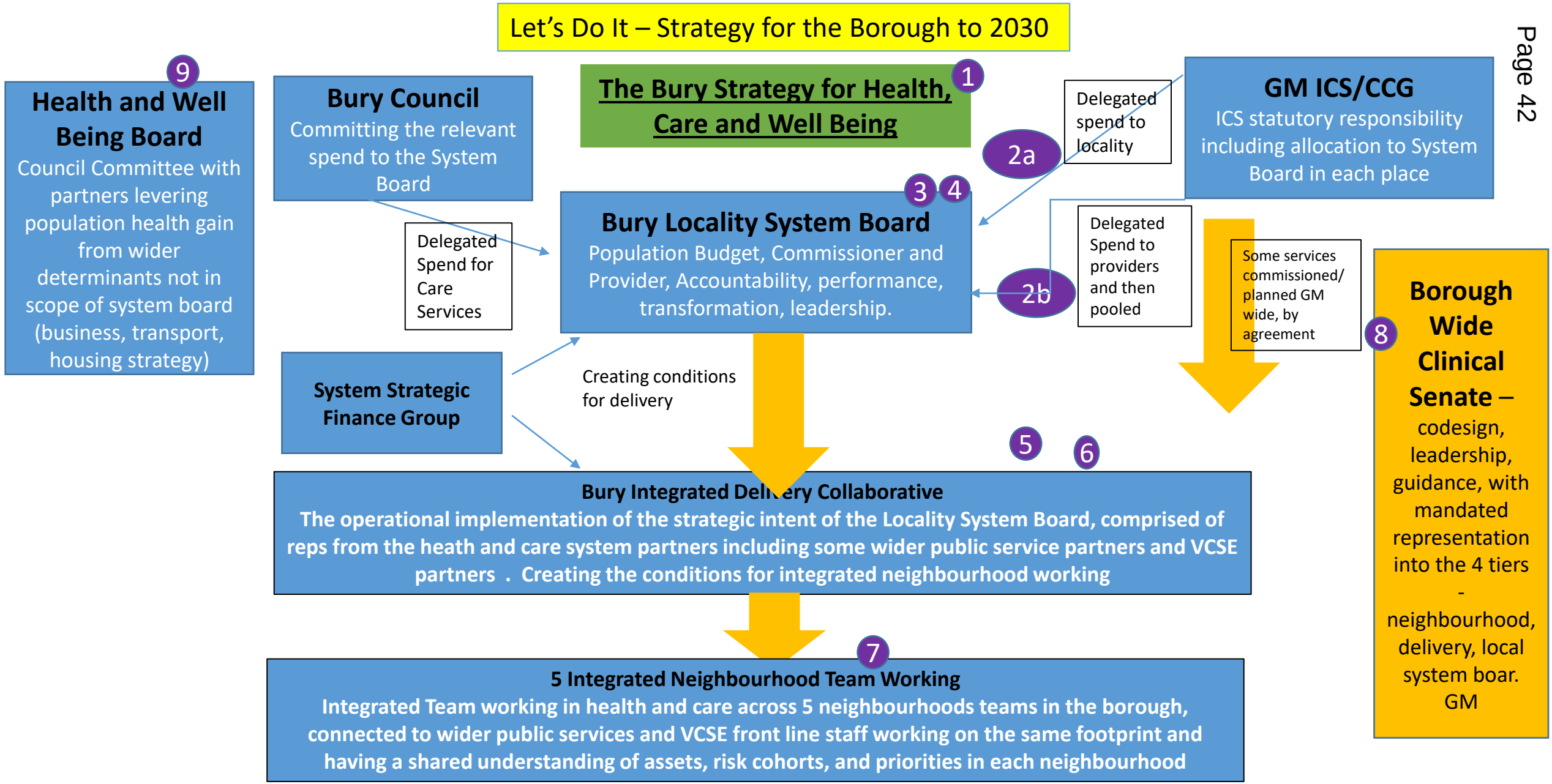
Update to Strategic Commissioning Board – April 2022

Will Blandamer – Executive Director, Strategic Commissioning

1. Bury's objectives: Bury 2030 ('Lets Do It') and Bury Locality Plan

- Step Change in Population Health and in addressing health inequality
- Residents in control of their health and well being, and connected to communities
- People in control of how health and care services are organised around them
- Services delivered closer to home/in home where possible – home first
- Focus on services that are planned and preventative rather than unplanned and reactive
- Front line staff working together in 5 Neighbourhood teams in health & care, and on the same spatial footprint with wider public services, and with communities
- Clinical/professional leadership, political and managerial leadership working together for the residents of Bury
- Collaboration at a NE Sector & across GM where required to transform hospital wide services
- Timely and effective access pathways for more specialist health and care services
- Costs controlled by earlier intervention, prevention, and the strengths within people, families, communities

2. The Bury Health, Care and Well Being Partnership System from 1/4/22



3. System Governance documentation

1	Bury Health, Care and Well Being Strategy - a refreshed Locality Plan – in the context of Lets Do It as the strategy for the borough, that operates essentially as a framework agreement for all partners in the health and care system – where every subsequent agreement can describe its fidelity to these principles – and describing the respective roles of the system board, delivery board and neighbourhood team working, as well as health and well being board and clinical senate.	To be Developed
2a	The accountability agreement between the GM ICS and the Locality System Board for the money allocated via locality	To be confirmed
2b	The mechanism by which provider allocations are pooled	To be confirmed
3	The governance framework for the operation of the Bury Locality System Board – the mechanism by which an integrated budget for the borough (pooled, aligned and in view) will be managed and overseen. It will set strategy, confirm priorities, and create investment propositions between partners to the integrated delivery board. Partners to this are Council, NCA, PCFT, PCN rep, VCFA, and GM ICS lead. The pooled budget at the System Board will be no less than the current level	To be Developed
4.	The terms of reference of the Bury Locality System Board	First Draft available
5	An alliance agreement between partners on the Integrated Delivery Collaborative that describes how they will work together in pursuit of the common ambition, and particularly to create the conditions or neighbourhood working.	Current LCO MOU to be developed
6.	The terms of reference for the Bury Integrated Delivery Collaborative	First draft available
7	A template agreement between an integrated neighbourhood team that clarifies expectations of the Integrated Delivery Collaborative in supporting the neighbourhood team, and the expectations of the competence of neighbourhood teams – leadership, co-ordination, priority setting. With a presumption of supporting further devolution to neighbourhood teams.	To be developed
8	Governance Framework and funding agreement for the operation of the Clinical Senate.	To be Developed
9	Terms of Reference for the Health and Well Being Board– describing specifically the role of the health and well being board operating as a ‘standing commission’ to connect all borough activities (including for example wider determinants) in pursuit of a population health system focused on reducing health inequalities	Council Approved March 2021.

5. The Bury System Board – Purpose (1 of 2)

1. Ensure alignment of all organisations to the Bury Health, Care and Well-being Partnership vision and objectives, as described in the Strategic Plan for Health and Care in the Borough. noting the triple aim of improved population health, improved experience, and financial sustainability
2. Promote and encourage commitment to the integration principles and integration objectives amongst all parties.
3. Jointly manage the Bury Health, Care and Well Being Locality Integrated fund – established to reflect the scope of services agreed to be managed at a locality level in accordance with the GM ICS accountability agreements, and doing so on the basis of 'formally pooled, aligned and in view'.
4. Formulate, agree and ensure that implementation of strategies for achieving the integration objectives and the management of the Bury System Partnership.
5. Discuss strategic issues and resolve challenges such that the integration objectives can be achieved.
6. Respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Bury Health, Care and Well-being Partnership or any parties to the extent that they affect the parties' involvement in the Bury System Partnership.
7. Agree policy as required.
8. Agree performance outcomes/targets for the Bury Health, Care and Well-being Partnership such that it achieves the integration objectives.

4. The Bury System Board – Purpose (2 of 2)

9. Review the performance of the Bury System Partnership, holding the Bury Integrated Delivery Collaborative to account, and determine strategies to improve performance or rectify poor performance.

10. Ensure that the Bury Integrated Delivery Collaborative identifies and manages the risks associated with the Bury System Partnership, integrating where necessary with the parties' own risk management arrangements.

11. Generally, ensure the continued effectiveness of the Bury System Partnership, including by managing relationships between the parties and between the Bury Health, Care and Well-being Partnership and its stakeholders.

12. Ensure that the Bury Health, Care and Well-being Partnership accounts to relevant regulators and other stakeholders through whatever means are required by such regulators or are determined by the System Board, including, to the extent relevant, integration with communications and accountability arrangements in place within the parties.

13. Address any actual or potential conflicts of interests which arise for members of the System Board or within the Bury Health, Care and Well-being Partnership generally, in accordance with a protocol to be agreed between the parties (such protocol to be consistent with the parties' own arrangements in respect of declaration and conflicts of interests, and compliant with relevant statutory duties).

14. Oversee the implementation of, and ensure the parties' compliance with, this agreement and all other services contracts.

15. Review the governance arrangements for the Bury Health, Care and Well-being Partnership at least annually.

16. Ensure consistent representation to the decision making arrangements of the GM ICS such that the GM ICS creates the conditions for rapid delivery of the system transformation described in the refreshed locality plan

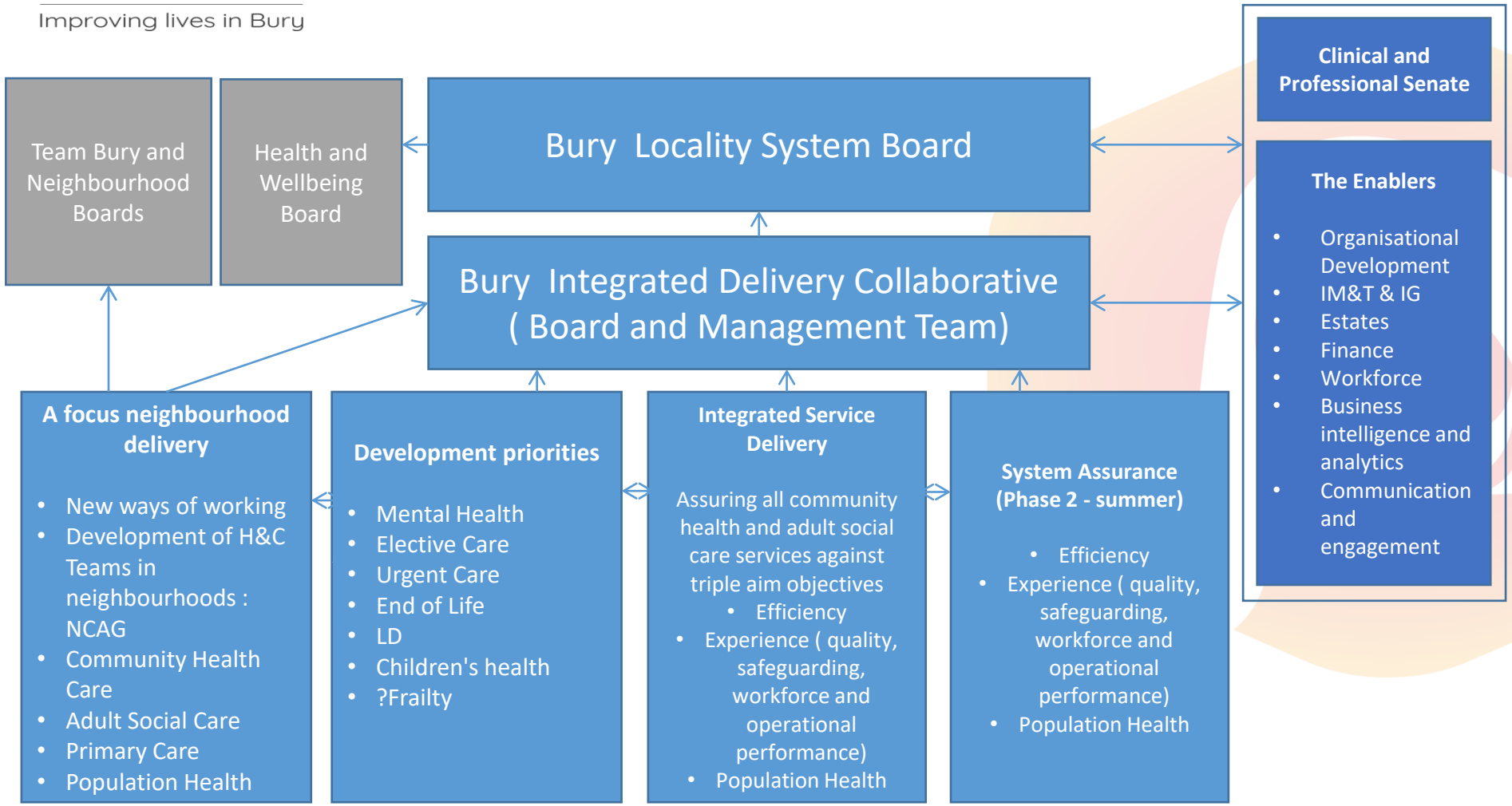
5. Bury System Board – Potential Membership

- Leader of the Council
- Senior Clinical Leader/s including Medicine, and Nursing in the Borough (as determined by the Clinical Senate)
- The Chief Executive of the Local Authority/Place Based Lead for the GM ICS
- Chief Officer NCA Bury Care Organisation
- Senior Officer Pennine Care
- Executive Member of the Council Adult Care and Health
- Executive Member of the Council - Childrens
- Representative of the 4 Primary Care Networks
- Chief Officer Bury Voluntary and Community Faith Alliance
- Strategic Finance Group Chair
- Chair, and Management Lead of Integrated Delivery Collaborative
- Director of Childrens Services
- Director of Adult services
- Director of Public Health
- Others as agreed

BURY LOCAL CARE ORGANISATION

Improving lives in Bury

Proposed role of the Integrated Delivery Collaborative

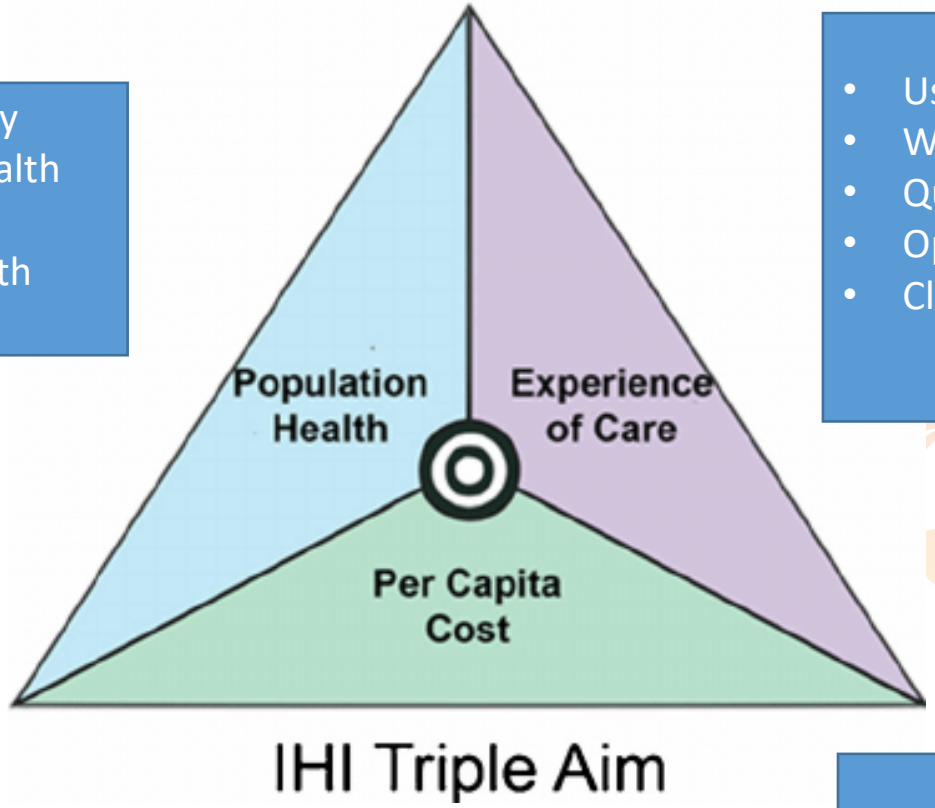


The delivery of programmes will include a plurality of providers working together including the voluntary and community sector to support delivery of our triple aim objectives

7.Core Objectives for the Integrated Delivery Collaborative

BURY LOCAL CARE ORGANISATION
Improving lives in Bury

- Life expectancy
- Population health indicators
- Reducing health inequalities



IHI Triple Aim

- User experience
- Workforce behaviours
- Quality and Safeguarding
- Operational performance
- Clinical outcomes

- System Control Total
- Programme budgets
- ?Neighbourhood budgets

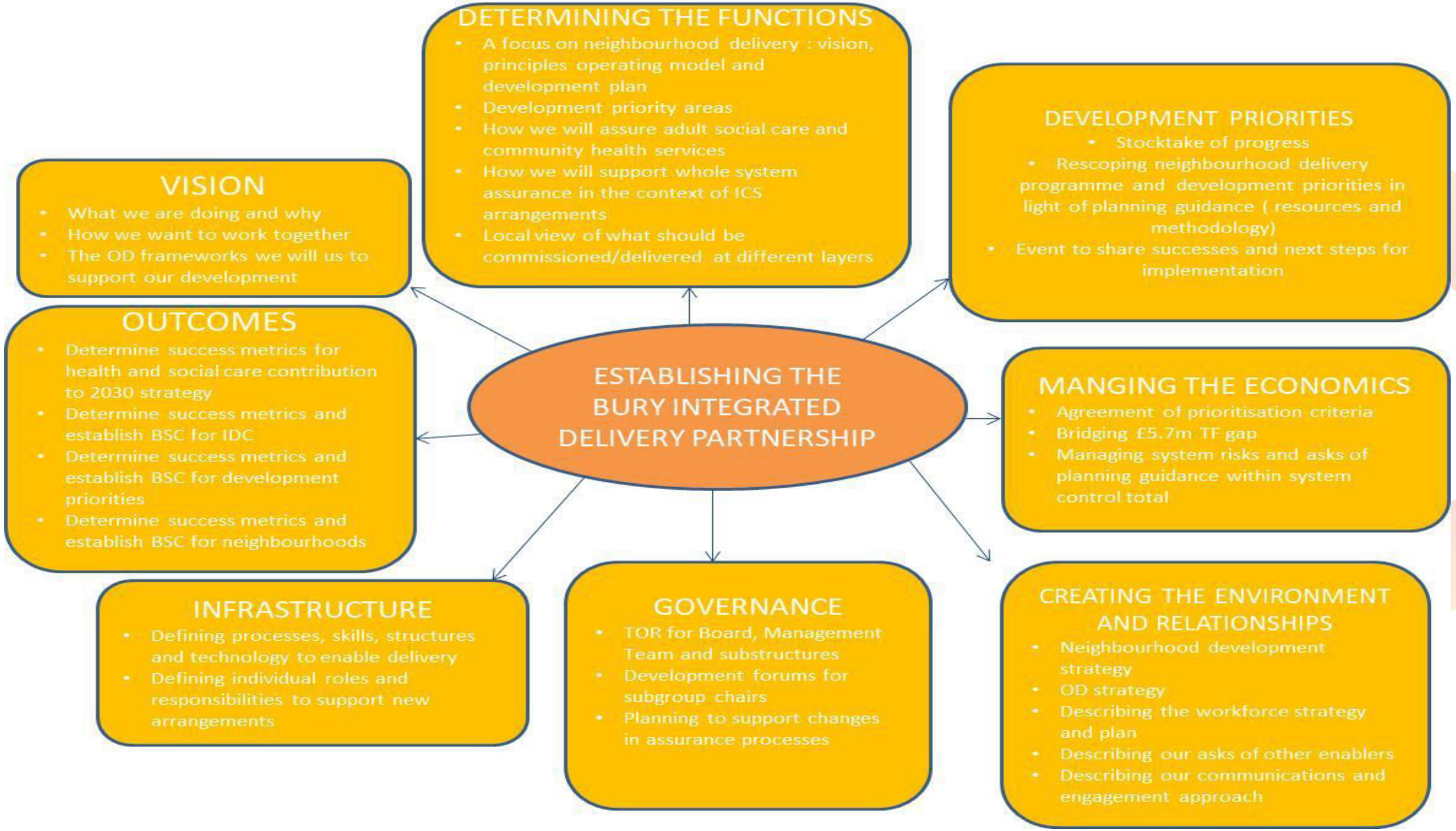
8. Bury Integrated Delivery Collaborative – Draft Terms of Reference

1. Promote and encourage commitment to the integration principles and integration objectives amongst all parties.
2. Implement strategies agreed by the Bury System Board to achieve the integration objectives.
3. Identify and escalate to the Bury System Board strategic issues and resolve challenges such that the integration objectives can be achieved.
4. Implement decisions on the System Board in response to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Bury Health, Care and Well-being Partnership or any parties to the extent that they affect the parties' involvement in the Bury System Partnership.
5. Manage the performance of the Bury Health, Care and Well-being Partnership , accounting to the System Board in this respect.
6. Identify and manage the risks associated with the Bury Health, Care and Well-being Partnership , integrating where necessary with the parties' own risk management arrangements.
7. Implement arrangements through which the Bury Health, Care and Well-being Partnership accounts to relevant regulators and other stakeholders through whatever means are required by such regulators or are determined by the System Board, including, to the extent relevant, integration with communications and accountability arrangements in place within the parties.
8. Address any actual or potential conflicts of interests which arise for members of the Bury Integrated Delivery Collaborative or within the Bury Health, Care and Well-being Partnership generally, in accordance with a protocol to be agreed between the parties (such protocol to be consistent with the parties' own arrangements in respect of declaration and conflicts of interests, and compliant with relevant statutory duties).

9. Bury Integrated Delivery Collaborative – Draft Membership

- An independent Chair
- Dedicated Management Lead/s for the Integrated Delivery Collaborative
- Managing Director- Persona
- 4 PCN Clinical Directors
- NCA Representative – Hospital Services
- NCA Representative – Community Services
- Chief Officer – Bardoc
- Chief Officer – GP Federation
- Pennine Care Operational Lead
- Adult Social Care Lead
- Childrens Services Lead
- Director of Health and Care – Bury Council
- Representative 6 town Housing
- VCFA representative
- GM ICS representative
- Healthwatch
- Borough Public Service Reform Lead

10. Integrated Delivery Collaborative - Programme of Development



11. Integrated Delivery Collaborative success factors : The 1st 12 months

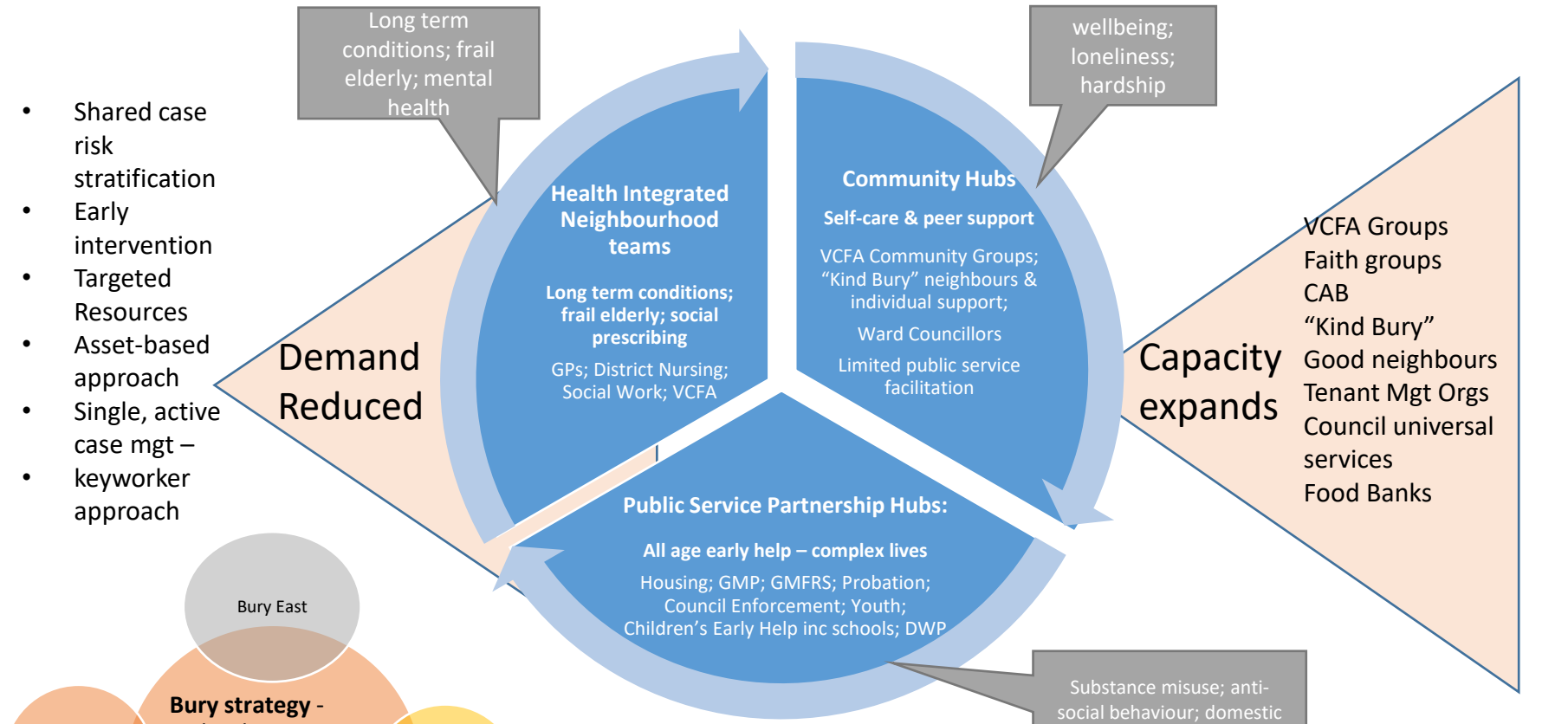
BURY LOCAL CARE ORGANISATION
Improving lives in Bury

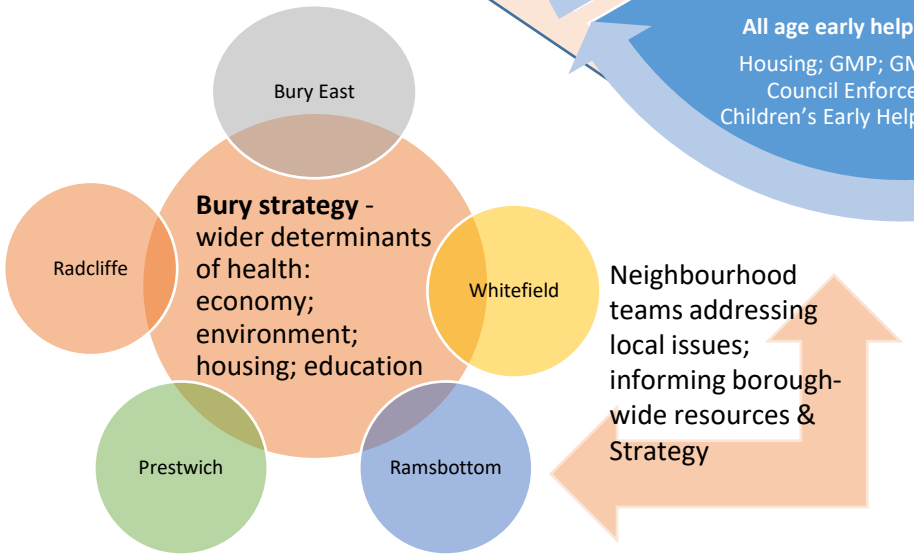
- Improvement in strategic triple aim outcomes: short term measures to be agreed
- Full commitment of all partner organisations (including primary care) recognising neighbourhood teams as a currency of delivery: 360 assessments
- Increased income to the Borough through external funding sources
- Strong relationships with partner organisations outside of health care, users and the public
- Neighbourhood team understanding and developing local priorities for their population
- Practical evidence of teams working differently together
- Infrastructure (people and governance) is viewed as effective to support our move towards the new ICS arrangements
- Agreed OD and workforce strategy ,with implementation plan underway: short term measures to be agreed including a proposal for the 'way we do things in Bury'

12. Neighbourhood Team Development - Components of a Neighbourhood Team

Three Components of one team in each neighbourhood

- Shared case risk stratification
- Early intervention
- Targeted Resources
- Asset-based approach
- Single, active case mgt –
- keyworker approach





Neighbourhood teams addressing local issues; informing borough-wide resources & Strategy

13. Key Issues in developing integrated neighbourhood teams …

1. Making this real – “lets do it” – where neighbourhood team development and delivery is at the heart of everything we are doing.

2. Further Service alignment to neighbourhood team model

3. Integrated neighbourhood teams knowing the assets of communities – and knowing how to support residents to connect.

4. Knowing cohorts of risk and vulnerability – including models of risk stratification

5. Connection to Primary Care Networks

6. IM&T and data sharing

7. Governance required to genuinely devolve power, responsibility, budget.

14. Outstanding Issues at GM level that determine our capability

1. The mechanisms by which money arrives into the system board. Currently described in two ways – from GM ICS directly into a locality, and from GM ICS via providers into a pooled budget. The relative balance and content of each is crucial.

2. The scope of services considered primarily rooted to localities, and those services that are best planned and commissioned at a GM level. This should determine the size of the pool.

3. The retention and expertise and capacity in the locality to drive forward the transformation. We need clarity on the CCG workforce transition to a GM ICS and the sense of continued accountability to the place with the required skills and expertise available to us

4. Ensuring the availability of clinical leadership (CCG clinical leadership not included in the 'employment promise) to drive transformation from a population health perspective.

5. The decision making governance of the GM ICS arrangements, ensuring localities influence the shape and direction of implementation and the allocation decisions that underpin them.

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Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Consider
Item No	6c	**Confidential / Freedom of Information Status**	No
Title	NCA Footprint working arrangements		
Presented By	Geoff Little		
Author	Carnall Farrar		
Clinical Lead	Jeff Schryer		
Council Lead	Cllr Andrea Simpson		

Executive Summary

The 4 GM districts of Bury, Salford, Rochdale and Oldham are connected through the relationship with the Northern Care Alliance delivery of acute and community services. NCA have worked hard to develop a unit of managerial and clinical leadership in each of the 4 districts ('Care Organisation') that has been invaluable during the response to the pandemic.

This paper is the outcome of a brief joint commission between the 4 districts and NCA. It seeks to describe the degree of consistency between the partnership arrangements in each of the 4 districts in response to the pandemic, as a necessary precondition to continued partneship working between each District, the NCA Care Org, and the NCA organization as a whole.

In doing so it creates opportunities to accelerate transformation of in scope acute and community services in each of the 4 districts, confirms a shared ambition and philosophy – particularly around the pre-eminence of place based working and integrated neighbourhood team delivery.

The partnership and its shared approach has been helpful in the meantime in contributing to the emergent model of ICS for GM as a whole.

The paper does not commit to collective decision making on thisfootprint, does not limit the soverienty of the Bury localty, and is not a comprehensive model (in the sense that we have important working relationships with other key providers e.g MFT). It does however create the conditions for the important relationship with NCA partners to flourish.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receive the report and comment on the approach described.

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?	Yes					
How do proposals align with Locality Plan?	Core					
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?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality	Yes	☐	No	☐	N/A	☐

Implications						
Impact Assessment been completed?						
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.		

Proposition for locality working in the context of the GM ICS

March 2021

NHS Bury Clinical Commissioning Group

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

NHS Salford Clinical Commissioning Group

NHS Oldham Clinical Commissioning Group

Bury Council

Rochdale Borough Council

Salford City Council

Oldham Council

Contents

Executive summary (1/3)

This document sets out our **proposals for future arrangements within the new ICS** to **feed into and contribute towards the development of plans** at a GM level. In coming together to undertake this work, our aim is to **contribute towards to the means of securing greater consistency in the place based arrangements** across GM. It has been developed over the month of March in parallel to the evolving thinking underway at the GM level, taking the emerging ICS proposals and design principles into account. Leaders of health and care, including politicians, clinicians and executives across all four of our localities and the NCA have been involved in inputting to these proposals through a combination of one-to-one interviews, locality meetings and pan-locality workshops.

Our localities of Bury, Rochdale, Oldham and Salford make up four of the ten localities across Greater Manchester (GM) with a combined population of approximately 1 million. Whilst each of our populations have differing demographic profiles, the health of people has been generally worse than the England average and life expectancy for both men and women is lower than the England average. This means we need to work extra hard to tackle inequalities and improve outcomes, by designing our health and care system based around people, communities and their specific needs, and maximising the potential for economic contribution. We share a single acute and community healthcare provider – the Northern Care Alliance NHS Group (NCA). The NCA is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust, in April 2017.

Following the publication of the White Paper in February 2021, work is underway at the GM level to design the architecture that will enable GM to operate as an ICS – holding the statutory ICS responsibilities but pursuing broader objectives, including population health, social determinants and public service reform. In these proposals, place is described as the “cornerstone of integrated local systems”. We support this concept and believe that a focus on place is pivotal: it is widely accepted that this should be the default setting for the vast majority of care and decision-making.

Although our four localities have been on distinctive and separate journeys towards making integrated care a reality for our populations, there is much commonality across the arrangements we have put in place. In each of our localities, we have a **strategic joint commissioning board** (or equivalent) and an **integrated Local Care Organisation.** We all have **integrated funds** for health and care in place using a Section 75 agreement. The scale of these ranges from £449m (Oldham) to £607m (Salford). We are all firmly of the belief that it is the blend of **political, clinical and professional leadership** that makes our collaborations a success, and we are all keen to build on what we already have in place which includes building on the scope of our existing pooled and aligned budget arrangements under any future proposals. This is because we have seen significant progressive benefits from our increasing levels of integration over the years.

Our overarching principles have informed the development of this proposition. Our core principle is that **place-based working is the cornerstone** of integrated local systems – this is where most care is provided and there is greatest opportunity to improve population health outcomes. Our approach supports **primacy of place**, as we believe decision-making should be as close to the 'issue', problem or population as possible and follow the **principle of subsidiarity**, with place-level decision-making and solution-finding putting the community served as the focus. However, we recognise that **not everything can be planned and / or delivered** at a neighbourhood or locality level and that we have decades of experience in collaborating at a **GM level** to plan and deliver consistent standards of care.

Executive summary (2/3)

We have considered three different spatial levels in the new system architecture, each with a distinctive purpose: **GM-wide, locality and neighbourhood (the latter two referred to as 'place')**. We have aligned on a proposition for the optimal scope of services to be **planned** at different spatial levels. This is based on the principle that nearly all community-based services and a significant proportion of acute services are best planned at locality level to ensure flexibility to meet the needs of the local population, to manage demand for health and care, and enable local people, communities and organisations to be part of plans, decisions and solution-finding. We have also considered the optimal scope for services to be **delivered** at different spatial levels, recognising that not all services best planned at one level are best delivered there – for example, some elements of primary care will be best planned at GM level but need to be delivered on a neighbourhood and locality level.

We also recognise that GM has benefited from working on **pan-locality basis**, particularly for acute physical and mental healthcare, with different footprints being relevant dependent on the nature of the service being planned or delivered. We see opportunity to build on this to **enhance collaboration,** ensuring it is effective in the context of the ICS and supports the delivery of system-wide goals. Our four localities are keen to work together in the future, but we also think there could be benefit in different pan-locality footprint configurations depending on the nature of the opportunity identified, for example working with Bolton FT. We believe that pan-locality collaboration would work well for **planning** some services. The main rationale for these services to be planned at a footprint that is wider than locality is around scale and population size. These are services which benefit from being planned and purchased for a larger population than locality to drive maximum benefits in support of GM-wide strategic goals, but not as large as GM. The NCA already delivers acute health services across our four localities, with significant opportunities to improve service resilience and outcomes across this delivery footprint. Every opportunity should be explored to secure the benefits of pan-locality collaboration (either across our four localities or in different configurations as appropriate) as part of the new ICS architecture.

In terms of governance, our shared view is that the GM ICS NHS Board should be organised as a **Committee in Common** with the GM Partnership Board to ensure that health and care are not divided. Each of the **ten localities should be represented** on this Committee in Common in order to reflect the interests of all places that make up GM, and not go backwards from our partnership intentions. Each Locality should then have a **Joint Committee** that is responsible for setting the strategic direction and decision making on the integrated fund. Each locality should establish an **Integrated Delivery Collaborative** as a formal alliance to include partners from the VCSE, wider public services and wider care services e.g. care homes, based on the requirements of the locality.

Political, clinical and professional leadership should be part of the core membership for each of the governance groups. Funding should be delegated from the ICS NHS Board to the Locality System Partnership Board (name TBD). The intention is to **retain the scale and scope of place based population health budgets commensurate with the scope of services coordinated and planned at that level**. Provider collaborative funding should be aligned with localities' strategic plans. Over time, we would expect funding to be devolved down to the Neighbourhood level where this is feasible.

Executive summary (3/3)

The next steps for further development of this work include:

- Refining the overarching principles with all partners, including primary care and the VCSE
- Conducting further engagement on these proposals e.g. with primary care providers and public health commissioners
- Working with with all partners (including Councils) to refine propositions for the Neighbourhood-level, including the governance, staff and skill mix required and how this will be organised
- Further reviewing the benefits and alternative propositions for mental health community services with relevant organisations
- Developing a proposition for how the Health and Wellbeing Boards should interact with the Locality System Partnership Boards
- Ensuring leadership alignment behind this proposition (including political support)
- Identifying potential challenges that need to be worked through and develop mitigating strategies recognising the specific complexities of each locality
- Sharing this proposition more widely with colleagues in GM
- Identifying specific areas, programmes or opportunities to take forward at a pan-locality level – agreeing the footprint and nature of the arrangements required to do so
- Beginning to implement governance proposals and establish new / amend existing governance groups as required in each locality
- Identifying any capability gaps at locality level and working with GM ICS to resolve these ahead of formal transition to the new arrangements

Background and context

Purpose of this document

This document sets out our proposals for future arrangements within the new ICS to feed into and contribute towards the development of plans at a GM level. In coming together to undertake this work, our aim is to contribute towards to the means of securing greater consistency in the place based arrangements across GM

It has been developed over the month of March in parallel to the evolving thinking underway at the GM level, taking the emerging ICS proposals and design principles into account. Leaders of health and care, including politicians, clinicians and executives across all four of our localities and the NCA have been involved in inputting to these proposals through a combination of one-to-one interviews, locality meetings and pan-locality workshops. For full details of all engagement undertaken, please see Appendix pp.40-41. A key principle of the work has been to build on what we already have in place and the progress we have made to date individually as localities, drawing on the strength and commonality across the four of us. This document starts by describing in more detail the journeys we have been on to date, where we are different and where we have much in common.

The document covers:

- Where we are on our integration journeys
- How we want to work in the future, including our proposition for:
  - The overarching principles we should be adhering to
  - The purpose of each spatial level
  - The future scope of each spatial level
    - Planning and strategic coordination
    - Delivery alliance
  - Potential for pan-locality collaboration
  - The future governance arrangements
    - Overarching system architecture, including how localities will work with GM
    - Proposition for localities
    - Proposition for pan-locality
  - The associated financial flows
- Next steps, including identifying areas where we know there is further work to be done

Source: Developing the GM ICS (Merged PEB 23.03.21)
https://www.northerncarealliance.nhs.uk/about-us/; https://www.gmhsc.org.uk/;

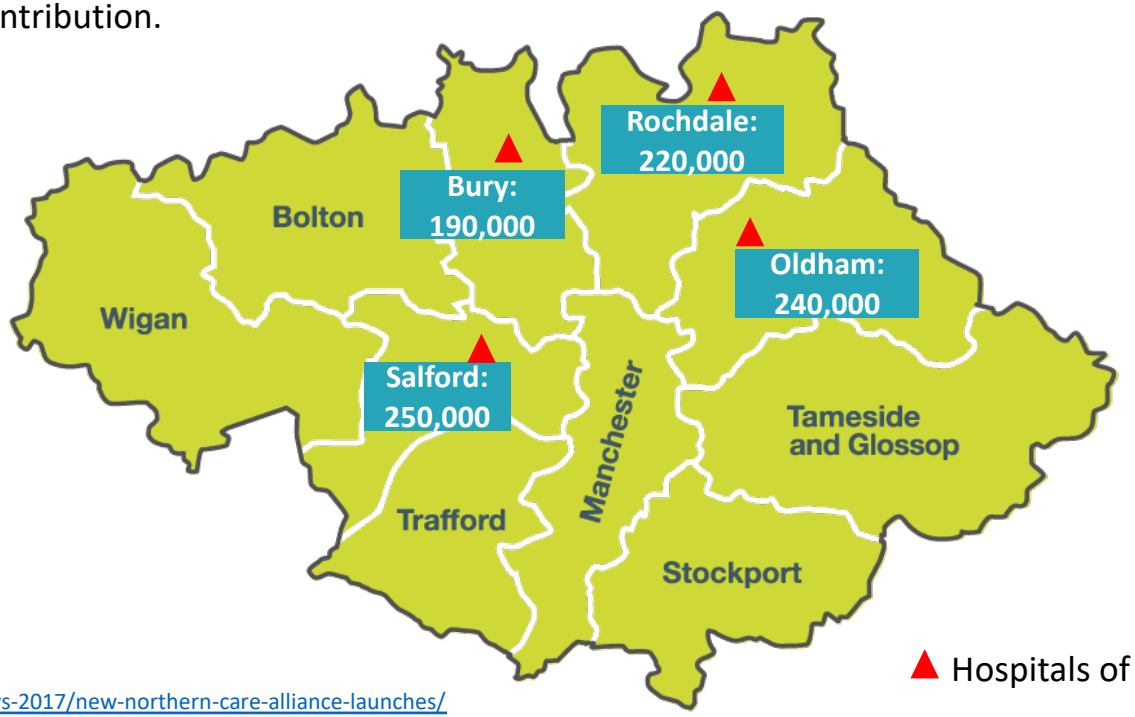
Who we are

Our localities of Bury, Rochdale, Oldham and Salford make up four of the ten localities across Greater Manchester (GM) with a combined population of approximately 1 million. Across the four, there is significant deprivation with examples below:

- In Bury there is a wide range between the least and most deprived communities, and this has a notable effect on health outcomes
- Salford is one of the 20% most deprived districts/unitary authorities in England and 21.1% (10,460) of children live in low income families
- Almost a third of the population of Rochdale live in areas amongst the 10% most deprived in the country, an increase on the proportion seen in 2010. In contrast, only 24,350 people live in areas in the least deprived quartile
- Oldham currently has four areas within the borough which are among the top 1% of the nation's most deprived areas. Only three wards do not contain any areas that fall within the nation's top 20% most deprived

Whilst each of our populations have differing demographic profiles, the health of people has been generally worse than the England average and life expectancy for both men and women is lower than the England average. This means we need to work extra hard to tackle inequalities and improve outcomes, by designing our health and care system based around people, communities and their specific needs, and maximising the potential for economic contribution.

We share a single acute and community healthcare provider – the Northern Care Alliance NHS Group (NCA). The NCA is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust, in April 2017. The Group provides a range of healthcare services including four hospitals and associated community services - Salford Royal, The Royal Oldham Hospital, Fairfield General Hospital in Bury, and Rochdale Infirmary (marked in red on the map).



Sources: https://www.srft.nhs.uk/media-centre/latest-news/news-archive/news-2017/new-northern-care-alliance-launches/

Background context

Since 2001, GM has been at the forefront of integrated care in the UK. In November 2014, GM reached a historic milestone: leaders across the ten local authorities signed a unique deal with Government to devolve a wide range of powers, budgets, and responsibilities to GM Combined Authority (GMCA) and an elected GM Mayor. In April 2016, GM took control and responsibility for its £6bn health and social care budget and has been working to deliver sustainable, integrated health and care.

In February 2021, the Secretary of State for Health and Care set out before Parliament a White Paper describing a blueprint for the future of health and care, including a number of reforms to the Health and Care Act centred on the creation of Integrated Care Systems nationally. We very much see these changes as an extension of the journey we have been on to date given the aim to make it easier to work across boundaries and remove barriers. The White Paper describes how place arrangements will be supported by the principle of subsidiarity, with allowances for joint committees at place level and strengthened clinical leadership and makes it clear that ICSs and local places will be able to arrange this as best fits local circumstances rather than being prescribed through legislation.

Work is underway at the GM level to design the architecture that will enable GM to operate as an ICS – holding the statutory ICS responsibilities but pursuing broader objectives, including population health, social determinants and public service reform. In these proposals, place is described as the “cornerstone of integrated local systems”. We support this concept and believe that a focus on place is pivotal: it is widely accepted that this should be the default setting for the vast majority of care and decision-making.

Alongside this, we recognise the benefits of collaboration across all partnerships, particularly new models of provider collaboration across GM. We are all proud to be part of the make up of GM and recognise the significant experience and capability that operating at scale over all ten localities affords. Significant progress, recognised on a national stage, has been made through the GM partnership and we want to continue to support and build on this.

Within this overall framework, our four localities have a history of working together on common agendas. Initially, Bury, Oldham and Rochdale came together as the North East sector given the shared relationship with the Pennine Acute. Since 2016, relationships have extended to include Salford given the creation of the Northern Care Alliance (NCA). During the Covid pandemic we have all had to work together in a new and more urgent way, and we achieved this successfully as a result of the relationships we have built.

As GM considers how to take the next steps of development in response to the White Paper, we have come together to align on the arrangements that we think will be most effective in order for each of our localities, and GM as a whole, to deliver on our common goals.

Source: Developing the GM ICS (Merged PEB 23.03.21)
https://www.northerncarealliance.nhs.uk/about-us/; https://www.gmhsc.org.uk/;

Where we are on our integration journeys

Summary: whilst we are all at different stages of our integration journeys, there is much we share in common

Although our four localities have all been on distinctive and separate journeys towards making integrated care a reality for our populations (see Appendix pp.28-39), there is much commonality across the arrangements we have put in place.

In each of our localities, we have a **strategic joint commissioning board (or equivalent)** which allows Council Cabinet members and CCG Governing Body members to come together and take joint decisions about health and care. We each aspire to **devolve as much work as possible to the neighbourhood level**, with PCNs co-terminous with majority but not all of our neighbourhood footprints (a result of differing historic arrangements in each locality). We all work with the Northern Care Alliance, which provides acute and community services through its place-based **Care Organisations** (and, in Salford, also provides adult social care). In the North East Sector, we work with Pennine Care as our main mental health provider, with Greater Manchester Mental Health providing this role in Salford. In each locality we have strong relationships with a variety of VSCE organisations. In all four localities we have developed strong provider partnerships; in Salford, an Integrated Care Organisation governed through the partnership, in Rochdale a lead provider model for adults, and in Bury and Oldham we are working on the basis of an alliance model.

We all have integrated funds in place, including pooled budgets for health and care using a Section 75 agreement. In some places we treat the BCF separately because of the national reporting requirements, and in some places it is rolled into our pooled budget arrangements. We use the following common terms to define how our budget is allocated:

- **Pooled:** anything covered under S75 in formal pooling arrangements and decided jointly (Bury: £340m; Oldham: £449m; Rochdale: £402m; Salford: £424m)
- **Aligned:** anything that cannot be pooled or is not yet formally pooled but is decided jointly by the Joint Commissioning Board (or equivalent) and then signed off by the relevant organisation (Bury: £139m; Oldham: £0m; Rochdale: £110m; Salford: £182m)
- **'In view':** services or budgets which are not pooled or aligned (so are effectively independent) but for which decision making and spending is reported to the Joint Commissioning Board
- **Independent:** services which are currently separate budgets and commissioned separately by the CCG / Council respectively where the Joint Commissioning Board does not have sight routinely

We are all firmly of the belief that it is the blend of political, clinical and professional leadership that makes our collaborations a success. We are all keen to consolidate and build on what we already have in place which includes not diminishing the overall scope and breadth of our existing integration arrangements under any future proposals.

We have seen progressive benefits from our increasing levels of integration over the years

In each of our localities, we have:

- A genuine **shared and strategic vision** across partners, with **high levels of trust** and **positive relationships**
- Combined **political, clinical and executive expertise, skills and experience** – this is very powerful and, in our experience, greater than the sum of the parts
- No unilateral decisions – **we all have a voice** which means there is greater buy-in and ownership of decisions made and the impact of decisions on other parts of the system are jointly understood, owned and managed
- Greater focus together on **prevention, early intervention, tackling inequalities**, **asset based neighbourhood support**
- **Improved patient and service user experience** through more seamless services and pathways
- **Improved opportunities for engagement, co-design and co-production** with people with lived experience
- **Stronger VCSE infrastructure** and recognised value of the sector by all partners
- **Protected frontline services** through an increased ability to make the best use of limited resources – spending money smarter
- Created **efficiency savings** from joint working
- Been able to **manage peaks and troughs more effectively** through the ability to plan over a longer time period
- Benefitted from **increased flexibility to invest/disinvest disproportionately** across health and social care (to deliver outcomes)
- **Minimised financial risk** as a result of the increasing size of our pooled budget arrangements
- **Eliminated the debate** as to who should fund the “grey areas” of health and social care

We would be happy to share any of the learning from our respective journeys’ with other localities in GM and vice versa

Source: Salford’s Journey of Integrating Health and Social Care March 2021 v0.3

How we want to work in the future

Introduction

In this section, we set out our proposition for:

- The **purpose** of the different spatial levels: Neighbourhood or Locality ('Place') and GM
- The **services in scope** for the remit of the Locality and GM partnerships i.e. those services that should be **planned** at a locality level versus those services that would be better planned at a GM level
- The **services in scope** for the remit of the Local Delivery Collaboratives and GM Collaboratives i.e. those services that should be **delivered** at a locality level versus those services that would be better coordinated at GM. Our proposal recognises that some services, such as core primary care contracts, are better planned at GM level but delivered locally
- The potential to **build on existing pan-locality collaboration efforts**, to maximise the effectiveness of both planning and delivery in support of GM-wide goals
- The **role and core membership** of each of the key groups in the new system governance
- The **financial flows** from GM to locality

We also describe the **principles** we have co-developed which we have used as the basis for all of our proposals.

We intend these proposals to **feed into and contribute towards** the system design work that is ongoing at GM level.

It is important to note that these proposals represent **our thoughts at a point in time** and as such should be treated as a starter for ten. We are cognisant that **they will evolve** and be refined over time and further developments progress both within our localities and across the wider GM system.

Our emerging overarching principles have informed the development of this proposition

- A place-based approach has **people, families and communities at its heart**. We will adopt an **asset-based approach** that recognises and builds on what individuals, families and communities can achieve, encouraging behaviour change that builds independence and supports residents to be in control
- By working in partnership, we aim to **improve population health** and **reduce inequalities** in a way that has greater impact than the sum of the individual organisations
- Our approach will maximise our **contribution to local economic potential** and the role individual organisations can make to growth and an **inclusive and sustainable economy**
- **Place-based working is the cornerstone** of integrated local systems – we believe this is where most care is provided and there is greatest opportunity to improve population health outcomes. Our approach will support **primacy of place.** Neighbourhoods will be used as the building block for the integration delivery model
- There is recognition that **not everything can be planned and / or delivered at a neighbourhood or locality level** and we have decades of experience in collaborating at **GM level** to plan and deliver consistent standards of care. Decision-making should, however, be as close to the 'issue', problem or population as possible, following the **principle of subsidiarity**, with place-level decision-making putting the community served as the focus
- Whilst the flow of NHS resources will change in the new arrangements, our objective is to **generally retain and build on the scale and scope of existing place-based integrated funds**. Specifically, this will enable decisions to invest in early intervention and prevention in communities despite the time lag between that investment and the return on investment in the form of reduced demand for late intervention; and decisions to invest in improvements by organisations in one part of the system when the financial and performance benefits fall to different organisations elsewhere in the system. These are decisions that can only be taken when there are shared objectives, a long term version and trust at place level alongside the appropriate mechanisms to move resources across agency boundaries and to plan financially across multiple years. The integrated funds in localities will be **commensurate with the scope of services** coordinated and planned at that level under future arrangements. Our ultimate ambition is for resources to be allocated based on need and not adversely impact upon areas that have the greatest health inequalities
- It is essential to our success that any new structures align local leadership, combining **political, clinical and organisational** viewpoints
- We will **actively build relationships**, fostering strong relationships between organisations at all levels, and between communities and organisations. We will adopt an **uncompromising commitment to trust, honesty, collaboration, innovation and mutual support** to enable people to speak openly and free of jargon
- We recognise the **platform we have to collaborate** across our four localities and are also committed to working across other pan-locality footprints where this beneficial
- We will share our data to build a shared understanding of key issues and population needs

Source: 'Localising decision-making', Local Government Association
Developing the GM ICS (Merged PEB 23.03.21)

We started by defining the purpose of the different spatial levels in the ICS

Place (locality or neighb-ourhood)

- Use local intelligence to create a genuine shared vision by engaging and co-producing with local communities and people with lived experience
- Set the system strategy for place-based care and service reform, and agree resource allocation to deliver the outcomes for the people of the locality, as well as performance and financial ambitions
- Pool budgets and maximise use of limited resources to ensure financial sustainability, strategically overseeing joint working arrangements for the locality and all locality providers, including the integration of budgets across NHS and LA partners
- Lever the influence of wider partners on population health and wellbeing, with a focus on early intervention and prevention
- Target inequalities and promote inclusion with communities and residents, working in partnership in a way that has greater impact than the sum of the individual organisations
- Develop locality wide and neighbourhood teams, including PCN development and supporting neighbourhood working
- Ensure staff are empowered to actively shape and co-design services, increasing satisfaction and wellbeing in their roles
- Ensure the voice of place is heard in GM
- Create a system information sharing agreement to enable better information flows and joined up data for population health
- Make a positive contribution towards social and economic development

GM-wide

- Ensure a coherent strategy and manage the impact of changes across GM, ensuring the needs of the population are being met, acting as a 'sum of the parts' of all ten localities
- Secure clinical and financial sustainability across the whole of the health and social care landscape
- Streamline commissioning and set outcomes for consistent roll out across localities
- Ensure adequate funding for strategic planning to address inequalities by delegating money, responsibility and accountability to localities
- Have impact on system leadership, including national influence
- Tackle service planning where there have been resilience or safety issues, including reconfiguration of acute care at scale
- Ensure a strategic approach to securing a workforce for GM, supporting wider employment opportunities
- Maximise impact from health innovation and digital by harnessing the breakthrough opportunities of digital technology
- Further develop the partnership between the NHS, local government, universities and science and knowledge industries

Source: Workshop discussions and 'Developing the GM ICS (Merged PEB 23.03.21)'

We have aligned on an emerging proposition for the optimal scope of services under the remit of the Locality and GM partnerships (planning)

Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality							
• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Some General & Acute planned care (adults) (e.g. outpatients) • Maternity community • Paediatric outpatients	• Ambulance Services - emergency • Patient Transport
• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• Some General & Acute planned care (adults) • All planned and urgent & emergency specialised services (see Appendix p.41), including: – Major Trauma, Critical Care, Paediatric Intensive Care, NICU – Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	
GM ICS							

NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Source: Spatial level planning template returns 2021

We have also aligned on an emerging proposition for the optimal scope of services to be delivered by Local Delivery Collaboratives and coordinated by GM Collaboratives (delivery)

Public health	Primary care	Community services	Social care	Mental health	Diagnostics	Secondary / acute care	Emergency services & transport
Place i.e., Neighbourhood/Locality							
• Health Improvement Services • Lifestyle, Health Promotion & Early Detection • Family Planning, Sexual Health & Terminations of Pregnancy • Drug & Alcohol Services • VSCE Grants Programmes • Social Prescribing	• General Medical Services - additional/local schemes • General Dental Services - additional/local schemes • General Pharmaceutical Services - additional/local schemes • GP Out of Hours • GP Extended Hours	• Community - Nursing & Care, AHPs, Health Visiting, School, Family, Paediatrics • Intermediate care – Residential, Home Care • Individual Placements – CHC • Hospice Care	• Adult Social Care – Residential, Home Care, Day Care, Other • Children's Social Care	• Individual Placements - MH • CAMHS • Children's Health & Wellbeing • Community Mental Health including LD • IAPT	• Some diagnostics (e.g. X-Rays. Phlebotomy)	• General & Acute urgent & emergency care • Maternity community • Paediatric Outpatients	• Ambulance Services - emergency • Patient Transport
• Vaccination & Immunisation • Health Check Programmes	• General Medical Services - national contracts • General Dental Services - national contract • General Ophthalmic Services - national contract • General Ophthalmic Services - additional/local schemes • General Pharmaceutical Services - national contract			• Specialised services • Intensive Care • Inpatients	• Some diagnostics (e.g. ultrasound, CT, MRI)	• General & Acute planned care (adults) • All planned and urgent & emergency specialised services (see Appendix p.41), including: – Major Trauma, Critical Care, Paediatric Intensive Care, NICU – Cancer, Cardiac, Vascular, Renal, IBD, Neurosciences, Infectious Diseases, Women's & Children's • Non-specialised cancer • Maternity Units (birthing) • Paediatric admissions • NHS 111	
GM ICS							

NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Source: Spatial level planning template returns 2021

We recognise that GM already operates on a number of pan-locality footprints under current arrangements, and propose to enhance this in the context of the ICS

GM has a successful **history of working on a pan-locality basis**, particularly for acute physical and mental healthcare, with different footprints being relevant dependent on the nature of the service being planned or delivered. Examples include the provision of Major Trauma services (delivered on a GM footprint through a lead and key provider model), the configuration of high acuity and emergency General Surgery (through a sector collaboration model) and the provision of Renal services (delivered through two aligned models, covering the north and south of GM).

We believe, as part of the **new ICS construct**, we should **build on and enhance these arrangements** to drive **maximum benefits in support of GM-wide strategic goals** within the new ICS architecture. We recognise that there will be different pan-locality configurations, depending on the nature and scope of the opportunity being pursued, particularly given that each locality has a unique set of relationships based on provider footprints, patient flows and geography.

Opportunities for pan-locality collaboration (either across our four localities or in different configurations as appropriate) include:

- Making **effective use of resources**, leveraging capacity across localities – both workforce (clinical and non-clinical) and buildings
- **Identifying** and **targeting inequalities across localities**
- **Co-ordinating change and improvement programmes** that impact on more than one locality
- Developing **Single Shared Services** that ensure the sustainability and resilience of inpatient services across our shared footprint (and, where applicable, with neighbouring localities) including the delivery plan for the Pennine transaction
- **Planning acute service across the NCA footprint** (excl. complex, tertiary and quaternary) in the context of GM models of care
- Acting as a **delivery vehicle for services best delivered on a larger footprint** than locality without requiring GM level delivery
- **Co-ordinating service improvement, pathway transformation and standardisation to best practice**, with knowledge sharing and cross locality learning
- Acting as one voice to support **effective and streamlined** decision-making, leveraging **combined brainpower**

Pan-locality collaboration could support the effectiveness of both planning and delivery of services

Potential for joint planning

In exploring the opportunities, we identified that some **joint planning** could be done on pan-locality basis, such as intermediate care bedded facilities. There is also potential to consider the development of key enablers, such as workforce, IT / digital, BI functions.

Given the Northern Care Alliance is one of our shared acute providers, we think it makes sense to consider any potential site reconfiguration in the future on this footprint. Working together and planning how we use all the hospital sites within the NCA has worked well for us during Covid, allowing us to create a 'cold' site in Rochdale that can be used by each of our localities and the rest of GM. We want to explore future opportunities in this vein, making sure they work for and provide an asset for GM as well as the four of our localities.

There is also the opportunity to share best practice, standardise models and work towards consistent outcomes. We already have a five-year NCA-wide Cancer Plan in development, outlining how we will address cancer priorities, creating locality alignment and system commitment. We want to avoid unwarranted variation in services. Drug and alcohol services and sexual health services are already commissioned jointly across Bury, Oldham and Rochdale. We propose that this remains the case under the future arrangements.

Potential for joint delivery

Operating at the pan-locality level, either across specific localities or multiple providers, could also provide a good **delivery vehicle** for GM-level planning in some areas. This could include some elements of general and acute care, particularly given the NCA already delivers acute services across our combined footprint.

The main rationale for these services to be delivered at a footprint that is wider than locality is around scale and population size. There are some services which benefit from being delivered across a larger population than locality given the minimum volume thresholds to attain the highest quality, and the need to meet specific workforce standards, but should not necessarily be delivered at GM level which could cause access problems for our local populations.

Operating pan-locality could act as a vehicle for delivery of some GM-wide decisions. It could also support the delivery of other GM-wide service strategies that impact all ten localities, including future plans for mental health provision and planned care. It is recognised, however, that the footprint for pan-locality delivery will vary. For example, Salford, Bolton and Wigan have a history of close working, with a particularly strong relationship between Salford and Bolton due to population flows and previous decisions regarding the configuration of paediatric and maternity services.

There will be other opportunities for partnerships beyond our four localities, for example with Manchester or Tameside.

We have developed a governance proposition, setting out the roles of each of the key groups in the new system

GM ICS Partnership Board | GM ICS NHS Board

- Committee in Common*
- Develop and agree the overall strategy (including financial strategy) for health and care
- Develop and agree the priorities and approaches to improving population health and reducing health inequalities
- Allocate NHS funds with regard to the overall strategy for health and care and facilitate Councils and the NHS to be able to bring budgets together as part of place-based arrangements
- Drive innovation and digital best practice in health and care
- Make effective links to wider public sector services, budgets and reform e.g. OPE
- Maximise the contribution of health and care to the wider social and economic recovery from the pandemic and the wider Local Industrial Strategy, and hold NHS providers to account for the delivery of constitutional and other standards

Council

Statutory duty to provide a range of services to the community

- Represent the electorate
- Statutory duty to provide education services; children's safeguarding and social care; adult social care; waste collection; planning and housing services; road maintenance; and library services

Locality System Partnership Board (name TBD)

- Joint Committee
- Setting strategic direction for locality, form the locality's strategic relationship with GM ICS and others
- Align local organisational, political and clinical leadership
- Lead the development of a local strategy for health and care, to meet outcomes, performance and financial ambitions
- Oversee the co-ordination and transformation of local health and care services
- Strategically oversee the integrated budgets across NHS and LA
- Influence improved population health and reduction in inequalities in a way that has greater impact than the sum of the individual organisations

Clinical & professional senate

- Advisory group to Locality System Partnership Board
- Influencing policy and pathway design

Locality Integrated Delivery Collaborative

- Formal Alliance
- Oversee implementation of the strategy
- Lead strategic development of delivery arrangements within the locality, including provider evolution for partnership working and technology
- Have devolved / delegated decision making within an agreed scheme of delegation for the locality

Pan-locality Management group

NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

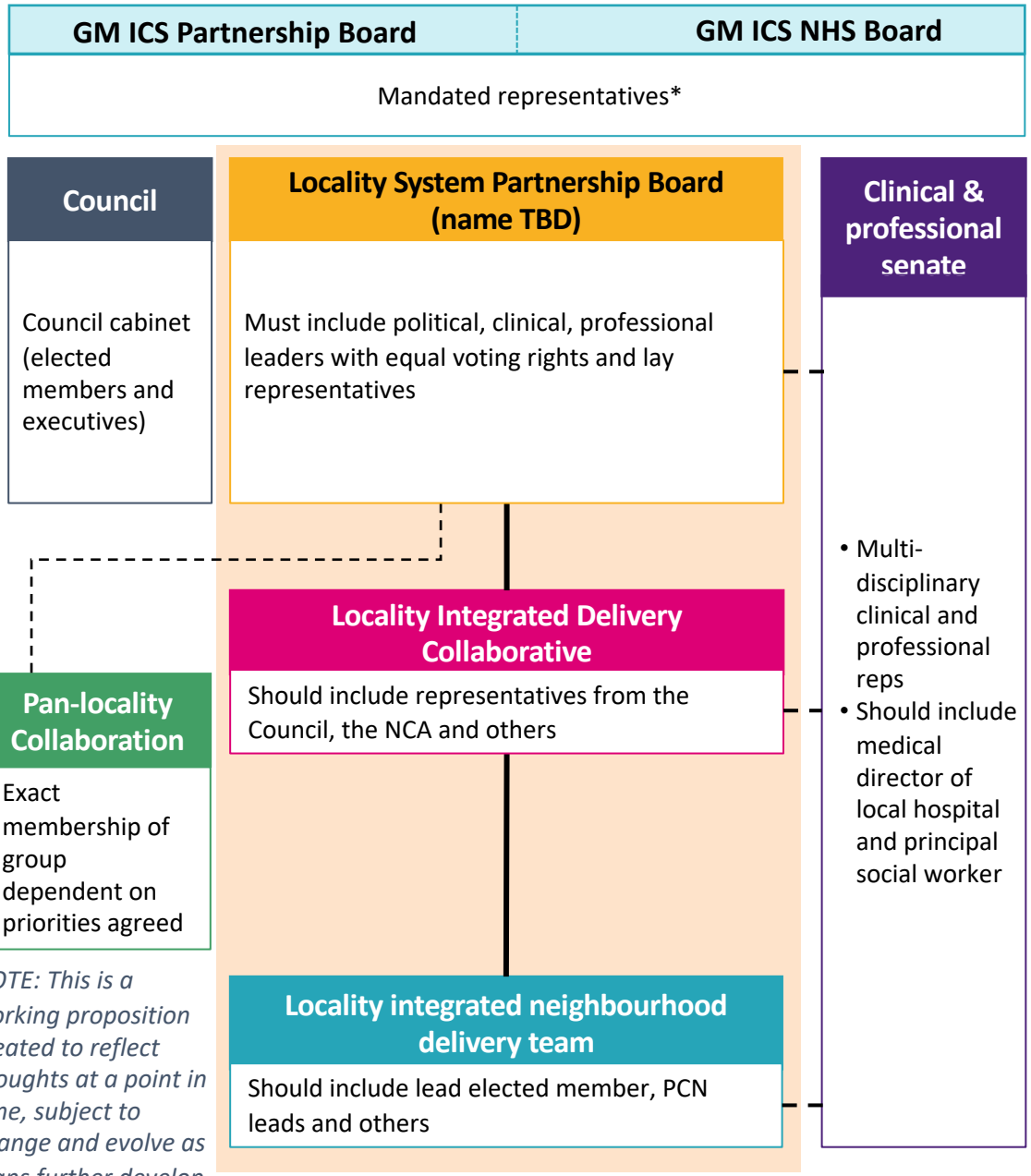
Locality integrated neighbourhood delivery team

- Sub-committee of Integrated Delivery Collaborative
- Integrated Teams delivering 'next generation' neighbourhood provision, built on PCNs and the LCO
- Bringing together wider public services and VCSE frontline staff in neighbourhoods to tackle social determinants of health outcomes (e.g. debt, social isolation and physical inactivity).
- Shared understanding of assets, risk cohorts, and priorities in each neighbourhood

- Platform for collaboration across wider footprint than locality based on common purpose and a common set of values
- Facilitates opportunity to share, learn and co-design
- Supports the identification and delivery of pan-locality transformation opportunities that have not yet been taken advantage of
- Enables a common voice within GM where this is required

* We recognise that the design of the GM-level governance will need to be discussed and resolved by parties across GM – this proposal represents our shared view

This is supplemented by a proposition for the core membership of each of the groups



NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Mandated representatives from*:
- The GM ICS
- The provider collaboratives (Provider Assembly, PBC, PFB)
- The GM Combined Authority
- The political leaders of the ten Councils
- The clinical leaders of ten Locality System Partnership Boards

- Should include representatives from the Council (adult's, children's and public health), the NHS ICS (locality leadership), the NCA, the mental health provider(s), primary care provider leadership, the VCSE, Healthwatch
- Should include at a minimum the Accountable Chief Executives or Chief Officer (NCA) of the Local Authority and statutory NHS organisations
- Should include pooled fund manager as a representative of the Finance Directors from all partners organisations
- **Each locality will supplement the proposed core membership with their own identified members**

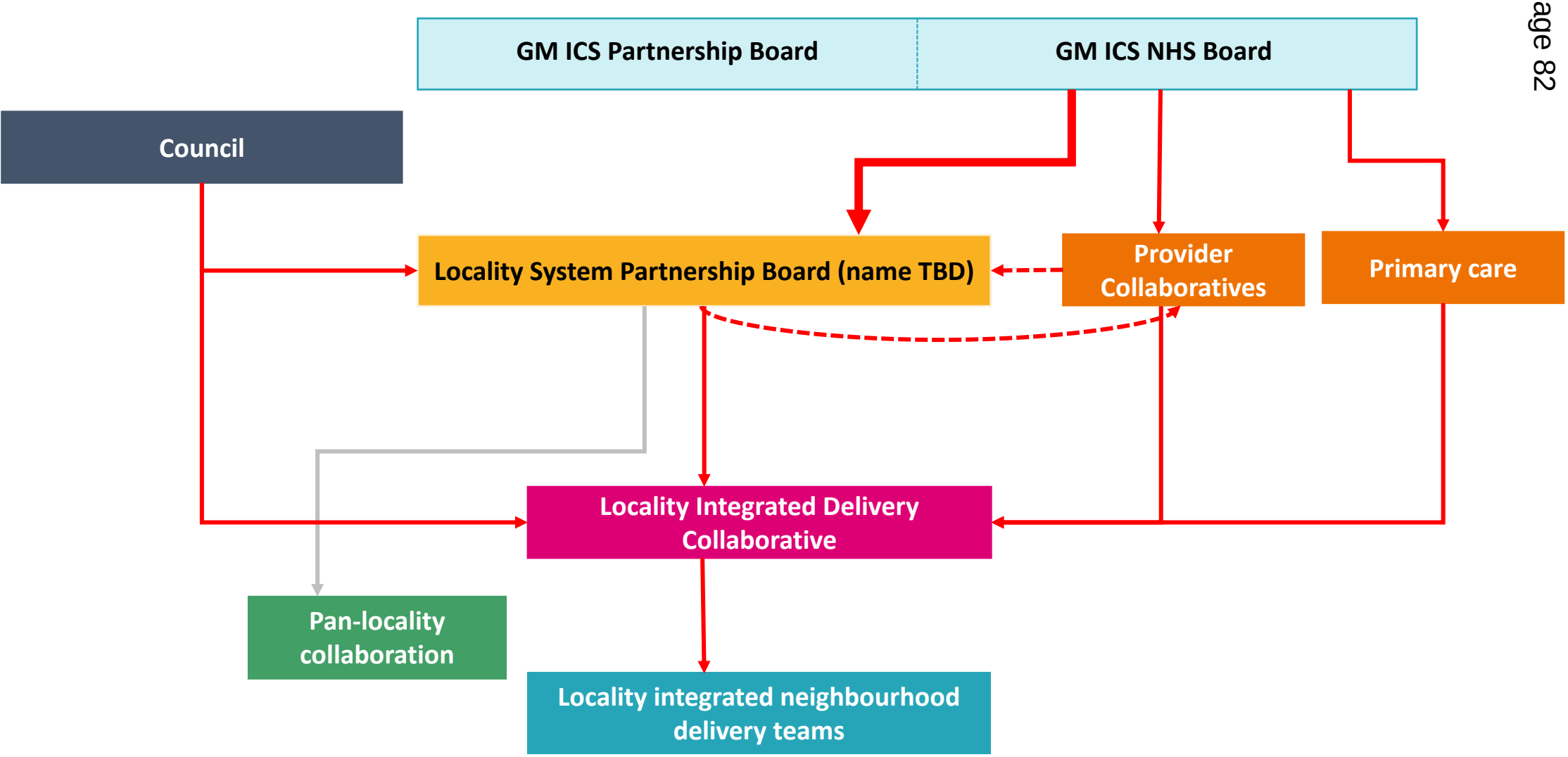
- Should include representatives from the Council (adults', children's and public health), the NCA (Care Organisation), the mental health provider, primary care, the VCSE
- Should include at least some wider public service partners (e.g. DWP, housing, fire service etc.)
- Should include Neighbourhood leads from every Neighbourhood
- **Each locality will supplement the proposed core membership with their own identified members**

- Lead elected member
- PCN lead
- Neighbourhood leadership from adults' and children's community services
- **Each locality will supplement the proposed core membership with their own identified members**

From organisations in the defined footprint:
- Chief Executives / Accountable Officers; Chief of Strategy / Directors of Strategic Commissioning or equivalent
- Local Directors of Commissioning, relevant leads from clinical and care organisations

* We recognise that the design of the GM-level governance will need to be discussed and resolved by parties across GM – this proposal represents our shared view

Funding should be delegated from the ICS NHS Board to the Locality System Partnership Board (1/2)



NOTE: This is a working proposition created to reflect thoughts at a point in time, subject to change and evolve as plans further develop

Funding should be delegated from the ICS NHS Board to the Locality System Partnership Board (2/2)

Body	Financial flows
GM ICS Partnership Board / GM ICS NHS Board	• Receives NHS budget allocation for the system • Delegates funds to localities – these should be commensurate to the scope of the Locality System Partnership Board (see p.16) • Provides some funding directly to provider collaboratives • Provides some funding directly to primary care
Council	• Councils fund the Locality System Partnership Board directly, contributing to the integrated fund for the locality • Councils can fund the Locality Integrated Delivery Collaborative directly if they choose
Locality System Partnership Board (name TBD)	• Receives funding from the GM ICS Partnership Board / GM ICS NHS Board and the Council to create an integrated fund for the locality • The integrated fund is used to fund the Locality Integrated Delivery Collaborative • The Locality System Partnership Board can decide to 'passport' some of its funding to provider collaboratives • The Locality System Partnership Board can decide to spend some of its budget on pan-locality initiatives
Provider collaboratives	• Receive funding from the GM ICS Partnership Board / GM ICS NHS Board • The provider collaboratives have a responsibility to align budgets with localities and indeed will make up part of the relevant Locality System Partnership Board membership
Primary care	• Receives funding from the GM ICS Partnership Board / GM ICS NHS Board
Locality Integrated Delivery Collaborative	• Receives funding from the the Locality System Partnership Board • Provides funding for the locality integrated neighbourhood delivery teams
Locality integrated neighbourhood delivery teams	• Receive funding from the Locality Integrated Delivery Collaborative • The ultimate aim is to work towards delegated funding at a neighbourhood level
Pan-locality collaboration	• May receive some funding from the Locality System Partnership Boards for pan-locality initiatives, but does not hold its own budget

Conclusion

Drawing on our shared principles, we believe the following proposition will best serve our local populations and a provide a proposition for GM that aligns with our ambition to facilitate delivery of health and care consistently in our localities:

- Each locality should form a **strategic partnership board between political, clinical and professional leaders** of health and care
- The board should hold an **integrated fund ,** including resources directly delegated from the GM ICS NHS Board, proportionate to cover the full scope of services as set out on p.16. This will enable decisions that can only be taken when there are shared objectives, a long term version and trust at place level alongside the appropriate mechanisms to move resources across agency boundaries and to plan financially across multiple years
- The integrated funds should build on the total budget that is **pooled or aligned** in each locality currently
- Each locality should establish an **Integrated Delivery Collaborative** as a formal alliance to include partners from the VCSE, wider public services and wider care services e.g. care homes, based on the requirements of the locality
- Provider collaboratives should be **aligned** with localities' strategic plans
- Funding should be **devolved to the Neighbourhood level** as far as possible
- **Pan-locality collaboration** (either across our four localities or in different configurations as appropriate / required) should be progressed where this delivered benefit for localities or GM or both

This would be supported by the following proposition for GM: The GM ICS NHS Board should be organised as a **Committee in Common** with the GM Partnership Board to ensure that health and care are not divided. **Each of the ten localities should be represented on the GM ICS Committee in Common** in order to reflect the interests of all places that make up GM, and not go backwards from our partnership intentions. We recognise that the design of the GM-level governance will need to be discussed and resolved by parties across GM, however this proposal represents our shared view.

Next steps

Next steps

- Refine overarching principles with all partners, including primary care and the VCSE
- Conduct further engagement e.g. with primary care providers and public health commissioners
- Work with all partners (including Councils) to refine propositions for the Neighbourhood-level, including the governance, staff and skill mix required and how this will be organised
- Further review the benefits and alternative propositions for mental health community services with relevant organisations
- Develop a proposition for how the Health and Wellbeing Boards should interact with the Locality System Partnership Boards
- Ensure leadership alignment behind this proposition (including political support)
- Identify potential challenges that need to be worked through and develop mitigating strategies recognising the specific complexities of each locality
- Share this proposition more widely with colleagues in GM
- Identify specific areas, programmes or opportunities to take forward at a pan-locality level – agree the footprint and nature of the arrangements required to do so
- Begin to implement governance proposals and establish new / amend existing governance groups as required in each locality
- Identify any capability gaps at locality level and work with GM ICS to resolve these ahead of formal transition to the new arrangements

Appendix

Transforming health and care in Bury

The refreshed Bury Locality Plan 2019 described a series of key strategic priorities; To secure a step change in Population Health and addressing health inequality , including addressing the wider determinants of population heath, To create the conditions for residents in control of their health and care, To create conditions for residents to be in control of how services are organised around them , To ensure services are delivered closer to home/in home where possible, and reduce reliance on institutional care, To Staff support front line staff in working together in 5 Neighbourhood teams in health & care, and connected to wider public services, and with communities, To secure timely and effective access pathways for more specialist health and care services

The Locality Plan 2019 was also a milestone in creating new models of partnership and collaboration in the Bury health and care system. This included a "one commissioning organization" ethos describing a series joint strategic commissioning arrangements, with joint posts, integrated teams (for example business intelligence and communications), the establishment of the Strategic Commissioning Board with a large pooled budget with S75 arrangements (including adult social care, community health services and some children's services) and all other relevant budgets are aligned or "in view".

The new partnership arrangements also included the launch n 2019 of the Bury Local Care Organisation – a formal alliance of provider partners operating as if a single provider accountable for delivering financially sustainable, joined up all age services at a neighbourhood level: The alliance included Bury Council, GP Federation, Voluntary, Community and Faith Alliance, NCA, Pennine Care, BARDOC Ltd, and Persona Care Ltd.

We have an increasing focus on neighbourhood working as a unit of delivery and common currency for service design for integrated health and care, the alignment of wider public services, and the role of community and voluntary capacity. At the neighbourhood level, community nursing, mental health, voluntary sector, pharmacy and social care work together in joined up teams. There are four Primary Care Networks, supporting resilience and service delivery for primary care.

Our well-established system partnership were relied upon through the Covid period, enabling us to increase and improve out of hospital care; urgent care, accelerated discharges, outpatients which in turn significantly reduced hospital activity to release capacity for Covid patients.

We have also continued our programme of recovery and transformational – bringing system wide focus to transforming elective care, mental health, primary care, and other important themes. And we have recast our Health and Well Being board to operate as a focal point for the population health system programme addressing wider determinants, behaviours change, community connectedness and the contribution of the health and care system to addressing health inequalities.

Case study – active case management

- Patients with long term conditions, particularly vulnerable patients and high intensity users of health and social care, can be at risk of requiring hospital care
- In 2019, Bury set up an active case management (ACM) programme, actively managing care to improve health and wellbeing, enabling patients to remain at home longer and use less reactive specialist care, using a MDT of health, social, voluntary and community professionals
- Outcomes include positive feedback from GPs, improved patient care, efficiency and money-saving for GPs (for example through referrals to Bury Council's Staying Well Team for Older People and pharmacy review), improved access to and communication between services
- ACM may have contributed to the ~~25%~~ decline in Fairfield A&E self-presenting attendances observed in Urgent care data from January 2020 to January 2021

Source: https://burylco.org.uk/wp-content/uploads/2020/11/ACM-Presentation-web-version-1.pdf; https://www.buryccg.nhs.uk/download/governing_body_papers/2017/2017-03-22/08a-Locality-Plan-2017-2021-DRAFT-v1.0.pdf

Our current integration arrangements in Bury

Council

CCG

CCG committees (finance and contract, performance)

Health and wellbeing board

- Works with partners on the wider determinants of health and wellbeing
- Includes senior leaders from Bury council, NHS, Healthwatch, GM Fire, Police, and voluntary and community sectors

Strategic commissioning board (SCB)

- Makes decisions about the priorities and money, with recovery/transformation programmes reporting in
- Includes the clinical cabinet of the CCG, political cabinet of the council, and reps from joint appointments

System board

- Drives strategy, transformation and shared commitment to the work
- Includes leaders from the council, CCG, LCO, Voluntary, Community & Faith Alliance (VCFA), Bury Care Organisation

LCO partnership board

- Drives the joined-up services in out of hospital service
- Is an independently chaired focal point for joined up working arrangements in the provision of community based health and care
- Includes leaders from the council, GP Federation, VCFA, Persona Care Ltd, NCA, BARDOC Ltd and Pennine Care

Recovery and Transformation Board

System-wide oversight of the the programme of health and care transformation

Source: 200812 Health and Care Recovery and Transformation - Overview

In Bury we have an integrated fund (pooled or aligned) of £479m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total	**340.0**	**Total**	**139.0**	**Total**	**38.6**	-	-
Total CCG contribution:	**236.9**	**Total CCG:**	**77.1**	**Total CCG:**	**38.6**		
Acute Services	83.6	Acute Services	76.6	Acute Services - Ambulance Services	8.7		
Community Health Services & Intermediate Care	34.9	Other Programme Services including transformation	0.5	Primary Care Co-Commissioning	28.9		
Continuing Care Services	20.2			Prescribing & Drugs	1.0		
Mental Health & LD Services	36.0						
Other Programme Services inc. transformation	15.8						
Prescribing & Drugs	33.5						
Primary Care Services - Other	9.3						
CCG Running Costs (including staffing)	3.8						
Total LA contribution:	**103.0**	**Total LA:**	**61.8**				
CYP**	12.5	CYP***	29.2				
Department of Operations	1.1	Department of Operations	15.1				
OCO - Adult Social Care Operations	7.6	Art Gallery & Museum	0.7				
OCO - Commissioning & Procurement	56.8	Housing General Fund	0.6				
OCO - Public Health	10.4	Business, Growth & Infrastructure	3.4				
OCO - Departmental Support Services & Workforce Modernisation	4.7	Corporate Core Services	5.6				
Corporate Core Services	7.9	Non-Service Specific	7.2				
Non-Service Specific	2.0						

Of the total CCG budget (£350m), £314m (89%) is pooled or aligned

**including Early Help & School Readiness, Social Care & Safeguarding, Education & Inclusion, Children´s Commissioning
*** including Social Care & Safeguarding and Education & Inclusion

Source: Pooled Budget Breakdown for CF Q3 SCB report (2021)
OCO: Oldham Care Organisation

Building an alliance in Oldham to enable a tailored neighbourhood approach

Oldham has a strong history of working together, a place where everyone is encouraged to do their bit to create a confident, prosperous and ambitious place to live and work. Oldham Cares was set up in 2016 as a one-system approach bringing together Oldham Council, CCG, GPs and other health and social care providers together. Oldham Cares covers all CCG commissioning, adult social care, children's services, public health, mental health and learning disabilities as well as primary, community and acute care.

The model has three interdependent goals: building thriving communities that are resilient and supported, through co-operative services which focus on delivering social value, helping work towards an inclusive economy. By working in this way, we aim to:

- Support people to be more in control of their lives
- Have a health and social care system that is geared towards wellbeing and the prevention of ill health
- Ensure good access to health services at home and in the community

Until recently Oldham was set up as an alliance of 13 different organisations but has recently moved to describe the partnership core as comprising five main entities: the Council, CCG, NCA (acute and community), the mental health trust and 5 GP networks. There is a strategic joint commissioning board with S75 arrangements in place to pool budgets between health and social care. This has enabled us to move resources around to meet urgent needs of the population, for example our discharge hub, digital hub and Emergency Department streaming. More recently, local flexibility, openness and existing integration have also enabled a faster Covid response including deployment of teams in a fast and organisational employer neutral way.

Oldham has worked hard on developing a neighbourhood approach and enabling care closer to home. Flexibility in local decision-making has enabled us to deliver a more holistic and tailored approach for the local population, for example the introduction of Oldham's Health Check which includes specific checks on diabetes and mental health, and gives patients a quick route into follow-up services. Our care delivery teams are fully integrated at PCN level.

Case study – Vaccination

- The JSNA highlights Oldham's large and growing BME communities, as well as high deprivation levels
- Insight into the population using the Thriving Communities Index has enabled risk stratification and active engagement of people least likely to take up the vaccine
- Clinical, political and community leadership have supported targeted interventions, including GPs and politicians going door-to-door, some of the UK's biggest vaccine pop-up clinics, very early vaccination of homeless people and steps to increase vaccine uptake in BME communities
- These proactive steps have resulted in Oldham's 1st vaccine uptake % being close (within 2%) to the GM average, despite Oldham's high levels of deprivation and associated barriers

Source: http://www.oldham-council.co.uk/jsna/wp-content/uploads/2018/11/Oldham_in_Profile_2019.pdf; https://www.local.gov.uk/oldham-council-and-unity-partnership

Our current integration arrangements in Oldham

Council

CCG

CCG committees (finance and contract, performance)

Health and wellbeing board

- Owner and responsible body for driving the work and priorities outlined in the Health and Wellbeing Strategy and the Oldham Locality Plan and producing the Joint Strategic Needs Assessment
- Includes CCG, local authority, housing and police representation

Strategic joint commissioning board / Commissioning partnership board

- Supported by a joint commissioning team with pooled delegated budgets through a section 75 agreement.
- Includes representation from the council (including Leader, Children's Services and Health and Social Care), CCG (including chair, clinical and financial officers)

ICO alliance board

- Oldham Cares Alliance Board operates as a joint executive management team overseeing the delivery of the alliance agreement and service transformation

In Oldham we have a total integrated fund (pooled or aligned) of £449m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total	**448.7**	-	-	**Total**	**29.0**	**Total**	**206.1**
CCG total:	**360.2**			**CCG Total:**	**29**	**CCG Total:**	**56.7**
Acute Services	194			Acute Services	18.4	Primary Care Services	12.9
Community Health Services	42.5			Acute - Emergeny Transport	10.6	Primary Care Co-Commissioning	39.5
Continuing Care Services	16.4					Running Costs	4.3
Other Programme Services	17.5						
Mental Health Services	43.9						
Prescribing	45.9						
Council Total:	**88.5**					**Council Total:**	**149.4**
						People and Place	61.3
Better Care Fund	11					Childrens Services Inc. Social Care	54.1
Community Equipment	0.7					Communities and Reform Inc. Public Health	34.3
DFG (Capital)	2.1					Commissioning	9.4
Learning Disability	18.8					Chief Execs	6.9
Mental Health	13.5					C and T	10.2
Physical Support	29.3					Community Health and Social Care	-26.8
Sensory Support	1						
Support with Memory & Cognition	3.1						
Other Adult Social Care	9						

Of the total CCG budget (£446m), £360m (81%) is pooled or aligned

All CCG budgets are Integrated Single Finance System

Source: S75 Split for Carnall Farrar 31.3.21 (2020/21)

Working together to provide the best care we can in Rochdale

We started work on integrated care in Rochdale back in 2013 due to the reconfiguration of acute care. Commissioners tendered for some out-of-hospital services, and Pennine Acute saw the opportunity to deliver both hospital and community services in a streamlined an integrated way. When the contract went live in 2015, it did so through a partnership board, with involvement of primary and mental health care, carers' services, local authority, housing, voluntary and the third sector. We were therefore already on our integration journey prior to the GM devolution deal, and we now have a mature locality system with a strong history of partnership working.

Our Integrated Commissioning Board is made up of the Local Authority and CCG, and is responsible for oversight of plans to make best use of resources in Rochdale. We have a pooled budget in place covering adult's and childrens' services, including a joint savings programme. In addition we have also established a joint LA/CCG Executive leadership team which works across the whole remit of the LA and CCG. Our Integrated Commissioning Directorate, with single leadership across the CCG and LA, has been in place for three years, further enabling the bringing together of political, clinical and managerial leadership. This integration has also allowed for more consistency across organisations e.g. Real Living Wage, sick pay, maternity leave etc.

Our Local Care Organisation was established in 2017. There is a contract in place with the LCO, with Pennine Acute as the lead provider. The LCO contract currently includes Integrated Neighbourhood Teams, Intermediate Tier of Service and primary care discretionary spend. The LCO has a partnership agreement in place which includes Primary Care, Mental health, Adult Social Care, Community and Acute Care and voluntary sector. Primary care is represented in this agreement through the GP Federation, the out of hours provider and primary care network directors.

Our plans to include the programme budget for urgent care into the LCO Contract were hampered by command and control arrangements implemented through Covid. However, as a locality we have operated as though we have contracted in this way with the LCO taking a lead on urgent care system development. An LCO Executive Leadership Group has been established which has provided a mechanism to unblock organisational barriers and implement system change quickly and effectively.

The reasoning for all these closer links across commissioners and providers is very simple: we all want to work together to provide the best care we can within the Rochdale pound for the Rochdale people, and improve their health and wellbeing. As a result, we have seen some impressive improvements. We have halved our intermediate care length of stay by changing the delivery model and supporting self-care and community resilience. Our lengths of hospital stay and delayed transfers of care are reduced and we are turning the curve compared with other areas and are managing the growth in A&E attendances.

Case study – Discharge

- Different pathways, access criteria, protocols and discharge arrangements exist across the localities
- Building on previous pilots, Rochdale's 'Discharge to Assess' scheme is fully mobilised, aiming to get people home as soon as they are fit (or to a specific Discharge to Assess bed if the patient is not ready), to reduce the number of excess bed days
- Joint working between health and care colleagues has meant Rochdale has well established and successful discharge mechanisms
- Changes in discharge arrangements have been beneficial, alongside news ways of working for neighbourhood teams and joined up communication

Source: https://improvement.nhs.uk/resources/discharge-assess-home-day/; https://www.england.nhs.uk/blog/bold-moves-towards-integrated-care/
Integrated Commissioning Board Annual Review; https://www.england.nhs.uk/blog/bold-moves-towards-integrated-care/

Our current integration arrangements in Rochdale

Council

CCG

CCG committees (finance and contract, performance)

Health Overview and Scrutiny Committee

- Reviews and scrutinises local health services and matters relating to the planning, provision and operation of local health services
- Includes Rochdale Borough Councillors

Integrated commissioning board (ICB)

- Overseeing a pooled budget and with delegated authority for all health and care spend where possible to delegate
- Includes CCG governing body members and Rochdale Borough Councillors

LCO Board

- Responsible for organising and delivering care locally for the people of Rochdale
- One Rochdale Health and Care Board includes health and care sectors, including voluntary and leaders from across the system (commissioner and provider)

Strategic Place Board

- Works with partners on the wider determinants of health, with specific focus on tackling health inequalities
- Formerly the Health and wellbeing board
- Includes local authority and CCG representatives and the local HealthWatch

Clinical and Professional Advisory Board

- Ensures clinical and professional advice is provided across the health, public health and social care agenda

Bridging team

- In place since January 2020, works across commissioning and the LCO to facilitate joint working, and has contributed to joint ownership across the system

Source: Framework partnership agreement relating to the commissioning of integrated health and social care services (S75 Pooled Budget 20202021 Final.pdf)

In Rochdale we have a total integrated fund (pooled or aligned) of £512m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total (pooled or BCF)	**401.9**	**Total***	**110.4**	-	-	**Total**	**23.7**
Total Pooled budget:	**361.7**	**Total from CCG**	**100.7**			**Total from CCG**	10.7
Acute Services	139.2	Acute Services	49.3			Ambulance Service	9.9
Learning Disability / Mental Health	66.1	Primary Care & Co Commissioning	45.9			Continuing Health Assess/Supp	0.8
Adults, Older People & Physical Disability	43.7	Core Running Costs	4.1				
Primary Care Prescribing	40.9	Other CCG	1.3				
Other Adults services	14.5						
Cared for Children and Safeguarding	30.7						
Children's Health Community Services	7.2	**Total from council**	**9.7**			**Total from council**	13.0
Other Children's services	19.4	Health Protection	0.2			Children's Social Care/Schools	13.0
		Physical Activity	0.5				
Total Better Care Fund	**32.9**	Other Public Health	1.2				
		Link4Life	2.4				
Adult Social Care**	3.0	Management and Strategy	0.2				
Public Health**	0.3	Shared Services with Bury	0.6				
Children's Social Care**	4.0	Sufficiency and Access	0.0				
		School Improvement, Org. and Personnel	0.9				
		Educational Psychology/ coordinator	0.5				
		Regional Adoption Agency	1.3				
		Public Health**	1.6				
		Children's Social Care**	0.5				

Of the total CCG budget (£385m), £374m (97%) is pooled or aligned

* planned figures for services which sit outside of the pooled budget, not under the control of the ICB. Decision making around these budgets remains with the LA or CCG

** uncontrollable budgets such as depreciation and internal recharges within the LA

Source: S75 Pooled Budget 20202021 Final.pdf; Direct communication with Jonathan Evans

Salford's journey of integrating health and care

Salford has a strong history of planning and delivering integrated health and care services, working in partnership in an ever-increasing way. Our boundaries are coterminous and we have benefited from a healthy financial position historically, placing us in an ideal position to take forward arrangements for integrated care. We are proud to have been recognised for our good practice: this includes a CCG rated outstanding for 5 years, an outstanding hospital (with a customer care focused experience), 3 outstanding GP practices and council and very good mental health services. Salford is the only area in GM with a specific care homes practice, which is run by SRFT. We also have our own local clinical assessment system (LCAS), which is flagged as gold standard within GM.

Our journey towards integration started with a shared vision: Salford people will start, live and age well . This means people in Salford will get the best start in life, will go on to have a fulfilling and productive adulthood, will be able to manage their health into their older age and die in a dignified manner in a setting of their choosing. Our aim is for people across Salford to experience health on a parallel with the "best" in GM and for the gaps between communities to be narrower than ever. Aligning around this has enabled successful interchange of views, innovation, and effective and joined-up solutions to problems.

We have had a pooled budget between the NHS and the Council since 2001 for adult learning disabilities and community equipment. We then expanded our approach to integrated commissioning and integrated resourcing to cover all of Older People's Services in 2013. In 2015, we became one of eight national Primary and Acute Care NHS England Vanguards to test new models of care. We subsequently expanded the scope of integration to all Adult services in 2016, with the provision of Adult Social Care transferring to Salford Royal Foundation Trust from the Council, integrating with community health services and establishing the Salford Integrated Care Organisation (ICO), one of the first ICOs in England (now Salford Care Organisation).

In the same year, we increased our pooled budget to over £300m, covering public health and health and care service budgets for all adults. This was then extended to children and public health in 2019, meaning we now have a single integrated health and care fund for children's, public health, adults and primary care spend. Whilst we have had an integrated commissioning team for joint decision making between the CCG and the Council in place since 2010, we have since revised our governance structures and commissioning architecture to reflect the latest Integrated Fund developments. As a result of our efforts we have seen many benefits, including a 5% reduction in A&E admissions (pre-Covid), Adult Social Care outcomes above national benchmarks, social prescribing reducing prescription medicines, rapid and significant improvement in Care Home CQC ratings.

Case study – Adult's Integrated Care programme

- Salford has had a 5-year invest to save approach to resourcing, integrated planning and delivery, investment in community support and prevention and sophistication of risk sharing arrangements in social services
- A specific initiative was Salford's Adults Integrated Care Programme (ICP), made up of 12 projects testing new ways of integrated working from 2017-2020
- Evaluation of the ICP found a reduction in non-elective admissions of 3.7%, and a reduction in A&E attendances of 0.7% (3,400 fewer per year than a comparison group). Both are signs of success across many of the 12 projects
- In addition, the ICP evaluation found examples of improvements in quality of life measures and both patient and staff experience across the 12 projects

Source: Salford's Proposed Place Based Approach
Evaluation of Salford Together: Adults Integrated Care Programme (ICP)
Salford Integrated Commissioning Partnership Agreement V1.0.pdf

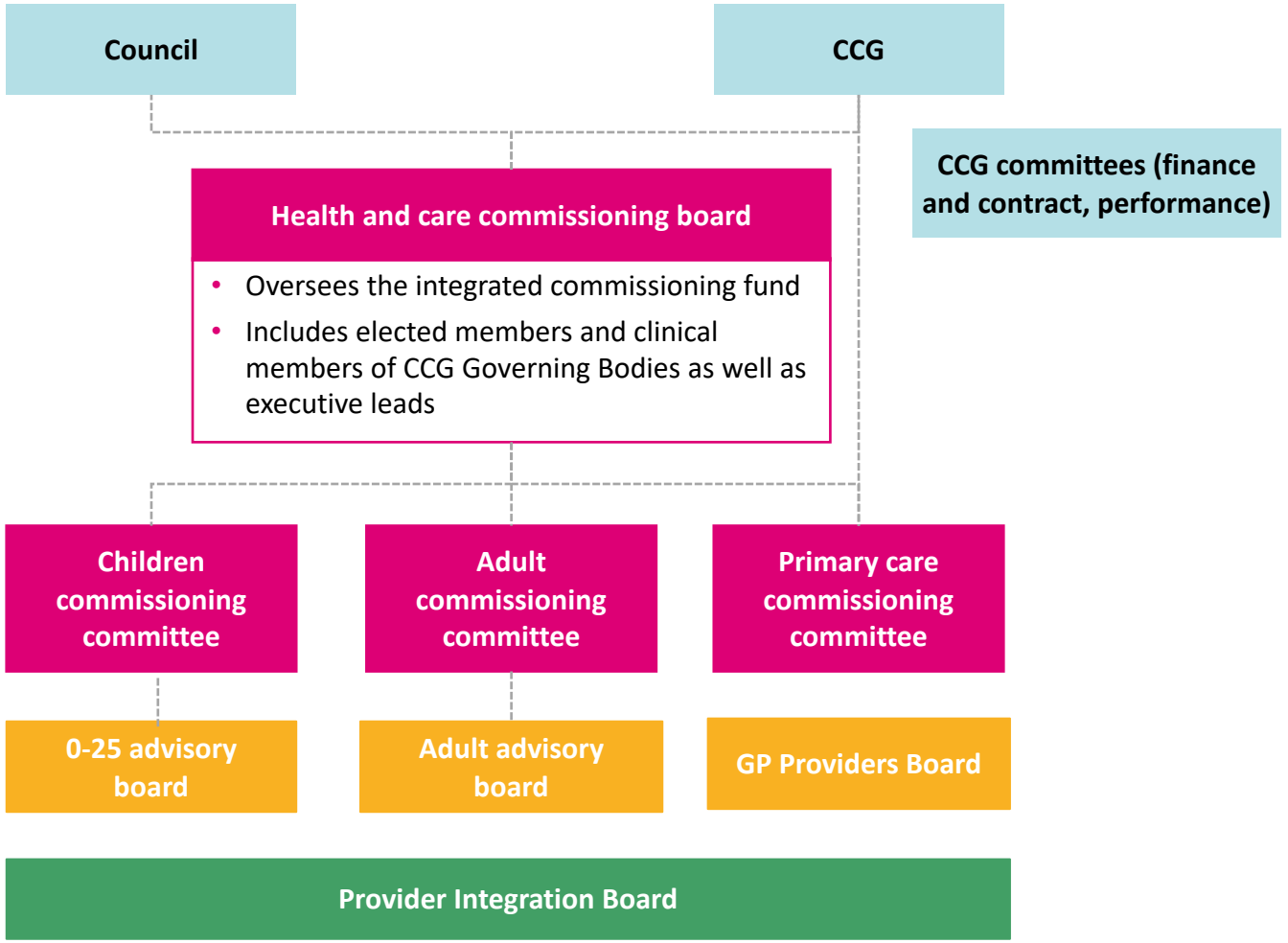
Our current integration arrangements in Salford

Health and Social Care Scrutiny Panel

- Scrutinises committees and monitors the performance of the authority and reviews policies against the strategic plan
- Includes Councillors, Healthwatch and Salford CVS representation

Health and Wellbeing board

- Works with partners on the wider determinants of health and ensures Salford has a Joint Strategic Needs Assessment
- Includes representation from the local authority, CCG, Healthwatch, Salford Primary Care Together and the voluntary sector, among others



Source: Salford Integrated Commissioning Partnership Agreement V1.0.pdf

In Salford we have an integrated fund (pooled or aligned) of £607m

POOLED	£m	ALIGNED	£m	IN VIEW	£m	INDEPENDENT	£m
Total	**424.4**	**Total***	**182.3**	**Total***	**30.8**	-	-
		*All CCG funded		*All CCG funded			
Acute services	139.0	Acute services	78.4	In view series	20		
Community services	42.5	Adults Community Services	0.1	Committed developments	4.8		
Adult Social Care	100.5	Adults Ambulance Services	10.3	Running costs	5.9		
Adults Mental health services	43.4	Adults NHS 111	0.8				
Adults Continuing Health Care & Nursing Care	6.7	Termination of Pregnancies	0.6				
Adults Public Health Services	8.4						
Adults Committed Developments	3.3	Total Primary Care:	**92.1**				
Other children's services**	89.8	Co-Commissioning	40.5				
		Locally Commissioned Services	8.0				
		Prescribing	40.9				
		Out of Hours	1.7				

Of the total CCG budget (£474m*), £443m (94%) is pooled or aligned

* Total CCG budget is the sum of the CCG funded Aligned and 'In view' services with the Total Pooled services, minus the Council income to the integrated fund. The Total Council income into the integrated fund was £163.3m (£79.8m Children's services, £83.5m Adults services)

**including Safeguarding, Looked After Children, Localities, Complex Needs SEN, Partnerships, Asset Management & Delivery, Transforming Learning, Skills & Work / Careers, Helping Families, Resources & Investment, Children's Administration, Specific Grants, PH Looked After Children (next steps post), PH 0-19 Services, Home Safety, Early Years, Youth Service, Placements/Non Contracted Activity

Source: SFG Finance Papers 2019-20 Final.xlsb (2019/2020 figures)

Note: Total Council income into the integrated fund is £163.3m (£79.8m Children's services, £83.5m Adults services)

Engagement - Interviews

Name	Role	Organisation
Dr Jeffery Schryer	Chair	Bury CCG
Will Blandamer	Executive Director for Strategic Commissioning	Bury CCG / Council
Cllr Eamonn O'Brien	Leader	Bury Council
Geoff Little	Chief Executive & Accountable Officer	Bury Council / CCG
Tyrone Roberts	Chief Officer & Nursing Director	Bury Care Organisation (NCA)
Warren Heppolette	Executive lead for Strategy & System Development	GM Health and Care Partnership
Sarah Price	Chief Officer	GM Health and Care Partnership
Neil Thwaite	Chief Executive Officer	Greater Manchester Mental Health NHS FT
Raj Jain	Chief Executive	NCA
Ian Moston	Director of Finance and Information	NCA
Judith Adams	Executive Chief Delivery Officer	NCA
Jack Sharp	Chief of Strategy	NCA
Jo Purcell	Director of Strategy	NCA
Bill McCarthy	North West Regional Director	NHS England / Improvement
Mike Barker	Strategic Director of Health and Resources & Chief Operating Officer	Oldham CCG / Council
Cllr Dr Zahid Chauhan	Cabinet Member for Health & Social Care	Oldham Council
Dr Carolyn Wilkins	Chief Executive & Accountable Officer	Oldham Council / CCG
Claire Molloy	Chief Executive Officer	Pennine Care NHS FT
Steve Taylor	Chief Officer and Managing Director	Rochdale Care Organisation – NCA
Chris Duffy	Clinical Chair	Rochdale CCG
Claire Richardson	Director of Strategic Commissioning & DASS	Rochdale CCG / Council
Cllr Allen Brett	Leader of Council	Rochdale Council
Cllr Daalat Ali	Lead member for Health	Rochdale Council
Steve Rumbelow	Chief Executive Officer / Accountable Officer	Rochdale Council / CCG
Karen Proctor	Director of Commissioning	Salford CCG
Dr Tom Tasker	Chair	Salford CCG
Steve Dixon	Accountable Officer	Salford CCG
Cllr John Merry	Deputy City Mabyor	Salford City Council
Tom Stannard	Chief Executive	Salford City Council
Dr Peter Turkington	Chief Officer and Medical Director	Salford Care Organisation (NCA)
David Jago	Chief Officer & Finance Director	Salford Care Organisation (NCA)

Engagement – Workshops and meetings

Workshop	Date	Attendees
Initial locality proposition development session	15/03/2021	Jack Sharp, Jo Purcell, Karen Proctor, Will Blandamer, Mike Barker, Claire Richardson
Bury	23/03/2021	Geoff Little, Cllr Eamonn O'Brien, Dr Jeffrey Schryer, Will Blandamer, Pat Crawford, Lisa Kitto, Kath Wynne Jones, Julie Gonda
Oldham	17/03/2021	Mike Barker, Bal Duper, Dale Phillipson, David Jago, Elizabeth Foster, Ben Galbraith, Karl Dean, Julia Veall, Karen Maneely, Mark Warren, Salim Mohammad, Rebekah Sutcliffe, Claire Smith, Tamara Zatman
Rochdale	19/03/2021	Steve Rumbelow, Claire Richardson, Cllr Daalat Ali, Dr Bodrul Alam
Salford	18/03/2021	Dr Tom Tasker, Paul Dennett, Karen Proctor, Charlotte Ramsden, Tom Stannard, Muna Abdelzaziz, Cllr Merry, Raj Jain, Dr Peter Turkington, Alison Page, Neil Thwaite, Cllr Reynolds, Gillian McLaughlan
Locality proposition refinement session	24/03/2021	Raj Jain, Dr Carolyn Wilkins, Steve Rumbelow, Tom Stannard, Steve Dixon, Jack Sharp, Jo Purcell, Karen Proctor, Will Blandamer, Mike Barker, Claire Richardson

Finance mtg	Date	Attendees
Bury	22/03/2021	Carol Shannon-Jarvis, Lisa Kitto, Sam Evans, Pat Crawford, Simon O'Hare
Oldham	19/03/2021	Alistair Ross, Ben Galbraith, Amanda Fox
Rochdale	17/03/2021	Sam Evans, Jonathan Evans
Salford	22/03/2021	Phil Kemp

In addition, representatives from each locality and the NCA (Mike Barker, Will Blandamer, Karen Proctor, Jo Purcell, Claire Richardson, Jack Sharp) have met on a weekly basis as a task and finish group to oversee the development of this work.

Detail of specialised services to be planned at the GM level

NHS England

GM: Devolved Specialised Services

Internal Medicine	Cancer	Blood & Infection	Trauma	Women's & Children's	Mental Health (from April 2018)
Cardiac Surgery Cardiac ICD/CRT Cardiac MRI Cardiac EP and Ablation Cardiac PPCI Vascular Surgery Complex IBD Faecal Incontinence TEMS Surgery Acute Kidney Injury Renal Dialysis	OG Cancer Kidney Bladder Prostate Cancer Chemotherapy (Adult) PET-CT Head & Neck Cancer Thoracic Surgery	HIV (Adult) Specialised Immunology Specialised Allergy	Specialised Rehab Neurosurgery (Adult) Specialised Neurosciences Specialised Orthopaedics Specialised Ophthalmology Complex Spinal Surgery Major Trauma Implantable Hearing Aids (BAHA)	Paed Rheumatology Paed Endocrinology & Diabetes Paed Respiratory Paed Allergy Neonatal Critical Care Gynae: Endometriosis Gynae: Urogenital/Anorectal Gynae: Incontinence/Prolapse Gynae: Cancer	**CAMHS Tier 4 General Adolescent** **CAMHS Tier 4 Eating Disorders** **Adult Inpatient Eating Disorders** **Specialised Perinatal Mental Health – Mother and Baby Unit** **Low Secure Mental Health** **Low Secure and Forensic Support Team Services - Learning Disabilities**

Key:
•New Specialised Mental Health Services added to the GM Devolution Portfolio From April 2018

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Agenda Item 7

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Approve
Item No	7	**Confidential / Freedom of Information Status**	No
Title	Radcliffe Strategic Regeneration Framework		
Presented By	Geoff Little - Accountable Officer Bury CCG and Chief Executive, Bury Council		
Author	Paul Lakin – Director - Business Growth and Infrastructure		
Clinical Lead	TBC		
Council Lead	Cllr O Brien		

Executive Summary

The SCB is committed to addressing population health and health inequalities, and recognises the importance of the wider determinants of health alongside issues around the operation of the health and care system.

This paper provides an overview of a key Council priority on the regeneration of Radcliffe – coordinated through the Radcliffe Strategic Regeneration Framework and its nine key priorities. The paper also highlights the opportunity of securing funding to support this ambition through the Levelling Up fund.

Recommendations

The SCB is invited to reflect on the work, to note the opportunity of the hub in the town and the ambition to use the hub to influence the regeneration of the town, and to support the ambition of the SRF in contributing to improved population health and well-being and reduced inequalities.

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.
Key link to the delivery of the Bury 2030 strategy and 'Let's Do It'	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☒	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk	Yes	☐	No	☒	N/A	☐

Implications						
Register?						
Additional details						

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

1. Introduction

This paper is designed to consider how the Council, the CCG and other key public services could work together to improve health, employment and education outcomes in our key Towns. There is a strong case to focus on Radcliffe which is the most deprived town in the Borough. The recent publication of a Strategic Regeneration framework brings a focus on the key physical, economic, social and environmental changes that are proposed for the Town. As key partners we need to work alongside this framework to ensure that an equal effort is put into closing key education, health and employment outcomes.

2. Background

The town of Radcliffe suffers from a higher level of deprivation that any other part of the Borough of Bury. This means that across the board from household income levels, worklessness, poor health and education attainment it lags-behind other areas. This has a real impact of life chances and outcomes for people from the town.

To tackle the problems the town faces the Council published a 'Strategic Regeneration Framework' which was approved by Cabinet in October 2020. It identifies a series of proposed interventions designed to improve the Town. The primary focus of the SRF is the Town Centre, which is exhibiting signs of long-term decline with a limited shopping offer, minimal civic amenity and night-time offer.

The Strategic Regeneration Framework identified nine objectives:

- **A unique town centre** – To enhance positive existing town centre assets, and to encourage a focussed retail strategy, which attracts in high quality retail and diversifies the town centre by encouraging new uses to encourage the evening and night-time economy.
- **A distinctive town** – To use Radcliffe's industrial heritage as the starting point for guidelines for the design of new buildings within the town, to preserve existing high quality heritage assets, and ensure the town centre is safe and accessible to all.

- **A town built on the river** – To celebrate Radcliffe's key natural asset: its situation on the river Irwell.
- **A town that promotes health and wellbeing** – To ensure that Radcliffe builds upon the ambitions set out in the Bury Strategy 2030 to address health inequalities and improve health outcomes for residents, and to increase accessibility to leisure facilities, green space, and the blue network.
- **A town for learning** – To provide new educational facilities for Radcliffe through the new high school at Coney Green, and to encourage adult learning and re-skilling across the town.
- **A town that encourages creativity** – To encourage small and medium size entrepreneurs to set up and flourish in Radcliffe.
- **A town to live** – To introduce new and innovative housing to cater to the needs of all Radcliffe residents.
- **A sustainable town** – To ensure that Radcliffe is carbon neutral by 2030, to encourage active travel and sustainable development, to ensure all new development is zero carbon, and to integrate green infrastructure into proposals where possible.

The need to move towards implementing the SRF has led to the prioritisation of a bid to the Governments 'Levelling-Up' fund (details in section 3).

The regeneration plans will improve the physical appearance and functionality of the town centre, they will help breathe new life into the town and will help deliver new housing development which in-turn will reinforce the viability of the town centre. However, to be successful the plans for the physical regeneration must also include an ambition by the key public partners to work together to improve the lives of people already resident in the town.

The public health data demonstrates that compared to both the rest of the Borough and against England averages:

- There is a higher level of income deprivation
- There are more households living in poverty
- There are more older people living in poverty
- There is a lower level of educational attainment

It is not right or equitable that people should suffer from worse life outcomes because of the town in which they live.

The challenge for the regeneration programmes is to work creatively to develop local policy responses and approaches that can meaningfully bridge the gaps that exist between Radcliffe and the rest of Bury and England as a whole.

3. The Levelling-UP Fund

The Levelling-Up is the Governments main intervention programme to fund projects in areas of England that are lagging-behind the most prosperous. Bury Council is

submitting two proposals, one for Bury Town Centre and another for Radcliffe.

The proposals for developing amenities in Radcliffe are being scoped and designed to focus on a newly positioned town centre; including at its heart a Public Services Hub where a civic core will sit alongside leisure, library, flexible workspace and consolidated retail. The Hub will function as a collaborative space that facilitates improved delivery of public facing services and supports business growth within the town centre. The development site includes state-of-the-art new-build accommodation and refurbishment of the existing Market Chambers; complimented and supported by improved public realm and connectivity with public transport as well as green and blue infrastructure.

Work is currently underway to produce a business case for the project in line with the Government guidelines; ensuring that the proposals are focused upon strategic alignment and a strong case for change; that the development will deliver an optimum solution that represents value for money; and that the project can be realised within the required parameters of cost, time, and quality outputs.

Once completed, the business case will form the basis of a bid to the Government's Levelling Up Fund. The Fund is available for projects requiring up to £20m of funding, focusing on projects that deliver visible change including (i) small transport projects, (ii) regeneration and town centre investment and (iii) cultural investment.

The Fund is operated on a competitive basis; considering the priority category of the borough, deliverability, strategic fit and value for money realised by the project. As outlined in the 2021 Budget announcement, Bury has been designated within highest priority category to potentially receive funding, and the Council is committed to aligning the project programme to a commencement date within 2021/22 and completing by 2024.

Bids must be submitted by 18th June 2021 and a decision is expected in the Autumn 2021.

4 Governance

The Council has established robust governance structure to ensure that there are clear roles and responsibilities for oversight and delivery of the Radcliffe SRF, and to ensure that proposals receive feedback from a wide cross section of Radcliffe stakeholders. Each tier in the hierarchy has a clear terms of reference and division of responsibilities to enable the delivery of the SRF and other regeneration initiatives that may emerge over time.

The governance structure is based on similar examples from other Local Authorities who have successfully bid for recent regenerations monies from central government, and includes:

The **Radcliffe Regeneration Advisory Group** which is a forum for community group and business representatives to provide feedback and give recommendations on the SRF's proposals. The Advisory Group's membership

includes all Radcliffe Ward Members, key Council officers, and representatives from numerous community groups and businesses.

The **Radcliffe Cabinet Committee**, which provides leadership for the delivery of the SRF and fosters cross party engagement. The RCC meets every two months to monitor progress in delivering the SRF, and to make recommendations to Cabinet in relation to investment decisions. Membership to the group includes: the Council Leader with two Cabinet Members with voting rights plus four Ward Councillors (two Labour and one each from Conservative and Radcliffe First).

The **Radcliffe Regeneration Delivery Board**, which provides expert oversight, monitors and shapes the direction of the SRF's projects. It also seeks out opportunities for securing public and private funding to support delivery of the SRF programme. The group is chaired by Sir Howard Bernstein and includes Christian Wakeford MP, the Leader of the Council, the Council CEO, and senior staff from the Council, Transport for Greater Manchester, and the Greater Manchester Combined Authority.

The **Programme Management Office**, the "engine room" of the SRF, leading on the day-to-day development and delivery of the SRF's projects.

5 Measuring the progress

5.1 The proposals for the Levelling-Up fund will require the development of an evaluation framework. This is required by Government to assess the both the direct impacts of the investment made via the planned interventions but also the wider impacts of the investment that can be measured.

5.2 As the Council seeks to further deepen our engagement and involvement in the Town through a multi-agency approach it will be important that there is an effective baselining of the current metrics around indicators such as educational performance, life expectancy, other key health indicators and economic participation so that the impact of different interventions and public policy approaches can be measured.

6 Lessons from Radcliffe for the rest of the Borough

6.1 There is an opportunity to develop more comprehensive strategies connecting the diversification and development of town centres to better lives for people in the surrounding neighbourhoods.

6.2 The challenges are different in each of the key Towns in the Borough. The use of effective baselining of data and the capability to analyse it to the point that effective public health, education and community participation policy responses can be formulated.

6.3 For example, the data in Radcliffe demonstrates a multi-agency and likely comprehensive approach will be required to tackle the multiple causes of deprivation. In other towns it may be that a more focused or narrow approach may be more appropriate, if key indicators suggest that there are more specific and less general

challenges.

6.4 There is broad recognition that national public health campaigns must be augmented at a local level if they are to succeed. This requires local partners to design different and often unique approaches to meet the challenges of poor health, by designing new models of delivery and promoting effective cross-organisation interventions.

7 Actions Required

The Strategic Regeneration Framework for Radcliffe, and the opportunities of the well-being hub and wider levelling up fund investment in the borough connect to the strategic objectives in health and care on multiple levels, and there are opportunities to connect to and shape the work.

- Opportunities to explore the co-location of health and care services in a well-being hub, reflective of the further development of the integrated neighbourhood team working in Radcliffe already in place.

- Opportunities to strengthen the connection of the integrated neighbourhood team for health and care with other public service delivery on the same footprint – recognizing that partners such as housing GMP, DWP etc. have a major impact on population health and well-being.

- Ensuring that the focus of any hub building isn't only on the co-location of public services but is on an outward facing and community orientated space where communities can connect with each. Connecting residents to each other and their communities is a cornerstone of the transformation in adult social care and in other aspects of health and care services.

- Ensuring that the regeneration framework for Radcliffe 'builds in' opportunities to promote health and wellbeing – for example in access to green and blue space, in promoting physical activity, and in creating spaces for communities to connect and own and be in control of.

- To explore the opportunities of the regeneration around new models of housing provision necessary to respond to future demand – where housing promotes independence and well-being and connectedness for residents who may otherwise use institutional care.

Geoff Little
Accountable Officer
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April 2021

Version 4
- Adds WB edits

Version 5
- Adds GL final edits

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Agenda Item 8

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Approve
Item No	8	**Confidential / Freedom of Information Status**	No
Title	Bury Mental Health Urgent and Emergency Care by Appointment Service – Evaluation Report		
Presented By	Julie Gonda - Director of Community Commissioning (DASS)		
Author	Kez Hayat – Programme Manager Nasima Begum – Commissioning Manager		
Clinical Lead	Daniel Cooke		
Council Lead	Councilor Andrea Simpson		

Executive Summary

This report is seeking approval for the Pennine Care Foundation Trust (PCFT) Urgent and Emergency Care by Appointment Mental Health pre-ED streaming service to continue at Fairfield General Hospital. This is a Greater Manchester Urgent Emergency Care (GMUEC) by Appointment programme which describes having a pre-ED streaming/triage model across GM hospital sites. The aims are to successfully, and safely, deflect patients away from the ED if they can be more appropriately treated in an alternative clinical environment.

This project was supported by Strategic Commissioning Board (SCB) in October 2020 to be piloted for 6 months from the GM Winter Pressure funding and an evaluation to be brought back in March 2021 to SCB.

The UEC by Appointment streaming started from 23 November 2020 at FGH and the service is operational 7 days per week from 8am – 9pm. The UECA receives referrals from:

- A&E Mental Health Liaison Teams (Currently FGH & Oldham Royal Infirmary)
- GM CAS via Adastra
- PCFT 24 Hour Helpline
- GP's

The service aims to provide urgent appointments for people with mental health needs who would have otherwise accessed urgent care services at the Emergency Department (ED), contacted NHS 111 or been directed to an ED by their GP in crisis.

These people generally present in a self-defined crisis and require access to an urgent mental health assessment but not necessarily in an ED environment. The service aims to provide an urgent mental health assessment within 24-72 hours to determine the persons mental health needs thereafter.

Executive Summary
UEC by Appointment was operational from the 4/11/20. Throughout November 2020 the UECA diverted a total of 100 people with data collected for 32 of the cases referred. The demand within urgent care services due to the COVID 19 pandemic has increased the need to divert people from ED's to reduce the risks relating to cross infection and contribute to work of the wider system to maximize capacity within urgent care. The SCB to be aware that whilst the board is considering a decision in April 2021, the project was only funded out of non-recurrent GM winter pressures monies until 31st March 2021. Due to a time lag to get a decision to the Provider before the 31st March 2021, this project has been extended for another month taking this to 30th April 2021, the provider agreed to pick up the cost of £22,603 for the additional month. The cost to continue the UECA service for a further 12 months t is £271,233.
Recommendations
It is recommended that the Strategic Commissioning Board: • Note the content of the evaluation report demonstrating the rate of deflection away from A&E which is proving to have a positive impact for both patients and services. • Approve 12 month funding of £271,233 for the continuation of the UEC by Appointment service. • Be aware that this will form part of the wider development of mental health 24/7 crisis offer in Bury and contribute to the front end Urgent Care redesign at Fairfield hospital.

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	Yes	☐	No	☒	N/A	☐

Implications						
from the proposal or decision being requested?						
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☒	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
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: Attached in Appendix 2						
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	
	implications.

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

Bury Urgent and Emergency Care by Appointment – Evaluation Report

1. Introduction

1.1. The Urgent & Emergency Care by Appointment (UECA) focuses on the pre-Emergency Department (attendance and admission avoidance) element of the pathway to help safely reduce hospital attendances and admissions. The purpose of this report is to highlight the impact of UECA at A&E front door pilot and request approval for a further 12 month funding for pre-ED streaming for mental health to continue at Fairfield General Hospital (FGH).

1.2. The Mental Health Streaming in the ED department is part of a wider Greater Manchester Urgent Emergency Care (GMUEC) by Appointment programme which describes having a pre-ED streaming/triage model across GM hospital sites with the benefits of being able to successfully, and safely, deflect patients away from the ED if they can be more appropriately treated in an alternative clinical environment.

1.3. Attached is the evaluation report (Appendix 1) with details demonstrating the effectiveness of the mental health UECA service in FGH from the 23 November 2020 until February 2021.

2. Background

2.1. There is recognition that improvement of the urgent and emergency care system is a major priority, both nationally and across GM, and that the reasons for the strain on the emergency care system are complex. In September 2020 Pennine Care Foundation Trust (PCFT) were asked to develop and provide an alternative mental health assessment pathway to support the wider streaming redesign for the FGH A&E site

2.2. The service aims to provide urgent appointments for people with mental health needs who would have otherwise accessed urgent care services at the Emergency Department (ED), contacted NHS 111 or been directed to an ED by their GP in crisis. The aim is to provide an urgent mental health assessment within 24-72 hours to determine the persons mental health needs thereafter.

2.3. The service is delivered between 8am to 9pm, 7 days a week, from the PCFT North Division, with the following staffing:

- Band 6 Nurses – Mental Health Practitioner
- Administrator
- Band 7 Management

2.4. The UECA receives referrals from:

- A&E Mental Health Liaison Teams (Currently FGH & Oldham Royal Infirmary)
- GM Clinical Assessment Service via Adastra
- PCFT 24 Hour Helpline
- GP's

2.5. The UECA service works in collaboration with PCFT services to ensure that patients have access to the right care. Following a psychosocial needs, and risk management assessment, a plan is agreed with the patient, and the UECA service will refer and/or signpost the patient to services within the borough. Patients will be referred to a variety of services including, Integrated Neighborhood Teams (INT's), 3rd Sector Services, Primary and Secondary care. Key interfaces for UECA are the Mental Health Liaison Team (MHLT) and the Access and Crisis team. MHLT provide clinical streaming for people who present to the ED who can be safely diverted to the UECA. Additionally, where a person is thought to be at risk the service will link and refer into safeguarding teams across the Bury system.

2.6. It is important to acknowledge that the urgent care system must be seen within the context of the new crisis care models evolving within and across localities, these will have a direct impact on crisis provision to deliver a comprehensive crisis pathway across Pennine Care footprint that meets the expectations for MH as outlined in the NHS Five Year Forward View and Long Term Plan (2019).

3. Urgent and Emergency Care pre-ED streaming pathway

3.1. The UECA service has been working in collaboration with the Bury Access and Crisis Service and Mental Health Liaison to meet the demands or urgent mental health referrals received via Primary Care. The majority of diverted cases originated in primary care where the GP felt that, due to the mental health presentation and associated risks, the person required an urgent mental health assessment.

3.2. In all the cases referred, UECA has successfully offered that urgent assessment or triaged with the primary care practitioner to offer an alternative assessment option to what would have resulted in a presentation to the ED. The detail of the referral pathways from a GP to UECA are as follows: Where a GP contacts the Access and Crisis Team requesting an urgent mental health assessment, patient's details and presenting complaints are obtained and contact is made with the patient within 2 hours. A telephone triage is completed to review current presentation and associated risks and an assessment is booked into the UEC for assessment in 24-72 hours if clinically indicated.

3.3. Improvement of the urgent and emergency care system is one of the major NHS priorities; the national A&E Improvement Plan proposes specific, mandated improvement Initiatives that all systems must implement. One of the mandated initiatives is ***Streaming at the front door – to ambulatory and primary care within the department.***

3.4 The NHS Long Term Plan (LTP) has committed to improving and widening access to care for children and adults needing mental health support. One of the key aims being to "Make it easier and quicker for people of all ages to receive mental health crisis care, around the clock, 365 days a year, including through NHS 111"

3.5 The GM MH Crisis model has taken the LTP commitments and identified the following priorities in relation to crisis and acute mental health:

- 24/7 Open Access Crisis Lines
- Home Based Treatment Teams resourced to core fidelity
- A&E/Liaison MH in Acute Hospitals meeting 'Core 241 standards for adults
- All age A&E/Liaison in Acute Hospitals
- MH Urgent Care Centres adjacent to Acute Hospital A&E

3.6 The UEC by appointment service contributes to meeting the national, GM and local priorities in relation to A&E improvement as well as a MH crisis offer.

3.7 The UEC by appointment service will help support individuals when they are most vulnerable and in need of care and will also have a positive impact on alleviating some of the pressures that other parts of the system such as Primary Care, Physical health, Police and universal MH services are experiencing.

3.2. The UEC by appointment service will form part of a seamless 24/7 MH crisis pathway in Bury linking into crisis offers within neighborhoods that are delivered in conjunction with VCF partners.

3.2. The 12 month costs of the UEC by appointment service are £271,233 and will be funded from Bury CCG's baseline MH funding and form part of Bury's commitment against the Mental Health Investment Standard in 2021/22.

Urgent and emergency care by appointment	WTE	21/22
Team Manager	0.40	21,283
MH Practitioner	4.00	171,556
Admin	1.00	25,708
Non Pay		15,927
Estate Contribution		nil
Corporate clinical delivery support costs and Surplus		33,409
CQUIN		3,349
Total		**271,233**

4 Associated Risks & Benefits

4.1. This service meets the national GM requirements and local priorities in relation to A&E, 24/7 MH Crisis offer and Bury Urgent Care Redesign and would result in potential organizational and reputational risks if it was not implemented.

4.2. The pre-ED triage/streaming allows non-urgent patient to be diverted away from A&E which reduces the risk of ED being overwhelmed and potential risk of transmitting COVID 19.

4.3. Without any triage at Urgent Care front door could potentially lead to more people in A&E waiting to be seen and breaching national waiting time targets.

4.4. Not all patients accessing ED need full mental health assessment and could be waiting a long time and disengage from services resulting in poor outcomes and potential presentations and pressures in other parts of the local health and care system and wider public sector

4.4. The evaluation report demonstrates the effectiveness of having pre-ED triage in diverting people to more appropriate services resulting in the right care at the right time to not only deal with the immediate crisis but also work with partners to manage the underlying causes of MH crisis in order to mitigate relapse.

4.5 The service offers the potential for financial efficiencies to be realised in the urgent care, MH and wider Bury system

4.6. The UEC by appointment is one of a number of services that has been identified as part of the 2021/22 MH investment priorities and there is some risk that Bury's 2021/22 MH funding allocation may not be sufficient to progress the other MH priorities identified at the pace required.

5 Recommendations

5.1 The Strategic Commissioning Board is recommended to:

- Note the content of this report alongside the evaluation report detailing the impact of the UECA pilot over the last 4 months.
- Approve funding of £271, 233 for a further 12 months to allow UEC by Appointment service to continue at FGH site.
- The service to continue ongoing monitoring and evaluation of the impact on deflections from UEC and patient outcomes.
- Support the ongoing development of designing, delivering comprehensive and accessible local crisis pathways for Bury in line with National and local priorities.

Nasima Begum
Commissioning Manager
Nasimabegum@nhs.net
March 2021

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:	Nasima Begum (Commissioning Manager)
2	Directorate/ Corporate Area	Commissioning
3	Head of or Director (as appropriate):	Julie Gonda (Director of Community Commissioning)
4	Who is the EA for?	NHS Bury CCG
4.1	Name of Other organisation if appropriate	Pennine Care Foundation Trust
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.	This is continuation of The Urgent and Emergency Care (UEC) by Appointment model in Fairfield Genral Hospital. This is having a pre-ED streaming/triage model Fairfield Genral Hospital Site with the benefits of being able to successfully, and safely, deflect patients away from the ED if they can be more appropriately treated in an alternative clinical environment. This started in December 2020 and have showed to have positive impact on patients and services. The concept of Triage would mean a wider Multidisciplinary team to support initial assessment and sign posting. This would bring added benefits for mental health patients during a crisis to ensure that a Multi-Disciplinary Team response is provided alongside Acute physical health.
6	Why is it needed? Please give a brief description of the activity.	This is a requirement of Greater Manchester UEC by Appointment model. A Mental Health Urgent care team will provide urgent support outside of A&E to prevent unnecessary attendance and admission into acute services and urgent care streaming for those

		patients who do not need immediate Mental Health intervention. This Business case focuses the Mental Health input at front door. For mental health, the streaming function would have: • additional nurses who would be able to provide more appointment sessions and assessment and follow up appointments per week in each Borough • Develop a close working relationship with the community safe haven as another divert opportunity • The service in each borough would offer assessments to the patients on the wards who have not self-harmed and could in HMR offer support to the ACU for mental health and age related assessments this would allow the Liaison Mental Health to respond to the Emergency Department, Urgent Care Centre (UTC) and future Urgent Treatment Centre in a more timely manner • Following robust triage/screening the service will accept referrals from GM and Locality Clinical Assessment Service (CAS) teams, the Pennine Care 24/7 Helpline, the Liaison Mental Health team, the front door at A&E, the UCC and the new UTC being developed in Bury. This will enable a reduction in the presentation at the urgent and emergency care services.
7	What are the intended outcomes of the activity?	The UEC by Appointment streaming started from 23 November 2020 at FGH and service is operational 7 days per week from 8am – 9pm. The UECA receives referrals from: A&E Mental Health Liaison Teams (Currently FGH & Oldham Royal Infirmary) GMCAS via Adastra PCFT 24 Hour Helpline GP's The service aims to provide urgent appointments for people with mental health needs who would have otherwise accessed urgent care services at the

		Emergency Department (ED), contacted NHS 111 or been directed to an ED by their GP in crisis. These people generally present in a self-defined crisis and require access to an urgent mental health assessment but not necessarily in an ED environment. The service aims to provide an urgent mental health assessment within 24-72 hours to determine the persons mental health needs thereafter.
8	Date of completion of analysis (and date of implementation if different). Please explain any difference	Date of completion of EIA: 18th March 2021 Implementation date: April 2021
9	Who does it affect?	All patients coming through to A&E front door.

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 Mental Health patients, vulnerable adults and their families should be streamed prior to Emergency Department registration in an accessible compassionate and safe way. This will eliminate any unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010
	To advance equality of opportunity between people who share a protected characteristic and those who do not.	Yes	All streaming practitioners across the Urgent Emergency Care (UEC) system should utilise the UK Mental Health triage Tool, already operational in GM CAS to provide standardisation of practice and a shared language of mental health clinical prioritisation across the UEC system. 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 mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health speciality for treatment in agreed and safe time scales. The mental health speciality should be involved with all mental health patients streamed away from ED and the front door 24 hours a day, 7 days a week.

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 group will be assessed using UK mental Health Triage Tool
	Disability	Yes		Ensure where mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health specialty for treatment in agreed and safe time scales
	Gender	Yes		Ensure where mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health specialty for treatment in agreed and safe time scales Mental Health patients, vulnerable adults and their families should be streamed prior to ED registration in an accessible compassionate
	Pregnancy or maternity	Yes		
	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		

				and safe way.
	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**		
	In January 2020, prior to the current Covid 19 Crisis, the GM UEC Improvement and Transformation Board approved a high-level urgent care by appointment model as a refreshed priority for UEC integration with two primary ambitions: • To reduce attendances to Emergency Departments by improving access to, and utilisation of, primary and community-based services by rapidly developing and testing a GM 'UEC by Appointment' model. • By April 2022, we will reduce: o Ambulance attendances by 100 per day across GM o ED walk in attendances by 300 per day across GM			
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?	Improve access to A&E and more urgent cases can be seen in a timely manner. this will apply to equality groups		

	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?	This from door streaming would allow Ability to provide follow-up appointments for all patients presenting with serious self-harm in timely manner. Establish relationship with wider community team to divert patient who are clinically non-urgent. Improved staff and team morale for a team that can respond in a timely manner for MH Patients in crisis and refer to appropriate onward services as required.
	What steps are to be taken now in relation to the implementation of the activity?	Prior to the development of UECA, the Access and Crisis Team were only able to provide one urgent assessment per day, resulting in patients being diverted to ED if the appointment in the Access and Crisis Team was already occupied. Utilising the UEC resource has prevented the need to divert patients to ED. It is intended that the model continues for the next 12 months.
	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 evaluation has demonstrated the benefits of streaming at front of A&E. It is anticipated that learning of the streaming function would allow better understand of mental health support needed to develop/remodel in RAID/CORE24 service in the future. Robust monitoring criteria will be agreed between Commissioners and Providers to ensure a sustainable and cost-effective model of urgent and emergency care can be commissioned for the populations of Bury.		

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

<table>
<tr><td></td><td>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).

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></td><td></td><td></td><td></td></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.</td></tr>
</table>

<table>
<tr><td></td><td>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 proportion of the population).</td></tr>
<tr><td>Sexual Orientation</td><td>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</td></tr>
<tr><td>Religion or Belief</td><td>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.</td></tr>
</table>

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. <u>Travelers</u> - 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. <u>Military Veterans</u> 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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Agenda Item 9

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Consider
Item No	9	**Confidential / Freedom of Information Status**	No
Title	Bury Inclusion Strategy Update		
Presented By	Lisa Featherstone on behalf of Lynne Ridsdale, Deputy Chief Executive		
Author	Lynne Ridsdale, Deputy Chief Executive		
Clinical Lead	Dr. Jeff Schryer		
Council Lead	Councillor Tahir Rafiq		

Executive Summary

In December 2020 the Strategic Commissioning Board endorsed a joint Inclusion Strategy and Implementation Plan following a joint equalities review which took place in the summer of 2020.

This paper details in the initial progress against the implementation plan and key activity over the last quarter, including recruitment, a review of the Equality Analysis process, celebrating International Women's Day and developing an Action Plan for Race alongside broader community engagement plans across all protected characteristics.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note this update and continue to champion inclusion
- Thank the members of the IWG thanked for their work and leadership
- Comment on the activities proposed to focus on race during 2021/22
- Endorse the attached best practice guide for inclusion in digital working

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Yes
The Public Sector Equalities Duties covers both the Council and CCG. Bury CCG are mandated through the Equalities Delivery Standards. Promoting equalities within the Council is through the Equality Framework for Local Government. Inclusion objectives aligned to Bury's Let's Do It! Strategy and Corporate Plan.	

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

Implications						
patient experience implications?						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The Inclusion Strategy sets out seven objectives to deliver better outcomes including resident/patient access and experience across both formal health and care provision across the Borough and to promote equality and diversity within self-care provision and engagement.					
How do proposals align with Locality Plan?	The Inclusion Strategy stresses the importance of data and engagement across all protected characteristics, to increase access to and engagement with services including those in relation to health, care and wellbeing.					
How do proposals align with the Commissioning Strategy?	As per Health and Wellbeing Strategy. Commissioning activity should take account of all Protected Characteristics and an Equality Assessment be made against any policy or investment decision. The Inclusion Strategy is strengthening the local approach to this and the importance of inclusion data in decision making.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	The seven objectives of the Inclusion Strategy detail step being taken in relation to data, performance, scrutiny and engagement to address inequalities across all protected characteristics.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/	None specifically based on this report.					

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

Governance and Reporting		
Meeting	**Date**	**Outcome**
Inclusion Working Group	25/03/2021	Report noted

Implementation Update on Bury's Inclusion Strategy

1. Background

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

The review was to result in a strategy and outcomes framework which was approved by the SCB in December 2020. The strategy sets out seven strategic objectives for delivery across a total of thirteen protected characteristics, to reflect the requirements of the Equalities Act and prioritise additional groups that have been agreed for local focus. The additional protected groups identified within the strategy are:

- care leavers and Looked After Children
- Socio economically vulnerable people
- Military veterans
- Carers

The inclusion strategy is at the heart of the Together principle of the Bury *Let's do it* strategy. The Together principle promotes inclusion; collaboration and community empowerment as some of the conditions required to improve outcomes within the Borough.

The inclusion strategy gave a commitment to updates every six months. This report provides an interim update on delivery to date.

2. Implementation update

The strategy committed to an indicative delivery plan, including the following objectives to be complete by the end of the 2020/21 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

Work is underway against all of these objectives, led by the Inclusion Working Group (IWG). This group has met fortnightly since the summer of 2020 as part of the Equality Review and is made up of members of the Employee Equality Groups (open to all Bury CCG, Bury Council and Six Town Housing staff), and the Clinical leads for Inclusion. Progress is summarised below

2.1 Leadership capacity

In February 2021 an appointment was made to the newly established post of Director People and Inclusion. The IWG participated in the recruitment exercise through a Stakeholder Interview Panel and their feedback was considered by the final recruitment panel. The candidate is due to start in Bury at the beginning of May 2021.

Bury CCG will in-house its Equality, Diversity and Human Rights offer from 1st April 2021, taking into account the recommendations included within the independent equalities review. It is likely that a new post will be established and recruited to, but no decisions have yet been taken. The CCG has reflected this position within the current open risk relating to delivery of statutory Equality and Diversity duties, which will be kept under review and was noted to the CCG's Quality and performance Committee in March 2021.

2.2 Equality Analysis

The existing Equality Analysis templates, guidance and processes have been reviewed across Bury CCG and Bury Council. This has included taking the best from both organisation's existing documentation and enhancing this with peer best practice from networks including the Greater Manchester Equality and Diversity leads group and internal Inclusion Working Group.

A revised Equality Analysis template and guidance has been produced (appended) and this has been tested across a number of departments, prior to intended sign off in April 2021 ahead of the training outlined below. The major changes of note in relation to previous approaches are:

- A greater focus on data, in particular given Inclusion Objective 2 of the

Strategy outlines the intent 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. The revised EA is more explicit in relation to outlining both existing data and measures to address any gaps in data.

- A greater focus on engagement, in particular given Inclusion Objective 3 to strengthen Community Engagement. The revised EA requires higher detail of engagement undertaken, the impact of this on the developing policy/decision being sought, and outline of ongoing engagement activity to continue to assess impact.

- Additional local communities of interest included against which potential impact will be assessed, in addition to the Protected Characteristics as set out in the Equalities Act

- A section has been included on the EA for Quality Assurance to improve the levels of completeness and quality of EA, to ensure full consideration of each element of the process

It was recommended in the external review that the Equalities Assessment template is launched through a training programme for responsible managers. A partner has been commissioned to provide this training which will be delivered to 60 staff across the CCG and Council, with each directorate identifying senior managers who most often are involved in policy and service development. The training is expected to take place in the second half of April 2021.

2.3 Community Engagement

Funding has been secured from the Ministry of Housing, Communities and Local Government (MHCLG) Community Champions initiative to enable better understand our current and emerging communities, in real time and at a granular level. The work has a particular focus on the community experience of Covid-19 but is an opportunity to establish meaningful community engagement mechanisms more widely.

A network of champions will be established across our communities – geographically, of interest and experience – to strengthen engagement. Based on our the Covid Outbreak Plan and findings of the Community Hubs Equality Analysis, Champions will be pursued from the BAME community, Jewish community, Veterans, asylum seekers and homeless and those with a learning disability. In response to the findings from Greater Manchester insight work, which showed that young people are significantly more worried about Covid-19, it would also include young people too. A gap analysis to confirm which audiences to target would be carried out first.

Proposals are also being developed for a series of listening events to take place across protected characteristics. This builds on the inaugural BAME listening event which took place in conjunction with ADAB in 2020 and will again be co-designed with local community groups and the Bury VCFA to ensure that the context, content and format are best suited to respective communities. The initial sessions to take place are a follow-on BAME listening event and a session focusing on Women & Girls,

including a link into work at a regional level on this.

2.4 Race Action Planning

The Inclusion Strategy identified that in each year of implementation there would be a particular focus on an identified protected characteristic. It was agreed that for 2021/22 the focus would be race in response to the Public Health England evidence of disparities in the risk and outcomes of Covid19 across communities and the focus brought about on race following the killing of George Floyd in May 2020.

The SCB resolved in June 2020 that, "as an employer and service provider, Bury Council and NHS Bury CCG remain determined to oppose racist attitudes in everything we do". The Inclusion Working Group has proposed the following activities for the next year, to deliver this commitment. This work will complement other planned activity within the strategy in particular plans to deliver Workforce Race Equality Standards which addresses data; internal procedures and workforce representation:

- A programme of communications and awareness raising concerning race equality. An early example of this in action was the promotion through the Inclusion Working Group of the first national Race Equality Week which took place from the 1st February 2021, including a corporate promise to Implement *and champion the Inclusion Strategy and prioritisation of race as a chosen protected characteristic in 2021*
- Consultation and determination of acceptable language concerning race. The acronym "BAME" (Black, Asian and Minority Ethnic) is not wholly supported
- A pilot "reciprocal mentoring" scheme within the council and CCG, to increase the understanding of senior leaders about lived experience of racially diverse colleagues and support the development of those people who contribute
- Cultural events to celebrate faith and heritage, through the Town of Culture Board. For example, preparations for Ramadan are currently underway and engagement of the Seldom Heard Voices initiative to increase inclusion, participation and representation within Bury's cultural offer and opportunities.

The indicative activities above will be developed into a detailed plan by the Director of People and Inclusion when they take up post

3 Wider Inclusion Activity

In line with the spirit of the strategy additional work has been pursued beyond the specific objectives agreed. This has included:

- On Monday 8th March 2021, Bury Council and Bury CCG made a positive and active contribution to the celebration of International Women's Day. Central to this was a montage of Bury women and their contribution over the last twelve months to the Covid response and recovery. Over 100 women from across the Team Bury network including Council, CCG, Fire Service, voluntary and community sector shared their image as part of the IWD/GM Women initiative which received over 5,000 direct views on Facebook alone and over 250 interactions on social media. A series of profiles and stories were shared through two discussion groups, internally and externally, which highlighted women at the heart of Bury's Covid response

- Staff-led peer “lunchtime learning” exercises have been provided as part of the one hour per week protected time allowed for all staff during the emergency. So far an awareness session has been delivered about Islam and a further session on trans awareness is scheduled for 31 March
- The IWG has produced a best practice guide to inclusion in digital working, in consultation with the wider staff networks they represent and based on the findings of an Equality Assessment. The guidance is appended for approval from the SCB and will be published to all staff

4 Recommendations

The SCB Is asked to:

- Note this update and continue to champion inclusion
- Thank the members of the IWG thanked for their work and leadership
- Agree the new joint Equality Analysis documentation
- Comment on the activities proposed to focus on race during 2021/22
- Endorse the attached best practice guide for inclusion in digital working

Lynne Ridsdale
Deputy Chief Executive (Corporate Core), Bury Council
l.ridsdale@bury.gov.uk
March 2021

EQUALITY ANALYSIS

This Equality Analysis considers the effect of Bury Council/ Bury CCG activity on different groups protected from discrimination under the Equality Act 2010. This is to consider if there are any unintended consequences for some groups from key changes made by a public body and their contractor partners organisations and to consider if the activity will be fully effective for all protected groups. It involves using equality information and the results of engagement with protected groups and others, to manage risk and to understand the actual or potential effect of activity, including any adverse impacts on those affected by the change under consideration.

For support with completing this Equality Analysis please contact corporate.core@bury.gov.uk / *0161 253 6592*

SECTION 1 – RESPONSIBILITY AND ACCOUNTABILITY *Refer to Equality Analysis guidance page 4*	
1.1 Name of policy/ project/ decision	
1. 2 Lead for policy/ project/ decision	
1.3 Committee/Board signing off policy/ project/ decision	
1.4 Author of Equality Analysis	*Name:* *Role:* *Contact details:*
1.5 Date EA completed	
1.6 Quality Assurance	*Name:* *Role:* *Contact details:* *Comments:*
1.7 Date QA completed	
1.8 Departmental recording	*Reference:* *Date:*
1.9 Next review date	

SECTION 2 – AIMS AND OUTCOMES OF POLICY / PROJECT *Refer to Equality Analysis guidance page 5*	
2.1 Detail of policy/ decision being sought	
2.2 What are the intended outcomes of this?	

SECTION 3 – ESTABLISHING RELEVANCE TO EQUALITY & HUMAN RIGHTS *Refer to Equality Analysis guidance pages 5-8 and 11* Please outline the relevance of the activity/ policy to the Public Sector Equality Duty		
General Public Sector Equality Duties	**Relevance (Yes/No)**	**Rationale behind relevance decision**
3.1 To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010		
3.2 To advance equality of opportunity between people who share a protected characteristic and those who do not.		
3.3 To foster good relations between people who share a protected characteristic and those who do not		
3.4 Please outline the considerations taken, including any mitigations, to ensure activity is not detrimental to the Human Rights of any individual affected by the decision being sought.		

SECTION 4 – EQUALITIES DATA *Refer to Equality Analysis guidance page 8*			
Protected characteristic	**Outcome sought**	**Base data**	**Data gaps (to include in Section 8 log)**
4.1 Age			
4.2 Disability			
4.3 Gender			
4.4 Pregnancy or Maternity			
4.5 Race			
4.6 Religion and belief			
4.7 Sexual Orientation			
4.8 Marriage or Civil Partnership			
4.9 Gender Reassignment			
4.10 Carers			
4.11 Looked After Children and Care Leavers			
4.12 Armed Forces personnel including veterans			
4.13 Socio-economically vulnerable			

SECTION 5 – STAKEHOLDERS AND ENGAGEMENT *Refer to Equality Analysis guidance page 8 and 9*		
	Internal Stakeholders	External Stakeholders
5.1 Identify stakeholders		
5.2 Engagement undertaken		
5.3 Outcomes of engagement		
5.4 Outstanding actions following engagement (include in Section 8 log)		

SECTION 6 – CONCLUSION OF IMPACT *Refer to Equality Analysis guidance page 9* Please outline whether the activity/ policy has a positive or negative effect on any groups of people with protected inclusion characteristics		
Protected Characteristic	**Positive/ Neutral Negative/**	**Impact (include reference to data/ engagement)**
6.1 Age		
6.2 Disability		
6.3 Gender		
6.4 Pregnancy or Maternity		
6.5 Race		
6.6 Religion and belief		
6.7 Sexual Orientation		
6.8 Marriage or Civil Partnership		
6.9 Gender Reassignment		
6.10 Carers		
6.11 Looked After Children and Care Leavers		
6.12 Armed Forces personnel including veterans		
6.13 Socio-economically vulnerable		
6.14 Overall impact - What will the likely overall effect of your activity be on equality, including consideration on intersectionality?		

SECTION 7 – ACTION LOG *Refer to Equality Analysis guidance page 10*			
Action Identified	Lead	Due Date	Comments and Sign off (when complete)
7.1 Actions to address gaps identified in section 4			
7.2 Actions to address gaps identified in section 5			
7.3 Mitigations to address negative impacts identified in section 6			
7.4 Opportunities to further inclusion (equality, diversity and human rights) including to advance opportunities and engagements across protected characteristics			

SECTION 8 - REVIEW *Refer to Equality Analysis guidance page 10*			
Review Milestone	Lead	Due Date	Comments (and sign off when complete)

Please make sure that every section of the Equality Analysis has been fully completed. The author of the EA should then seek Quality Assurance sign off and departmental recording.

SECTION 9 – QUALITY ASSURANCE *Refer to Equality Analysis guidance page x*		
Consideration	**Yes/ No**	**Rationale and details of further actions required**
Have all section been completed fully?		
Has the duty to eliminate unlawful discrimination, harassment, victimization and other conducted prohibited by the PSED and Equalities Act been considered and acted upon?		
Has the duty to advance equality of opportunity between people who share a protected characteristic and those who do not been considered and acted upon		
Has the duty to foster good relations between people who share a		

protected characteristic and those who do not, been consider and acted upon		
Has the action log fully detailed any required activity to address gaps in data, insight and/or engagement in relation to inclusion impact?		
Have clear and robust reviewing arrangements been set out?		
Are there any further comments to be made in relation to this EA		

EQUALITY ANALYSIS GUIDANCE

Bury Council and Bury Clinical Commissioning Group (Bury CCG) are committed to providing fair and inclusive services, engagement and employment opportunities. To help us do this, and also to comply with the Public Sector Equality Duty, we have developed an equality analysis process, supported by this guidance. Its aim is to provide a comprehensive and consistent approach for analysing the effect upon inclusion (equality, diversity, and human right) and community cohesion of all our services, policies and practices.

What is Equality Analysis?

Equality analysis is a way of considering the effect of our services, policies and practices on different groups protected from discrimination by the Equality Act. The process prompts consideration of whether proposed activity may have unintended consequences for some groups and to consider if the policy or practice will be fully effective for all target groups.

It involves using **equality information** and the **results of engagement** with protected groups and others, to understand the actual or potential effect of your service, policy or practice, and manage business risk. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Why do Equality Analysis take place?

All public bodies are required to 'analyse the effect' of their services, policies and practices upon equality, and determine whether they further the aims of the duty for the protected groups. The aims of the duty are:

- to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- to advance equality of opportunity between people who share a protected characteristic and those who do not (i.e. to remove or minimise disadvantages or barriers, and to meet the needs of people from protected groups where these are different from the needs of other people)
- to foster good relations between people who share a protected characteristic and those who do not (i.e. to tackle prejudice and promote understanding)

The protected groups are race, disability, gender, gender reassignment, age, sexual orientation, religion or belief, and pregnancy and maternity. In addition, there is the need to have due regard to eliminate unlawful discrimination against someone because they are married or in a legally recognised same sex civil partnership.

Furthermore, Bury Council and Bury CCG have identified the following communities of interest for which equality analysis activity should include – these are looked after children and care leavers; carers; armed forces personnel including veterans; and socio-economically vulnerable.

Full compliance with legislative requirements can be found in Section 3 of the Bury Inclusion Strategy: https://councildecisions.bury.gov.uk/documents/s25287/AI%206%20-%20Bury%20Inclusion%20Strategy_v4.pdf

When should an Equality Analysis take place?

Equality Analysis is an integral part of commissioning activity, policy development and review, informing policy as it develops. If integrated well, equality analysis will be a tool for improved decision-making, and it should not mean unnecessary additional activity.

The following process should be used when revising, introducing or measuring new:

- policies
- strategies
- procedures
- services
- project
- working practices
- structures/restructures
- Commissioning
- Communication and engagement campaign
- Procurement
- Decommissioning

Will be referred to as '**activity**' throughout the EA process

It also includes the implementation of policies developed:

- outside of the Council – for example by government or Team Bury
- outside the NHS – for example by national or local government,
- or funding decided elsewhere as we still have the discretion to consider mitigating measures or alternative ways of doing things to minimise the impact on services and protected characteristic groups.

Remember to look at the cumulative effect; if a number of changes are made at once to a range of policies or services, the effect of all of them together may be more than the combined effects of each individual change.

The objective is not to simply complete a specific form or template, but to understand the effects of a policy on equality and any actions needed as a result. The time and effort involved should be in proportion to the importance of the policy to equality and good relations.

How does the Equality Analysis fit with the development of plans?

Consider Activity				Take Account of findings	Mitigate or change plans as necessary	Implement plans, service specifications, policies etc.
EA	Identify stakeholders and analyse equality	Engage with relevant people if appropriate	Identify effects on protected groups/ Human Rights analysis	Suggest mitigation actions		Submit summary to appropriate governance structure

EA involves looking at the earliest stages of development / consideration for what steps could be taken to advance equality as well as eliminate discrimination, including any action to meet the needs of those affected by 'key changes' such as policy or service re-design or to remove or minimise disadvantage. An EA should be completed prior to submission of a plan or policy for sign off; the absence of an EA will delay the consideration of the item.

What are the risks of not carrying out an Equality Analysis?

If activities including services, policies and practices are not analysed for their effects on equality then you are at risk of breaching the Public Sector Equality Duty. The Equality and Human Rights Commission monitors and enforces compliance with and has the power to take organisations to a judicial review if necessary. You may also be open to legal challenge from other interested parties.

What support is available to complete an EIA

For assistance with the EA template or process please email corporate.core@bury.gov.uk or call 0161 253 6592

Note – during the early months of 2021 additional resources are being developed to further support the completion of EAs including the a set of exemplars; databank to assist with demographic data and details on training opportunities. This guidance will be updated as they become available.

Completing the EA template

SECTION 1 – RESPONSIBILITY AND ACCOUNTABILITY
This section outlines the accountability completing and quality assuring the Equality Analysis. **1.1-1.5 : EA responsibility** Equality analysis is an integral part of policy development/service review and this form should be completed by the person responsible for developing the policy or drawing up the Service Plan. It is not the responsibility for an equality specialist. **1.6-1.7 : Quality Assurance** Once you have completed an Equality Analysis it is to be reviewed for content completeness, accuracy and quality. If you require support from the Joint Inclusion Working Group with this please contact corporate.core@bury.gov.uk **1.8: Departmental Recording** Upon completion of the Quality Assurance of the EA, the EA should be logged within the department of the activity lead (as set out in 1.2). If you are unclear who to speak to in your department please contact corporate.core@bury.gov.uk **1.9: Next Review Date** As with Risk Logs, EA documentation should be kept live during the development and implementation of activity. It should be agreed by the leads set out in 1.1-1.5 how and when the EA will be reviewed with a specific date stated and adhered to.

SECTION 2 – AIMS AND OUTCOMES OF POLICY / PROJECT

If you are analysing a policy, include information about why it is being developed, what you hope it will achieve, the key people it will affect and involve etc. You should include information about any relevant legislation or government guidance which may affect your decision to develop the policy.

If you are analysing a service and developing a Service Plan, briefly describe the purpose and role of the service and detail the main stakeholders.

SECTION 3 – ESTABLISHING RELEVANCE TO EQUALITY & HUMAN RIGHTS

Identify how relevant the policy/service is to the aims of the Public Sector Equality Duty and the protected equality characteristics as set out on page 1 of this guidance.

To identify relevance, it is useful to think about:-

- Links to an inclusion objective within the joint Bury Council/ Bury CCG Inclusion Strategy [inset link when available]
- If there is a link to an area where equality objectives have been set by the Council The numbers and different types of service users, employees or the wider community who are affected, and also the significance of the effect on them.
- Whether it is a major policy or service area which could have significant implications for how functions are delivered in terms of equality
- If there could be a significant effect on how other organisations operate in terms of equality (For example a review of funding criteria.)
- Whether the policy or service relates to functions that you are aware are important to particular protected groups
- If the outcomes could affect different protected groups differently
- If the policy or service relates to an area with known issues or inequalities (For example access to buildings for disabled people or racist/homophobic bullying in schools.)

The table below provides some illustrations of relevance but is not an exhaustive list, rather lists examples:

3.1 Policies that have a relevance to eliminating discrimination and harassment could relate to:	Dignity at work; equal opportunities; equal pay; Bullying and harassment
3.2 Policies that have a relevance to advancing equality of opportunity could relate to:	Methods and access to services; car parking policy for staff with disabilities; customer care training; dementia support services; leadership programme; work life balance
3.3 Polices that have relevance to foster good relations could relate to:	Community cohesion activity; patient public forums/panels; communications; engagement plans to support long term conditions; working with the voluntary,

	community and faith sector; social marketing; staff engagement forums

3.4 Human Rights Analysis

As part of the Equality Analysis, Human Rights of people affected by the activity should be analysed. These rights are enshrined in the Human Rights Act 1998 and protected by the European Convention on Human Rights. Below is brief explanation of these rights and a flowchart to help with the analysis.

The Human Rights Act 1998 : 15 Articles covered by the Human Rights Act 1998:

Absolute Rights

- the right to life;
- the right not to be tortured or treated in an inhuman or degrading way;
- the right to be free from slavery or forced labour;
- the right to liberty and security;
- the right to a fair trial;
- the right to no punishment without law;
- the right to respect for private and family life, home and correspondence;
- the right to freedom of thought, conscience and religion;
- the right to freedom of expression;
- the right to freedom of assembly and association;
- the right to marry and found a family;
- the right not to be discriminated against in relation to the enjoyment
- of any of the rights contained in the European Convention;
- the right to peaceful enjoyment of possessions;
- the right to education; and
- the right to free elections.

Absolute rights

These rights cannot be infringed no matter how necessary it might seem to do so. They are as follows:

Article 2: Right to Life

You have the absolute right to have your life protected by law. There are only certain very limited circumstances where it is acceptable for the State to take away someone's life, for example, if a police officer acts justifiably in self-defence.

Article 3: Prohibition of Torture

You have the absolute right not to be tortured or subjected to treatment or punishment which is inhuman or degrading.

Article 4: Prohibition of Slavery and Forced Labour

You have the absolute right not to be treated as a slave or forced to perform certain kinds of labour.

Article 7: No Punishment without Law
You normally have the right not to be found guilty of an offence arising out of actions which at the time you committed them were not criminal. You are also protected against later increases in the possible sentence for an offence.

Limited rights

Certain rights of the European Convention on Human Rights are limited in the UK by specific limitation. These are limited rights. They are as follows:

Article 5: Right to Liberty and Security
You have the right not to be deprived of your liberty - 'arrested or detained' - except in limited cases specified in the Article (for example, where you are suspected or convicted of committing a crime) and where this is justified by a clear legal procedure.

Article 6: Right to a Fair Trial
You have the right to a fair and public hearing within a reasonable period of time. This applies to both criminal charges against you or sorting out cases concerning your civil rights and obligations. Hearings must be by an independent and impartial tribunal established by law. It is possible to exclude the public from the hearing (through not the judgment) if that is necessary to protect things like national security or public order. If it is a criminal charge you are presumed innocent until proved guilty according to law and have certain guaranteed rights to defend yourself.

Article 12: Right to Marry
Men and women have the right to marry and start a family. The national law will still govern how and at what age this can take place, and now includes same-sex marriages and partnerships.

Qualified rights

Any infringement needs to promote a specific legitimate aim - in interests of national security, public safety etc. The infringement must be properly regulated by the law and must be necessary in a democratic society. This latter concept means the interference with the right must be a proportionate response to the legitimate aim. If the aim can be achieved by a less intrusive method, then that method must be used instead. They are as follows:

Article 8: Right to Respect for Private and Family Life
You have the right to respect for your private and family life, your home and your correspondence. This right can only be restricted in specified circumstances.

Article 9: Freedom of Thought, Conscience and Religion
You are free to hold a broad range of views, beliefs and thoughts, as well as religious faith. Limitations are permitted only in specified circumstances.

Article 10: Freedom of Expression
You have the right to hold opinions and express your views on your own or in a group.

This applies even if they are unpopular or disturbing. This right can only be restricted in certain circumstances.

Article 11: Freedom of Assembly and Association
You have the right to assemble with other people in a peaceful way. You also have the right to associate with other people, which can include the right to form a trade union. These rights may be restricted only in specified circumstances.

Article 14: Prohibition of Discrimination
In the application of the Convention rights, you have the right not to be treated differently because of your race, religion, sex, political views or any other status, unless this can be justified objectively. Everyone must have equal access to Convention rights, whatever their status.

Also see Appendix 1: Human Rights flowchart to assist with this consideration.

SECTION 4 – EQUALITIES DATA

Under the Public Sector Equality Duty, all services should publish relevant equality information on the internet and update it annually.

4.1-4.3 : Equality Data Table
Relating back to section 2 and considering the regard to the Public Sector Equality Duty I in section 3, this table should be completed to outline the desired impact and consequences of the activity/proposals.

Against this should be the latest data and insight to demonstrate a particular need. This may be quantitative or qualitative. Equality information examples include: Internal/external performance information, risk assessments, NICE guidance, Joint Strategic Needs Assessment, local demographics, insight work, service user data broken down by protected characteristic, commissioning plans, national regional and local reports, previous audits, resident/patient experience- complaints, trends in PALS inquiries, satisfaction rates, open forums, views of frontline staff, other staff, other stakeholders, user groups data outcomes and from other EAs.

Where there are gaps in data, particularly in relation to specific protected characteristics these should be identified with plans outlined for addressing this.

Please consider where activity cuts across a number of protected characteristics, creating overlapping and interdependent systems of discrimination or disadvantage. Data in relation to inclusion should consider multiple characteristics, e.g. when consider customer satisfaction is there a differential between age AND race AND gender.

SECTION 5 – STAKEHOLDERS AND ENGAGEMENT

Before any work is undertaken it is vital and thorough stakeholder identification and analysis takes place. This considers who could be impacted by activity proposed or the decision being sought.

5.1: **Identify Stakeholders**

Stakeholders will be both internal (to the team or organisation) and external (the general public, partners, regional bodies). Consider those who are, could, or should be using a service, are an intended audience of activity and in particular those most impacted. Also consider those not currently engaged with who need to be included.

5.2: Engagement undertaken
The nature of engagement will be dependent on the activity and stakeholder group. It may be mandated in style, content and timescale by regulations. If not, then seek to explore options that are most accessible to each particular group. One-size fits all will not generate the breadth of engagement required across all protected characteristics.

Where possible detail dates of meetings, links to papers/consultations, and details of particular groups addressed.

5.3: Outcomes of engagement
The act of carrying out engagement is not sufficient. The findings from the engagement activity should inform policy development or activity proposals. This may include additional mitigations to address the potential for a negative consequence on a particular protected characteristic or larger adjustments to planned activity due to new insight generated from the engagement.

5.4: **Outstanding actions following engagement**
Any actions yet to be take place are to be detailed to inform the EA action log. This is to ensure engagement activity is actioned.

SECTION 6 – CONCLUSION OF IMPACT

6.1-6.14: Impact Table
Equality analysis helps you to think about what would happen in relation to equality and good relations if you were to adopt the policy/service plan. It is important to look at it not only in terms of identifying and removing negative effects and discrimination, but also as an opportunity to identify ways to advance equality of opportunity and to foster good relations.

You may find it useful to ask yourself the following questions:-

- Could the outcomes differ between protected groups?
- What are the key findings of your engagement?
- Is there different take-up of services by different groups?
- Could your proposals affect different groups disproportionately?
- If there is a greater effect on one group, is that consistent with your aims?
- Would you deliver practical benefits for protected groups?
- Have you missed any opportunities to advance equality and foster good relations?
- Could the outcomes disadvantage people from a particular group?
- Could any part of the policy/service plan discriminate unlawfully?
- Are there any other policies/plans that need to change to support the effectiveness of the proposals under consideration?

Having carried out your analysis you should then be in a position to make an informed judgement as to whether to proceed with your policy/service plan, change it or if there are adverse effects which cannot be justified or mitigated you may wish to consider stopping it altogether.

SECTION 7 – ACTIONS LOG

This section brings together the outstanding actions that are to take place as a result of conducting the EA. Each action should have a named lead and target date to focus activity and demonstrate accountability.

Add additional rows as required. Where there are no current outstanding actions detail 'no current action required' date this.

SECTION 8 – REVIEW

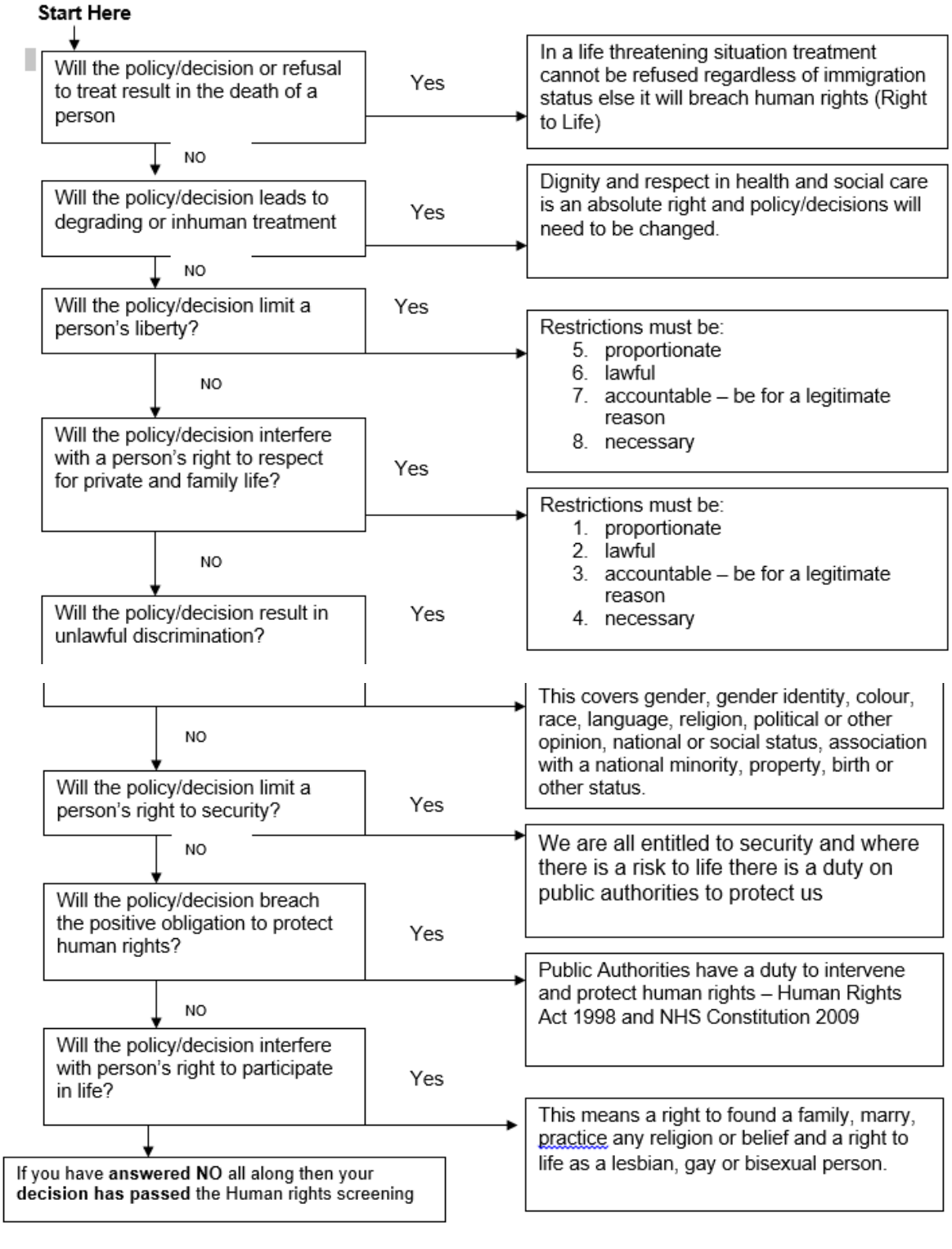
Whilst equality analysis can help you anticipate the effects of your policy/service review, it is only after your proposals are implemented that you will see the actual effect. Appropriate ongoing monitoring and review can allow you to pick up on any negative consequences or areas where it is not creating the intended results and make alterations as appropriate.

Every effort should be made to employ good management practice and plan the EA you are undertaking in advance of any decision-making meeting, to allow time for quality assurance and improvement should it be required.

Bury COUNCIL

NHS Bury Clinical Commissioning Group

Human Rights Flow Chart



NHS Bury Clinical Commissioning Group

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Bury Council

Microsoft Teams Inclusion Guidelines (March 2021)

Inclusion relates to treating people fairly and equally according to their needs.

Bury Council and Bury Clinical Commissioning Group recognise the usual practice of using Microsoft Teams could have an adverse or negative impact on certain protected groups.

All public bodies have a duty to analyse their practices to see if they could further the aims of the Public Sector Equality Duty by:

- eliminating unlawful discrimination harassment and victimisation and other conduct prohibited by the Equality Act 2010. based on age, disability, sexual orientation, gender recognition, religion as well as the Council's additional protected groups of carers
- advancing equality of opportunity between people who share a protected characteristic and those who do not
- fostering good relations between people who share a protected characteristic and those who do not

Following a review and an Equality Analysis of our digital inclusion practice on the use of Microsoft Teams the following guidelines have been developed:-

Inclusion and accessibility considerations

It is important that we can all meet, chat and collaborate equally with Teams. To assist with this you can access a full overview of accessibility tools in Microsoft teams here:-

https://support.microsoft.com/en-us/office/accessibility-overview-of-microsoft-teams-2d4009e7-1300-4766-87e8-7a217496c3d5

The following are of particular note and more details can be found in the link above**:**

- To see or change your Teams software settings, click your profile picture at the top of the app. You can change your picture, status, contrast settings, language and access keyboard shortcuts. This may be needed to address visual impairments and some people with sight loss see more clearly with contrasting colours; yellow on black is a good colour as yellow is the last colour to go.

- By clicking on the three dots on the top tab enables you to turn on live captions which allow for subtitles to be shown. Live Captions can make your meeting more inclusive to participants who are deaf or hard-of-hearing and for people with different levels of language proficiency by giving them another way to follow along. This will only apply to the single user and not the other participants. To make sure your live captions are as accurate as possible, try to follow these best practices:-

    - Speak clearly, slowly, and directly into the mic. As your distance from the mic increases, captions may become less accurate.

    - Avoid locations with background noise.

    - Avoid having multiple people speak at the same time.

- If an attendee prefers not to speak, questions can be posed in the chat function. When using the chat function, use plain language and do not use acronyms that may exclude others. Posts and chat messages can be read aloud using Immersive Reader, by hovering over the message with your mouse, select more options, and then Immersive Reader.

- It is possible to add a colleague to a call to assist an attendee with for example interpretation or to aid understanding if someone who has learning differences. To add someone new to a call select 'Show participants' and type the name or phone number into the search box. This could also take place prior to the call by contacting the meeting Chair who will ensure an invite to the meeting is sent.

- Teams is compatible with screen-readers and other accessibility support.

In addition:

- If participants wished to be addressed by their gender (he, she or they) they should indicate their preference in the chat. Otherwise try to keep the conversation gender neutral.

- Avoid sitting in front of a bright light source or window as people may not see or recognise you particularly if they have a sight impairment

- Participants may need cues to speak if they have sight impairment, have certain mental health conditions or are on the autistic spectrum, by introducing yourself before speaking and by speaking slowly and clearly discussions will be easier to follow.

- The use of the camera facility in the meeting is **NOT** required and its use always remains at the discretion of the attendee. However, to make the experience accessible for participants who are deaf or hard of hearing it may be necessary to turn on video when speaking to allow deaf participants to lip read.

- Participants may need to temporarily step out of the meeting. They can, if they wish, give a reason why, but they are not obliged to and should not be pressed for a reason.

- To create a friendly and inclusive meeting space refrain from expressing prejudice or inappropriate terminology. All employees and thereby attendees should make themselves aware of the Council's Equality & Diversity Policy as this is relevant for Teams meetings, and its compliance is always required. Further information can be found here: http://intranet/CHttpHandler.ashx?id=13415&p=0

- Share documents via email or MS Teams beforehand as some people can struggle to read on-line whilst others are talking. This would apply particularly if English is not their first language. For participants who use British Sign Language (BSL) as their first language, the syntax is not the same as English so they may need it visually interpreted prior to the meeting so they can be equally prepared.

Safeguarding

- For safeguarding purposes, children should not join or be in screenshot of meetings. To assist with this you can blur your background before joining the meetings. To do this located Background Filters just below the video image and select Blur.

- Your usual safeguarding procedures for reporting concerns to the Designated Person in your organisation still apply. If you unsure who this is, please contact the Multi Agency Safeguarding Hub on 0161 253 6999 for further advice. Mark Gay is the Local Authority Designated Officer if you need to discuss concerns. You can contact him on 0161 253 5342 or 07583 877250. In

an emergency or risk of a criminal offence contact the police. Further information is available regarding safeguarding procedures at http://intranet/index.aspx?articleid=12592

- Do not disclose confidential information. This can include information such as members of staff being off on sick leave.

- Check with the Chair whether it is appropriate to share the recording with absentees as it may not be appropriate if someone has disclosed something in a meeting that they would not necessarily want to share with others out of the meeting.

This is not an exhaustive list and the links provide further information. It will be reviewed every 6 months owing to technological advancements and anticipating a more inclusive audience.

Bury Council

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Receive
Item No	10.1	**Confidential / Freedom of Information Status**	No
Title	Integrated Commissioning Fund Quarter 4 (provisional figures)		
Presented By	P Crawford, Interim CFO NHS Bury CCG		
Author	P Crawford - Interim CFO NHS Bury CCG; L Kitto - Interim s151 Officer Bury Council; C Shannon-Jarvis - Associate CFO NHS Bury CCG		
Clinical Lead	n/a		
Council Lead	L Kitto - Interim s151 Officer Bury Council		

Executive Summary

This report provides an update on the ICF budget and **provisional** forecast outturn for 2020/21 for Quarter 4. It also incorporates a review of ICF achievements.

The total ICF budget is £511m.The CCG's total contribution has increased to £361.6m. This includes the CCG's increased allocation to the pooled budget of £15m of which £10.5m relates to a commitment made in 2019/20 and £4.5m to an increased allocation agreed in year. In turn, the Council's contribution has reduced by £15m in recognition of the fact that an additional £10.5m allocation was made in 2019/20 and an additional allocation of £4.5m will be made in 2021/22. These variations do not affect the financial position in net terms.

The ICF is currently forecasting an underspend of £1.3m. There is a £0.4m overspend on services held within the Section 75 Pooled Fund, £1.7m underspend on the Aligned Fund 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. Underspends stem from unallocated COVID-19 grants.

Summary	20/21 Budget £'000	20/21 Forecast Outturn £'000	20/21 Variance £'000
Section 75 Pooled Budget	0	375	375
Aligned Budget	0	(1,683)	(1,683)
In-View Budget	0	(28)	(28)
ICF Net Expenditure	**0**	**(1,336)**	**(1,336)**
CCG Expenditure	346,631	346,631	0
Council Expenditure	164,891	163,555	(1,336)
Expenditure	**511,522**	**510,186**	**(1,336)**
CCG Contribution	(357,131)	(361,631)	(4,500)
Council Contribution	(154,391)	(149,891)	4,500
Contribution	**(511,522)**	**(511,522)**	**(1,336)**
Net Expenditure	**(0)**	**(1,336)**	**(1,336)**

Recommendations
It is recommended that the SCB: • Note that all Quarter 4 figures are provisional as Month 12 has not yet closed. • Note the increase in CCG allocations received since the Quarter 3 report to SCB and accept their allocation to the ICF. • Note the ICF forecast underspend at Quarter 4 of £1.3m (provisional) and the assumptions on which it is based. • Note the need for a longer term solution to be found to support the services funded from Transformation and other short term funding solutions and that a further report will be brought to the SCB meeting in May. • 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?						

Implications						
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?						
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 4

1. Introduction

1.1. This report provides a high level summary of the financial position of the Bury Integrated Commissioning Fund (ICF) at Quarter 4. **All figures are provisional as Month 12 has not yet closed.** Appendix 1 provides a detailed summary of the ICF. Individual financial reports for the Council and CCG are available on request.

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.

1.3. The ICF is comprised of 3 budgets:

- a section 75 pooled budget - SCB has delegated decision making powers;
- an aligned budget - SCB can make recommendations. Decision making powers remain with the originating statutory body; and
- an in-view budget which impact on the CCG and Council - decisions are made by bodies other than the partners.

1.4. In light of the changing NHS Financial arrangements, the CCG's financial position is reported in line with the reporting structures mandated for the NHS under the command and control regime, and which applied throughout the year.

1.5. The CCG received formal notification of its financial allocation in November 2020. Retrospective allocations were received in the first half of the year, sufficient to ensure a breakeven position. These allocations, totalling £7.1m, compensate for the impact of COVID and variances in business as usual spend. For the second half year the CCG managed within its notified allocation. Additional allocations, totalling £4.7m, were made for expenditure deemed "out of envelope". The Hospital Discharge Programme (HDP) was the main component of this. As allocations were received, they were brought into the ICF pooled, aligned and in-view budgets to match expenditure.

1.6. The CCG budget reflects the ambition to achieve community, primary care and the Mental Health Investment Standard (MHIS) in 2020/21. Investments have been agreed with Pennine Care NHSFT and our voluntary sector providers to ensure the CCG achieves the MHIS annual target of £34.1m. Also included are QIPP savings totalling £0.9m (0.5% of H2 allocation).

1.7. HDP expenditure of £7.0m was incurred to support rapid discharge from acute providers and additional costs incurred to avoid acute hospital admissions during the COVID pandemic.

1.8. For Council led services, the total net ICF expenditure budget remains at £164.9m with grants received in year offset by matching expenditure.

1.9. The CCG increased its contribution to the pooled budget by £15m during 2020/21. Of this £10.5m relates to a commitment made last year and £4.5m to an increased allocation agreed in year. In turn, the Council has reduced its contribution by £15m

reflecting the fact that an additional allocation of £10.5m was made in 2019/20 and an additional allocation of £4.5m will be made in 2021/22. Taken together, these variations in contributions do not affect the financial position in net terms.

2. ICF Summary Financial Performance

2.1 The ICF arrangements reflect the 2019/20 agreed principles. During Quarter 4 additional allocations of £9m have been received by the CCG. Of these £7.7m has been added to the Pooled Fund; £3.0m is for the Hospital Discharge Programme, £3.2m locality funding, £0.7m charge exempt overseas visitors adjustment, £0.3m pay & pension pressures, and the remainder for a number of smaller schemes. £1.3m has been added to the In-view fund reflecting Bury CCG's role in hosting arrangements.

2.2 The total budget reported during this period is £511m across the three commissioning areas, as indicated in the table below:

Summary	20/21 Contribution £'000	20/21 Forecast Expenditure £'000	20/21 Variance £'000
Section 75 Pooled Budget	(333,108)	333,483	375
Aligned Budget	(138,582)	136,899	(1,683)
In-View Budget	(39,832)	39,804	(28)
Integrated Commissioning Fund	**(511,522)**	**510,186**	**(1,336)**

2.3 At Quarter 4 the ICF is forecasting an underspend of £1.3m (provisional) against budget overall. This position reflects full year allocations received and anticipated by the CCG and is subject to final confirmation. It should be noted that the CCG still carries an underlying deficit of c£20m.

2.4 There is a £0.4m overspend on services held within the Section 75 Pooled Fund, £1.7m underspend on the Aligned Fund and breakeven position on in-view services.

3. Section 75 Pooled Fund

3.1 The summary position of pooled services is set out in the following Table.

3.2 CCG COVID funding is included within the Pooled Fund. The Council's position reflects additional costs from increased demand for services as well as significant income losses. These have been offset to some extent by government grants provided however some of the impacts will continue to impact in 2021/22 and future years.

3.3 Throughout the year, the Council and CCG have worked together to tackle the COVID pandemic and to deploy resources to ensure the best possible response. The aim has been to optimise NHS funding for the locality, including Council access to more than £4.7m of NHS funding streams for the year related to the HDP.

Service area	20/21 Budget £'000	20/21 Forecast Outturn £'000	20/21 Variance £'000
Acute Health Services	84,252	84,699	447
Community Health & Care Services	86,698	86,912	213
Mental Health & Learning Disabilities Services	37,867	36,484	(1,384)
Primary Care Services	43,026	43,057	31
Adult Social Care	16,782	16,318	(464)
Childrens Services and Social Care	12,549	13,128	580
Public Health	10,435	10,226	(209)
Other CCG & Council Services	41,499	42,660	1,161
Total Pool Expenditure	**333,108**	**333,483**	**375**
Contributions	**(333,108)**	**(333,108)**	**0**
Section 75 Pooled Budget	**(0)**	**375**	**375**

COVID Expenditure

3.4 COVID-19 CCG related costs for the year are:

CCG COVID Expenditure Analysis forecast outturn	Expenditure £'000
Hospital Discharge Programme	7,053
HDP Scheme 2+6 weeks care home costs	349
Support for stay at home models	1,760
Remote management of patients	1,096
Existing workforce additional shifts to meet increased demand	271
Other COVID-19 Virus/Antibody (Serology) Testing - Not Reimburse	187
PPE & locally procured	181
Remote working for non-patient activities	167
Other Covid-19	947
Total CCG Net Expenditure	**12,011**

3.5 In response to the COVID-19 crisis £110.3m (provisional) of grants have been made available to Bury Council to date, a full analysis of which can be found within the Council's Quarter 4 financial report once available. Many of the grants provided have been awarded to reimburse the Council for additional spending commitments made by the government including business rates reliefs, grants and support to businesses, support to care providers and also welfare assistance to vulnerable groups within the borough.

Hospital Discharge Programme (HDP)

3.6 The HDP provided a source of funding totalling £7.0m to systems through the emergency COVID-19 period to ensure that discharges from hospitals were enacted swiftly and hospital admissions were avoided wherever possible to ensure that acute hospital capacity was available to deal with any increases in demand.

3.7 Bury Council and CCG worked collaboratively to ensure this funding was utilised effectively and that the acute sector was supported to deliver the expected capacity.

3.8 Beds within the Care Sector were immediately commissioned in March 2020 under the HDP guidance. Patients requiring an increase in their Healthcare packages, home care and reablement were also supported by this funding from March – August 2020.

3.9 From the 1st September, new HDP guidance was implemented and a discharge to assess model was put into place, for which a maximum of 6 weeks funding can be reclaimed by the CCG for patients discharged from hospital.

4 Aligned Fund

4.1 A summary position of aligned services is set out in the Table below. The net forecast underspend of £1.7m is as a result of unallocated grants received in year.

Service area	20/21 Budget £'000	20/21 Forecast Outturn £'000	20/21 Variance £'000
Acute Health Services	76,738	77,147	409
Childrens Services and Social Care	29,230	29,640	411
Operations	15,085	21,049	5,964
Other CCG & Council Services	17,529	9,063	(8,466)
Total Aligned Expenditure	**138,582**	**136,899**	**(1,683)**
Contributions	**(138,582)**	**(138,582)**	**0**
Aligned Budget	**0**	**(1,683)**	**(1,683)**

4.2 The key overspends in operations of £6.0m are due to reduced ability for the Council to generate income from commercial services including civic venues and catering services, parking services and from the markets. This is offset by underspends in other services as a result of unallocated grants.

5 In-View Services

5.1 The Table below provides a summary position for In-view services. These are broadly in line with budget.

Service area	20/21 Budget £'000	20/21 Forecast Outturn £'000	20/21 Variance £'000
Delegated Co-Commissioning Budgets	28,875	28,828	(47)
Other CCG & Council Services	10,958	10,976	19
Total In-View Expenditure	**39,832**	**39,804**	**(28)**
Contributions	**(39,832)**	**(39,832)**	**0**
In-View Budget	**0**	**(28)**	**(28)**

6 Financial Risks

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

6.2 Sufficient allocations were received to cover the continuation of COVID related schemes and additional demands, eliminating the funding risk previously reported.

6.3 As part of the NHS financial reset all funding allocations have been reviewed and transformation funding has ceased. Due to delays in the achievement of deflection savings, there is a risk of services needing to be funded recurrently without realizable savings to cover the costs. LCO colleagues are working on revised programme phasing into 2021/22. Strong evaluation processes will be essential in determining if/how to continue transformation programmes.

6.4 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. 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 clinical, service 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.

6.5 Under the terms agreed for the ICF, financial risk is 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.

7 ICF: Achievements

7.1 On 4 September 2019, the Cabinet approved the proposed expansion of the health and social care commissioning pooled budget and the creation of a wider integrated commissioning fund (ICF). The S75 agreement and financial framework were approved on 10 March 2020 by the Council's Cabinet.

7.2 The objectives of the ICF are to deliver Integrated Commissioning that will focus on:

- developing joined up, population based, public health, and **preventative and early intervention strategies**;
- adopt an **asset based approach** to providing a single system of health and wellbeing, focusing on increasing the capacity and assets of people and place
- enable the improvement of the **quality and efficiency of the services** within the arrangement;

- improve the **outcomes** for users of the services that will fall within the scope of the partnership agreement;
- ensure relevant **national conditions** and **local objectives** are met; and
- make more **effective use of resources** through the establishment and utilisation of the pooled fund.

7.3 The Bury Locality Plan for Health and Social Care Transformation 2017-21 further reinforced this ambition and set out the desire to form a 'One Commissioning Organisation' (OCO) which would have a remit to:

- bring together health and social care commissioning functions of the CCG and Council into one structure;
- create pooled and aligned budget arrangements for health and social care;
- develop a single health and social care commissioning strategy;
- create a shared approach to maximizing social value;
- strategically commission for outcomes against a wide ranging and dynamic local evidence base; and
- recognise the role of the new Local Care Organisation as a single provider accountable for delivering all age services at a neighbourhood level.

7.4 Over the last 2 years a number of significant developments have established a more solid base from which future developments can be shaped, as follows:

- co-location of the CCG and Council staff members within the Bury Campus;
- establishment of an OCO Partnership Board, which includes Clinicians, Lay Members, Executives and Elected Members;
- tested how commissioning would work through an integrated model – Mental Health, CHC and LD, Carers and SEND;
- established a single Joint Executive Team across both CCG and Council;
- appointed a single CCG Chief Executive and CCG Accountable Officer in October 2018; and
- appointed a single Chief Finance Officer across both the CCG and LA in June 2019.
- established the Strategic Commissioning Board as a sub-committee of the Governing Body and Council Cabinet.

7.5 Investments were made in service improvements from Transformation Funds over a 5 year period. The COVID-19 pandemic, which started in early 2020, has caused fully integrated working on COVID related activities and has led to a greater focus on a smaller number of key services. In general other strategies, transformation and service improvement schemes put in motion by the OCO for the start of 2020/21 were stood down nationally due to the COVID outbreak and these remained suspended for the full financial year.

7.6 A commitment was given at the December SCB to prioritise funding for transformation funded services and LCO Management costs for 2021/22 onwards. With this commitment there was a £5.7m financial risk as recurrent funding was still to be identified. It was felt that there was an even greater significant financial and operational risk to terminating the services or delaying a decision. It was therefore agreed the financial risk was to be managed and mitigated by all system partners over the following months.

7.7 Three schemes in particular, requiring a total investment of £4.5m have continued and have brought significant support to Bury patients during the pandemic. It is the case that improved out of hospital services in this COVID-19 year has impacted on the demand for acute services and led to a reduction in the rate of growth in urgent care.

7.8 The services are:

- Intermediate care at home
- Rapid community response
- Integrated neighbourhood teams

7.9 It was anticipated that these services would generate savings sufficient to support their continuation. Funding for these services was due to end in May 2021, though under the national financial regime they have continued to be funded during 2021. NHSE/I have confirmed that block arrangements will continue until the end of September 2021 which may delay the financial pressure of the three schemes.

7.10 A task and finish group was convened with key finance and service leads to discuss funding options which currently are:

- Funding diverted from A&E and NEL growth
  Implications are being worked through in context of the national financial framework and plans for 2021/22 due to be submitted in May 2021.
- Savings from the Intermediate Care beds review.
  The final savings from this review are still to be clarified as stranded costs and costs to support the reprovision of beds at Killelea have yet to be confirmed.
- Non-Recurrent Transformation Funds.

7.11 Discussions are continuing with the aim to find a longer term solution to enable continuity of these services. Accordingly a further report will be brought to the May SCB meeting.

7.12 In practice, COVID has achieved in one year, a rapid move towards

- effective collaboration with all system partners in dealing with the pandemic;
- enhanced and improved out of hospital care – urgent care, accelerated discharges, outpatients, as well as the roll out of test and trace and COVID vaccination programme;
- significantly reduced hospital activity to release COVID capacity;
- better use of technology - virtual clinical assessments, meetings, and agile working.

7.13 Whilst it is the case that some activity will return to the acute hospitals, most notably elective activity to address the massively increased waiting lists, there is now the opportunity to consolidate on best practices introduced during 2020/21.

7.14 Embedding new ways of working and effective partnerships represents a major step forwards that can be built on in the next post COVID period through developing new care models and approaches and by enhancing effective neighbourhood and locality working.

8 Recommendations

8.1 The SCB is asked to:

- Note that all Quarter 4 figures are provisional as Month 12 has not yet closed.
- Note the increase to the ICF budget as a result of CCG budget allocations received since the Quarter 3 report to SCB and accept their allocation to the ICF.
- Note the ICF forecast financial position at Quarter 4 of £1.3m underspend (provisional) and the assumptions on which it is based.
- Note the need for a longer term solution to be found to support the services funded from Transformation and other short term funding solutions and that a further report will be brought to the SCB meeting in May.
- Note the financial risks to Bury.

Carol Shannon-Jarvis
Associate CFO
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March 2021

Appendices:

Service area	20/21 Budget £'000	20/21 Forecast Outturn £'000	20/21 Variance £'000
CCG Pool Contribution	(230,061)	(230,061)	0
LA Pool Contribution	(92,547)	(92,547)	0
CCG Pool Additional Contribution	(10,500)	(15,000)	(4,500)
LA Pool Additional Contribution	0	4,500	4,500
Total Pool Contribution	**(333,108)**	**(333,108)**	**0**
Acute Health Services	84,252	84,699	447
Community Health Services	24,202	22,997	(1,205)
Continuing Healthcare	22,749	23,881	1,132
Mental Health & Learning Disabilities Services	37,867	36,484	(1,384)
Primary Care Services	43,026	43,057	31
Adult Social Care	16,782	16,318	(464)
Care in the Community	39,747	40,034	287
Public Health	10,435	10,226	(209)
Other OCO Services	21,740	21,507	(233)
Childrens Social Care	6,515	7,356	841
Other Childrens Services	6,034	5,773	(261)
Other CCG Services	8,759	9,185	427
Other Council Services	11,000	11,968	967
Total Pool Expenditure	**333,108**	**333,483**	**375**
Section 75 Pooled Budget	**(0)**	**375**	**375**
CCG Aligned Contribution	(76,738)	(76,738)	0
LA Aligned Contribution	(61,844)	(61,844)	0
Total Aligned Contribution	**(138,582)**	**(138,582)**	**0**
Acute Health Services	76,738	77,147	409
Childrens Social Care	15,866	15,605	(261)
Other Childrens Services	13,364	14,035	672
Business, Growth & Infrastructure	3,395	3,561	166
Operations	15,085	21,049	5,964
Other CCG Services	0	0	0
Other Council Services	14,134	5,502	(8,631)
Total Aligned Expenditure	**138,582**	**136,899**	**(1,683)**
Aligned Budget	**0**	**(1,683)**	**(1,683)**
CCG In View Contribution	(39,832)	(39,832)	0
LA In View Contribution	0	0	0
Total In View Contribution	**(39,832)**	**(39,832)**	**0**
Delegated Co-Commissioning Budgets	28,875	28,828	(47)
Other CCG Services	10,958	10,976	19
Other Council Services	0	0	0
Total In View Expenditure	**39,832**	**39,804**	**(28)**
In-View Budget	**0**	**(28)**	**(28)**
CCG Total Contribution	(357,131)	(361,631)	(4,500)
LA Total Contribution	(154,391)	(149,891)	4,500
Total Contribution	**(511,522)**	**(511,522)**	**0**
CCG Expenditure	346,631	346,631	0
LA Expenditure	164,891	163,555	(1,336)
Total Expenditure	**511,522**	**510,186**	**(1,336)**
Bury Integrated Commissioning Fund Total	**(0)**	**(1,336)**	**(1,336)**

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	12 April 2021	**Action**	Receive
Item No	10.2	**Confidential / Freedom of Information Status**	No
Title	NHS 2021/22 Priorities and Operational Planning Guidance		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning, Bury Council and NHS Bury CCG Pat Crawford, Interim Chief Financial Officer, NHS Bury CCG		
Author	Will Blandamer, Executive Director of Strategic Commissioning, Bury Council and NHS Bury CCG		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The attached guidance issued on the 25th March 2021 sets out the priorities for the year ahead against a backdrop of the challenge to restore services, meet new care demands and reduce the back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Notes the NHS 2021/22 Priorities and Operational Planning Guidance.

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	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	

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

Classification: Official

Publications approval reference: PAR468

2021/22 priorities and operational planning guidance

25 March 2021

Thank you to you and your teams for your extraordinary efforts over the last year. On 29 January we marked 12 months since we started to treat this country's first patients with COVID-19 and began to see the impact of the pandemic on our health services. Since then, with thanks to the whole NHS team, we have treated over 390,000 people with COVID-19 in hospitals, and many more in primary, community and mental health care. We have continued to deliver other essential services, treating over 275,000 people with cancer and dealing with increases in urgent and emergency demand.

At the time of writing, the NHS has delivered more than 26 million COVID-19 vaccinations to people across England, and is on course to hit its target of offering a first dose of the vaccine to all people in the top nine priority groups by 15 April. Data shows that the vaccination programme is having a significant impact on transmission rates and, coupled with the public's adherence to social restrictions, this means that hospitalisation rates have been falling across all regions and local areas.

While this gives us cause for optimism, we do not yet know what the pattern of COVID-19 transmission will look like over the next 12 months and it is clear that the impact of the last year will be felt throughout 2021/22 and beyond. As we rise to the challenge of restoring services, meeting the new care demands and reducing the care back logs that are a direct consequence of the pandemic, we know that it has also taken its toll on our people. By supporting staff recovery, their health and wellbeing and improving workforce supply we can restore services in a sustainable way.

The pandemic has shone a brighter light on health inequalities. We will need to take further steps to develop population health management approaches that address inequalities in access, experience and outcomes, working with local partners across health, social care, and beyond. To support this, we have set out five priority areas for tackling health inequalities that systems are asked to give particular focus to in the first half of 2021/22 (see accompanying guidance). Tackling inequalities of outcome is also central to the investments we will make this year to improve outcomes on cancer, cardiovascular disease, mental health and maternity services as well as to expand smoking cessation and weight management services.

To achieve these goals, while restoring services and recovering backlogs, will require us to do things differently, accelerating delivery against and redoubling our commitment to strategic goals we all agreed in the Long Term Plan (LTP). The NHS has shown this year it's ability to adapt, develop new services at scale and pace and has, for example, made real strides in embedding digital approaches to patient care. We now need to build on these improvements alongside the development of system working and collaboration.

Effective partnership working across systems will be at the heart of this and the financial framework arrangements for 2021/22 will therefore continue to support a system-based approach to funding and planning.

It is within this context that we are setting out our priorities for the year ahead:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

F. Working collaboratively across systems to deliver on these priorities.

The Government has agreed an overall financial settlement for the NHS for the first half of the year which provides an additional £6.6bn + £1.5bn for COVID-19 costs above the original mandate. The financial settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS going into the second half of the year. In addition, £1.5bn funding has been allocated for elective recovery, mental health and workforce development.

While we are setting out priorities for the full year, we are therefore asking systems to develop fully triangulated plans across activity, workforce and money for the first half of the year. For mental health we can provide funding for the full year and these plans should therefore extend to 12 months (see accompanying guidance).

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

Our people need to be at the heart of plans for recovery and transformation and those plans should reflect the need for staff to get the support, rest and recuperation that they need. For

the first half of 2021/22, we are asking systems to review and refresh their people plans to reflect the progress made in 2020/21, as well as to show: greater progress on equality, diversity and inclusion; progress on compassionate and inclusive cultures; and increasing workforce supply. These themes were highlighted as part of the review of local plans in September 2020.

A1 Looking after our people and helping them to recover

Different people will need to recover from the demands of the pandemic in different ways, and staff safety remains a priority. Employers need to put support in place to help staff given what they have been through over the last 12 months.

- We encourage trusts to allow staff to carry over all unused annual leave and offer flexibility for staff to take or buyback unused leave. System financial performance assessment will exclude higher accruals for annual leave in 2020/21. All staff should be encouraged to take time off to recover, making use of annual leave which may be carried over from 2020/21.

- Individual health and wellbeing conversations should be a regular part of supporting all staff with an expectation that a plan is agreed at least annually and should take place over the course of first half of the year. Staff safety remains a priority and these plans should include risk assessment, flexible working, compliance with infection prevention and control policy, and testing policy, as well as drawing on the range of preventative health and wellbeing support available.

- Occupational health and wellbeing support should be available to all staff, including rapid access to psychological and specialist support. We will provide national investment to roll out mental health hubs in each ICS and to expand.

A2 Belonging in the NHS and addressing inequalities

COVID-19 has surfaced inequalities that can be harmful to our people and addressing this remains an urgent priority. We expect systems to:

- develop improvement plans based on the latest WRES findings, including to improve diversity through recruitment and promotion practices

- accelerate the delivery of the model employer goals.

A3 Embed new ways of working and delivering care

During the pandemic, our people adopted innovative ways of working to make best use of their skills and experience to benefit our patients. Now is the time to embed those workforce transformations to support recovery and longer-term changes:

- Providers should maximise the use of and potential benefits of e-rostering, giving staff better control and visibility of their working patterns, supporting service improvements and the most effective deployment of staff. Providers are asked to show how they intend to meet the highest level of attainment as set out by our 'meaningful use standards' for e-job planning and e-rostering.

- Local systems are also encouraged make use of interventions to facilitate flexibility and staff movement across systems, including remote working plans, technology-enhanced learning and the option of staff digital passports.

A4 Grow for the future

During the pandemic we were able to grow our workforce through a range of innovative measures that helped us to successfully deal with COVID-19 while treating patients with a range of other conditions. Now we need to take steps to sustainably increase the size of our workforce in line with measures set out in the NHS Long Term Plan. Systems are asked to:

- Develop and deliver a local workforce supply plan with a focus on both recruitment and retention, demonstrating effective collaboration between employers to increase overall supply, widen labour participation in the health and care system, and support economic recovery.

- Ensure system plans draw on national interventions to introduce medical support workers (MSWs), and make use of associated national funding, increase health care support workers (HCSWs) and international recruitment of nursing staff.

- Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to allow students to qualify and register as close to their initial expected date as possible.

- Develop and implement robust postgraduate (medical and dental) training recovery plans that integrate local training needs into service delivery planning.

- Ensure that workforce plans cover all sectors – mental health, community health, primary care and hospital services. The plans should support the major expansion and development of integrated teams in the community, with primary care networks (PCNs) serving as the foundation, assisted to make full use of their Additional Roles Reimbursement Scheme funding, including through the options of rotational or joint employment.

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

Offering a first dose to the adult population by the end of July remains key to saving lives, reducing the likelihood of increased pressure on the NHS, and reducing the spread of COVID-19 as social distancing is eased. This will continue to be delivered through implementing a mixed model of vaccine delivery through vaccination centres, hospital hubs, general practice and community pharmacy capacity. The precise local model will vary according to the needs of the local population and include targeted approaches where these are required to increase uptake, particularly in under-served populations.

General practice will retain an important role in the COVID-19 vaccination programme, with PCN groupings having the option to vaccinate cohorts 10-12 (18-49 year olds) (when the national supply availability means those groups can begin to be vaccinated) if they can also fulfil the requirements of the GMS contract.

It is not currently known for how long people who receive a COVID-19 vaccine will be protected. This is because, as is the case with many vaccines, the protection they confer may weaken over time. It is also possible that new variants of the virus may emerge against which current vaccines are less effective. The Joint Committee on Vaccination and Immunisation (JCVI) will issue advice in due course and systems will need to consider:

- being prepared for a COVID-19 re-vaccination programme from autumn, with high uptake ambitions for seasonal flu vaccination, alongside:
- the possibility of COVID-19 vaccination of children, should vaccines be authorised for use in under 18s and recommended by the JCVI in this population.

PCNs will also have an important ongoing role in response to the pandemic that will involve the continued use of home oximetry, alongside hospital-led ‘virtual wards’, proactive care pathways delivered virtually in people’s homes. As well as enabling safe and more timely discharge, COVID Virtual Wards have the potential to support some COVID patients who would otherwise be admitted to hospital. Systems are encouraged take this into account as they continue to prepare for any future potential surge requirements for COVID patients.

We will continue national funding to maintain the dedicated Post COVID Assessment clinics that have been established and all systems are asked to ensure that they provide timely and equitable access to Post COVID Syndrome (‘Long COVID’) assessment services.

We will also conduct a stocktake of both physical critical care capacity and workforce, which will inform next steps in creating a resilient and sustainable service. This will include critical care transfer services.

All NHS organisations should ensure continued reliable application of the recommendations in the UK Infection Prevention and Control guidance updated by Public Health England to reflect the most up-to-date scientific understanding of how to prevent and control COVID-19 infection.

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

The pandemic has had a significant impact on NHS activity, and while the majority of care and activity has been maintained through the winter and the second wave, elective care has been disrupted and there are new demands on mental health services.

During the pandemic collaboration across providers helped ensure that every COVID-19 patient requiring hospital treatment received it and staff could work where they were most needed. In addition, pathway changes were rapidly implemented, helping ensure patients were only in hospital if they needed to be. This same approach will now help us transform the design and delivery of services across systems, to reduce unwarranted variation in access and outcomes, redesign clinical pathways to increase productivity, and accelerate progress on digitally-enabled care. In 2021/22 we will:

C1 Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services

The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. We need to be ambitious and plan to recover towards previous levels of activity and beyond where possible over the next few years. An additional £1bn funding has been made available to the NHS in 2021/22 to support the start of this recovery of elective activity, and the recovery of cancer services. Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021 that:

- maximise available physical and workforce capacity across each system (including via the Independent Sector- IS), learning from other systems and taking into account the high-impact changes including adapting the ward environment to enhance flow

and physical segregation of patients,[1] segregating elective care flow through the hospital and developing service transformation initiatives to drive elective recovery

- prioritise the clinically most urgent patients, eg for cancer and P1/P2 surgical treatments
- incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk (drawing on both primary and secondary care)
- include actions to maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable
- address the longest waiters and ensure health inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation
- safeguard the health and wellbeing of staff, taking account of the need for people to recover from what they have been through

Given these factors, systems are asked to plan for the highest possible level of activity. We understand that current restrictions affect output. The Government has made additional funding available to allow systems to step activity back up and so systems that achieve activity levels above set thresholds, ie the levels funded from core system envelopes, will be able to draw down from the additional £1bn Elective Recovery Fund (ERF) for 2021/22. The threshold level is set against a baseline value of all elective activity delivered in 2019/20, allowing for available funding, workforce recovery and negative productivity impacts of the pandemic through 2021/22. For April 2021 it will be set at 70%, rising by 5 percentage points in subsequent months to 85% from July.

Acute providers' access to the ERF will be subject to meeting 'gateway criteria' including addressing health inequalities, transformation of outpatient services, implementing system-led elective working, tackling the longest waits and supporting staff.

The remaining national contracts between NHS England and acute independent sector providers end on 31 March and local commissioning will be restored. Targeted collaborative partnerships with IS providers to support delivery of system capacity plans will continue be an important element of elective recovery plans. Over the next 2 months we will explore with system leaders and IS providers evolved mechanisms for effective working, contracting and

[1] In line with infection prevention and control guidance published by Public Health England

planning to establish how we can most effectively use IS capacity to support recovery over the next two to three years.

Systems are asked to recover elective activity in a way that takes full advantage of elective high-impact changes and transformation opportunities, and demonstrates learning from other systems, in particular:

- Create clear accountability for elective recovery, and implement key supporting tools, at system level, including common tracking of waiting lists; clinical review and prioritisation; dynamic planning of elective capacity and shared capacity, demand and monitoring data

- Maximise opportunities to implement high impact service models in elective care at system level such as dedicated fast track hubs for high volume, low complexity care with standardised clinical pathways; dedicated elective service pathways within acute sites; elective activity coordination hubs for booking and scheduling across sites to tackle backlogs at system level

- To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and thereby improve performance in three specialties: cardiac, musculoskeletal (MSK) and eye care with support via the National Pathway Improvement Programme. The aim should be to achieve what was top quartile performance against benchmarks on those pathways, and we will ask the National Pathway Improvement Programme in conjunction with GIRFT to support the development of and accredit plans as part of the national elective recovery programme.

- Embed outpatient transformation, taking all possible steps to avoid outpatient attendances of low clinical value and redeploying that capacity where it is needed, alongside increased mobilisation of Advice & Guidance and Patient Initiated Follow-Up services. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don’t involve a procedure). Initial activity goals and the gateway to access ERF have been set to reflect the feedback on not incentivising the avoidance of clinically unnecessary referrals and appointments. For the second half of the year we anticipate a national data collection and counting methodology. In future we will use this to inform the way in which the payment system further supports implementation of these reforms.

- Access available support to help deploy the innovative approaches to optimising workforce capacity that are best suited to local system needs, including system wide

workforce planning, passporting to allow flexible working of employed and bank staff between organisations

Recovery of the highest possible diagnostic activity volumes will be particularly critical to support elective recovery. Capital and revenue funding have been made available to deliver additional capacity and efficiencies through new Community Diagnostic Hubs (CDHs) and pathology and imaging networks. All systems are expected to work with regions to deliver increased capacity to meet the diagnostic needs for their population, in line with the recommendations of the Richards review. System plans should set out their proposals for how this additional capacity will be delivered, including through the development of CDHs.

In order to tackle the backlog, systems will when feasible need to return to, and in time and with support, move above 2019/20 baseline of activity. We will look to support systems who can identify and develop innovative and transformative approaches to restore activity to above pre-pandemic levels, with mechanisms to ensure that the insights generated can be applied across the NHS.

C2 Restore full operation of all cancer services

NHS staff have worked hard to prioritise cancer services during the pandemic, and the overwhelming majority of cancer treatment has continued. However, some people have not contacted their GP with symptoms. Local systems, drawing on advice and analysis from their Cancer Alliance, will ensure that there is sufficient diagnostic and treatment capacity in place to meet the needs of cancer to:

- return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower) and
- meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022.

The national cancer team will support local systems and Cancer Alliances to learn from each other, and to plan by providing estimates of the level of additional referrals and treatment required to address the shortfall.

Cancer Alliances are asked to draw up a single delivery plan on behalf of their integrated care systems(s) ICSs) for April 2021 to September 2021 to deliver the following actions:

- **Getting patients to come forward**
  - work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on groups under-represented among those who have come forward. Systems should

actively support their practices as they complete the QOF Quality Improvement module on early cancer diagnosis, which has been continued into 2021/22 as part of GP contract arrangements, and

- work with public health commissioning teams to restore all cancer screening programmes. This should include using the additional £50m investment committed funding for breast cancer screening to meet national standards and to recover backlogs by end March 2022. We will also begin to extend bowel cancer screening to include 50-60 year olds, with rollout to 56 year olds from April 2021.

- **Investigate and diagnose**
  - extend the centralised clinical prioritisation and hub model established during the pandemic for cancer surgery to patients on cancer diagnostic pathways (starting with endoscopy where appropriate), ensuring a joint approach across cancer screening and symptomatic pathways
  - using national service development funding Alliances are encouraged to:
    - increase take up of innovations like colon capsule endoscopy and Cytosponge to support effective clinical prioritisation for diagnostics
    - accelerate the development of Rapid Diagnostic Centre pathways for those cancer pathways which have been most challenged during the pandemic and
    - restore first phase Targeted Lung Health Check projects at the earliest opportunity, and begin planning the launch of the Phase 2 projects.

- **Treat**
  - embed the system-first approach to collaboration established during the pandemic – including centralised clinical triage and centralised surgical hubs where appropriate – as an enduring legacy of the pandemic
  - agree personalised stratified follow up (PSFU) pathways in three additional cancer types and implement one by March 2022, in addition to breast, prostate and colorectal cancer.

Systems will be expected to meet the new Faster Diagnosis Standard from Q3, to be introduced initially at a level of 75%. To support delivery, Faster Diagnosis Standard data will begin to be published from spring 2021. Systems should, as soon as possible, also ensure a renewed focus on improving performance against the existing Cancer Waiting Times standards. Cancer Alliances are asked to draw up on behalf of their ICS(s) an action plan for improving operational performance, with a particular focus on pathways which are most adversely affecting overall performance.

C3 Expand and improve mental health services and services for people with a learning disability and/or autism

Our mental health workforce has continued to provide people with the support they need during the pandemic. We know, however, that COVID-19 has not only affected the delivery of services but is also likely to cause an increase in demand.

The ambitions set out in the Mental Health Implementation Plan 2019/20–2023/24, which expand and transform services, remain the foundation for our mental health response to COVID-19, enabling local systems to expand capacity, improve quality and tackle the treatment gap. An additional £500m of funding has been made available in 2021/22 to address the impact of COVID-19.

In 2021/22 we expect local systems to:

- Deliver the mental health ambitions outlined in the Long Term Plan, expanding and transforming core mental health services (and in doing so prepare for implementation of recommendations for Clinical Review of Standards for mental health). This includes:
  - continuing to increase children and young people's access to NHS-funded community mental health services, noting the revised metric and importance of continued focus on quality of care
  - delivery of physical health checks for people with Serious Mental Illness (SMI), noting that GPs will be incentivised to deliver the checks in 2021/22 via a significant strengthening of relevant QOF indicators
  - investing fully in community mental health, including funding for new integrated models for Serious Mental Illness (adult and older adult) and SDF funding to expand and transform services. To support this a new metric will measure those accessing community mental health services. To support integration with general practice, the NHS contract and GP contract have introduced new co-funding requirements for embedded additional PCN posts.

- maintain transformations and beneficial changes made as part of COVID-19, where clinically appropriate, including 24/7 open access, freephone all age crisis lines and staff wellbeing hubs

- maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy

- have a workforce strategy and plan that delivers the scale of workforce growth required to meet LTP ambitions

- enable all NHS Led Provider Collaboratives to go live by 1 July 2021
- ensure that all providers, including in scope third sector and independent sector providers, submit comprehensive data to the Mental Health Services Data Set and IAPT Data Set
- have a strategy and effective leadership for digital mental health, and ensure that digitally-enabled models of therapy are rolled out in specific mental health pathways.

All CCGs must, as a minimum, invest in mental health services to meet the Mental Health Investment Standard.

It is vital to continue to make progress on our LTP commitments for people with a learning disability, autism or both. We need to make progress on the delivery of annual health checks for people with a learning disability. We also need to improve the accuracy of GP Learning Disability Registers to make sure the identification and coding of patients is complete, in particular for under-represented groups such as children and young people and people from Black, Asian and Minority Ethnic backgrounds.

Systems will be expected to maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability, autism or both. This will be supported by improved community capacity to enable more people to receive personalised care, closer to home. Pilots and early adopter sites for keyworkers for children and young people with the most complex needs will continue, with remaining areas preparing for delivery in 2022/23.

To tackle the inequalities experienced by people with a learning disability highlighted and exacerbated by the pandemic, systems are asked to implement the actions coming out of LeDeR reviews. The national programme requirement is for 100% of reviews to be completed within six months of notification.

C4 Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review

Donna Ockenden’s interim report has challenged everyone who works in maternity services to redouble efforts to continue to improve outcomes and patient experience and to reduce unwarranted variation. All trusts have completed an assurance assessment tool and reported it though systems as set out in the 14 December letter from Amanda Pritchard, Ruth May and Steve Powis. For 2021/22 we are investing more than £80m of additional funding to improve maternity safety and meet the Immediate and Essential Actions from the Ockenden report.

Local maternity systems (LMSs) should be taking on greater responsibility for ensuring that maternity services are safe for all who access them, and should be accountable to ICSs for doing so. As part of their work to make maternity care safer, more personalised and more equitable, they should oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report.

Systems are expected to continue delivery of the maternity transformation measures set out in the Long Term Plan, including offering every woman a personalised care and support plan, implementing all elements of the Saving Babies' Lives care bundle, and making progress towards the implementation of the continuity of carer model of midwifery.

Further detail on the full set of actions and priorities under these broad headings is set out in the accompanying guidance.

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

The Long Term Plan committed to a significant real terms expenditure increase on primary medical and community health services to improve prevention and keep people out of hospital. In 2021/22 this commitment will again be met and will support:

- restoring and increasing access to primary care services
- implementing population health management and personalised care approaches to improve health outcomes and address health inequalities and
- transforming community services and avoiding unnecessary hospital admissions and improving flow, in particular on the emergency pathway.

D1 Restoring and increasing access to primary care services

The success of the COVID vaccination programme has proven beyond doubt the value and potential of PCNs. Systems should continue to prioritise local investment and support for PCN development, including enabling stronger integration of care with community-based services.

PCNs are the critical enabler of workforce expansion in general practice. All systems are expected to support their PCNs to:

- achieve their share of 15,500 FTE PCN roles to be in place by the end of the financial year, in line with the target of 26,000 by 2023/24

- expand the number of GPs towards the 6,000 target, with consistent local delivery of national GP recruitment and retention initiatives and thereby
- continue to make progress towards delivering 50 million more appointments in general practice by 2024.

National funding for general practice capacity also continues through an additional £120m in first half of the year, which will taper in the second quarter as COVID pressures decrease.

Overall appointment volumes in general practices remain high. Systems are asked to support those practices where there are access challenges so that all practices are delivering appropriate pre-pandemic appointment levels. This includes all practices offering face-to-face consultations. Systems are asked to continue to support practices to increase significantly the use of online consultations, as part of embedding total triage.

Practices continue to reach out to clinically vulnerable patients and, as set out in section C. Systems should support their PCNs to work closely with local communities to address health inequalities. The ongoing effort to tackle the backlog of clinically prioritised long-term condition management reviews, including medication reviews and routine vaccinations will be supported via the re-introduction of QOF indicators from April.

The Community Pharmacy Consultation Service (CPCS) has been extended, as part of the existing advanced service, to include the ability to receive referrals from General Practice and support the management of low acuity patients in alternative settings, supporting workload pressures. Local pharmacy contractors, PCNs and GP practices should be working with their local LPC, LMC and regional teams to agree implementation of this service locally prior to being able to receive referrals.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing infection prevention control measures, and targeting capacity to minimise deterioration in oral health and reduce health inequalities. We will continue to support dental teams to deliver as comprehensive a service as possible.

D2 Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

COVID-19 has highlighted the correlation between poorer health outcomes and ethnicity and deprivation, specifically. Systems are encouraged to adopt population health management techniques as part of their targeted recovery strategies, aiming for equitable access, excellent experience and optimal outcomes for all groups. NHS England and NHS Improvement will continue to work with systems to develop the real-time data tools and techniques being used so effectively by the COVID vaccination programme, at a granular

local level. It also includes the use of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex needs, and those awaiting multiple appointments. Systems should provide proactive, multi-disciplinary, cross sector support to these patients, in line with the NHS Comprehensive Model for Personalised Care.

The NHS Long Term Plan sets out a path for improvements for people with conditions such as diabetes, CVD and obesity. These are even more important given we now know the clear association with poorer outcomes with COVID-19. We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated SRO, covering both primary and secondary prevention deliverables as outlined in the Long Term Plan. These plans should set out how ICS allocations will be deployed in support of the expansion of smoking cessation services, improved uptake of the NHS diabetes prevention programme and CVD prevention. The NHS digital weight management services will also be made more widely available following additional government investment announced in March. Systems are also asked to review their plans and make progress against the LTP high impact actions to support stroke, cardiac and respiratory care.

Delivering the NHS Comprehensive Model for Personalised Care, thereby giving people more control over their own health, will underpin systems' efforts to recover services and address health inequalities. Systems will continue and, where possible, accelerate the delivery of existing requirements, including personal health budgets, social prescribing referrals and personalised care and support plans. In 2020/21 1 million personalised care interventions were delivered and we expect at least 1.2 million to be delivered in 2021/22 in line with our LTP ambition. Implementation will be supported by recruitment to three additional roles funded through the ARRS: Social Prescribing Link Workers, Health and Wellbeing Coaches, and Care Coordinators.

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay

E1 Transforming community services and improve discharge

With national transformation funding and the increase in primary and community care services funded through baseline allocations we are asking every system to set out plans to accelerate the rollout of the 2-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022. Additional transformation funding will be released subject to those plans and a commitment by all

community service providers to provide complete and accurate data to the Community Services Dataset (CSDS) in 2021/22.

Systems have achieved significant reductions in long stays during 2020/21 equivalent to freeing up 6,000 beds and 11,000 staff across acute and community settings. All providers should continue to deliver timely and appropriate discharge from hospital inpatient settings and seek to deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days. To support this we will continue to fund the first six weeks of additional care after discharge from an NHS setting during the first quarter and first four weeks from the beginning of July. We will review the position with Government for the second half of the year.

Together, these actions will enable more patients to be cared in the optimal setting and will reduce the pressure on our hospitals by improving flow through the emergency pathway and freeing up capacity to support the restoration of elective care.

E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments

Systems are asked to continue to progress the work already underway through the NHS 111 First and Same Day Emergency Care programmes. Specifically, systems should:

- promote the use of NHS 111 as a primary route into all urgent care services
- maximise the use of booked time slots in A&E with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend
- maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services
- adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 emergency department to avoid unnecessary hospital admissions.

To assess the level of pressure within urgent and emergency care systems and monitor their recovery, systems are asked during Q1 to roll out the Emergency Care Data Set (ECDS) to all services and implement the collection of those measures that are not already in place, including:

- the time to initial assessment for all patients presenting to A&E

- the proportion of patients spending more than 12 hours in A&E from time of arrival
- the proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed.

A response to the consultation to the UEC clinically-led review of standards will be published in due course, and with agreement with government on next steps. For the first part of the year, systems are asked to focus on implementing data collection, and UEC recovery.

F. Working collaboratively across systems to deliver on these priorities

F1 Effective collaboration and partnership working across systems

The priorities set out in this guidance will only be delivered through effective partnership working across systems, including effective provider collaboration and place-based partnerships with local government. The accompanying guidance sets out the expectations for how ICSs are expected to build on existing arrangements during 2021/22. These requirements include having system-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners.

ICSs will be asked to set out, by the end of Q1, the delivery and governance arrangements that will support delivery of the NHS priorities set out above. These must be set out in a memorandum of understanding (MOU) and agreed with regional NHS England and NHS Improvement teams. In line with the proposed new NHS System Oversight Framework the MOU will also be expected to set out the oversight mechanisms and structures that reflect these delivery and governance arrangements, including the respective roles of the ICS and regional NHSEI team.

F2 Develop local priorities that reflect local circumstances and health inequalities

ICSs across the country entered the pandemic with a varying range of circumstances and different health groups with a range of needs. COVID-19 has exacerbated this disparity and, in recovering services, systems now face varying challenges.

In recognition of these challenges, systems are asked to develop their own set of local health and care priorities that reflect the needs of their population, aligned to the four primary purposes of an ICS:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access

- enhancing productivity and value for money
- helping the NHS support broader social and economic development.

F3 Develop the underpinning digital and data capability to support population-based approaches

Meeting population need requires smart digital foundations, connected health and care services, locally joined-up person-level data across health and care partners, and robust analytical capability aligned across system partners. This will be described in the forthcoming NHSX What Good Looks Like framework, which will support ICSs to benchmark and enable regional teams to develop an appropriate support offer.

To underpin this, systems should commence their procurement of a shared care record so that a minimum viable product is live in September and roadmap for development to include wider data sources and use for population health is ready for April 2022.

F4 Develop ICSs as organisations to meet the expectations set out in Integrating Care

We expect ICSs to take steps in their development during 2021/22 to ensure they are able to deliver the four core purposes described above. ICSs are asked to set out how they will organise themselves to support this, including through:

- Updating their system development plans, detailing the work they will undertake to ensure their system has the necessary functions, leadership, capabilities and governance
- Preparing for moving to a statutory footing from April 2022, subject to legislation.

F5 Implement ICS-level financial arrangements

The financial framework arrangement for 2021/22 will continue to build on the system-based approach to funding and planning. Systems should ensure that they are continuing to take actions to strengthen their system financial governance arrangements and building collaborative plans to optimise system resources.

For the six-month period to 30 September 2021, we will be issuing system envelopes based on the H2 2020/21 funding envelopes and including a continuation of the system top-up and COVID-19 fixed allocation arrangements. The total quantum will be adjusted to issue additional funding for known pressures and key policy priorities (including inflation, primary care and mental health services).

System envelopes will also be adjusted to reflect an efficiency requirement increasing through the second quarter and with an increased requirement for those systems that had

deficits compared to 19/20 financial trajectories at the end of 2019/20. We will be developing specific system productivity measures to align with the focus on clinical pathway transformation and the reduction in unwarranted variation as part of the national elective recovery programme underpinned by more effective rostering of staff. We will also set goals for outpatient transformation as we approach the second half of the year.

The current block contract payments approach will continue for NHS providers. Further detail on the construction of H1 system funding and organisational plans, the contracting and payments approach for NHS and non-NHS organisations, and the processes to amend plans and access recovery funding, is outlined in the accompanying guidance.

Finally, we are asking local systems to return a draft summary plan by 6 May using the templates issued and covering the key actions set out in this letter, with final plans due by 3 June. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity plans.

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Agenda Item 10.3

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Receive
Item No	10.3	**Confidential / Freedom of Information Status**	No
Title	Integrated Commissioning Fund and Indicative Financial Plan		
Presented By	P Crawford, Interim Bury CFO; L Kitto - Interim s151 Officer Bury Council; C Shannon-Jarvis - Associate CFO NHS Bury CCG		
Author	Carol Shannon-Jarvis Associate CFO		
Clinical Lead			
Council Lead			

Executive Summary

The Council/ CCG Joint Health and Care Finance Group have proposed and revised, for 2021/22, the main purposes of the ICF, factors to consider, and key deliverables and risks. These are set out in the first part of this report and are recommended for adoption by the SCB. Small changes are proposed to the operation of the ICF, in terms of elements of the Pooled Fund, Aligned Fund and In-View Fund and, given uncertainty around the ICS transition and CCG funding arrangements as well as savings requirements, it is proposed that the 50/50 risk share be reviewed on a quarterly basis.

NHS Planning Guidance 2021/22 was released on 25th March 2021. A summary of that paper is provided as a separate agenda item. This report provides an early overview of an indicative ICF financial plan for 2021/22. Whilst Bury Council's budget is approved, in continuing response to the COVID pandemic the NHS national top down command and control framework remains in place. The CCG received its notified allocation for the first half year to September 2021 (H1) on 26th March. This is based on the second half of 2020/21 and anticipates lower COVID reimbursements and some efficiency savings. Further guidance is expected later in the year regarding allocations for the CCG's second half year to 31 March 2022 (H2).

CCG initial financial plans for the full year for Mental Health are subject to a separate return, along with H1 for all other services and associated revenue costs, and both are due to be submitted to NHSE/ I on 6 May 2021. Plans for H2 will be submitted following receipt of NHS guidance later in the year.

This report presents an early working position for the ICF budget. It assumes H1 funding for 2021/22 is rolled over into H2 with additional efficiency savings. It also assumes that CCG services are unaffected by the proposed transition of CCGs into an ICS by April 2022.

The initial position indicates total ICF expenditure budgets of in excess of up to £550m split as follows:

- pooled budget £300m-£350m
- aligned budget £100m-£150m

Executive Summary
• In-view budget <£50m The total ICF contribution for 2021/22, will be made up of the Council contribution of £150m+ which includes the additional 2021/22 contribution of £4.5m agreed in 2020/21. The indicative CCG contribution is £300m+. A further paper will be brought to the May meeting of the SCB which will include the CCG's full year Mental Health and H1 Budgets and an indicative H2 position. As and when known, later in the year, CCG allocations for H2 and related confirmed budgets will be presented to the SCB for approval. Effectively this paper reflects the continuation of the CCG's budgeting and reporting arrangements adopted during the 2020/21 financial year.
Recommendations
It is recommended that the Strategic Commissioning Board: • Approve the revisions to the proposed main purposes of the ICF. • Consider and Agree the factors to consider. • Consider and Approve the key deliverables. • Regarding the two changes proposed to the key decisions: - Note intended changes to the elements of the Pooled, Aligned and In-View Funds, - Agree 50/50 risk share to be reviewed on a quarterly basis. • Note the indicative opening ICF budgets that are based on Bury Council approved plans, the working position for CCG Mental Health and H1 allocations and H2 indicative plans. • Note a further update on CCG financial plans will be brought to the May SCB. • Note that further updates will be brought to SCB once 12 month CCG allocations have been announced. • Note the uncertain CCG financial regime beyond September 2021.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☐
Have any departments/organisations who	Yes	☐	No	☐	N/A	☐

Implications						
will be affected been consulted ?						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☐
Are there any financial implications?	Yes	☐	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
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.		

2021/22 Integrated Commissioning Fund (ICF) Budget

1. Introduction

1.1. The first part of this report provides an overview of the proposed operation of the ICF for 2021/22. It sets out the main purpose of implementing the ICF, factors to consider, key decisions and key deliverables.

1.2. The report also presents an early working position for Bury ICF financial plans for 2021/22. Whilst Bury Council has approved plans for 2021/22, NHS Planning Guidance 2021/22 was released on 25th March, and first half year (H1) CCG allocations were notified on 26th March, along with the full year Mental Health allocations. CCG financial plans relating to both of these allocations are to be separately submitted to NHSE/I on 6th May 2021.

1.3. The detail within the report relates to 2021/22. Following GM CCGs transition into a single GM ICS, arrangements from 2022/23 will need to be developed with future partners.

2. Overview of the Proposed Operation of the ICF

2.1. The main purpose of implementing the ICF, in relation to the services that fall within the scope of the partnership agreement, is to:

a) improve the quality and efficiency services;
b) improve the outcomes for users of the services;
c) improve population health for Bury residents (*NEW*);
d) secure a focus on prevention and early intervention to avoid the need for services (*NEW*);
e) ensure the relevant National Conditions and Local Objectives are met;
f) make more effective use of resources through the establishment and utilisation of the pooled fund for use on revenue expenditure required to deliver and the services.

Note c) and d) above have both been added by the Council/ CCG Joint Health and Care Finance Group for 2021/22.

2.2. Factors to consider, address and/ or prepare for during 2021/22 are (*NEW*):

a) Success of the ICF to date. (This is covered by the ICF Q4 2020/21 financial report);
b) Respective risks to OCO Partners in 2021/22;
c) Deliverables for 2021/22 (see paragraph 2.4);
d) White Paper & ICS transition (full details and impact not yet known);
e) Carnall Farrar proposition on locality working in the context of the GM ICS (in draft).

2.3. Key decisions for 2021/22 are:
a) OCO – continue to include ALL CCG and in scope Council services;
b) Continue with 3 subcategories and allocation of services to:
    a. *Section 75 Pooled Budget*
    b. *Aligned Budget*

c. *In-View Budget*

Note some minor redistribution between funds is under discussion (NEW);

c) Continue with financial offset arrangements between subcategories;
d) Continue with current risk shares (50/50);
   - subject to review at each SCB meeting following each quarter end (*NEW*)
e) No requirement to hold a contingency/ investment reserve in each fund budget;
f) Section 75 budget to continue to be hosted by the Council.

2.4. Key deliverables are (*NEW*):
a) COVID related activities;
b) GM ICS transition, including implications for OCO;
c) develop new arrangements and relationships with new Partners;
d) develop new pooling arrangements - GM ICS, Council, Providers - from 1/4/22;
e) 'Lets Do It' strategy/ Corporate Plan progression including service transformation;
f) review of care packages and CHC;
g) review of MH & LD services;
h) continuous review for improved efficiency and best use of Bury £;
i) other, including addressing cost pressures, reducing transaction detail;
j) savings/ disinvestment/ resolve Transformation Fund 'gap'.

3. Indicative ICF Financial Plan 2021/22

3.1. The Council 2021/22 budget was approved at the full Council meeting of 26th February 2021. The Council's budget faces significant financial risks. The need to deliver £8.5m in savings in 2021/22 needs to be monitored closely throughout the year. The Council is also using £12.3m from reserves to deliver a balanced budget. The reliance on reserves in 2021/22 and 2022/23 impacts on the Council's financial resilience and sustainability and will need careful monitoring and managing.

3.2. A breakdown of the budget between ICF budgets, including any proposed reallocations between each category of Funds for SCB approval, will be provided to SCB in May once CCG plans and their breakdown are available.

3.3. NHS Planning Guidance 2021/22 was released on 25th March 2021. A summary of that paper is provided as a separate SCB agenda item. The CCG received its notified allocation for a full year for Mental Health only and also, for all other expenditure, for the first half year to September 2021 (H1) on 26th March. This was a change to the previously notified guidance.

3.4. The CCG allocation is broadly based on the second half of 2020/21 financial year (with adjustments) and anticipates lower COVID reimbursements and some efficiency savings. It generally provides for lower growth and inflation assumptions.

3.5. This report provides an early overview of an indicative ICF financial plan for 2021/22. It assumes CCG H1 funding for 2021/22 is rolled over into H2 with an additional efficiency savings requirement being added. It assumes that CCG services are unaffected by the proposed transition of CCGs into an ICS by April 2022.

3.6. At this stage it looks as though the CCG has a pressure of up to £4m for H1. This is an in-year improvement that does not affect the previously reported underlying deficit of c£20m. However, it is important to stress that the CCG has had only 3 working days to look at detailed guidance so this position cannot be relied upon to give a true CCG position for H1.

3.7. This indicative position reflects adherence to national requirements regarding achievement of investment standards for Mental Health, Community Services and Primary Care as laid out in the NHS 10 year plan.

3.8. CCG financial plans for the full year for Mental Health are subject to a separate return, along with H1 for all other services and associated revenue costs, and both are due to be submitted to NHSE/ I on 6 May 2021.

3.9. The NHS national top down command and control framework will remain in place at least for H1. Further guidance is expected later in the year regarding allocations for the CCG second half year to 31 March 2022 (H2), when H2 plans will be submitted in accordance with NHS timescales.

3.10. Current indications show an overall ICF expenditure budget of £500m-£550m split between the 3 budgets as:

- pooled budget £300m-£350m – all health, social care and health related functions it is possible and the SCB has deemed it appropriate to pool.
- aligned budget £100m-£150m – all health, social care and health related functions that cannot be pooled or the SCB has deemed it not appropriate to pool.
- In-view budget <£50m – those budgets for which Bury incur cost and services, but decisions are made by an external body.

3.11. This is funded through a Council contribution of £150m+ which includes an additional contribution of £4.5m as agreed in 2020/21 and CCG contribution of £300m+.

3.12. For Council budgets although the COVID-19 pandemic brings significant uncertainty and financial pressures it will not affect the setting of budgets for services. In developing the Council's budget consideration of changes in demand, the fall out to time limited funding and inflationary increases have been taken into account. The Council has also committed to becoming a Real Living Wage employer and funding to reflect the additional costs associated with this have also been built in to the base budget. There are however financial pressures which means that the Council needs to deliver savings of £13m and is also planning to use £12.3m of reserves in order to achieve a balanced position. Detailed plans have been developed and will be closely monitored throughout the year.

3.13. For the CCG the financial regime is currently unchanged from 2020/21. The command and control approach put in place in 2020/21 in response to the COVID pandemic and interim financial arrangements will continue for H1 2021/22. The contracting process remains suspended with all NHS providers, who will remain on block payments as notified by NHSE/I. Independent sector hospital capacity has returned to previous levels and guidance is being issued on payments to all other non-NHS providers.

3.14. For the CCG this means we have received firm allocations for the first 6 months of the year from April to September (H1). The allocations for the period from October (Month 7) until the end of the year are currently unknown.

3.15. As with last year an updated ICF paper will be presented to SCB in May based on the CCG financial plan submission for H1 and an indicative position for H2.

4. Actions Required

The Strategic Commissioning Board is required to:

- Approve the revisions to the proposed main purposes of the ICF.
- Consider and Agree the factors to consider.
- Consider and Approve the key deliverables.
- Regarding the two changes proposed to the key decisions:
  - Note intended changes to the elements of the Pooled, Aligned and In-View Fund, and
  - Agree that the 50/50 risk share be reviewed on a quarterly basis.
- Note the opening indicative ICF budgets based on Council approved budgets and NHS March planning guidance.
- Note the uncertain finance regime beyond September
- Note that an updated paper will be brought to SCB once CCG financial plans have been approved by Governing Body and submitted to NHSE/I

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March 2021

Appendix A: Council 21/22 Budget Papers CCG to follow in May

The Councils Budget 202122 and

Appendix B: CCG Budgets by Cost Centre To follow in May

Appendix C: Council Budgets by Service To follow in May

Classification Open	Item No.

Meeting:	Cabinet
Meeting date:	23 February 2021
Title of report:	The Council's Budget 2021/22 and the Medium Term Financial Strategy 2021/22 - 2024/25
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 sets out the key elements of the 2021/22 budget proposals and the framework for the longer term Medium Term Financial Strategy (MTFS) 2021 – 2025. It makes available the latest financial information that will underpin the 2021/22 budget and the MTFS. The report also sets out the process that will lead to the agreement of the budget and the setting of the 2021/22 Council tax on 24 February 2021.

1.2 The information presented in this report is structured over the following areas:

- The financial context within which the budget and the MTFS will be agreed
- The summary revenue budget position 2020/21
- Developing the Medium Term Financial Strategy
- The options proposed to deliver a balanced budget in 2021/22
- The robustness of the budget and the adequacy of reserves
- The residual financial risks and uncertainties
- The financial framework

1.3 In setting the budget, consideration of the Housing Revenue Account and the Schools budget have been taken. Separate reports for these are set out elsewhere on the agenda.

Recommendation(s)

That Cabinet:

- **Approve the medium-term financial strategy and the assumptions regarding resources and spending requirements;**
- **Note the Council Tax base at 53,828 on which the Council Tax funding has been calculated as approved by Cabinet in December 2020;**
- **Approve the net revenue budget of £169.247m for 2021/22 and note that this includes an assumed increase in the council tax of 1.99%;**
- **Note the further option of a 3% social care levy and that this is not reflected the strategy;**
- **Approve the permanent spending allocations of £25.211m in 2021/22;**
- **Note the budget gap of £20.388m in 2021/22;**
- **Approve the budget reductions of £21.898m over the 4 years of which £8.056m applies to the 2021/22 financial year;**
- **Approve the use of reserves of £12.332m in 2021/22 and note the planned use of reserves of £14.355m in 2022/23;**
- **Note the forecast position on reserves;**
- **Note the Directorate cash limits;**
- **Note the significant financial risks for funding, income and demand pressures in future years and for the impact of Covid to impact on the strategy.**

Key considerations

Background

2 FINANCIAL CONTEXT AND BACKGROUND

2.1 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 including Social Care funding existed. Whilst a challenging situation, the emergence and impact of the Covid-19 pandemic brings even greater uncertainty and financial risk for some time to come.

2.2 The economic reality is fast changing and challenging and the extent of how long the effects of the pandemic will continue cannot be predicted with any great certainty. It is however inevitable that it will bring additional pressures in demand for the services provided by the Council and our partners. The significant financial impact of Covid-19 cannot be understated and as the economic impact of Waves 1 and 2 are still unfolding the potential for an even greater impact beyond is one which the Council needs to consider and plan for. In response to this, the Council has developed a plan for living with Covid-19 as part of a two year corporate plan. This corporate plans aligns to the first two years of the proposed budget strategy.

2.3 Over recent months the Council has been reviewing and reporting on its financial position and in November 2020 Cabinet received a financial planning document and

financial framework within which its 2021/22 budget was to 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 fact that Local Authorities continue to work with one year only settlements. Since then the Local Government Finance Settlement has been announced. Some of the granularity on the settlement is still emerging and the strategy is being updated as new information emerges. The detail set out in the report is based on the most up to date position but may change before the final budget is presented to Full Council on 24 February.

2.4 In October 2020, the Council launched a public consultation on the Bury 2030 strategy and it is essential that budget planning aligns to the vision and priorities set out in the strategy. The final Bury 2030 strategy proposes an ambitious reform agenda to improve outcomes for people in Bury through the following principles:

- A local, place-based approach to working with communities to improve social, environmental, health and economic outcomes
- Harnessing the enterprise of local people and businesses to drive economic growth, and ensuring every resident has the opportunity to connect to the opportunity of this growth through their skills, networks and scope for meaningful work
- A new collaborative approach to delivering together with communities, to share ownership of issues and opportunity and combine all resources
- A strengths-based approach to public service delivery, to build on the resources people have to solve issues and target resources on the gaps rather than taking a deficit-based view

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

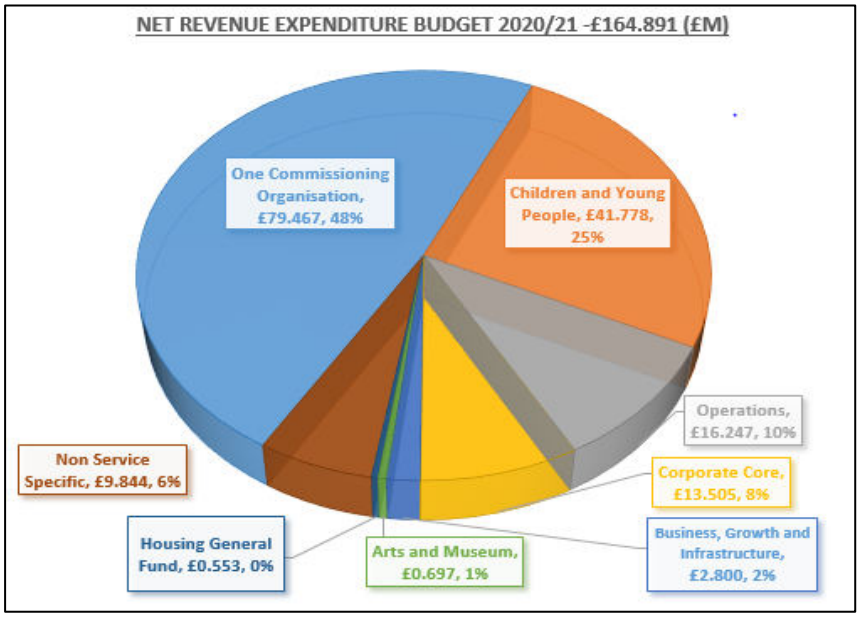
- the need to drive internal improvements across core key functions within the partnership such as organisation strategy; programme delivery and IT/Digital infrastructure;
- a requirement to develop the internal capabilities to deliver vision of Bury 2030 outcomes;
- public service reform to support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

2.6 It is within this context and underpinned by the Council's capital strategy that the Council's approach to setting the 2020/21 budget has been developed. Over recent months Cabinet and the Executive Team have been involved in detailed discussions on how the Council's budget may be reshaped and transformed to deliver the services and outcomes that are needed but within a reduced 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-19. 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.

2.7 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 and has been significantly affected by Covid and this is likely to impact for some time to come.

2.8 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:



2.9 Since 2010 the Government has reduced the funding for Local Government as part of its efforts to reduce the fiscal deficit and as part of austerity measures. This has resulted in the need for significant savings over recent years.

2.10 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. The Council also has priorities that require capital investment and the revenue requirements to fund these are included in the strategy.

2.11 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. The Government has provided one-off funding throughout 2020/21 to help Local Authorities manage in in-year position and impact of Covid. This funding has largely covered the cost in year but is however one-off and the longer-term impacts of Covid currently need to be manged within the financial strategy.

Local Government Finance Settlement

2.12 The Council continues to work with a one year only Local Government Finance Settlement. The anticipated 3-year funding settlement for Local Authorities and the outcome of the Fair Funding Review and Business Rates Retention Scheme have been delayed further as a result of the Covid pandemic. The pandemic itself has

also placed significant pressure on the Council's financial position both now and in future financial years and the uncertainty that all of this presents and continues to present is a key risk in the strategy overall.

2.13 Such significant uncertainty must be considered in deciding the Council Tax increase position as part of the budget setting process. Within this context, the council needs to achieve a balance of ambition, prudence and resilience in setting its medium term financial strategy.

2.14 The 2020/21 Local Government Finance Settlement was announced on 17 December 2020. The settlement confirmed the following national amounts:

- proposals for Council Tax referendum limits for 2020/21 and the option to extend the Adults Social Care levy;
- The continuation of the existing £2.5bn of existing Social Care grants into 2020/21 including the Improved Better Care Funding, Winter Pressures Grant and Social Care Support Grant;
- Additional funding of £300m for social care;
- £670m for a Local Council Tax Support grant to fund authorities for the expected increase in local council tax support in 2021/22;
- £1.55bn Covid funding to fund expenditure and income losses to the middle of 2021/22;
- £750m for rough sleepers of which £165m relates to the Troubled Families programme;
- £4bn levelling up fund focusing on town centre regeneration and culture. This is capital monies for which Local Authorities can bid for in the future.
- £622m allocations of the New Homes Bonus;
- £11m Lower Tier Services Grant Allocation;
- Confirmation of the Dedicated Schools Grant in line with the previously announced 3 year settlement;

2.15 The Government has also stated that it will seek to find a new consensus for broader reforms for local government including the Fair Funding Review and the Business Rates Retention Scheme when the post-COVID future is clearer. The Government has also announced a commitment in the Health and Care Bill announced in February 2021 for adult social care reform later this year. For planning purposes, no changes in have been assumed.

2.16 The settlement is largely a 'roll over' settlement with some inflationary increases and specific increases for social care and one-off monies to reflect additional costs of the Covid-19 pandemic. The settlement has been highlighted by the government as providing a 4.5% increase to local authorities. The largest proportion of the Spending Power increase is however from locally raised council tax which is the subject to local decision making.

2.17 The Council must ensure it has a robust financial base and also holds sufficient reserves to mitigate against planned or unplanned expenditure and other risks. Reserves can only be spent once and therefore a strategy that does not rely on the one–off use of reserves to support was a key feature on which the 2020/21 budget was based. The impact of the pandemic has however meant that reserves are needed to support some of the anticipated short term financial impacts on the council. This is in line with the Council's strategy.

2.18 Table 1 sets out the base revenue forecasts through to 2024/25. By 2024/25 the council is estimated to have £176.360m revenue resource. These figures assume a 2% council tax increase in each year. An increase for the social care levy is not assumed in the figures however would generate a further £2.2m in 2021/22 if the full 3% increase was applied. The setting of the council tax precept is one for full council after taking advice from officers and information available at that time.

2.19 The assumptions underpinning the figures in Table 1 below are:

- 2% annual increase in council tax for each financial year
- No impact of the anticipated Fair Funding and Business Rates Retention Schemes;
- The Better Care Fund, the main element of the Improved Better Care Fund and other longstanding government grants continue to be received at their current levels over the medium term.
- The new Social Care Grant is assumed as one-year only grant for 2021/22.

Table 1

Revenue Resource Forecasts 2021/22 – 2024/25				
	2021/22	**2022/23**	**2023/24**	**2024/25**
	£m	**£m**	**£m**	**£m**
Council Tax	87.992	91.975	96.094	99.501
Business Rates	59.204	60.551	62.073	63.649
Better Care Grant and core i-BCF	7.405	7.405	7.405	7.405
Lower Tier Grant	0.252	0.000	0.000	0.000
Social Care Grants	4.770	4.770	4.770	4.770
New Homes Bonus	0.253	0.035	0.000	0.000
Covid-19 Grant	5.330	0.000	0.000	0.000
Local Council tax Support Grant	2.080	0.000	0.000	0.000
New Social Care Grant	0.926	0.000	0.000	0.000
Other Government Grants	1.035	1.035	1.035	1.035
TOTAL	**169.247**	**165.771**	**171.377**	**176.360**

Council Tax and Business Rates

2.20 Incorporated in the resource forecasts is an assumption that the council tax increases available to the council as part of the Local Government Finance Settlement are taken. Not only does this approach ensure the council's financial sustainability over the medium term, it is also assumed in the Governments estimates of the funding available to local authorities. At this stage the Adults Social Care levy is not included although there is an assumption from government that it will be taken by Local Authorities.

2.21 Collection rates for both Council Tax and Business Rates have been significantly impacted during 2020/21 and assumptions have been made for future years. The collection fund is forecasting a deficit position as a result of Covid and new accounting arrangements have been approved that enables Council's to spread the impact on the 2020/21 deficit over 3 financial years. The spread of the deficit is

included in the funding assumptions. The calculation of the Council Tax base 2020/21 is set out in Appendix 1.

2.22 Assumptions for future years have been made on the latest available information and reflect lower collection rates than have been assumed in previous years. There is a risk that the actual collection rates may be lower still than that assumed – the ending of the government's furlough arrangements and the ability of our businesses to recover economically are likely to be significant factors in collection rates. The full impact is only likely to emerge during the year and the position will be closely monitored.

2.23 With many local authorities forecasting substantial reduction in rates revenue for 2021/22 and higher thresholds in calculating when Government would support any losses, the 12 members of the Greater Manchester and Cheshire Pool have agreed to dissolve the current business rates pool from 2021/22. Whilst this means that Bury will now be considered as an individual authority for the purposes of the business rates retention scheme, Bury will still remain part of the Greater Manchester 100% retention scheme.

2.24 The provisional Local Government Finance Settlement set out the maximum level of council tax that can be raised in 2020/21. SR2020 committed the Government to allowing a 2% increase in the core council tax and an extension to the ability to raise a further 3% adult social care levy.

Adult Social Care Levy

2.25 In addition to taking the maximum increase in council tax income, the council has a further option of extending the adult social care levy for a further year. No assumptions on the adults social care levy have been assumed in the financial information set out in the report. The 3% adults social care levy would generate an additional £2.2m of funding in 2021/22 and this would also be available in future years as recurring income.

3 FORECAST OUTTURN POSITION 2020/21

3.1 It is important that the current year's position is taken into consideration and that any trends and information available are reflected on. Monitoring at the end of the third quarter, December 2020, shows that the council is forecasting a small underspend of £0.053m which is broadly a break-even position. Whilst overall this is a positive position there are a number of significant risks within the budget that are currently being offset by short term government grant funding which is not guaranteed beyond the current financial year. This remains a significant risk for future years. Table 2 below provides a summary of the forecast position based on information available at the end of December 2020.

Table 2

2020/21 Forecast Revenue Out Turn Position – as at 31 December 2020			
Directorate	**Approved Budget**	**Forecast Out Turn**	**Forecast (Under)/Over Spend**
	£m	**£m**	**£m**
One Commissioning Organisation	79.498	79.385	(0.113)
Children and Young People	41.778	43.255	1.477
Operations	16.247	24.059	7.812
Corporate Core	13.473	13.680	0.207
Business, Growth and Infrastructure	3.397	3.777	0.380
Arts and Museum	0.697	0.719	0.022
Housing General Fund	0.553	1.116	0.563
Non Service Specific	9.247	(1.153)	(10.400)
TOTAL	**164.891**	**164.838**	**(0.053)**

3.2 The budget remains under regular review by the Chief Executive and the Executive Team and is reported on a quarterly basis to Cabinet. The potential for the position to change as a result of the Covid pandemic remains a risk and will continue to be managed and monitored carefully for the remainder of the year. A separate report on the Council's financial position at the end of December 2020 is set out as a separate report to the Committee. The main variances in Table 2 reflect loss of income in the Operations Directorate and additional grant income received from the government which is shown in the Non-Service specific line.

4 DEVELOPING THE MEDIUM TERM FINANCIAL STRATEGY AND THE 2020/21 BUDGET

4.1 The spending needs of the council have been developed alongside the resource forecasting. In developing spending need, consideration has been given to ensuring the budget:

- delivers investment in projects and programmes that will support the ambitions and objectives set out in the Bury 2030 plan;
- reflects the response and recovery to the Covid pandemic;
- delivers the long-term financial sustainability of services and the council as a whole;
- ensures financial resilience in the medium term;
- continues to drive forward the implementation of the council's change agenda to ensure core services, infrastructure and resources can be used flexibly and effectively to meet future challenges and deliver for residents, businesses and communities.

Permanent Spending Need

4.2 The additional permanent allocations proposed total £45.119m over the 4 year period and are set out in Appendix 2 to the report and are summarised in Table 3. It is

important to note that the allocations for 2022/23 onwards are only indicative and will be updated and refreshed at regular intervals. The key areas are:

Decisions made in-year and full year effect (£2.115m in 2021/22)

4.3 During the year, some decisions have been made that have a permanent impact on the Council's budget. This includes a decision made earlier in the year to provide a loan to Manchester Airport Group which is a key strategic investment for the Council. Additionally, some decisions were made in the 2020/21 budget that have a full year effect in 2021/22 including the funding of the approved capital programme and increase in corporate capacity.

Pay Inflation (£0.250m in 2020/21)

4.4 A pay freeze has been assumed in 2021/22 and this is based on government announcements and its intention to freeze public sector pay. A 'catch up' element to reflect the higher than budgeted for pay award from April 2020 has however been factored in. The pay bill is driven by the national pay agreement and is therefore outside of the control of the council. Should a pay award be announced, the cost of this will have to be managed within service budgets in 2021/2. Pay awards of 2% per annum have been assumed for all later years of the strategy.

Contractual Inflation (£4.125m in 2020/21)

4.5 The council has a range of contracts to which there is a contractual commitment to increase by an inflationary amount each year. This has been built into the budget and includes the increases in the national living wage that needs to be reflected in payments to care providers.

Demand (£4.361m in 2020/21)

4.6 The council is experiencing increases in demand for some services as a result of demographic change. The main areas are:

- Adult social care including the number of people accessing services as well as an increase in the complexity of need;
- Placements for the support for children who are looked after, at risk and children with disabilities;
- Costs of children transitioning to adults services;
- realignment of costs previously funded from the Dedicated Schools Grant.

Fall Out of Time Limited Funding (£0.723m)

4.7 Some adult social care services have been funded from time limited resources over the past few years included health transformation funding. As there remains a strong alignment with the council's key objectives and outcomes it is proposed that the funding for these services is put on a sustainable basis going forward.

Unachieved Savings (£1.110m)

4.8 The recent monitoring is showing that a significant number of savings agreed in previous financial years are not considered to be deliverable. It is not considered prudent or sustainable for services to carry forward savings targets that realistically cannot be achieved and it is proposed that these be added back into the budget. Some of the unachieved savings in 2020/21 directly relate to Covid however those relating to the Corporate Landlord model and the Architects Service are considered

to be undeliverable in the long term. There may be an opportunity for some costs to be reduced over time as part of the transformation programme.

Budget Realignment (£2.295m)

4.9 The Council has a number of funding streams available from which services are funded. A review of costs and where they are charged to has been carried out and has established that some realignment is required.

Borrowing to Support the Capital Programme (£2m over 2021/22 and 2022/23)

4.10 The council's capital strategy and draft capital programme has been developed. Delivering the capital programme will require investment that can only be supported through borrowing. A total of £2m has been built into the financial strategy to support the borrowing costs needed to deliver the priority projects identified including the Radcliffe Regeneration Framework and the Council's regeneration ambitions. This approach is considered prudent and ensures that the council has a sustainable basis on which its capital programme is built.

Income Losses (£9.233m in 2021/22)

4.11 The Covid pandemic has impacted significantly on the Council's income assumptions. This includes the dividend and loan repayment interest that the Council receives from its investment in Manchester Airport Group and also income from car parking and leisure services. For planning purposes, it is assumed that all income losses will be short term and will be recovered by the 2023/24 financial year. This is a planning assumption and will be kept under review.

Summary Spending Position

4.12 Bringing all of these elements together indicates that the council has a spending need of £190.102m in 2020/21 increasing to £210.010m in 2024/25. A breakdown of this is shown in the Table 3.

Table 3

Summary Forecast Spending Requirement 2021/22 – 2024/25				
	2021/22	**2022/23**	**2023/24**	**2024/25**
	£m	**£m**	**£m**	**£m**
Budget/Spending Requirement Brought Forward	***164.891***	***190.102***	***199.865***	***200.484***
Decisions Made in Year and full year effect	2.115	0.000	0.000	0.000
Pay Inflation	0.250	1.865	1.870	1.904
Contractual Inflation	4.125	5.771	5.988	6.254
Demand	4.361	1.534	1.448	1.362
Fall-Out of Time Limited Funding	0.723	0.132	0.007	0.007
Unachieved Savings	1.110	0.000	0.000	0.000
Budget Re-alignment	2.295	0.000	0.000	0.000
Borrowing to Support Capital Programme	1.000	1.000	0.000	0.000
Income Losses	9.233	(0.539)	(8.694)	0.000
Sub Total	**25.211**	**9.763**	**0.619**	**9.526**
TOTAL FORECAST ONGOING SPENDING REQUIREMENT	**190.102**	**199.865**	**200.484**	**210.010**

5 PROPOSALS FOR BALANCING THE BUDGET

5.1 Comparing the forecast resources to the forecast spending needs shows that there is a funding gap that needs to be addressed. The gap in 2021/22 is £20.388m and is significantly higher than previously anticipated due to Covid. Some of the gap is resulting from increased demand that will have a long-term impact and some of it relates to a short-term income loss. To avoid unnecessary long term budget reductions, a balanced approach using a combination of budget reductions and the use of one-off reserves is proposed.

5.2 Savings options totalling £8.056m for 2021/22 increasing to £21.298m by 2024/25 have been developed and full details are set out in the Appendix 3 and 4 to the report. All of the options have been subject to a corporate assurance process to ensure they are deliverable. Cabinet are recommended to approve these options. In addition to the budget option, planned use of reserves of £12.332m is proposed in 2021/22.

5.3 In the longer term a further planned use of reserves totalling £14.355m is proposed with an ongoing savings requirement of £10.950m remaining in the last 2 financial years. The position will change over time as the MTFS is updated to reflect changes in demand, legislation and funding frameworks and will be reported to Cabinet at regular intervals. A summary of the financial gap is set out in Table 4 below.

Table 4

Forecast Financial Gap 2021/22 - 2024-25				
	2021/22	**2022/23**	**2023/24**	**2024/25**
	£m	**£m**	**£m**	**£m**
Forecast Spending Requirement	190.102	199.865	200.484	210.010
Savings from prior years	(0.467)	(0.802)	(0.802)	(0.802)
Savings from 20/21 process in future years	0.000	(8.056)	(18.937)	(21.398)
Forecast Resources	(169.247)	(165.771)	(171.377)	(176.359)
FUNDING SHORTFALL/(SURPLUS)	**20.388**	**25.236**	**9.368**	**11.450**
Efficiency Proposals	(4.053)	(3.711)	(0.500)	(0.500)
Service Reduction Proposals	(4.003)	(7.170)	(1.961)	0.000
Planned Use of Reserves	(12.332)	(14.355)	0.000	0.000
Sub Total	**(20.388)**	**(25.236)**	**(2.461)**	**(0.500)**
CUMULATIVE SHORTFALL/(SURPLUS)	**0.000**	**0.000**	**6.907**	**10.950**
IN YEAR SHORTFALL/(SURPLUS)			**6.907**	**4.043**

Efficiency Proposals

5.4 Appendix 3 sets out the detail on efficiency options totalling £4.053m in 2021/22 which increase to £8.764m in 2024/25. These options are deemed to have no impact on service delivery and the majority of which reflect budget reductions to reflect actual expenditure. Others include a review of contracts with external providers and additional income growth as a result of the Council's investment in the economic regeneration and housing agenda. A removal of staffing budgets to reflect staffing in the Children and Young People's Directorate is also included. Efficiency savings will be challenged and reviewed throughout the lifetime of the strategy.

Transformation

5.5 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 one-off fund of £5.8m was created to support transformation with the expectation that long term, recurring savings would be delivered. In managing the gap, it is proposed that a total of £5m ongoing savings 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.

5.6 Transformation projects will be pursued that improve service outcomes and can deliver efficiency savings as well. Initial areas of focus are set out in Table 5 below:

Table 5

Transformation Workstream	Proposed savings option
Leadership	**Agile Working model** – improvement in staff productivity and reduction in Council owned and occupied buildings and operating costs. This will also create carbon reductions.
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

5.7 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 service 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.

5.8 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:

- The Bury 2030 Strategy and Corporate Plan.
- Customer services related to the specific budget option proposed.
- Data expectations and potential.

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

5.10 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.

5.11 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.

Budget Reductions

5.12 A set of budget reductions are set out in Appendix 4 and are summarised as follows:

Transformation and Innovative Commissioning

5.13 The Council seeks to commission services for adults and children in a way that secures the transformation and innovation in the way those services are delivered. The Council will work with providers to engage differently with people – recognising and building on people's strengths, connecting people to communities and ensuring all care is outcome focused. The Council's 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. 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. We will work jointly with Persona to reshape the existing provision, transforming services and developing new ways of working to realise efficiencies, and in some cases, this may mean the reduction or closure of services.

5.14 The Council 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.

5.15 The Council will 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

5.16 The Council 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 and a transformation programme is being developed.

Development of Assistive Technology

5.17 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.

5.18 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

5.19 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 the Council needs 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 realise 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 Efficient Commissioning of Adult Care Services

5.20 A number of areas have been prioritised to strengthening our approach to the effective commissioning of adult care services: -

- Working with Bury CCG to review and refine the operation of the Continuing Health care arrangements,
- More effective and efficient payment of Care at Home,
- Continuation of the work in respect of effective market management of care services in borough ensuring the right mix of services available to reflect future demand and transformed services
- More effective management of personal budgets

5.21 The proposals in adult social care are in line with the 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 and the scale of the transformation required by the health and care system as a whole. 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

5.22 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
- Personalised conversations
- New quality assurance framework

- Providing social care with the tools and information to work differently

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

5.24 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 about irrationally removing support packages but rather developing alternative options that may not have been available at the point of assessment due to new ways of transformational working.

Operations

Civic Venues

5.25 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. It is proposed that the civic venues do not reopen and in doing so, this will generate an ongoing saving as well as avoid the cost of future capital investment. Future opportunities for the venues will be considered as part of regeneration plans.

Waste Review and Vehicle Rationalisation

5.26 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 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

5.27 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.

5.28 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.

5.29 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 streetlights being dimmed. A number of pilots have already taken place across Bury, with no negative feedback being received.

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

Children and Young People

5.31 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.

5.32 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.

5.33 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.

Fees and Charges

5.34 The budget assumes an inflationary increases in the Council's fees and charges.

Cash Limits

5.35 Proposed cash limits for each Directorate are set out at Appendix 5

6 RESERVES

6.1 The proposals for the 2021/22 budget creates a reliance on one-off reserves. When the 2020/21 budget was set the reliance on one-off reserves was removed and an ongoing planned contribution to reserves of £0.567m was built in. At the same time the surplus on the collection fund was released and £10m applied to the general reserves in order to boost financial resilience. A review of provisions and reserves was also carried out as part of the 2019/20 closure process and reserves aligned to strategic risks. As a final measure, a reserves strategy that has introduced greater governance, transparency and controls over the use of reserves was approved by Cabinet in July 2020.

6.2 This approach has served the Council well and has ensured that as much financial resilience as possible has been factored into the strategy. The Covid pandemic and the short-term impact on income means that the Council is proposing to use some of the earmarked and general reserves to manage the position both in 2021/22 and 2022/23. In total this amounts to £26.687m. Whilst the position for 2022/23 is likely to change the proposed approach creates a significant dependency on reserves and regular monitoring and mitigating actions will be needed should there be any other emerging issues or risks that need to be managed.

7 ROBUSTNESS OF THE BUDGET AND THE ADEQUACY OF RESERVES

7.1 Section 25 of the Local Government Act 2003 requires that, in giving consideration to budget proposals, members must have regard to the advice of the Council's Chief Finance Officer on the robustness of the estimates and the adequacy of the Council's reserves.

7.2 The basis on which the budget has been prepared, as in previous years, relies on the forecast of activity and the impact of changes in policy previously agreed by the Council. These forecasts are kept under review as part of the budget monitoring process and actions identified to address financial risks arising from the changes in the forecast as they occur.

7.3 The Council holds reserves for a number of reasons:

- To enable the Council to manage variations in the demand for services which cause in year budget pressures.
- To fund specific projects or identified demands in the budget.
- To enable the Council to deal with unexpected events such as flooding or destruction of a major asset.

7.4 Setting an appropriate level of reserves is a matter of judgement taking into account:

- The level of risk evident within the budget as set out above.
- A judgement on the effectiveness of budgetary control within the organisation; and;
- The degree to which funds have already been set aside for specific purposes which will reduced the need for general reserves.

7.5 Based on the budget proposals set out in the report and taking account of the current forecast out turn position, the Council will see a reduction in its general reserves from a projected £26.814m at the end of 2020/21 to £23.149m at the end of 2021/22. The projected reserves position takes this into account:

- One-off release from the collection fund 2019/20 (£10m)
- Higher than budgeted contribution to the pooled fund in 2020/21 by the Clinical Commissioning Group to offset the lower than budgeted contribution in 2019/20 that was met from the Council's general reserves (£10.5m);
- Planned annual contribution to reserves from 2020/21 onwards (£0.567m).

7.6 The Covid pandemic and the impact on income means that reserves will be needed to balance the budget in at least the first 2 years of the financial strategy. The robustness and resilience of reserves is key and will be monitored on an ongoing basis.

7.7 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.

7.8 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. To improve the governance and management of reserves, a reserves policy was approved by Cabinet in July 2020.

7.9 A forecast of reserves has been carried out and is set out in Table 6 below.

Table 6

Forecast Position on Reserves - Assumes all ongoing savings delivered				
	2019/20	**2020/21**	**2021/22**	**2022/23**
General Reserves	6.989	26.814	23.149	16.955
Corporate Reserves	7.794	6.794	5.794	4.794
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	14.480
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**	**75.312**	**55.025**	**36.471**
DSG Reserve	(20.067)	(25.544)	(25.607)	(24.991)
TOTAL FORECAST RESERVES	**50.676**	**49.768**	**29.4187**	**11.480**

7.10 The overall forecast position shows that the Council should have sufficient financial resilience in the short term. There are however a number of key risks that should they crystallise in an of the financial year are likely to created further pressure on the reserves position and therefore it is ever more important that reserves now become a permanent feature of the monitoring reports to Cabinet on a quarterly basis. Table 7

below sets out the scale of a small variance in the assumptions made, showing the potential of both a positive and negative movement of 1% across the main areas within the MTFS.

Table 7

Financial Risk in the MTFS	
	Potential Full Year Impact £m
Pay (1%)	0.986
Price inflation (1%)	1.500
Council Tax Collection Rate	0.879
Business Rates Collection Rate	0.592

7.11 Other key risks that will need to be factored and reflected in the ongoing monitoring throughout the year include:

- the economic uncertainty resulting from Covid and the potential impact of Brexit. The impact of the pandemic is already emerging through increased demand and loss of income but the wider economic impact on the ability of businesses to survive and/or pay business rates will be a key factor. Demand for welfare services when the furlough and other support schemes available come to an end is also likely;
- the financial regime within which the Clinical Commissioning Groups operate is uncertain and unknown. The relationship of health and social care funding through the pooled fund and transformation funding is a central part of the Council's budget;
- the future of grants, particularly those in relation to social care, is unknown. Social Care grants, including the Better Care Fund, equate to £9.2m in 2021/22. A 1% change in these is £0.920m;
- pay awards have not yet been finalised. The pay bill is driven by the national pay agreement and changes above and that assumed in the MTFS will need to be managed as a risk in year;
- the lack of a long-term national strategy to fund the increasing costs of social care is a significant risk. The ability for councils to continue to try and manage demand within their existing budgets is not sustainable and is placing increasing risk on councils.
- The deficit on the Dedicated schools Grant that is currently forecast to be £25m by the end of the 2020/21 financial year and which is currently offset by the Council's reserves. The Council is currently working with the Department for education on a recovery plan as part of the Safety Valve project and it is anticipated that some of the financial pressure will be reduced as an outcome of this work.

7.12 Budgetary control processes are in place to manage in year expenditure. Effectiveness of budgetary control is a combination of systems and processes as well as the risk environment within which the Council is operating. It therefore remains an essential requirement that the Council continues to ensure that processes are

effective in maintaining a grip on in year expenditure and also that there is a clear focus on delivering a balanced and sustainable budget.

7.13 In response to the Covid pandemic, the Council introduced some accounting principles intended to provide greater financial grip in responding to the financial impact of the pandemic. The principles agreed are still in place and are as follows:

- 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.

8 FINANCIAL FRAMEWORK

8.1 The Council has previously adopted four 'Golden Rules' as part of its long-term approach to financial management and overall financial framework and these have been met in the current financial year. These 'Golden Rules' are as follows:

- The level of General Fund balances retained by the Council to meet unexpected changes in the budget or to fund events that cannot be foreseen will be based on an assessment of the risks faced by the Council.
- Use of one-off options to support the on-going revenue budget must be in the short term only and supported by a robust strategy to address underlying pressures in the Council's cost base.
- Prudential borrowing can be undertaken to support capital spending relating to regeneration/growth initiatives and commercialisation/transformation of council services. All proposals to be subject to robust business cases assessing prudence, sustainability and affordability.
- Pressures and savings will be assessed on a 3 year, rather than a one year basis through a revised medium term financial strategy.

Capital Strategy

8.2 The Capital Strategy is prepared in accordance with the latest Chartered Institute of Public Finance and Accountancy (CIPFA) Prudential and Treasury Management Codes of Practice. The strategy provides a framework within which the Council's capital investment plans will be delivered. These plans are driven by the Council's objectives and are linked to the development of the Bury 2030 strategy.

8.3 The proposed capital strategy and programme 2021/22 – 2023/24 also takes the essential elements of previous year's strategies and programmes and moves them forward to the forthcoming year. Capital spending is a key determinant of future

revenue commitments and the capital programme and revenue budget are interlinked and have been developed as integrated strategies.

8.4 The ability for the Council to deliver its ambitions relating to capital will to some extent be affected by the Council's ability to afford the borrowing costs associate with this. A closer alignment of the revenue and capital budget is currently being developed and it is anticipated that the financial strategy in future years will be a fully integrated one that includes revenue, capital and growth and investment strategies. The co-dependency and inter dependencies of the strategies is becoming more evident as the Council set out its longer-term plan and ambitions in both the Bury 2030 Strategy and the Corporate Plan.

Treasury Management Strategy

8.5 The treasury management strategy is prepared in accordance with the CIPFA Prudential and Treasury Management Codes of Practice. The strategy sets out the Council's approach to managing investments, cash flows, money market and capital market transactions. The strategy provides a framework for the effective control of risks associated with these activities.

8.6 The Treasury Management strategy for 2020/21 reflects the Council's capital expenditure plans as set out in the capital strategy. The strategy also sets out the position in relation to the prudential indicators arising from the Council's capital expenditure plans. As well as borrowing and investment strategies, the Treasury Management strategy also covers the current treasury position, economic outlook and interest rates forecasts, risk and creditworthiness. Finally the strategy also includes the council's policy on borrowing in advance of need and the Minimum Revenue Provision (MRP) policy statement. No changes to the MRP policy or the treasury management strategy are proposed although some updates will be made and the strategy for 2021/22 will be presented to Full Council in March 2021.

Housing Revenue Account

8.7 A separate Housing Revenue Account report has been prepared for presentation to Cabinet and is set out as a separate report on the agenda. This report sets out the recommended dwelling and non-dwelling rents and service charge increase to be applied from April 2021. The report is a key element of the Council's overall medium term financial strategy.

Dedicated Schools Grant

8.8 A separate report on the Dedicated Schools Grant (DSG) is set out elsewhere on the agenda. This report sets the schools budget for 2021/22 and also the hourly rates for the early years education. The report also sets out the position the DSG deficit relating to high needs and information on the recovery plan and the DfE's Safety Valve Project which the Council is currently part of.

Local Taxation and Benefits Discretionary Policies

8.9 Annually the Council reviews and updates policies covering discretionary Council Tax discounts, discretionary business rates relief, local welfare provision and discretionary housing payments. These policies provide support to local businesses and some of the poorest and most vulnerable residents within the borough. These policies operate within a legislative framework determined by various Local Government Acts of Parliament. During 2020/21, the welfare policies have been

updated and criteria expanded to reflect new and emerging groups of residents within the borough in need of welfare support. Some one-off grant funding has been provided to support our most vulnerable residents and it is likely that demand for support will continue to grow, particularly as the economic impact of the pandemic unfolds and some of the temporary support mechanisms come to an end include mortgage and debt holidays, furlough etc. The financial impact of these policies is currently being managed within the financial strategy, but more costs may need to be built in should demand continue to grow.

Counter Fraud and Corruption

8.10 The Council has a series of refreshed policies and procedures to support the provision of an appropriate counter fraud service to minimise fraud and to investigate potential fraud and corruption. The Accounts and Audit Regulations 2015 state that the Council must have measures in place 'to enable the prevention and detection of inaccuracies and fraud'. In this context fraud also refers to cases of bribery and corruption. The budget proposals contained in this report rely on effective processes for mitigating the risk of financial loss from fraud, bribery and corruption. Fraud measures required to meet the requirements of MHCLG for the business grants that have been provided to support businesses affected by the pandemic have been complied with and the Council is continuing to be part of the national groups and data sharing arrangements.

CIPFA Financial Management Code

8.11 CIPFA's Financial Management Code was published in October 2019. The objectives of the code are 'to support good practice in financial management and to assist Local Authorities in demonstrating their financial sustainability'. The code is based upon a series of principles which will be supported by specific standards of practice which CIPFA consider necessary for a strong foundation. The foundation being the ability to:

- Financially manage the short, medium and long-term finances of a Local Authority
- Manage financial resilience to meet foreseen demands on services
- Financially manage unexpected shocks in their financial circumstances

8.12 Local Authorities are expected to comply with the requirements of the code by 1 April 2020 as a shadow year and full compliance from 1 April 2021. The Code will therefore provide Local Authorities with a platform for good financial management throughout 2020/21. Work is underway within the finance service to ensure compliance with the Code and an update will be provided to the Audit Committee. It is fully expected that the Council will be fully compliant with the code by 2021/22.

9 OTHER RISKS/OPPORTUNITIES

CCG Funding

9.1 Funding of the Clinical Commissioning Groups remains uncertain and the financial regime and framework has yet to be agreed. There is the potential for this to impact on the Council's budget particularly reflecting the relationship with the pooled fund and integrated care and commissioning. In recognition of the co-dependency of outcomes from NHS spend in the borough with Council spend, and the alignment of strategic vision, a proportion of council budget operates as an 'integrated' budget

with Bury CCG, including a proportion that is formally pooled. Work is ongoing to understand the 2021/22 financial allocation to the CCG and the financial regime in the NHS, and the opportunity to jointly invest and benefit from system wide health and care transformation will continue to be pursued.

Traded Services

9.2 There are a number of traded services across the Council that are failing to meet their income targets largely due to reduced demand, some of which relate to the academisation of schools. A review of traded services and options for financial sustainability will be brought forward during the year. No increase to income budgets has been assumed and any proposed increases in fees and charges will help to reduce the income shortfall. Any under recovery of income in the current financial year will be managed as a risk.

10 CONSULTATION

10.1 The Council commenced a budget conversation in November 2020 and this is continuing until mid-February 2021. Engagement with key stakeholders on the Bury 2030 strategy and priorities for the Council, has also provided an opportunity for future resourcing and the allocation of spending to be considered. The findings of this engagement has been factored into the budget setting process. Where required individual consultation on proposals will be carried out prior to implementation and this is set out in the individual budget proposals set out at Appendix 4.

10.2 As proposals are developed for implementation, detailed consultation with relevant stakeholders including trade unions will be undertaken. For efficiency options this includes consultations with staff and trade unions.

10.3 The Council's Overview and Scrutiny Committee and the Strategic Commissioning Board have been consulted on the proposals.

Community impact / Contribution to the Bury 2030 Strategy

Delivery of the Bury 2030 strategy is dependent upon 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*.

Equalities Duty

In considering the budget for 2021/22, Members must consider the Public Sector Equality Duty under s149 Equality Act 2010. The Council must, when exercising its functions, have due regard to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited by the Equality Act and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' under the Act and those who do not share a protected characteristic. A 'protected characteristic' is defined in the Act as age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Marriage and civil partnership are also protected characteristics for the purposes of the duty to eliminate discrimination. Members must consider how the decision will contribute to meeting these duties in light of other relevant circumstances such as economic and practical considerations.

Assessment of Risk:

The following risks apply to the decision:

Risk / opportunity	Mitigation
The Council has a statutory duty to set a legal budget for the following financial year. This report sets out an approach that enables this to be achieved within the required timescales.	The report sets out an approach for setting the 2021/22 budget taking into account all known factors and includes an assessment of risk.
Financial considerations are not reflected in decision making.	The financial outlook for the Council provides a financial framework which will support effective decision making.

Consultation:

Role of Overview and Scrutiny committee in budget process

Under the Council's Constitution, the Overview and Scrutiny Committee is required to advise and consider the cabinet's budget and Council Tax proposals and report to cabinet on the outcome of its deliberations before the matter is referred to council.

In considering the budget proposals, the committee can challenge how the budget has been constructed. It may wish to probe the assumptions that lie behind the budget strategy, ie is the approach incremental or is it starting from a base budget, what are the main savings

proposals, how will any growth be funded, are the financial implications of proposals from departments or committees built into the overall budget and has an appropriate level of reserves been set. This scrutiny needs to build on the work of the committee over the previous year in its budget monitoring activity and the work it will have done in evaluating performance and value for money. The Committee will also need to maintain a 'big picture' view of the financial pressures affecting the Council and understand how these might impact on existing budgets and budget setting in subsequent years.

Consultation

Some of the proposed savings will be subject to separate decision making processes (either by Officers, Cabinet or Council). Some of the proposed savings require a consultation process to be undertaken and the product of consultation (together with the equality analysis) must be conscientiously taken into account in finalising any decisions. In addition, the Local Government Finance Act 1992 requires the Council to consult business representatives on the Council's budget proposals.

Members will note that the Council has engaged in a public conservation as part of the 2021/22 budget process as set out earlier at paragraph 10 of the report under the heading "Consultation ". In considering this matter, Members must genuinely and conscientiously consider the feedback from this and have proper regard to it when making any decision in relation to the subject matter of that consultation. Members should carefully consider the results of the consultation.

Employee and Trade Union Consultation

The report recognises that notwithstanding efforts to reduce impacts on staff resulting from the level of funding cuts imposed, there may be staff reductions during the financial year 2021/22. Since the Budget Strategy Report was approved last year engagement has been ongoing with the Trade Unions to discuss budget saving implications. The Council will consult with Trade Unions about the 2021/22 budget proposals and the likely impact on staff, if posts become at risk of redundancy.

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 that income from all sources must meet all 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.

The Council 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.

The budget and the Council Tax must be set by 11th March in the preceding financial year. A failure to comply with the time limit will leave the Council open to challenge by way of judicial review.

When the Council is considering its budget, it must have regard to the Section 151 Officer's report on the robustness of the estimates and the adequacy of the reserves in the budget proposals (section 25 of the Local Government Act 2003). This ensures that Members make their decision on the basis of authoritative advice. Members should provide clear reasons if they disagree with the professional advice of the Section 151 Officer.

Capital Expenditure

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. The Local Authorities (Capital Financing and Accounting) Regulations 2003 (as amended) specify the prudential code for capital finance to which the Council must have regard in setting and reviewing their affordable borrowing limits (sections 3 and 5 of the 2003 Act).

Cap on Council tax Rises

The Localism Act 2011 provides for a council tax referendum to be held if an authority increases its relevant basic amount of council tax in excess of principles determined by the Secretary of State. The Local Government Finance Settlement for 2021/22 published in December 2020, announced that a referendum must be held if council tax for general spend is to be increased by 2% or more. Council tax for general spending requires a referendum if it rises by 2% or more alongside a maximum 3% adult social care precept.

Housing Revenue Account and Rents

The Local Government & Housing Act 1989 Part VI sets a statutory regime for housing finance. The Council has a general duty to review the rents of its houses from time to time and in fixing rents the Council must have regard, in particular, to the principle that the rents of dwellings of any class or description should bear broadly the same proportion to private sector market rents as the rents of dwellings of any other class or description. The review of the rents is a Cabinet function and is undertaken with regard to the provisions of Part VI of the 1989 Act which governs housing finance and housing subsidy. Rents for council houses are a credit to the HRA and outgoings a debit. The Council is under a duty to prevent a debit balance on the HRA which is ring- fenced. There are restrictions in the way in which the account can be operated and the proposals in this report must comply with these accounting requirements to ensure that the rent should be set so as to ensure that the Council is able to comply with its duty to prevent a debit balance arising on the HRA.

Charging

Each proposal to make or increase charges must comply with the statutory framework (including primary and secondary legislation and any statutory guidance issued) relating to the activity in respect of which charges are being levied, including any limitations on levels of charges.

Where reliance is placed on the power to charge for discretionary services (Section 93 of the Local Government Act 2003), any charges must be set so that when the charges are taken as a whole no surpluses are made (i.e. the power is limited to cost recovery).

In relation to certain activities which are subject to authorisation by the Council (e.g. licences), the Provision of Services Regulations 2009 prevent the recovery of charges in excess of the cost of the procedures and formalities under the scheme of authorisation, (i.e. the Council is permitted to recover costs only), and such costs must also be reasonable and proportionate.

Where activities are being undertaken for which charges are being made with the intention of producing surplus income, it is necessary to consider whether that activity is material and would amount to "commercial trading". For commercial trading, the Council must develop a business case and establish an arms' length company to undertake that activity (in accordance with the general trading power under Section 95 Local Government Act 2003), or identify another statutory power for a particular trading activity.

General

Section 106 of the Local Government Finance Act 1992 bars a councillor from voting on the Council's budget if he or she has an outstanding council tax debt of over two months. If a councillor is present at any meeting at which relevant matters are discussed, he or she must disclose that section 106 applies and may not vote. Failure to comply is a criminal offence

All decisions taken by or on behalf of the Council must:

- Be within the legal powers of the Council and of the body or person exercising powers on behalf of the Council.
- Comply with any procedural requirement imposed by law.
- Be undertaken in accordance with procedural requirements imposed by the Council e.g. procedure rules.
- Be fully and properly informed.
- Be properly motivated (i.e. for an appropriate, good and relevant reason).
- Be taken having regard to the Council's fiduciary duty to its taxpayers as elected members are trustees of the public interest and of its statutory purposes for which public powers are conferred on them. This general duty requires the Council to act prudently and in good faith in the interests of those to whom the duty is owed.
- Otherwise, be reasonable and proper in all the circumstances

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Financial Implications:

The financial implications are set out in the report.

Report Author and Contact Details:

Lisa Kitto

Interim Director of Financial Transformation (S151 Officer)

Background papers:

The Council's financial position as at 30 December 2020

The Council's financial position as at 30 September 2020

The Councils 2021/22 Budget and the Medium-Term Financial Strategy

Setting the Council Tax Base 2021/22

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

Term	Meaning

Appendix 1

Calculation of Council Tax Base 2021/22 (Based on all properties)										
Bands	**A Reduced**	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**TOTAL**
Total Number of Dwellings on the valuation list	0.00	30,366.00	18,565.00	17,304.00	9,185.00	5,496.00	1,853.00	1,275.00	178.00	84,222.00
Total Number of Exempt and Disabled Relief dwellings on the Valuation List	51.00	19.00	15.00	-25.00	-10.00	-31.00	10.00	-8.00	-21.00	0.00
Less: estimated discounts, exemptions and disabled relief	2.50	4,815.50	2,051.25	1,502.75	682.75	281.75	104.75	62.25	-3.00	9,500.50
Total Equivalent number of dwellings after discounts, exemptions and disabled relief	48.50	25,569.50	16,528.75	15,776.25	8,492.25	5,183.25	1,758.25	1,204.75	160.00	74,721.50
Factor stipulated in regulations	5/9	6/9	7/9	8/9	9/9	11/9	13/9	15/9	18/9	0.00
Band D equivalent	26.94	17,046.33	12,855.69	14,023.33	8,492.25	6,335.08	2,539.69	2,007.92	320.00	63,647.25
Net effect of Local Council Tax Support Scheme (LCTSS) and other adjustments	**7.55**	**4,165.42**	**1,338.86**	**738.85**	**263.55**	**118.68**	**37.04**	**16.01**	**0.31**	**6,686.27**
Additional Net Dwellings in 2020/21 based on known regeneration with the Borough and reductions in levels of discounts and exemptions										0.00
Total after LCTSS and Other Adjustments	19.40	12,880.91	11,516.84	13,284.48	8,228.70	6,216.41	2,502.65	1,991.90	319.69	56,960.98
Multiplied by estimated collection rate	**0.945**	**0.945**	**0.945**	**0.945**	**0.945**	**0.945**	**0.945**	**0.945**	**0.945**	
BAND D EQUIVALENTS	**18.33**	**12,172.46**	**10,883.41**	**12,553.84**	**7,776.13**	**5,874.50**	**2,365.01**	**1,882.35**	**302.11**	**53,828.13**

Band D Equivalent assuming 1.94% increase	**£1,643.31**
Total Tax Yield £'000	**£88,456.39**

Appendix 2

Proposed Permanent Spending Allocations to Budget 2021/22 (Indicative 2022/23 - 2024/25)					
Directorate	**Description**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
		£m	**£m**	**£m**	**£m**
Decisions Already Made					
Corporate	Employee Assistance Programme	0.015	0.000	0.000	0.000
Non-Service Specific	Borrowing Costs – Strategic Investment	1.100	0.000	0.000	0.000
Non-Service Specific	Borrowing to Support 2020/21 Capital Programme	0.500	0.000	0.000	0.000
Non-Service Specific	Corporate Capacity	0.500	0.000	0.000	0.000
TOTAL		**2.115**	**0.000**	**0.000**	**0.000**
Pay Inflation					
All	Pay Inflation	0.250	1.865	1.870	1.904
TOTAL		**0.250**	**1.865**	**1.870**	**1.904**
Contractual Inflation					
Corporate	Utilities	0.077	0.080	0.083	0.086
Corporate	Rent/Rates	0.039	0.040	0.042	0.043
Corporate	ICT Contracts	0.024	0.025	0.026	0.027
Children and Young People	Residential Care (including living wage)	0.597	0.626	0.663	0.700
Children and Young People	External Fostering Placements	0.178	0.188	0.200	0.212
Children and Young People	Fostering, Adoption and Leaving Care Allowances	0.329	0.347	0.367	0.389
Children and Young People	Support Packages and Direct Payments	0.093	0.097	0.102	0.106
Children and Young People	Premature Retirement Costs	0.011	0.012	0.012	0.012
One Commissioning Organisation	Community Care and Other Contracts	1.395	1.424	1.452	1.481
One Commissioning Organisation	Persona Contract	0.277	0.287	0.300	0.310
One Commissioning Organisation	Residential care (Including living wage)	0.911	2.399	2.493	2.638
Housing	Housing Contracts	0.000	0.050	0.050	0.050
Non Service Specific	GM transport Authority	0.194	0.196	0.198	0.200
TOTAL		**4.125**	**5.771**	**5.988**	**6.253**

Proposed Permanent Spending Allocations to Budget 2021/22 (Indicative 2022/23 - 2024/25)					
Directorate	**Description**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
		£m	**£m**	**£m**	**£m**
Demand					
Finance	Debt Collection Costs	0.050	0.050	0.050	0.050
Business, Growth and Infrastructure	Executive Post	0.175	0.000	0.000	0.000
Business, Growth and Infrastructure	New Homes Bonus Grant Adjustment	0.597	0.000	0.000	0.000
Corporate	Legal Costs	0.300	0.000	0.000	0.000
Corporate	Moderation	0.120	0.000	0.000	0.000
Children and Young People	Foster Placements	0.039	0.000	0.000	0.000
Children and Young People	Home to School Transport	0.441	0.000	0.000	0.000
Children and Young People	Increase in Looked After Children Placements	0.452	0.000	0.000	0.000
Children and Young People	Special Guardianship Orders	0.020	0.000	0.000	0.000
One Commissioning Organisation	Care in the Community	0.827	0.000	0.000	0.000
One Commissioning Organisation	Adults Demographics	1.000	0.960	1.000	1.000
One Commissioning Organisation	Transition from Children's Services	0.259	0.524	0.398	0.312
Operations	Winter Maintenance	0.082	0.000	0.000	0.000
TOTAL		**4.361**	**1.534**	**1.448**	**1.362**
Fall Out of Time Limited Funding					
One Commissioning Organisation	Transformation Funding	0.723	0.132	0.007	0.007
TOTAL		**0.723**	**0.132**	**0.007**	**0.007**

Proposed Permanent Spending Allocations to Budget 2021/22 (Indicative 2022/23 - 2024/25)					
Directorate	**Description**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
		£m	**£m**	**£m**	**£m**
Unachieved Savings					
Operations	Corporate Landlord	0.585	0.000	0.000	0.000
Operations	Architects	0.525	0.000	0.000	0.000
TOTAL		**1.110**	**0.000**	**0.000**	**0.000**
Budget Re-Alignment					
Children and Young	Costs previously charged to the Dedicated Schools Grant	2.295	0.000	0.000	0.000
TOTAL		**2.295**	**0.000**	**0.000**	**0.000**
Capital Programme					
Non-Service Specific	Borrowing Requirement to fund the capital programme	1.000	1.000	0.000	0.000
TOTAL		**1.000**	**1.000**	**0.000**	**0.000**
Income Losses					
Non-Service Specific	Airport Dividend	5.900	0.000	(5.900)	0.000
Non-Service Specific	Airport Loan Interest	2.256	0.000	(2.256)	0.000
Operations	Income Loss	1.077	(0.539)	(0.539)	0.000
TOTAL		**9.233**	**(0.539)**	**(8.695)**	**0.000**
GRAND TOTAL		**25.211**	**9.763**	**0.619**	**9.526**

Appendix 3

Directorate	Proposal Description	Proposed Budget Reduction			EIA Required	Consultation Required
		2021/22	2021/22	2022/23		
		£m	£m	£m		
Full Year Effect of Previously Agreed Efficiencies						
Children and Young People	**Early Help Model** Co-ordinated and streamlined management of buildings and increase in usage of the facilities.	(0.034)	0.000	0.000	Yes	Yes
Operations	**Procurement Review of Contracts** Review of supplier contracts across the service.	(0.083)	0.000	0.000	No	No
All Services	**Supplier Review of Contracts** Review of supplier contracts across the Council	(0.300)	(0.265)	0.000	No	No
Operations	Review of Highway Fees	(0.050)	(0.070)	0.000	Yes	No
TOTAL		**(0.467)**	**(0.335)**	**0.000**		
New Efficiencies Proposed						
Children and Young People	Removal of budget for vacant posts and reduced travel and expense costs.	(0.696)	0.309	0.000	No	No
Children and Young People	Contract Reviews for services provided by external agencies	(0.220)	(0.100)	0.000	No	No
Children and Young People	Reduced transport costs as a result of fewer out of borough placements.	(0.300)	(0.120)	0.000	No	No
Public Health	Reduced cost of external contract relating to substance misuse services	(0.040)	0.000	0.000	No	No
Corporate	Reduce budget for contributions to the pension fund	(0.075)	0.000	0.000	No	No
Corporate	Reduce central Apprentice Levy to reflect previously agreed internal funding mechanism	(0.239)	0.000	0.000	No	No
Corporate	Reduce central Apprenticeship Corporate budget to reflect previously agreed internal funding mechanism	(0.530)	0.000	0.000	No	No

Directorate	Proposal Description	Proposed Budget Reduction			EIA Required	Consultation Required
		2021/22	2022/23	2023/24		
		£m	£m	£m		
Corporate	Reduce Corporate Management Initiatives budget in line with expenditure	(0.200)	0.000	0.000	No	No
Corporate	Reduce Bury MBC Townside Fields budge in line with expenditure	(0.058)	0.000	0.000	No	No
Corporate	Reduce Car Leases Salary Sacrifice scheme in line with expenditure	(0.025)	0.000	0.000	No	No
Operations	Remove vehicle and equipment leasing costs to reflect approved borrowing through the capital programme	(0.170)	(0.300)	0.000	No	No
Business, Growth and Infrastructure	Assumed growth in the Council Tax base as a result of the investment in regeneration and housing	0.000	0.000	(0.500)	No	No
All	Transformation Agenda	(1.500)	(3.500)	0.000	Yes*	Yes*
TOTAL		**(4.053)**	**(3.711)**	**(0.500)**		
Proposed Budget Reductions						
One Commissioning Organisation (MTFS001)	Innovative Commissioning	1.050	1.750	0.200	Yes	Yes
One Commissioning Organisation (MTFS002)	Personalisation and Transformation	0.000	1.000	1.000	No	Yes
One Commissioning Organisation (MTFS003)	Development of Assistive Technology	0.000	0.500	0.000	Yes	Yes
One Commissioning Organisation (MTFS004)	Improved Housing Options	0.000	0.050	0.050	No	Yes
One Commissioning Organisation (MTFS005)	Effective and Efficient Commissioning	1.487	1.780	0.100	No	Yes
One Commissioning Organisation (MTFS006)	Review of Care Packages	0.797	2.055	0.611	No	Yes
Operations (MTFS007)	Closure of Civic Centres	0.132	0.000	0.000	Yes	No

Directorate	Proposal Description	Proposed Budget Reduction			EIA Required	Consultation Required
		2021/22	2022/23	2023/24		
		£m	£m	£m		
Operations (MTFS008)	Review of Waste Services and Fleet Rationalisation	0.237	0.025	0.000	No	No
Operations (MTFS009)	Street Light Dimming	0.020	0.010	0.000	Yes	No
Finance (MTFS010)	Closure of Prestwich Cash Office	0.030	0.000	0.000	No	Yes
Corporate Core (MTFS011)	Housing	0.250	0.000	0.000	No	Yes
TOTAL		**4.003**	**7.170**	**1.961**		

*It is envisaged that consultation and EIA maybe required for some aspects of the transformation agenda. As yet the detail is not known but these will be a consideration as transformation savings options are put forward.

APPENDIX 4

Reference	MTFS001
Executive Director	Will Blandamer
Cabinet Member	Cllr Andrea Simpson

Section A

Service Area	OCO – Adult Social Care
Budget Option Description	Innovative Commissioning

Budget Reduction Proposal – Detail and Objectives

We currently commission a significant number of services for adults with social care needs across all customer groups. The current budget for care packages for clients with Learning Disabilities in Bury is £16,584,400.00. In 2019/20 we supported 605 people with LD in Bury, to date this year we are supporting 556 people. In addition, £12,393,409 is spent with Persona, the Council's own trading company, which also provides social care to customers across a range of customer groups.

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 people's 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. 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.
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.
We will jointly reshape the existing Persona provision, transforming services and developing new ways of working to realise efficiencies, and in some cases, it will mean the potential reduction or closure of services;
We will also undertake a review of contracts in shared accommodation to analyse shared hours in a given property and comparing this to the hours described in individual customer support plans, removing any duplication with no detriment to service delivery.

In all initiatives, this is not solely about savings however working differently around the person to ensure, independence, rich social connections, links to the community and innovative solutions centred on the person.

	2021/22	2022/23	2023/24
	£m	£m	£m
Budget Reduction (£)	1.050	1.750	0.200
Council Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing
Which Budget Principle does the option relate to?	Demand Reduction & Internal Transformation

Section B
What impact does the proposal have. **Set out any impacts (positive and negative) on performance and costs**

Property
No property impacts.
Service Delivery
There should not be any impact on service delivery within the Council, but there is potential impact on wider partners.
Organisation (Including Other Directorates/Services)
Local Authority Provider Relationship Team to undertake review of core hours Local Authority LD social care team – assisting core hours review Providers – where there will be a reduction in funding
Workforce – Number of posts likely to be affected.
Potential job reductions within the social care provider market, including Persona
Communities and Service Users
Service users should still have outcomes met in line with their individual support plan
Other Partner Organisations
External providers and Persona

Section C
Key Risks and Mitigations

Risks	**Mitigations**
Staff capacity to undertake the reviews and negotiations needed	• Team managers to manage workload and priorities based on capacity • Flag up challenges/ issues to senior management
Savings are not achievable or are swallowed up by new demand	• The figures offered are realistic figures based on benchmarking and previous reviews; • Work Programme in place and monthly monitoring to be undertaken of savings and new demand
Service uses negatively impacted by change in service offer	• Consideration and advice on alternative, suitable services; • A communications & engagement plan to be developed; • Appropriate consultation and engagement to be undertaken as required. • Clear, consistent messaging around all savings and transformation.

Key Delivery Milestones
Include timescales for procurement, commissioning changes etc.

Milestone	Timeline
Individual plans worked up for each saving element and confirmed	December 2020
Matrix review and liaison with providers starts	October/ November 2020
Governance in place to review on a monthly basis progress and barriers	November 2020
Feedback on any concerns, challenges or barriers to savings along with any alternative budget options	January 2021

Section D

Consultation Required?	Yes

	Start Date	End Date
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact
***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	Yes
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	No
Groups with particular faiths and beliefs	No

EIA Required?	**Yes**

Section E: ***Financial Implications and Investment Requirements***

Investment requirements – Revenue and Capital
None

Reference	MTFS002
Executive Director	Will Blandamer
Cabinet Member	Cllr Andrea Simpson

Section A

Service Area	OCO Adult Care Services
Budget Option Description	Personalisation and Transformation

Budget Reduction Proposal – Detail and Objectives

There are currently 2,017 people in Bury receiving some form of care package via the Integrated Neighbourhood Teams.

The spending forecast in year according to protocol is as follows (please note this excludes out of borough placements):

Integrated Neighbourhood Team	Spend	Percentage of overall INT spend	Number of clients	Average spend per person
Bury East	£6,063,361.13	26%	432	£14,036
Bury West	£5,956,544.57	26%	468	£12,728
Bury North	£4,306,492.06	19%	359	£11,996
Prestwich	£3,964,605.57	17%	321	£12,351
Whitefield	£2,640,485.21	12%	250	£10,561
Total:	£22,931,488.54			

In Bury, data shows we are good at giving people information and advice and deflecting people away from the front door in terms of social care services, in line with prevention strategies. However, at the point of social care assessment we have a higher conversion rate into long term care of 12%, compared to GM neighbours where the average is only 7%. This demonstrates that Bury is not as effective as other areas in using community, asset-based approaches to support social care needs. Therefore, our social care teams need to work towards reducing the level of conversion from assessment into long term care.

Given the current level of spend across the INTs it is suggested that a savings target of £1,000,000 in 2021/22 and a further £1,000,000 in 2022/23 is distributed across the five INTs, this should be done proportionately based on spend therefore the suggested split is:

- Bury East £260,000 (26%)
- Bury West £260,000 (26%)
- Bury North £190,000 (19%)
- Prestwich £170,000 (17%)
- Whitefield £120,000 (12%)

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

This workforce development will ultimately lead to behavioural change of the social care workforce that over time will reduce the reliance on traditional care. This programme of development will be rolled out across the coming 12 months, it should be recognised that this will take some time to bed in and will need constant reinforcing from management.

Given there is work underway to change social care in Bury, it would be reasonable to cement this with a savings target. Having a realistic savings target will focus the mind of social care staff to understand this way of working is not tokenistic but a transformational change to working practice.

	2021/22	2022/23	2023/24
	£m	£m	£m
Budget Reduction (£)	0.000	1.000	1.000
Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing
Which Budget Principle does the option relate to?	Demand Reduction & Internal Transformation

Section B
What impact does the proposal have. **Set out any impacts (positive and negative) on performance and costs**

Property
No impacts – this saving element is about new ways of working with customers in Bury and reviewing existing care packages of care.
Service Delivery
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.
Organisation (Including Other Directorates/Services)
INT teams – undertaking new assessments and reviews Providers – negotiating care and support innovatively Wider VCF sector in terms of reviewing the support they can offer to work with clients with low level support needs.
Workforce – Number of posts likely to be affected.
No impacts – this saving element is about new ways of working and reviewing packages of care.
Communities and Service Users
Positive impacts on communities and service users in that the work will be undertaken in a person-centred way, a move of social care practice towards more personalised conversation and strength and asset based working. Supporting clients to live independently with choice and control. Also where possible designing/ redesigning services in co-production and involving people with LD their family and carers at every opportunity.
Other Partner Organisations
None

Section C:Key Risks and Mitigations

Risks	Mitigations
Staff capacity to deliver savings	• INT staff to understand the new ways of working, workforce development plan in place • Savings and progress would need to be monitored monthly to ensure on track and undertake any remedial actions
Savings are not achievable	• Clear work programme in place describing how savings will be achieved. • Monthly reporting on progress to savings targets, flagging up any issues or concerns
New assessments do not meet the expectations of customers	• Clear communication throughout the process, move towards personalised and strength asset-based conversations. Ensuring all work remains Care Act compliant.
Increased demand for services	• Using data we have projected demand and needs, working with providers to help shape the market place to meet the current and future needs.

Key Delivery Milestones
Include timescales for procurement, commissioning changes etc.

Milestone	Timeline
Individual plans worked up for each saving element (Team managers would need to devise a bespoke plan for their team)	December 2020
Governance in place to review on a monthly basis progress and barriers	November 2020
Feedback on any concerns, challenges or barriers to savings along with any alternative budget options	January 2021

Section D

Consultation Required?	No

	Start Date	End Date
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact
***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	Yes
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	Yes
Groups with particular faiths and beliefs	No

EIA Required?	Yes

Section E: ***Financial Implications and Investment Requirements***

Investment requirements – Revenue and Capital
None, other than costs already factored into workforce development and the reviewing team capacity

Reference	MTFS003
Executive Director	Will Blandamer
Cabinet Member	Cllr Andrea Simpson

Section A

Service Area	OCO Adult Social Care
Budget Option Description	Assistive Technology: Pushing the boundaries in Bury

Budget Reduction Proposal – Detail and Objectives
Assistive Technologies (AT) 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 technology 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. Whilst Bury has a long-standing telecare support service in place known as 'Carelink', there is evidence in other areas of the country, including Nottingham, Liverpool Southend, Knowsley and Hampshire that further use of AT can support customers with social care needs, and generate savings from social care budgets. Potential savings for Bury Council have been estimated as £500,000 based on the savings generated in other areas of the country.

	2021/22	**2022/23**	**2023/24**
	£m	**£m**	**£m**
Budget Reduction (£)	0.000	0.500	0.000
Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing
Which Budget Principle does the option relate to?	Internal Transformation and demand management

Section B: *What impact does the proposal have*. Set out any impacts (positive & negative) on performance and costs

Property
Potential positive impact in innovatively adapting properties in Bury using AT.
Service Delivery
Service delivery will continue with a different vision and alternative AT options for people, in most cases better options. This may result in some packages of care being reduced following a review process. This work is not focused on removing support, rather considering alternative options that may not have been available at the point of the original assessment due to new ways of transformational working.
Organisation (Including Other Directorates/Services)
Health and Social Care, potential care providers, housing providers and AT providers.
Workforce – Number of posts likely to be affected.
No impacts
Communities and Service Users

Positive impacts on communities and service users in that the work will be undertaken in a person-centred way, a move of social care practice towards more personalised alternative AT support. Supporting clients to live independently with wider choice and control. Also where possible designing/ redesigning services in co-production.
Other Partner Organisations
None

Section C:Key Risks and Mitigations

Risks	Mitigations
Savings are not achievable	• Clear work programme in place describing how savings will be achieved. • Monthly reporting on progress to savings targets, flagging up any issues or concerns
Reviews reduce or remove care that is not accepted by service user, family or carer	• Clear communication throughout the process, move towards personalised and strength asset based conversations. Ensuring all work remains care act compliant.

Key Delivery Milestones

Milestone	Timeline
Put forward as idea	Oct 2020
Individual plans worked up for each saving element	December 2020
Governance in place to review on a monthly basis progress and barriers	November 2020
Feedback on any concerns, challenges or barriers to savings	January 2021

Section D

Consultation Required?	Yes – around future AT developments and ideas	
	Start Date	**End Date**
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact: ***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*****?**

Disabled people	Yes
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	Yes
Groups with particular faiths and beliefs	No

EIA Required?	**yes**

Section E: ***Financial Implications and Investment Requirements***

Investment requirements – Revenue and Capital
AT development will likely need investment of: • Resource/ capacity of a team to lead and drive work • Potential capital costs in buying equipment/ Technology to trial

Reference	MTFS004
Executive Director	Will Blandamer
Cabinet Member	Cllr Andrea Simpson

Section A

Service Area	OCO Adult Social Care
Budget Option Description	Improved Housing Options

Budget Reduction Proposal – Detail and Objectives

The links between housing and social care have never been more important. The contribution of housing to the ambitions of social care is well understood, although in practice, housing and social care have often existed in silos.

It is important when the authority has properties to utilise, that they are of good quality, value for money, fit for purpose of intended client groups and are used well.

Empty spaces in properties for social care customers have financial implications, especially when we have high cost out of borough placements that can be adequately accommodated and supported in the borough.

In order to ensure that housing options for social care customers are effectively managed, a number of steps have been implemented:

- Reinstating the Living Options Group (LOG), to manage housing needs of social care customers;
- Void management programme established;
- Reconfigure or realign current housing stock
- Review current Service Level Agreements with housing providers ensuring value for money
- Work with providers to ensure quality homes for the future
- Monitoring of provider housing provision in contractual arrangements

The savings attached to the void management programme may appear low however, the voids management programme is an enabler to wider system savings.

A monthly highlight report will capture (using the LOG tracker) the outcomes/ outputs of the LOG and wider work. This will include any direct savings, cost avoidance and or other efficiencies.

	2021/22	**2022/23**	**2023/24**
	£m	**£m**	**£m**
Budget Reduction (£)	0.000	0.050	0.050
Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing process to manage Voids better
Which Budget Principle does the option relate to?	Demand Reduction & Internal Transformation

Section B

What impact does the proposal have. **Set out any impacts (positive and negative) on performance and costs**

Property

As part of the LOG work there may be a requirement to de-commission or repurpose unsuitable property in Bury for our department's cohorts.

Service Delivery
Service delivery will continue with a different vision, new ways of working and trying to find alternative options for people, in most cases better options. This may result in some existing placements being changed following a review process. In these instances, best interest outcomes will be considered whilst ensuring statutory requirements are met.
Organisation (Including Other Directorates/Services)
Social Work Teams Childrens Services especially in respect of transitions Housing colleagues Persona
Workforce – Number of posts likely to be affected.
No impacts – this saving element is about managing voids better.
Communities and Service Users
Positive impacts on communities and service users in that the work will be undertaken in a person-centred way, a move of social care practice towards more personalised conversation and strength and asset based working. Supporting clients to live independently with choice and control in their community.
Other Partner Organisations
Wider housing providers

Section C
Key Risks and Mitigations

Risks	Mitigations
Staff capacity to deliver savings for placement reviews	• Social care teams would need to commit to this work, with managers managing workload appropriately • The LOG group will speed up discussions and decisions
Savings are not achievable	• Clear work programme in place describing how savings will be achieved. • Monthly reporting on progress to savings targets, flagging up any issues or concerns
Reviews reduce or remove placements that is not accepted by service user, family or carer	• Clear communication throughout the process, move towards personalised and strength asset-based conversations. Ensuring all work remains care act compliant.
Social Care Development of workforce take longer than planned, this element of savings is highly reliant on the social care workforce undertaking new assessments and reviews in a different way	• Quality assurance framework developed along with training and development support for workforce.
Increased demand	• Using data we have projected demand and needs, working with providers to help shape the market place to meet the current and future needs.

Key Delivery Milestones: ***Include timescales for procurement, commissioning changes etc.***

Milestone	**Timeline**
List of voids – priority for review	October 2020
Individual plans worked up for each saving element	December 2020
Governance in place to review on a monthly basis progress and barriers	November 2020
Feedback on any concerns, challenges or barriers to savings along with any alternative budget options	January 2021

Section D

Consultation Required?	No

	Start Date	**End Date**
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact

Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following**?**

Disabled people	Yes
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	No
Groups with particular faiths and beliefs	No

EIA Required?	**Yes**

Section E: ***Financial Implications and Investment Requirements***

Investment requirements – Revenue and Capital
None currently known

Reference	MTFS005
Executive Director	Will Blandamer
Cabinet Member	Cllr Andrea Simpson

Section A

Service Area	OCO – Adult Social Care
Budget Option Description	Effective and Efficient Commissioning

Budget Reduction Proposal – Detail and Objectives

Commissioning services for adults with social care needs costs the council approximately £55m per year, working with a large number of providers, with whom we have positive relationships. A number of key approaches are adopted to ensure effective commissioning which generate financial efficiencies.

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.
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.

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.

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

- 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
- Working with Bury CCG to review and refine the operation of the Continuing Health Care arrangements.

	2021/22	2022/23	2023/24
	£m	£m	£m
Budget Reduction (£)	1.487	1.780	0.100
Council Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing
Which Budget Principle does the option relate to?	Demand Reduction & Internal Transformation

Section B
***What impact does the proposal have*. Set out any impacts (positive and negative) on performance and costs**

Property
No property impacts.
Service Delivery
There should not be any impact on service delivery within the Council, but there is potential impact on wider partners.
Organisation (Including Other Directorates/Services)
No impact
Workforce – Number of posts likely to be affected.
If we spend less within the social care market, there may be potential job reductions within the social care provider market
Communities and Service Users
Service users should still have outcomes met in line with their individual support plan
Other Partner Organisations
External providers and Persona

Section C
Key Risks and Mitigations

Risks	**Mitigations**
Savings are not achievable or are swallowed up by new demand	• The figures offered are realistic figures based on benchmarking; • Work Programme in place and monthly monitoring to be undertaken of savings and new demand

Key Delivery Milestones
Include timescales for procurement, commissioning changes etc.

Milestone	**Timeline**
Individual plans worked up for each saving element and confirmed	December 2020
Fee setting process and liaison with providers starts	October/ November 2020
Governance in place to review on a monthly basis	November 2020

progress and barriers	
Feedback on any concerns, challenges or barriers to savings along with any alternative budget options	January 2021

Section D

Consultation Required?	No

	Start Date	**End Date**
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact
***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	Yes
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	Yes
Groups with particular faiths and beliefs	No

EIA Required?	**Yes**

Section E

Financial Implications and Investment Requirements

Investment requirements – Revenue and Capital
No investment requirement

Reference	MTFS006
Executive Director	Will Blandamer
Cabinet Member	Cllr Andrea Simpson

Section A

Service Area	OCO Adult Social Care
Budget Option Description	Review of Care Packages

Budget Reduction Proposal – Detail and Objectives

The council spends £55m on packages of support for people with social care needs.

Care packages should be regularly reviewed to understand if a person's needs and outcomes aspired have changed also to consider if possible new support mechanisms and alternative options for people may have evolved.
Therefore, we will be undertaking a large-scale review programme of those people in Bury who receive a care package or placement of care, across all care needs, (Learning Disabilities, Physical Disabilities, Mental Health and Older People). This will ensure the care offered is:

- Right for the person
- Takes advantage of all available mechanisms of support
- Is person centred
- Identifies and builds on people's strengths
- Promotes prevention and independence and as far as possible supports integration with health
- Provides parity across all customers and involves family and carers.

For some this may mean a change or a reduction in care packages, in these instances best interest outcomes will be considered whilst ensuring statutory requirements are met.

Reviewing placements will generate efficiencies and will focus on:

- Reducing high-cost placements/care packages, replacing with alternative and more cost-efficient services and support
- Where possible bringing clients that are out of borough back in borough
- Considering where the VCF sector and community groups should or could offer support (in particular for lower-level needs such as befriending, peer support, life skills etc.). These services and support are more person centred and often cheaper than traditional support packages.
- Consideration if social prescribing is an option for individuals, in particular new clients coming through
- Ensure packages of care only meet the outcomes required from assessment and therefore are care act compliant.
- Ensure the consideration of the family and carers roles and how they can play in actively supporting the individual (if willing and able to do so). Making sure to link the carer up to available carer services.
- Guarantee all care conversations are personalised with a strength and asset-based focus.

	2021/22	2022/23	2023/24
	£m	£m	£m
Budget Reduction (£)	0.797	2.055	0.611
Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing
Which Budget Principle does the option relate to?	Demand Reduction& Internal Transformation

Section B
What impact does the proposal have. **Set out any impacts (positive and negative) on performance and costs**

Property
No impact
Service Delivery
Service delivery will continue with a different vision around all age thinking and alternative options for people, in most cases better options. This may result in some packages of care being reduced following a review process. This work is not focused on removing support rather considering alternative options that may not have been available at the point of assessment due to new ways of transformational working.
Organisation (Including Other Directorates/Services)
Ensuring reviews are prioritised
Workforce – Number of posts likely to be affected.
No impacts – this saving element is about reviewing care placements.
Communities and Service Users
Positive impacts on communities and service users in that the work will be undertaken in a person-centred way, a move of social care practice towards more personalised conversation and strength and asset-based working. Supporting clients to live independently with choice and control. Also, where possible designing/ redesigning services in co-production and involving their family and carers at every opportunity.
Other Partner Organisations

Section C
Key Risks and Mitigations

Risks	**Mitigations**
Savings are not achievable	• Clear work programme in place describing how savings will be achieved. • Monthly reporting on progress to savings targets, flagging up any issues or concerns
Clients out of borough cannot be brought in borough as there is no provision to meet their needs.	• Use this learning to develop future service to prevent those going out of borough in future • Working with providers in particular

	persona to see is reshaping service provision could be undertaken to meet needs in various ways. • Consider developing more home front door provision for the future cohort of clients
Reviews change, reduce or remove care that is not accepted by service user, family or carer	• Clear communication throughout the process, move towards personalised and strength asset-based conversations. Ensuring all work remains care act compliant.
Social Care Development of workforce take longer than planned, this element of savings is highly reliant on the social care workforce undertaking new assessments and reviews in a different way	• Quality assurance framework developed along with training and development support for workforce.
Increased demand for some services	• Using data we have projected demand and needs, working with providers to help shape the market place to meet the current and future needs.
Shared Lives scheme does not recruit enough carers for long term care	• Persona have a recruitment drive and PR work planned • Consider other providers if not suitable to sit with persona

Key Delivery Milestones
Include timescales for procurement, commissioning changes etc.

Milestone	Timeline
Individual plans worked up for each saving element	December 2020
List of high cost placement (over £50k in Supported Living) – priority for review	November/ December 2020
Governance in place to review on a monthly basis progress and barriers	November 2020
Feedback on any concerns, challenges or barriers to savings along with any alternative budget options	January 2021
Review phase starts	March 2021

Section D

Consultation Required?	No

	Start Date	End Date
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact

***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	Yes
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	No
Groups with particular faiths and beliefs	No

EIA Required?	**Yes**

Section E

Financial Implications and Investment Requirements

Investment requirements – Revenue and Capital
No investment requirement

Reference	MTFS007
Executive Director	Donna Ball
Cabinet Member	Cllr. David Jones

Section A

Service Area	Commercial Services
Budget Option Description	Closure of Civic Venues

Budget Reduction Proposal – Detail and Objectives

The Civic Venues within Bury consist of The Elizabethan Suite, based at Bury Town Hall, The Longfield Suite, Prestwich and Ramsbottom Civic Hall. Due to the COVID19 emergency, all Civic Venues have been closed until January 2021 with a proposed review in October / November 2020.

Prior to Covid the Civic Venues required a high level of subsidy (£515k per annum). Despite the best efforts from the Civics Team the level of subsidy has remained for many years and the worsening financial position of the Council means that a subsidised Civics Service can't be sustained. In addition, the Civic Venues struggle to remain competitive with private operators in the area.

Covid will have a further direct impact on Civics. The post-COVID income level is very unlikely to return to pre-COVID levels until late 2021 or beyond. This is due to issues of venue capacity caused by social distancing, and potential further local lockdown measures. Operating costs continue to increase causing the continued loss within the service. It is unlikely that many of the regular events within the Longfield Suite and Ramsbottom Civic Hall will return, creating a larger budget variance and traded loss.

The Longfield Suite is in a poor state of repair and requires large investment to return it to an operational state but is also involved in the wider regeneration plan for Prestwich. The Elizabethan Suite is also in need of major investment due to long term cuts in maintenance budgets.

Ramsbottom Civic Hall is currently being considered for a COVID testing centre with a view to continue this until March 2021.

At present all Civic Venue staff are continuing to be redeployed to the Community Hubs, assisting the Markets team with stewarding and supporting the Waterfold COVID testing site. This arrangement will need to be reviewed following a decision in respect of the potential closure of the Civic Halls.

Due to the continued increasing costs to operate the Venues and historic overspend of the service, it is proposed to close all three Venues permanently and hand the management of the sites to the Estates Team or the Administration Buildings Team to maintain the maintenance and health and safety requirements. Full savings will not be achieved until the existing Civics buildings are either disposed of, redeveloped or the asset transferred.

	2021/22	**2022/23**	**2023/24**
	£m	**£m**	**£m**
Budget Reduction (£)	0.132	0.000	0.000
Staffing Reduction (FTE)	11.5		
Is the proposal One-Off or Ongoing?	Ongoing		
Which Budget Principle does the option	Internal Transformation		

relate to?	

Section B

What impact does the proposal have. **Set out any impacts (positive and negative) on performance and costs**

Property
Closed buildings to be handed to estates as part of the wider estate work. Sale of sites could create additional capital for investment into new development areas with a view to generate income to contribute to the overall budget.
Service Delivery
The Service would be closed resulting in no Civic Venue offering within Bury.
Organisation (Including Other Directorates/Services)
Options to be considered and determined.
Workforce – Number of posts likely to be affected.
11.5 FTE permanent staff and 50 casual members of staff. (Reduction in casual staff does not create any saving as the expenditure is covered by event income).
Communities and Service Users
It may be feasible for some events to be driven to the Private sector, and other similar offerings across Bury. Closure of Ramsbottom Civic Hall would impact directly on the Friends of Ramsbottom Civic Hall (FORCH).

Other Partner Organisations

Section C

Key Risks and Mitigations

Risks	**Mitigations**
Ongoing Income loss / current impact of COVID	Full closure. Any deposits currently held by the Service would need to be returned.
Liability of current state of buildings (Corporate Landlord) / carbon agenda (Climate targets 2030)	Closed buildings to be handed to estates as part of the wider estate work. Sale of sites could create additional capital for investment into new development areas with a view to generate income to contribute to the overall budget.
Civic Functionality / community impact	It may be feasible for some events to be driven to the Private sector, and other similar offerings across Bury.

Friends of Ramsbottom Civic Hall (FORCH)	Closure of Ramsbottom Civic Hall would impact directly on the Friends of Ramsbottom Civic Hall (FORCH).
Timescale to dispose of buildings.	Ensure plans re: disposal are a priority.

Key Delivery Milestones
Include timescales for procurement, commissioning changes etc.

Milestone	**Timeline**
Cabinet Decision	November 2020

Section D

Consultation Required?	Yes

	Start Date	**End Date**
Staff	November / December 2020	March 2021
Trade Unions	November / December 2020	March 2021
Public	December 2020	March 2021
Service User	December 2020	March 2021
Other		

Equality Impact
***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	None
Particular Ethnic Groups	None
Men or Women (including impacts due to pregnancy/maternity)	None
People who are married or in a civil partnership	None
People of particular sexual orientation	None
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	None
People on low incomes	None
People in particular age groups	None
Groups with particular faiths and beliefs	None

EIA Required?	**No**

Section E

Financial Implications and Investment Requirements

Investment requirements – Revenue and Capital
Ongoing costs associated with retaining the buildings until they are disposed of.

Finance Comments – Will the proposal deliver the savings and within the agreed timescales?
Assumption is that all activity will cease and therefore the budget can be removed. Allowance has been made for budget to be transferred to manage the buildings. Timing of savings is dependent on relevant HR processes being completed such that there is no call on the service to pay staff from 1st April 2021.

Reference MTFS008
Executive Director
Cabinet Member

Section A

Service Area	Waste & Transport
Budget Option Description	Review of Waste Services – Fleet Rationalisation

Budget Reduction Proposal – Detail and Objectives

The following options will be given due consideration:-

Review of Waste Services

A range of options to be considered including: -

- Balancing of waste collection rounds
- Street cleansing litter bin rounds and sweeping schedules
- Waste collection service redesign i.e. consideration to 4 over 5 day working, commercial waste review etc

(Please note these options do not include reducing the frequency of waste collections).

Increasing household waste recycling rate

Via the public re-using and recycling, there is a direct positive link with the carbon and climate agenda, where significant carbon savings can be achieved. Options to be considered to achieve a recycling rate well above 60% which could significantly reduce disposal costs/GMWDA levy contribution, include: -

- A comprehensive, sustained communications campaign which would require recruitment of additional staff and ongoing engagement with residents.
- A weekly food waste collection service. This would require a new fleet of bespoke collection vehicles and recruitment of additional operational staff.
- Collection of a wider range of recyclables e.g. plastic pots, tubs and trays; textiles; batteries; small WEEE.
- A separate weekly or fortnightly collection of absorbent hygiene products e.g. disposable nappes and incontinence pads.
- Promotion of home composting, with an offer of subsidised compost bins to residents.

Fleet rationalisation

Confidence in the ability of round optimisation to make the above savings on waste collection is undermined by the impact of COVID. From April to end of Aug this year, relative to last, grey bin tonnages are up 14%, blue bins 22%, green bins 5% and brown bins 13%. This is as a result of lockdown and more people working from home. If the move to more home working becomes permanent this will make efficiencies (in terms of less vehicles and staff required to deliver the service) more difficult to achieve.

Optimisation within the street cleansing service is an unknown, with no indication at this stage of what, if any, efficiencies can be achieved. It is hoped that vehicle requirements could be reduced in respect of mechanical sweepers.

Savings related to caddy liners can be achieved but any changes could lead to reduced

food waste recycling rates leading to more food being placed in the residual waste stream, increasing disposal costs. The unfreezing of the increase in annual fees and charges will generate an increase in income from the sale of recycling bins and commercial waste services. Fleet rationalisation – every service that identifies a requirement for new vehicle/s must produce a business case for Exec Director / Cabinet Member approval accordingly. Replacement programme is very much in its infancy, so it is not known at this stage if a saving is possible. It is to be noted that the options cited above are just options at this stage, and engagement with the public will be undertaken.

	2021/22	2022/23
Budget Reduction (£)	0.237	0.025
Staffing Reduction (FTE)		

Is the proposal One-Off or Ongoing?	All ongoing
Which Budget Principle does the option relate to?	Carbon Neutral~~/Digital/~~Demand Reduction/Economic Growth/Internal Transformation

Section B

***What impact does the proposal have*. Set out any impacts (positive and negative) on performance and costs**

Property
None.
Service Delivery
New ways of working. Increased efficiencies.
Organisation (Including Other Directorates/Services)
Services that require new vehicles as part of the replacement programme.
Workforce – Number of posts likely to be affected.
Workforce of circa 65 on Waste Collection and 30 on Street Cleansing. 5 Operations Managers/Supervisors. Commercial Waste Officer. All posts potentially affected. A small number of operational posts may be lost if efficiencies are realised.
Communities and Service Users
Every household in borough impacted by waste collection and street cleansing services.
Other Partner Organisations
GMCA – Waste & Resources Team

Section C

Key Risks and Mitigations

Risks	Mitigations
Public reaction to reduced collection frequency and restricted issue of caddy liners.	Robust business case
Workforce 'buy-in'	Effective communications strategy, TU consultation.
DEFRA Resources & Waste Strategy	Any cost implications should be funded by Government.

Section D

Consultation Required?	Yes

	Start Date	End Date
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact
***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	
Particular Ethnic Groups	
Men or Women (including impacts due to pregnancy/maternity)	
People who are married or in a civil partnership	
People of particular sexual orientation	
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	
People on low incomes	
People in particular age groups	
Groups with particular faiths and beliefs	

EIA Required?	

Section E

Financial Implications and Investment Requirements

Investment requirements – Revenue and Capital
Ongoing costs associated with retaining the buildings until they are disposed of.

Finance Comments – Will the proposal deliver the savings and within the agreed timescales?
Assumption is that all activity will cease and therefore the budget can be removed. Allowance has been made for budget to be transferred to manage the buildings. Timing of savings is dependent on relevant HR processes being completed such that there is no call on the service to pay staff from 1st April 2021.

Reference	MTFS009
Executive Director	Donna Ball
Cabinet Member	Cllr Lucy Smith

Section A

Service Area	Streetscene (Street Lighting)
Budget Option Description	Dimming Street Lighting

Budget Reduction Proposal – Detail and Objectives

Dimming of Street Lighting.

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.

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.

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 streetlights being dimmed. A number of pilots have already taken place across Bury, with no negative feedback being received.

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

Partner agencies (i.e., Police) are involved in the development of the proposals.

	2021/22	**2022/23**	**2023/24**
	£m	**£m**	**£m**
Budget Reduction (£)	0.020	0.010	0.000
Staffing Reduction (FTE)	0	0	0

Is the proposal One-Off or Ongoing?	Ongoing
Which Budget Principle does the option relate to?	Carbon Neutral/~~Digital/Demand Reduction/Economic Growth/Internal Transformation~~

Section B

What impact does the proposal have. **Set out any impacts (positive and negative) on performance and costs**

Property
No impact.

Service Delivery
Initial reduction in energy costs. However, it is to be noted that over time the savings that are forecast may diminish due to the potential of energy companies increasing their unit cost.
Organisation (Including Other Directorates/Services)
No impact.
Workforce – Number of posts likely to be affected.
No impact.
Communities and Service Users
The proposed dimmed lighting levels will remain in line with the current British Standard Specification whilst providing adequate levels of lighting on the highway. The hours at which streetlights will be dimmed will be between 0:00hrs and 06:00hrs.
Other Partner Organisations
No impact

Section C

Key Risks and Mitigations

Risks	Mitigations
It is likely that cost savings will be eroded over time as the unit price of energy increases	Potential future investment to save to roll out dimming across entire street lighting stock, achieving further energy and carbon reductions.
Resistance is likely from elected members and the public	Community engagement and communications should highlight the carbon reduction and associated environmental benefits
Personal and transport safety	The proposed dimmed lighting levels will remain in line with the current British Standard Specification whilst providing adequate levels of lighting on the highway.

Key Delivery Milestones

Include timescales for procurement, commissioning changes etc.

Milestone	Timeline
Street lighting energy is charged as an unmetered supply which is assessed annually. Milestones will therefore be annual as submissions to our energy supplier are made.	The programme was originally programmed to be delivered over 5 years (20/21 to 24/25), however efforts are being made to deliver by 23/24.

Section D

Consultation Required?	No

	Start Date	End Date
Staff		
Trade Unions		
Public		
Service User		
Other		

Equality Impact
***Is there potential for the proposed budget reduction to have a disproportionate/ adverse impact on any of the following*?**

Disabled people	Yes (limited)
Particular Ethnic Groups	No
Men or Women (including impacts due to pregnancy/maternity)	No
People who are married or in a civil partnership	No
People of particular sexual orientation	No
People who are proposing to undergo, undergoing or undergone a process or part of a process of gender assignment	No
People on low incomes	No
People in particular age groups	Yes (limited)
Groups with particular faiths and beliefs	No

EIA Required?	**Yes**

Section E

Financial Implications and Investment Requirements

Investment requirements – Revenue and Capital
Proposal can be achieved with existing budgets.

Finance Comments – Will the proposal deliver the savings and within the agreed timescales?
Timing of savings will be dependent on the programme of fitting the necessary equipment

Proposed Cash Limits By Directorate 2021/22								
	Children and Young People	One Commissioning Organisation	Corporate Core	Business, Growth and Infrastructure	Operations	Non-Service Specific	Housing General Fund	Total
	£m	£m	£m	£m	£m	£m	£m	£m
2020/21 Budget	**41.778**	**79.498**	**14.170**	**3.397**	**16.247**	**9.247**	**0.553**	**164.891**
Previously Agreed Budget Changes	0.000	0.000	0.015	0.000	0.000	2.100	0.000	2.115
Pay Award	0.051	0.052	0.057	0.013	0.073	0.003	0.000	0.250
Inflation	1.214	2.593	0.018	0.007	0.099	0.194	0.000	4.125
Demand	1.102	2.196	0.170	0.175	0.082	0.597	0.000	4.322
Income Losses	0.000	0.000	0.000	0.000	1.077	8.156	0.000	9.233
Realignment of DSG Costs	2.295	0.000	0.000	0.000	0.000	0.000	0.000	2.295
Fall Out of Time Limited Funding	0.123	0.600	0.000	0.000	0.000	0.000	0.000	0.723
Undeliverable Savings from previous years	0.000	(0.111)	0.150	0.000	1.110	0.000	0.000	1.149
Full Year Effect of Prior Year Savings	(0.034)	0.000	(0.300)	0.000	(0.133)	0.000	0.000	(0.467)
Borrowing to support the capital programme	0.000	0.000	0.000	0.000	0.000	1.000	0.000	1.000
Planned Use of Reserves	0.000	0.000	0.000	0.000	0.000	(12.332)	0.000	(12.332)
Total Additional Budget	**4.752**	**5.329**	**0.110**	**0.196**	**2.308**	**(0.283)**	**0.000**	**12.412**
Efficiencies	(1.216)	(0.040)	(0.605)	0.000	(0.170)	(2.022)	0.000	(4.053)
Budget reductions	0.000	(3.334)	(0.280)	0.000	(0.389)	0.000	0.000	(4.003)
Total Budget Reductions	**(1.216)**	**(3.374)**	**(0.855)**	**0.000**	**(0.559)**	**(2.022)**	**0.000**	**(8.056)**
2021/22 Budget	**45.314**	**81.454**	**13.395**	**3.593**	**17.996**	**6.942**	**0.553**	**169.247**

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Approve
Item No	10.4	**Confidential / Freedom of Information Status**	No
Title	Adult Social Care Provider Fee Uplifts 2021/22		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Matthew Logan, Provider Relationship Lead Julie Gonda, Director of Community Commissioning (DASS)		
Clinical Lead	-		
Council Lead	Cllr Simpson, Communities and Wellbeing		

Executive Summary

This report details the fee engagement process including timelines and proposed recommendations for the fee proposal to contracted providers of adult social care services for the period 2021/22

Recommendations

It is recommended that the Strategic Commissioning Board approve the following Adult Social Care Provider Fee Uplifts:

Care Homes

Older Adults Residential Care

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£502.95	0.9%	£4.77	£507.72

Older Adults Residential Dementia

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£517.95	0.9%	£4.77	£522.72

Older Adults General Nursing

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£502.95	3.9%	£19.77	£522.72

Older Adults Nursing Dementia

Weekly Fee Rate	% Uplift	Increase (£)	Weekly Fee Rate

2020/21			2021/22
£532.95	6.4%	£34.77	£567.72

Adults Residential Care MH/LD/PD

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£502.95	0.9%	£4.77	£507.95

Care at Home

Care at Home (Framework)

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£16.13	2.3%	£0.37	£16.50

Care at Home Complex

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£16.13	2.3%	£0.37	£16.50

Supported Living

Supported Living Waking Hours

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£16.13	1.2%	£0.19	£16.32

Supported Living Sleep in rate

Hourly Fee Rate Sleep-in 2020/21	% Uplift	Increase (£)	Hourly Fee Rate Sleep-in 2021/22
£9.55	1.9%	£0.18	£9.73

Direct Payments (Personal Assistants)

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£10.48	1.9%	£0.20	£10.68

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

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 proposal to uplifts provider fees to allow Bury Adult Social Care Providers to meet the increased costs demands and thus continue to meet he needs of the people of Bury aligns to the Health and Wellbeing strategy.					
How do proposals align with Locality Plan?	The proposals to uplift provider fees aligns to the Locality Plan.					
How do proposals align with the Commissioning Strategy?	The proposals align to the commissioning strategy well as the support the over-arching sustainability of Adult Social Care Providers whilst also supporting the development of the market to meet the needs of Bury customers in the future and providing value for money.					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☒	N/A	☐
How do the proposals help to reduce health inequalities?	The setting of provider fees will ensure the continued sustainability and viability of the borough's care providers to tackling the health inequalities in the borough and ensuring the most vulnerable people in Bury have their needs met.					
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:						
Equality Assessment - Fee Setting 5.11.20.do						
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**
Community Commissioning Management Team (CCMT)	09/03/2021	Recommended

Adult Social Care Contracted Provider Fees 2021/22

1. Introduction

1.1 The Council has undertaken an engagement process with contracted providers of adult social care services in order to define both the fee proposals for 2021/22 and determine the final fee recommendations.

The Community Commissioning Division usually reviews fee rates on an annual basis. It is recommended that the fee arrangements proposed this year are also for one year only 1st April 2021 – 31st March 2022.

This report provides recommendations for the payment of fees in relation to the following service areas:

- Older Adults Residential Care
- Adults Mental Health (MH)/Learning Disabilities (LD)/Physical Disabilities (PD) Residential Care

- Care at Home
- Care at Home - Complex
- Supported Living
- Direct Payment

Not covered by this report:

- Out of Borough Services where we pay the host authority agreed annual rate.

2. Real Living Wage

2.1 The Council have recently announced a commitment that all paid carers will receive the Real Living Wage. This is currently £9.50p/h and any increase in fee rates to support the implementation of this will obviously affect those outlined in this report.

2.2.1 Work has started to develop a model to achieve this aim and fully engage with providers so any un-intended consequence can be managed, however, this is likely to take time. With a view to setting a level of fee increase as soon as possible it was felt that the standard fee uplift and any RLW uplift should be treated separately. Once work on the RLW has completed a second report with updated fee rates will come to CCMT and SCB for sign off.

3. Fee Proposal

3.1 In response to the above, and feedback from providers the following option is proposed:

a. Continue with the development of a tiered fee model specifically within Care Homes in order to support the strategic direction of Bury and future market development. Two years ago a dementia premium was introduced in Bury for the first time and last year a nursing dementia premium. This year those premiums will be increased and a general nursing premium will also be introduced.

b. This will form the basis of care home fee setting in the future with areas of development such as Dementia and nursing care receiving higher level increases. It is a common complaint that there is little reason for Providers to expand into those areas where we are seeing and continue to expect increased demand when there is little differentiation between the fee levels.

c. Standard Supported Living Fees in Bury were the highest in GM in 2020/21 giving scope to use the budget to increase fees in other areas and less in Supported Living but still retaining a competitive fee rate. A larger increase has therefore been proposed for Care at Home, another area of the market we are looking to develop.

4. Residential Care 2021/22 Fee Proposal

4.1. The Council proposes to increase the weekly fees paid per person to providers for the provision of Older Adults Residential Care as shown below:

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22

£502.95	0.9%	£4.77	**£507.72**

Older Adults Residential Dementia Care 2021/22 Fee Proposal

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£517.95	0.9%	£4.77	**£522.72**

Older Adults General Nursing Care 2021/22 Fee Proposal

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£502.95	3.9%	£19.77	**£522.72**

Older Adults Nursing Dementia Care 2021/22 Fee Proposal

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£532.95	6.4%	£34.77	**£567.72**

Adults Residential Care MH/LD/PD 2021/22 Fee Proposal

Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
£502.95	0.9%	£4.77	**£507.95**

5. Care at Home 2021/22 Fee Proposal

5.1. The Council proposes to increase the hourly fees paid per person to providers for the provision of Care at Home as shown below:

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£16.13	2.3%	£0.37	**£16.50**

5.2 The Council proposes to increase the hourly fees paid per person to providers for the provision of Care at Home Complex as shown below:

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£16.13	2.3%	£0.37	**£16.50**

6. Supported Living 2021/22 Fee Proposal

6.1. The Council proposes to increase the hourly rate paid per person to providers for the

provision of Supported Living services as shown below:

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£16.13	1.2%	£0.19	**£16.32**

The Council proposes to increase the hourly rate for Sleep-in support as shown below:

Hourly Fee Rate Sleep-in 2020/21	% Uplift	Increase (£)	Hourly Fee Rate Sleep-in 2021/22
£9.55	1.9%	£0.18	**£9.73**

7. Direct Payments 2021/22 Fees Proposal

7.1 The Council proposes to increase the hourly rate paid per person to a personal assistant for those in receipt of Direct Payments as shown below:

Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
£10.48	1.9%	£0.20	**£10.68**

8. Financial impact

8.1 The proposals above are funded by uplifts to the Council's core Adult Social Care budget, in accordance with the Budget Report approved by Council on 24 February 2021.

9 Added Value

9.1 One of the main focuses for this year's fee engagement has been to work alongside Providers to identify innovative support towards their sustainability and growth that is not reliant on just a fee uplift.

Additional support to be offered includes:

- Proposal to formalise Innovation and market sustainability fund. Providers would be able to bid for funding towards new and innovative ideas aimed at developing staff and improving provider efficiency and sustainability.
- Free qualifications for staff including Level 2 Health and Social Care via partnership with the Growth Company.
- Proposal to fund the purchase of discount cards for every staff member working for a Bury Care Provider. Work ongoing with relevant Council officers to extend Council benefits including discounted gym memberships to contracted providers. Designed to allow Providers to use this to support both recruitment and retention.
- Support the establishment of Bury Provider Network.

- Commitment to support providers looking to diversify/change their business model.

10 Financial Context 2020-21

10.1 The financial year 2020/21 has been like no other in recent times and the Council, and Adult Social Care particularly, faces delivering extremely challenging cost savings that dwarf even those required during Central Government's austerity programme. Local Authorities have been subject to ongoing funding reductions since 2010, however, the impact of the COVID-19 pandemic has exacerbated this even further. This is set against continuing economic and demographic pressures faced by the Council and Care Providers in Bury placing an ever greater strain on shrinking resources.

11 Fee Engagement Process 2021-22

11.1 The Council undertakes an annual fee engagement process with contracted providers, in line with good practice and statutory legislation, which states that when setting and reviewing fee costs, Councils should have due regard to the actual costs of providing care and other local factors, along with a responsibility for managing the local care market.

11.2 An overview of the fee engagement process can be found in Appendix 1 outlines the fee engagement timeline.

11.3 Alongside the standard fee engagement process which includes requesting cost pressures from Providers, the Council has expanded this to look at wider operational pressures as well. This with a view to continue working in partnership with providers to develop a more holistic offer of support. Fee engagement working groups have also been re-established and they are to continue as the Strategic Provider Working Groups throughout the year.

11.4 These working groups have not only discuss fee proposals but also strategic direction, mutual support and innovative practices in order to not only support the sustainability of the provider market but support its growth. Discussions have also started with CCG and CHC colleagues to ensure a joined up, system approach to provider engagement and they are invited to attend.

12 Cost Pressures

12.1 It is acknowledged that all providers of social care are facing the following national cost pressures over the next 12 months:

- National Living Wage 2.18% increase
- Inflation
- Unknown Brexit impact
- CQC Registration
- Energy Prices

Known and un-known COVID pressures including insurance increases/PPE costs etc

12.2 As shown above one of the cost pressures facing providers is the 2.18% increase in

the National Living Wage (NLW) from £8.72 per hour in 2020/21 for workers over the age of 25 to £8.91 per hour from April 2021. This increase has been captured for all care providers in the staffing element of their fee uplift.

12.3 It is evident that many providers of social care pay the majority of employees, at or near to the minimum wage and as employee costs equate to a large proportion of expenditure for social care providers, the mandatory requirement to increase pay to those employees that are paid the minimum wage will result in a cost pressure.

12.4 There will also be an expectation from those employees that are paid close to the minimum wage that the differential will continue to be maintained or there will be a real risk that the profession will become less attractive to existing or potential employees and providers will struggle to recruit either sufficient numbers or caliber of people.

13 Benchmarking AGMA Council Fee Rates

13.1 Another issue to consider when setting fee rates is that of fee rates paid in neighboring authorities, to ensure that the Council pays comparable rates to others, which creates an element of stability to the wider market across Greater Manchester (GM). Partners across GM are not yet in a position to share their fee rates, however dialogue will continue.

14 Consultation – Provider Feedback

14.1 Provider responses to the cost and operational pressure forms have been collated and questions/suggestions raised will be sent to all providers as a formal Question & Answer response along with the Offer letter. Pressures were broadly similar across providers with the main themes being:

- Increasing PPE/cleaning costs and those associated with the COVID pandemic.
- Increased in Insurance costs
- Year on year inflation and NLW uplifts
- Increased CQC costs
- Reduced occupancy and capacity with care homes and care at home providers.

15 Appendices

Appendix 1 Engagement Timeline

2021-22 Fee Engagement timeline.

Matthew Logan
Provider Relationship Lead
m.logan@bury.gov.uk

Template 3c

Equality Analysis Form

The following questions will document the effect of your service or proposed policy, procedure, working practice, strategy or decision (hereafter referred to as 'policy') on equality, and demonstrate that you have paid due regard to the Public Sector Equality Duty.

1. RESPONSIBILITY

Department	Community Commissioning Division	
Service	Provider Relationship Team	
Proposed policy	Provider fee setting	
Date	3/11/2020	
Officer responsible for the 'policy' and for completing the equality analysis	**Name**	Matthew Logan
	Post Title	Provider Relationship Lead
	Contact Number	0161 253 7252
	Signature	m.logan
	Date	3/11/2020

2. AIMS

What is the purpose of the policy/service and what is it intended to achieve?	Each year the Council carries out a fee setting process for its Adult Social Care Providers. This includes for: • Care Homes • Care at Home • Supported Living • Direct Payments The fees provided must be in line with the available Council budget, ensure the Council meets it duties under the Care Act and supports provider sustainability. The aim is to encourage a robust and vibrant market suitable for meeting the current needs of Bury's vulnerable people and the borough's future demands.
Who are the main stakeholders?	Commissioned Care Providers Bury Council Provider Relationship Team Bury Council Corporate Core

3. ESTABLISHING RELEVANCE TO EQUALITY

3a. Using the drop down lists below, please advise whether the policy/service has either a positive or negative effect on any groups of people with protected equality characteristics.
If you answer yes to any question, please also explain why and how that group of people will be affected.

Protected equality characteristic	Positive effect (Yes/No)	Negative effect (Yes/No)	Explanation
Race	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Seperate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Disability	Yes	Yes	Adult Social Care Providers support the most vulnerable people of society including those with levels of disbaility where required. The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision,

			contingency plans are already in place to ensure their needs continue to be met.
Gender	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic including Gender There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Gender reassignment	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic including gender reassignment There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.

Age	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic. Adult Social Care supports those over 18. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Sexual orientation	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic including sexual orientation. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Religion or belief	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to

			meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic inlcuing religion. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Caring responsibilities	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Pregnancy or maternity	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of

			protected equality characteristic. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.
Marriage or civil partnership	Yes	Yes	The setting of provider fees will ensure the continued sustainablity and viablity of the borough's care providers to meet the needs of Bury customers. The impact of this is felt by all those who receive commisioned service from Adult Social Care irrespective of protected equality characteristic. There is always a risk that the fee rate set results in providers choosing to exit the market. Where customers are left requiring alternative provision, contingency plans are already in place to ensure their needs continue to be met. Separate contratual and quality measures are employed with all Providers to ensure appropriate equality policies are implemented and adhered to and staff appropriately trained.

3b. Using the drop down lists below, please advise whether or not our policy/service has relevance to the Public Sector Equality Duty.
If you answer yes to any question, please explain why.

General Public Sector Equality Duties	Relevance (Yes/No)	Reason for the relevance
Need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010	Yes	Provider fee setting is for Adult Social Care Providers. Eligibility for Adult Social Care services is based on assessed support needs rather than protected characteristics; enable people to have their care and support needs met and live as independantly as possible.
Need to advance equality of opportunity between people who share a protected characteristic and those who do not (eg. by removing or minimising disadvantages or meeting needs)	Yes	Provider fee setting is for Adult Social Care Providers. Eligibility for Adult Social Care services is based on assessed support needs rather than protected characteristics; enable people to have their care and support needs met and live as independantly as possible.
Need to foster good relations between people who share a protected characteristic and those who do not (eg. by tackling prejudice or promoting understanding)	No	

If you answered 'YES' to any of the questions in 3a and 3b → **Go straight to Question 4**

If you answered 'NO' to all of the questions in 3a and 3b → **Go to Question 3c and <u>do not</u> answer questions 4-6**

3c. If you have answered 'No' to all the questions in 3a and 3b please explain why you feel that your policy/service has no relevance to equality.

N/A

4. EQUALITY INFORMATION AND ENGAGEMENT

4a. For a service plan, please list what equality information you currently have available, **OR** for a new/changed policy or practice please list what equality information you considered and engagement you have carried out in relation to it.

Please provide a link if the information is published on the web and advise when it was last updated?

(NB. Equality information can be both qualitative and quantitative. It includes knowledge of service users, satisfaction rates, compliments and complaints, the results of surveys or other engagement activities and should be broken down by equality characteristics where relevant.)

Details of the equality information or engagement	**Internet link if published**	**Date last updated**
Contract monitoring information		
Review template information		
Questionnaires	Provider consultation to be shared	
Face to face discussions	Strategic Provider Groups established	
Age-friendly Bury Plan		
GM Age-friendly Bury Strategy		
Bury Directory website		

4b. Are there any information gaps, and if so how do you plan to tackle them?

5. CONCLUSIONS OF THE EQUALITY ANALYSIS

What will the likely overall effect of your policy/service plan be on equality?	The fee setting process will support provider sustainability and allow those eligible for Adult Social Care services to continue to have their needs met.
If you identified any negative effects (see questions 3a) or discrimination what measures have you put in place to remove or mitigate them?	
Have you identified any further ways that you can advance equality of opportunity and/or foster good relations? If so, please give details.	
What steps do you intend to take now in respect of the implementation of your policy/service plan?	Consult with Providers around initial fee proposals, the challenges they face and what holistic response, alongside an increased fee rate, the Council and partners can provider.

6. MONITORING AND REVIEW

If you intend to proceed with your policy/service plan, please detail what monitoring arrangements (if appropriate) you will put in place to monitor the ongoing effects. Please also state when the policy/service plan will be reviewed.

TBC

COPIES OF THIS EQUALITY ANALYSIS FORM SHOULD BE ATTACHED TO ANY REPORTS/SERVICE PLANS AND ALSO SENT TO YOUR DEPARTMENTAL EQUALITY REPRESENTATIVE FOR RECORDING.

2021/22 Fee Engagement Timescales

Activity	Timescale
Formal launch fee consultation with request for care providers to take part in working group	**23/12/2020**
Initial working group meeting	**Week beginning 11/1/2021**
Second working group meeting	**Week beginning 1/2/2021**
Stage 2 - Letter and Cost Pressures Form issued to providers	**04/02/2021**
Third working group meeting	**Week beginning 22/2/2021**
Stage 3 - Fee proposal issues to providers for consultation	**Week beginning 8/3/2021**
Fourth working group meeting	**Week beginning 15/3/2021**
Stage 4 - Final fee offer issued	**13/04/2021**

Note: Working groups will continue following the end of this timeline to allow for continual engagement, development and support for Providers in developing innovative support solutions.

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	12 April 2021	**Action**	Receive
Item No	10.5	**Confidential / Freedom of Information Status**	No
Title	Sustainability of LCO Management & Clinical Costs		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning, Bury Council and NHS Bury CCG		
Author	Mui Wan, Associate Director of Finance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

A commitment was given at December SCB to prioritise funding for Transformation Fund and LCO Management costs 2021/22 onwards. With this commitment there was a £5.7m financial risk as funding was to be identified. It was felt that there was an even greater significant financial and operational risk to terminating the schemes or delaying a decision. It was therefore agreed the financial risk was to be managed and mitigated by all system partners over the following months. This report updates on current discussions to address that financial risk.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note content of the report;
- Accept further update on the clarification of financial pressures in May.

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	Yes	☐	No	☐	N/A	☐

Implications						
or public/patient) been undertaken in relation to this report?						
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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐

Implications						
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details						

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

BURY LOCAL CARE ORGANISATION
Improving lives in Bury

Current Situation

A commitment was given at December SCB to prioritise funding for Transformation Fund and LCO Management costs 2021/22 onwards. With this commitment there was a £5.7m financial risk as funding was to be identified. It was felt that there was an even greater significant financial and operational risk to terminating the schemes or delaying a decision. It was therefore agreed the financial risk was to be managed and mitigated by all system partners over the following months. This report updates on current discussions to address that financial risk.

Financial options

A task and finish group was convened with key finance and service leads to discuss mitigating options which currently are;

- Funding diverted from A&E and NEL growth

This is dependent on the financial framework which is due to be released at the end of March. Funding implications will need to be worked through and therefore the financial impacts will not be clear until early April.

- Savings from the Intermediate Care beds review.

The final savings from this review is still to be clarified as stranded costs and costs to support the reprovision of beds at Killelea are to be confirmed.

- Non-Recurrent Funds

We have been notified from GM that Transformation Fund which was unallocated in 2020-21 maybe received in 2021-22. Amounts are to be confirmed but will be non-recurrent.

All the above options are being considered in the absence of the 2021-22 financial guidance. NHSE have confirmed that current funding block arrangements will continue until the end of September 2021 which delays the financial pressure of the TF schemes.

Recommendation

SCB are asked to

- Note content of the report
- Accept further update on the clarification of financial pressures in May

Mui Wan
Associate Director of Finance

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Receive
Item No.	12	**Confidential**	No
Title	Performance Report		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

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

Recommendations

It is recommended that the Strategic Commissioning Board:

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

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being	Yes	☐	No	☒	N/A	☐

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

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

1. Introduction

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

2. Background

2.1. This paper is a summary of the information presented to the CCG's Quality and Performance Committee in March 2021 which related to the published position as at December 2020. However, where later data has since been published, this too is referenced within the report.

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

3. Constitutional Standards and COVID-19 Impact Review

COVID-19 Update

3.1 The NHS COVID-19 response was reduced to a level 3 incident with effect from 25th March 2021, with management of the incident moving from a national to a regional command, control and co-ordination structure. This mirrors the structure in place across summer 2020.

3.2 Subject to continued reducing community transmission and deaths, the national lockdown imposed on 6th January is being lifted in a phased manner. Bed occupancy at Fairfield General Hospital (FGH) of COVID-19 positive patients has reduced since the new year though has plateaued around 22-25 in the week leading up to 26th March.

3.3 National operational and financial planning guidance for 2021-22 was published on 25th March and outlines the following priorities for the year:

- Support the health and wellbeing of staff and take action on recruitment and retention;
- Deliver the COVID vaccination programme and continue to meet the needs of patients with COVID-19;
- Build on what has been learned to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services;
- Expand primary care capacity to improve access, local health outcomes and address health inequalities;
- Transform community, urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay; and
- Work collaboratively across systems to deliver on these priorities.

3.4 To achieve the above, additional funding is being made available for the first six months of 2021-22 with funding arrangements for the latter part of the year to be agreed at a later date.

3.5 The planning guidance is currently being reviewed locally to fully understand the requirements around the formulation and submission of financial, activity and performance plans. The guidance suggests that system, ie GM, level plans will be required and the expectation is that these will be based on individual CCG submissions.

Planned (Elective) Care

3.6 Work is ongoing to complete the transaction of the North Manchester General Hospital (NMGH) care organisation from Pennine Acute Hospitals Trust (PAHT) to Manchester University Foundation Trust (MFT). This includes working through those elective pathways that will transfer from NMGH to other Norther Care Alliance (NCA) care organisations, for example urology. The NCA will continue to deliver some services from the NMGH site through a Service Level Agreement. Completion of the NMGH transaction will take effect from 1 April 2021 whilst the transaction of the remaining PAHT care organisations into the NCA is expected to be complete by the end of September 2021.

3.7 The first in a series of workshops led by the Bury Elective Recovery and Transformation Group took place during March with a second planned for late-April. The first workshop brought key partners together to ensure a single shared understanding of the current challenge exists and to agree a set of principles that can be applied to future transformation. The second workshop will set neighbourhood working at its core.

3.8 In line with national guidance, the NCA has a structure in place to ensure clinical prioritisation of elective activity takes place. Although some elective activity remains paused, the NCA has continued to undertake surgery and procedures for those in most clinical need and this includes cancer or suspected cancer patients.

3.9 Capital works have also been undertaken at the FGH site to create a ‘Green Floor’ and this has enabled additional intermediate acuity capacity. To date this has allowed for ring-fenced inpatient capacity in Trauma and Orthopaedics (T&O) along with a recommencement of both day case and inpatient Ear Nose and Throat (ENT) surgery. Plans also include a review of the workforce strategy to enable the FGH site to be used to undertake some urology, general surgery and gynaecology procedures on behalf of other NCA care organisations.

3.10 Overall, the waiting list reduced slightly in December before increasing slightly again in January. There has, however, been a significant month on month increase in the number of patients waiting more than 52 weeks to commence treatment. For comparison, there were 1400 such waiters in January 2021 compared to 34 across the whole of 2019-20.

3.11 Specialty level developments include dermatology where, following a successful pilot in Bury, the tele-dermatology service is now being sustained through use of the SRFT Referral Assessment Service (RAS). In Ophthalmology, focus has now switched to the glaucoma pathway for which a GM-wide pathway has been agreed. Whilst the outcome of a pilot scheme at MFT is awaited, NHS Bury CCG is progressing plans to be able to implement some changes in advance of the future required workforce being in place.

3.12 Diagnostic performance remains a concern with significant under-performance continuing for Bury patients across all test types. Endoscopy, however, remains the single biggest diagnostic pressure and inevitably has a knock-on effect to elective and cancer waits. Plans are progressing within the locality with regard to the implementation of Community Diagnostic Hubs.

Cancer Care

3.13 The newly developed NCA cancer improvement plan is expected to be signed off by the end of March. The plan covers the immediate period and into Quarter 1 of 2021-22 alongside the development of a longer term plan to cover the period to 2026. NES CCGs also continue to meet with NCA cancer team colleagues on a fortnightly basis.

3.14 The increase in suspected cancer referrals (2WW) seen in recent months has been sustained though variation between tumour groups continues. In particular, suspected lung cancer referrals both nationally and in Bury remain significantly below the pre-COVID-19 level and the associated 'Do It For Yourself' awareness campaign is currently underway. In Bury, the reduction for lung is offset by a significant increase in suspected gastrointestinal cancer referrals.

3.15 In terms of performance against the NHS Constitution standards, the picture remains mixed in the most recent data with 31-day standards continuing to be achieved but ongoing challenge presented by the 2WW and 62 day wait standards.

3.16 Dermatology and breast services continue to present the biggest challenge in the most recent data though improvement has been noted within gynaecology following some short-term staffing issues. Within dermatology, the NCA aims to expand the use of one-stop clinics which require patients to attend fewer appointments. The trust has also recently undertaken a small pilot to electronically triage 2WW skin referrals with an option to provide advice and guidance if appropriate. The NCA has an improvement plan in place for dermatology and oversight of this is managed through the NCA Cancer Improvement Committee.

3.17 Breast services are impacted by both workforce capacity and clinical space constraints at the NMGH site though it is also noted that suspected breast cancer referrals have increased across GM this year too.

3.18 The NCA improvement plan also includes an intention to reduce the number of patients waiting in excess of 62 and 104 days for their treatment. Currently, a senior NCA cancer team meets regularly to review those waiting the longest.

Urgent Care

3.19 Performance at PAHT against the A&E four hour wait standard remains below target though this is reflected across GM too. The most recent data shows a further significant increase in the number of 12 hour breaches too. Between April and August 2020 there had been just one 12 hour trolley wait whilst there were 961 such waits between September and January.

3.20 In terms of A&E attendance numbers at PAHT, although there have been approximately 23% fewer attendances in 2020-21 than in 2019-20, a spike was seen in March 2021. At FGH specifically, there were an average of 155 attendances per day in January and

February 2021 though this increased to 187 per day in March (to 23rd). The increase in March has been most marked since around the 8th with the daily average standing at 193 for the period 8th to 23rd March. Work is ongoing within the locality to better understand what is driving the increase which is also reflected across GM.

3.21 Implementation of the urgent care redesign programme in Bury continues with planning for Phase 2 which will include the capital works required to develop a new purpose built Urgent Treatment Centre (UTC) now underway. The redesign programme is being led by the Locality Care Organisation (LCO) with oversight provided by the Urgent Care Programme Board.

3.22 The LCO is also leading on the implementation of the national urgent care transformation schemes and both streaming of patients upon arrival at the FGH A&E department and the NHS 111 First programme are both now fully operational in Bury with BARDOC providing the streaming function whilst PAHT continues to deliver the UTC function.

3.23 Renewed focus on discharge planning has taken place since the new year and has resulted in noticeable improvements in patient flow and continued strong performance at PAHT with regard to admissions with a length of stay in excess of both 7 and 21 days. National planning guidance for 2021-22 has confirmed that funding for discharge placements will continue for six months though the period funded is expected to reduce to four weeks from July 2021. An admission avoidance scheme was also implemented at the end of January as part of a GM-wide initiative. This scheme involves two GM hubs accessing appropriate NWAS incidents and deflecting these to a single point of contact in each locality.

3.24 Following approval at January's Strategic Commissioning Board (SCB) of the intermediate care review business case, a period of employee consultation is now underway for those staff affected by the recommendations. Notice has been served to the NCA on the service previously provided at the Bealey site and the LCO remains on target to implement the changes by summer 2021. The programmes aims to create a more balanced model of both bed and home-based care to support Bury residents at different stages of their recovery.

Mental Health

3.25 Strong performance continues for both the Dementia Diagnosis and the Early Intervention in Psychosis standards. Examples of positive patient feedback about the Bury Early Intervention in Psychosis team were shared during the most recent locality meeting with Pennine Care Foundation Trust (PCFT).

3.26 Challenge does, however, remain in achievement of the key Improving Access to Psychological Therapies (IAPT) standards. Although the recovery rate and 18 week wait standards have largely been achieved across the year to date, there is continued under-performance for the access and 6 week wait measures. Access numbers have been reduced in 2020-21 partly due to fewer referrals but also due to the suspension of community events, eg in local colleges, which can attract fairly significant numbers. Although such one-off events contribute towards the access target where a treatment element is included, they are unlikely to be reinstated to the same degree in the future by the PCFT service in order that there can be a focus on those requiring a fuller treatment episode. Digital therapy for IAPT continues via Silver Cloud for which waiting times are significantly shorter than for clinician-facing therapy.

3.27 A number of locally commissioned schemes to improve access to services have commenced in recent months. These include the newly commissioned urgent care by appointment for mental health scheme for which efforts are underway to secure funding into 2021-21, mental health practitioners now embedded within each Integrated Neighbourhood Team (INT), dedicated support to homeless people to support access to services and a new Consultant Access Service which was launched in October 2020.

3.28 Implementation of Bury's adult community crisis service continues and is expected to become operational during April 2021 with the contract for this 12 month pilot having been awarded to Bury Involvement Group (BIG). BIG will directly operate the evening service whilst the daytime element will be delivered by the Beacon Service under sub-contract arrangements.

3.29 PCFT currently operates a 24-hour crisis helpline, funded through dedicated COVID-19 monies and the expectation is for this to continue to be delivered during 2021-22 and funding arrangements for this are currently being finalised..

Maternity and Childrens Performance Measures

3.30 Unusually, the standard for children and young people (CYP) accessing the Community Eating Disorder Service (CEDS) was not achieved for routine cases in Quarter 3 though indicative data from PCFT shows a return to 100% performance in January. All urgent cases referred across 2020-21 were seen within the required one week timeframe.

3.31 Following a significant increase in referrals to the PCFT Healthy Young Minds (HYM) service between September and December which led to the service invoking its business continuity plan, January 2021 saw a reduction to below the 2019-20 though it is unclear whether such a reduction will be sustained. Work remains ongoing across the locality with PCFT to look at both the short and longer term actions required to alleviate recent issues and ensure service provision can meet demand in the future. This includes the commissioning of a new advice line which will initially be operational for six months.

3.32 In terms of performance, although CYP mental health access was lower in Quarters 2 and 3, the very high access rate in Quarter 1 means that the year to date position to December 2020 showed achievement. However, with provisional data showing low access in January, achievement by year-end is at risk.

3.33 A number of initiatives, both within the locality and across GM, have been put in place to increase the options for additional support to CYP during the COVID-19 response period, including text and online platforms. In advance of schools reopening in March, the HYM service worked closely with education partners again to support schools being better placed to support students.

4 Actions Required

4.1 The audience of this report is asked to:

- Receive this report.

Susan Sawbridge
Head of Performance
March 2021

Appendix A: Greater Manchester Constitutional Standards Summary

Measure Name	Standard	Latest Data	GM	Bury	North West	England
Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95.0%	Feb-21	79.4%	75.2%	81.8%	83.9%
A&E 12 Hour Trolley Wait	0	Feb-21	68	42	112	1038
Delayed Transfers of Care - Bed Days *(PAHT)*	200	Feb-20		35.1	917.1	5371.8
Delayed Transfers of Care - Bed Days *(PCFT)*				30.1		
Delayed Transfers of Care - Per 100,000	Null	Feb-20	19.2	12.2	15.6	12.4
Stranded Patients (LOS 7+ Days)	2196	Jan-21	2492	440	5829	36598
Super-Stranded Patients (LOS 21+ Days)	Null	Jan-21	979	155	2187	12406
Referral To Treatment - 18 Weeks	92.0%	Jan-21	61.4%	62.6%	63.9%	66.1%
Referral To Treatment - 52+ Weeks	0	Jan-21	22618	1400	44950	304916
Diagnostics Tests Waiting Times	1.0%	Jan-21	41.4%	52.1%	35.7%	33.4%
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93.0%	Jan-21	79.2%	74.5%	82.3%	83.4%
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93.0%	Jan-21	33.1%	9.9%	53.2%	62.7%
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96.0%	Jan-21	95.1%	98.7%	94.7%	94.0%
Cancer - 31-Day Wait For Subsequent Surgery	94.0%	Jan-21	95.4%	100.0%	87.5%	86.3%
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98.0%	Jan-21	100.0%	100.0%	99.4%	98.0%
Cancer - 31-Day Wait For Subsequent Radiotherapy	94.0%	Jan-21	99.7%	100.0%	99.6%	96.0%
Cancer - 62-Day Wait From Referral To Treatment	85.0%	Jan-21	67.1%	61.9%	68.4%	71.2%
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90.0%	Jan-21	84.6%	100.0%	86.1%	79.8%
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade	Null	Jan-21	78.7%	68.0%	81.1%	81.1%
Cancer - 104-Day Wait	0.0%	Jan-21	72	5	181	1029
Breast Cancer Screening Coverage (Aged 50-70)	70.0%	Mar-20	69.0%	75.0%	70.6%	71.9%
Bowel Cancer Screening Uptake (Aged 60-74)	60.0%	Mar-20	63.4%	63.8%	64.6%	65.4%
Cervical Cancer Screening Coverage (Aged Under 50)	80.0%	Mar-20	71.4%	73.3%	72.6%	70.1%
Cervical Cancer Screening Coverage (Aged 50-64)	80.0%	Mar-20	76.0%	76.2%	75.7%	76.1%
MRSA	0.0%	Jan-21	6	1	9	81
E.Coli	Null	Jan-21	130	11	310	2761
Estimated Diagnosis Rate for People with Dementia	66.7%	Feb-21	67.50%	74.3%	65.0%	61.1%
Improving Access to Psychological Therapies Access Rate	5.3%	Dec-20	4.17%	2.06%	3.59%	4.39%
Improving Access to Psychological Therapies Recovery Rate	50.0%	Dec-20	46.6%	46.7%	46.3%	49.7%
Improving Access to Psychological Therapies Seen Within 6 Weeks	75.0%	Dec-20	86.2%	73.3%	90.0%	92.7%
Improving Access to Psychological Therapies Seen Within 18 Weeks	95.0%	Dec-20	96.9%	96.7%	97.6%	98.5%
Early Intervention in Psychosis - Treated Within 2 Weeks of Referral	56.0%	Dec-20	78.7%	94.0%	50.5%	67.8%
First Treatment For Eating Disorders Within 1 Week Of Urgent Referral	95.0%	Dec-20	100.0%	100.0%	96.8%	76.5%
First Treatment For Eating Disorders Within 4 Weeks Of Routine Referral	95.0%	Dec-20	96.6%	100.0%	88.8%	79.5%
Access Rate to Children and Young People's Mental Health Services	33.2%	Dec-20	45.4%	48.4%	42.2%	40.6%
CPA follow up within 7 days	95.0%	Dec-19	96.2%	98.1%	96.6%	95.5%
Mixed Sex Accommodation	0.0%	Feb-20	1.9	1.5	1.3	3.00
Cancelled Operations	Null	Dec-19	1.7%	2.0%	1.3%	1.1%
Ambulance: Category 1 Average Response Time	420	Jan-21	07:09	07:48	08:12	07:38
Ambulance: Category 1 90th Percentile	900	Jan-21	11:34	12:32	13:47	13:26
Ambulance: Category 2 Average Response Time	1080	Jan-21	29:03	27:49	35:35	29:40
Ambulance: Category 2 90th Percentile	2400	Jan-21	60:19	56:34	77:58	64:12
Ambulance: Handover Delays (>60 Mins)	Null	Feb-21	1.0%	1.2%	0.8%	2.1%
Cancer Patient Experience	Null	Apr-18	8.88	8.72	8.87	8.80
General Practice Extended Access	Null	Mar-19	100.0%	100.0%		

As per GM Tableau on 25/03/2021. Assurance>Greater Mancheser Constitutional Standards Summary/Constitutional Standards Summary

Meeting: Strategic Commissioning Board			
Meeting Date	12 April 2021	**Action**	Information
Item No	14	**Confidential / Freedom of Information Status**	No
Title	Bury System Board and Bury System / Transition Board Meetings		
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 Meeting held on 16 December 2020;
- Bury System / Transition Board Meeting held on 18 February 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the Minutes of the Bury System Board Meeting held on 16 December 2020;
- receive the Minutes of the Bury System / Transition Board Meeting held on 18 February 2021.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being	Yes	☐	No	☒	N/A	☐

Implications						
requested?						
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?						
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 December 2020	Minutes being submitted for ratification
Bury System / Transition Board	18 February 2021	Minutes being submitted for ratification

Title	**Minutes of the Bury System Board** **16 December 2020**
Author	Jill Stott, LCO Governance Manager
Version	1.0
Target Audience	Members of the Bury System Board
Date Created	
Date of Issue	
To be Agreed	19 January 2021
Document Status (Draft/Final)	Draft

Document History:

Date	Version	Author	Notes
22.12.20	1.0	Jill Stott	Draft Minutes submitted to WB for checking
23.12.20	2.0		Amendments by WB
17.02.21			Approved by Bury System /Transition Board
Approved:			
Signature:			.....

Bury System Board

MINUTES OF MEETING
19 November 2020, 1 – 2.30pm Via Teams **Chair –** Dr Jeff Schryer

Members Present:

Dr Jeff Schryer, Chair Bury CCG (JS)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Mr Mike Woodhead, CFO, Bury CCG (MW)
Mr Chris O'Gorman, Independent Chair, LCO Board (CO'G)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Ms Mui Wan, Associate Director of Finance, Bury LCO (for Craig Carter, Director of Finance, NCA) M Wan
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council (AS)
Ms Julie Gonda, Director of Community Commissioning (DASS) (JG)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Ms Lesley Jones, Director of Public Health, Bury Council (LJ) – until item 8
Ms Sheila Durr, Executive Director Children and Young People, Bury Council (SD)
Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation (TR)
Ms Catherine Wilkinson, Director of Finance, Bury Care Organisation (CW)
Dr Daniel Cooke, Clinical Director, NHS Bury CCG (DC)

Others in attendance:
Ms Jill Stott, LCO Governance Manager (JMS)

Apologies

Apologies for absence were received from:
Ms Kath Wynne-Jones, Chief Officer, Bury LCO
Cllr Eamonn O'Brien, Leader of the Council
Dr Cathy Fines, Clinical Director, NHS Bury CCG

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 (19 November 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.	**Integrated Care System Guidance**
	WB's paper, *Next Steps to Integrated Health and Care in Bury*, had been shared with Board and he gave a comprehensive overview of its content at the meeting. He explained that the document served 2 purposes: to provide a framework for the GM response to the NHSEI paper on Integrating Care, along with an opportunity to review partnership arrangements in the context of proposed statutory changes for the CCG and Integrated Care System (ICS) roles. WB highlighted the main areas of the paper, covering the strategic intent behind it and explaining that work is now needed to define the characteristics of a future health and care system. He noted the progress already made on the local partnership architecture, emphasising that both Bury and GM are ahead of the curve with regards to next steps for an integrated care system (ICS). With regards to the future of CCGs he reported that GM support is to option 2 (a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS), but this is on the understanding that certain conditions are attached; these are that the required financial flows and decision-making processes are delegated to neighbourhood level. Explaining the intentions behind the organogram within the document WB highlighted the move for commissioners and providers to work together. He explained that the integrated delivery arrangements would include additional areas to those currently within scope of the LCO; these would include Children, Housing, wider PSR and some GM activity. Reporting from the LCO Board held earlier in the day WB said that the focus is not currently on form and function, but more about partnership working and connecting wider into the system. He said the intention is to create the conditions for neighbourhood working to be the default setting for locality work. He highlighted the need for clinical and professional leadership within the system. The paper highlighted the importance of considering CCG staff and their future in subsequent arrangements. WB went on to outline the proposed changes to formal committees throughout the shadow arrangements, explaining their remit and proposed membership. WB suggested that the authority and expertise within this Board should be used to convert it to the Transition Programme Board, led by an SRO and with a series of sub-groups beneath it. He said that the LCO would lead on the wider delivery arrangements. He referred to the positive work undertaken by JG and others on the neighbourhood programme to date. WB explained that the paper is due to go to SCB on 4 January before a GM response to NHSEI on 8 January. As the paper is part of an iterative process further comments were welcomed. The Board thanked WB for his helpful paper and comments were made by members.

AS highlighted the following:

- Correct infrastructure to be in place within the Bury locality in order to support neighbourhood working.
- PCNs to be integrated into the neighbourhood model
- Allocation and flow of money into neighbourhoods is key
- Increased focus on the needs of the population rather than individual organisations
- Recruitment of CCG staff to be within the locality

GL made the following points:

- Endorsed the recommendation for this Board to become the Transition Programme Board given the magnitude of this work
- OD plan for the year required, especially for CCG staff
- Risk around losing key staff from Bury
- Commitment to retain key planning skills in the locality
- Dedicated time needed to engage with political and clinical leaders and NCA leaders
- Further OD work required for SCB, Transition Programme Board and leadership of the NCA

He suggested that a timetable of work is needed for the coming year for focus on topics such as:

- Active Case Management
- Primary Care Networks
- Wider PSR agenda
- Budgets and reduction in demand
- Mental Health
- Embedding best practice

LD supported the move to a Transition Programme Board; she noted that the programme of work already underway in the neighbourhoods can be extended to incorporate the additional sub-groups outlined in the paper. She cited a number of areas of work which could act as the foundations for this work and be developed to support the programme:

- Neighbourhood model – model to be developed and expanded
- Operational governance – work by the LCO on the single line management model to be offered to the system
- Workforce Hub and system-wide forums in place (including staff side reps) which can support re-deployment procedures

A number of other comments were made by members:

- Need to avoid silo working, and to work together as one unit
- New language needed and a move away from “commissioner” and “provider”
- Need to ensure a consistent narrative to GM and retain the positive connections already in place
- Good relationships across organisations in Bury emphasised
- Risk in trying to continue with business as usual alongside a reorganisation

- Need to move at pace and being mindful that governance processes do not hinder this
- Further detail on a roadmap for this work including decision points

GL highlighted that due to the strong relationships across Bury, including clinical and political, the locality is in a strong position to achieve successful transformation. He noted that historically Bury has been underfunded and that the locality needs to influence what happens at GM level. He noted the risk around financial flows and responsibilities not being devolved to the locality.

GL highlighted the importance of the NCA's role across the NES in this work.

He suggested the SLM model should be expanded where appropriate and that an alternative partnership model should be aimed for where the SLM is not suitable.

JS summarised the main points of the discussion above:

- Key issue of financial flows in the system
- Key issue of neighbourhood model
- Importance of the relationship with the NES and the NCA
- Focus on population need and not organisational boundaries
- Utilisation of Single Line Management Framework
- Care of CCG staff
- Focus on planning and delivery of services
- Need for an OD programme to consider new ways of thinking, behaviours, language etc
- Importance of retaining connections across GM and not diluting authority

ID	Type		Owner
D/12/01	Decision	Proposals in the paper were broadly supported and WB was asked to begin to develop the transition framework, reporting to the System Board which would be repurposed as the System Transition Board	WB
A/12/01	Action	Further detail on a roadmap for the ICS programme, including responsibilities and reporting to come to the January board	WB
A/12/02	Action	ICS Transition Programme to be a standing agenda item	JMS

6 System-wide Financial Update

MW presented to Board on the latest financial position from both a local and GM level, along with information on the changes to the NHS financial regime.

He explained that the current GM forecast is a £78m deficit, a reduction on the original £108m figure; he noted that this has not yet been signed off by NHSE and that further key guidance is still awaited.

Key risks and issues were listed, including the effect of Covid-19, the vaccination programme, savings programmes and potential financial penalties around activity targets.

MW shared the latest locality financial position, noting that the true underlying position is a

	negative one. The challenges around the integrated care fund were highlighted, with significant pressures on both CCG and council budgets. MW shared some of the detail on the savings plans in place, noting the need for openness and transparency across the system, so that any risks and impacts are understood. He confirmed that further work on the impact of the savings plans is on-going, with an update to come to the January System Board. MW highlighted that traditional approaches to achieving savings via transformation programmes and efficiencies would not be enough to make the current savings needed. He also noted the importance of clinical buy-in to this process. The remainder of the presentation covered process and timelines, details of the comprehensive spending review and an update on the NHS financial regime. System Board thanked MW for his comprehensive update and discussion followed. WB noted that a Finance group would be included in the sub-groups listed in his earlier paper. JS suggested that a way needed to be found for the system as a whole to take ownership of finance issues. GL explained that the council's budget needs to be set and balanced by the end of March 2021 and that SCB would be reviewing draft proposals on a pooled budget at their 4 January meeting. He noted the clinical directors' engagement in this process. He said that although the CCG's position is showing as in balance the underlying position will be one of deficit going into the next financial year. He referred to the fixed budget option referenced in the NHS long term plan and the suggestion of a move towards that model. He said the intention would be to manage a total budget, creating savings as a system, but avoiding cuts. He suggested that the system could be made more efficient and effective, citing the work around Urgent Care as an example. Areas for focus were suggested as: • Best use of Workforce across the system • Increased use of technology • Reduction in demand by shifting resource from late to early intervention MW noted the potential for increased use of block contracts, but agreed that there may other ways of moving money around the system. Members put forward the suggestion that efficiencies on fixed costs, such as Estates, could be an option.

ID	Type		Owner
A/12/03	Action	Further details on the impact of system savings plans to come to January System Board	MW

7	**Closing Matters**
	Update from Bury Digital Board JS reported that Sanjay Kotegaonkar and Kate Waterhouse, supported by a wide range of stakeholders, have led work on reviewing options for the GP System of Choice work. There is currently no front runner in the process and further work is being progressed. **GP Connect** JS reported that weekly meetings are currently being held to resolve the issue of appointments from NHS111 and the Clinical Assessment Service being unable to be transferred to GP systems.

ID	Type		Owner
A/12/04	Action	Update on GP System of Choice work to come to a January or February System Board meeting	JS

Next Meeting	**Date: 19 January 2021, 1.30-3.30pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

Title	**Minutes of the Bury System/Transition Board** **18 February 2021**
Author	Jill Stott, LCO Governance Manager
Version	1.0
Target Audience	Members of the Bury System/Transition Board
Date Created	
Date of Issue	
To be Agreed	16 March 2021
Document Status (Draft/Final)	Draft

Document History:

Date	Version	Author	Notes
	1.0	Jill Stott	Draft Minutes submitted to WB for checking
Approved:			by Bury System/Transition Board 16.03.21
Signature:			.....

Bury System/Transition Board

MINUTES OF MEETING
18 February 2021, 10.30 – 12.30pm Via Teams **Chair –** Cllr Eamonn O'Brien

Members Present:

Cllr Eamonn O'Brien, Leader of the Council (EO'B)
Dr Jeff Schryer, Chair Bury CCG (JS)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Ms Pat Crawford, Interim CFO, Bury CCG (PC)
Mr Chris O'Gorman, Independent Chair, LCO Board (CO'G)
Ms Kath Wynne-Jones, Chief Officer, Bury LCO
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council (AS)
Ms Julie Gonda, Director of Community Commissioning (DASS) (JG)
Ms Lesley Jones, Director of Public Health, Bury Council (LJ) – until item
Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation (TR)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Mr Simon O'Hare, Interim Deputy CFO, Bury CCG (SO'H)

Others in attendance:

Ms Jill Stott, LCO Governance Manager (JMS)
Ms Kate Waterhouse, Joint CIO Bury Council & Bury CCG (KW)
Dr Sanjay Kotegaonkar, Clinical Lead IM&T Bury CCG (SK)
Ms Sam Merridale, Interim Programme Lead, Bury Urgent Care (SM)
Ms Zabina Rahman, Senior Project Manager, Primary Care Digital and IT, Bury CCG (ZR)

Apologies

Apologies for absence were received from:

Dr Cathy Fines, Clinical Director, NHS Bury CCG
Dr Daniel Cooke, Clinical Director, NHS Bury CCG
Ms Catherine Wilkinson, Director of Finance, Bury Care Organisation
Ms Sheila Durr, Executive Director Children and Young People, Bury Council
Ms Mui Wan, Associate Director of Finance, Bury LCO
Mr Keith Walker, Executive Director of Operations, PCFT
Ms Lynne Ridsdale, Deputy Chief Executive, Bury Council
Dr Kiran Patel, Medical Director, Bury LCO

MEETING NARRATIVE & OUTCOMES

1.	**Welcome and Apologies**
	EO'B welcomed those present to the Bury System Board and 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/Transition Board. None were declared.
3.	**Minutes of Last Meeting (16 December 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.
	TRANSITION PROGRAMME
5.	**White Paper: The Future of Health and Care**
	A presentation on the main aspects of the government white paper, *Integration and Innovation: working together to improve health and social care for all,* had been shared previously and GL presented on the main points. He summarised the background to the current position, emphasising the focus on the wellbeing of CCG staff and the requirement for some to be working at a locality level in the new regime. GL reminded the group of Bury's objectives and the need for alignment of future working with the Bury Let's Do It strategy. He said that the focus on addressing inequalities in the locality would be key, and that the move for services to be closer to home, supported by the work of the integrated neighbourhood teams, would form the bedrock of work in Bury. GL said that any future model would need to include clinical/political and professional leadership, including providers, and that collaboration across the NES would be an important part of the work. GL noted the financial position, referring to the circa £20m gap for the CCG and the gap in council finances. He suggested that early intervention work and more efficient services would play a key role in managing demand. GL explained the thinking behind the proposed partnership framework in Bury, consisting of 3 parts: **Bury Locality System Board** – comprising clinical/political/provider/non-executive leadership and holding accountability for a pooled budget in the system **Integrated Provider Delivery Collaborative** – the current LCO is a basis for this, but will need to grow and expand its scope. This will provide the conditions for a neighbourhood model and allow resources to be delegated to a neighbourhood level. **Integration of Service Delivery in Neighbourhoods** - building on the LCO Integrated Neighbourhood Teams, with connections to communities and wider public services. Primary Care Networks supported and developed as the way in which Primary care connects to neighbourhood working.

GL highlighted key points from the white paper, noting the intention to reduce bureaucracy and support integration. He noted the focus on the triple aim of population health, patient outcomes and value for money.

GL's next slide focused on key issues for Bury which included:

- The need for GM governance to include clinical and political leadership from the 10 localities, so that decisions are not out of a locality's control
- Control over resources and the power to delegate to neighbourhood level
- Concern over the proposal for the 2 boards of an ICS - an NHS ICS and a Health and Care Partnership ICS, which is viewed as a backward step for GM
- Ensure the retention of specific delegations secured as part of the original devolution agreement so that joint decision making continues at local level

GL explained the proposals for CCG staff in the new system and the national commitment to protecting NHS terms and conditions. He pointed out that this was not a cost cutting exercise and the plan is for some staff to work at GM level and some at a local level.

EO'B thanked GL for his helpful summary and comments and questions were invited.

AS noted the importance of retaining the clinical and leadership skills from the CCG and that it would be important for the PCNs to be represented on the Bury Locality Board. She highlighted the importance of non-executive leadership in any future model.

AS said that the flow of money through the system would be a crucial element of any future model, in order to support the work on health inequalities and population health.

AS reported that cabinet leads across GM had recently met and there is no desire there for a 2-tier system in GM (an ICS and a health and social care board) but that a combined committee is preferred.

(Lesley Jones left the meeting)

TR emphasised the need to focus on staff and relationships built up in the past as part of this massive change. He agreed with the intentions of the proposed partnership framework and the increased scope of the LCO.

KWJ reported on a development session at LCO Board the previous day, where, echoing LJ's question via the chat, the relationship between the HWB and the locality system board had been discussed. She said that there had been discussion around Primary Care and its relationship with GM.

KWJ explained that a schedule of key stakeholder interviews was in place, involving KWJ, CO'G and JG. She said that the right alignment across commissioner and provider partners would be key in the new system.

JS concurred with the comments made by AS, particularly with regards to PCN involvement. He noted the need for the inclusion of the patient voice in future work and how this could be incorporated into any design work.

He emphasised the need for health and wellbeing support to be on offer to CCG staff and

	the requirement to monitor the effects of such an enormous change on individuals' wellbeing. JS noted the huge change in the move towards collaborative working and the removal of the commissioner/provider split which has been part of the health culture for many years. He suggested there was much organisational development work to be done and work on a new language. JS suggested that governance in the system should be considered, with the intention of reducing the number of meetings. EO'B agreed that trust between organisations would be an important part of any new structure and that we should view ourselves as one group. HH agreed with the inclusion of PCN representation, but noted that urgent support is needed to enable them to fulfil a leadership function in any new model. HH agreed with the intention to reduce bureaucracy in the system, but noted that a provider day for community services has been arranged for April. JG said she would follow up on this. WB agreed with the inclusion of PCNs at all tiers and at locality system board level. He suggested the position of the HWB in the locality construct proposals may not be the right one for Bury and referred to the positive re-focusing work in the HWB, led by AS. WB said that the new Integrated Delivery Board (IDB) should give the opportunity to move money around the system; he said there would be opportunity to explore financial flows via the IDB, but that work on organisational form is separate from this. WB suggested that in Bury only 2 boards would be needed: Bury Locality System Board (providing strategic leadership) and the Integrated Delivery Board (supporting the strategy of the locality board). SJ expressed disappointment at the lack of focus on the VCFA in the white paper but confirmed that this is being addressed at a national level. SJ highlighted the risk of resources being utilised at GM level, leaving localities at a disadvantage. EO'B said that ways needed to be found to influence this and that Manchester is only 1 of the 10 localities in GM. He endorsed a distributed leadership model across place. TR agreed with the need for work on culture and trust between organisations to take place and asked if this had been started in GM. He suggested that Bury could begin this piece. GL then responded to the points above: He agreed that PCNs and Primary Care (PC) need to be involved in the work and that PC needs to be part of the LCO's delivery work and also part of the system's leadership. He emphasised the importance of representing the interests of place and of not losing skills from the system. He noted that there is a suggestion in the system that PC will be organised at GM level.

	With regards to money flows GL said this was about powers, duties and resources; that there were moves in the right direction, but that further negotiation was required. With regards to the HWB/system board question GL said that if this were to be one joint board it must have access to the necessary resources and encompass the elements of HWB, public health and a local partnership role. GL highlighted the risk around disrupting staff structures and losing trust in the system. With regards to the future form and function of the LCO GL said this would not be an employing organisation, but a partnership body. He said the public should receive services from a joined up partnership body and that the INTs would support this. Referring to WB's point about 2 boards in Bury GL highlighted the risk of replacing the commissioner/provider split with a strategic/delivery split. GL said that the VCFA should be represented on the locality board as one of the provider partners. GL said that the locality system board would need an infrastructure behind it and staff to support this. GL agreed that as part of the new culture there should be fewer meetings and that the system governance should be less complicated; he suggested regular monitoring on this should take place. EO'B alluded to the maturity of the relationships across Bury, suggesting that next steps are now around practicalities. He said that the public must be made aware of the intentions behind the changes, but that as a system Bury is in a good position for the new model.
6.	**Transition in Bury**
	WB introduced the next section of the agenda and covered the main highlights from the presentation on the Bury Transition Programme, with highlights from the 7 subgroups: **Clinical and Professional Senate Development** HH confirmed that networking has begun and views collated, including those of the PCNs. **Integrated Delivery Arrangements** Further detail given in the later paper from KWJ. CO'G confirmed that stakeholder interviews were scheduled with key partners, both in and outside of the LCO. **Neighbourhood Working** Extension of the existing working group to focus on the year of the neighbourhood **CCG Staff** HR colleagues from across the system are involved and further guidance is awaited **Financial Flows** SO'H explained that there is still a lack of clarity around money flows for the next financial year and that current focus is on making the right changes regarding activity.

Patient and Public Engagement
This connects in with existing work and also Healthwatch partners.

Powers and Governance
Locality construct across GM developed. Further details on this area to come to the next meeting

ID	Type		Owner
A/02/01	Action	Further details on powers and governance to come to the meeting of 16 March	WB

6(i) Transition in GM

A presentation had been shared around the Locality Construct and WB covered the main points from it. He explained that the outputs were from a group consisting of GM Directors of Strategy, GM Local Care Organisations, GM Strategic Commissioners, Finance Advisory Committee, GMHSCP.

WB noted the emphasis on primacy of place in this work and the desire to seek devolved powers to locality and neighbourhoods. He explained that all 10 localities are working to a similar model and that the focus is on a single system, moving away from the commissioner/provider split.

GL gave further background to these slides, which had been the result of 2 workshops with cross-sector representation. He said there was a commitment to avoid silo working and that additional work was underway on provider collaboration, innovation and population health. He said that work with the NES and NCA is part of this programme.

GL said that progress had been made on governance processes, but that there was more work to do around financial flows. He said that the group of key partners will continue to meet on a fortnightly basis and that a report would come to this Board as progress is made.

TR suggested that he and KWJ begin the discussions around culture and supporting the workforce and that an item on this could be on a future agenda.

KWJ alerted Board to the work she and LD are leading in the Workforce Hub; she suggested that this could be the forum for more strategic and OD work.

ID	Type		Owner
A/02/02	Action	Future agenda item to be on the system's culture and support to the workforce.	KWJ/TR

6(il) Stakeholder Engagement in the Development of the Integrated Delivery Board

KWJ's paper had been shared with Board and due to time constraints KWJ gave brief highlights from it. She outlined the stakeholder engagement approach over the next 2 weeks and the work underway on the vision for neighbourhoods and an integrated delivery board.

KWJ explained that discussions have begun around the roles and functions in future partnership arrangements and that KWJ/CO'G and JG are due to meet with the PCNs next week for further discussion on the role of the PCNs.

She referred to the 8 blocks of work supporting the establishment of integrated delivery in Bury; these included the vision, programmes, economics, governance, infrastructure and outcomes.

KWJ confirmed that the outputs from the stakeholder interviews would form part of a proposal on the integrated delivery board and its functions.

	WB gave his thanks to KWJ/CO'G/JG and other LCO colleagues for their consideration of what a future integrated delivery board might look like. He said this was a good example of imaginative thinking around the expansion of the LCO and demonstrated trust between partners across the system.
	SYSTEM BOARD
7.	**Urgent Care Update**
	A presentation on the latest updates in the Urgent Care programme had been shared with Board. LD gave the background to the work, including the public consultation process and requirements from GM. She reminded Board of the programme charter aims and outlined some of the outcomes to date around activity and finance. She said some of these had been delivered but that changes to financial flows made it hard to measure others. LD reported on the softer outcomes such as user experience and changes in staff behaviours that had been an output of this work. SM joined the meeting and gave an overview of the 4 work programmes within UC transformation. She explained the patient pathways for those attending the ED department and went on to highlight some of the main achievements in the programme: • Pre-ED streaming now fully live, with both non-clinical and clinical streaming at FGH front door • Mental health streaming to crisis team - additional clinics established for all Bury and HMR residents • Agreement from General Practices to take referrals from pre-ED streaming (1 per site per day) • "Virtual hub" for admission avoidance operational following deployment across GM last week, using Bury Rapid Response The data slide gave information on MH streaming and pre-ED streaming and demonstrated a reduction in ED attendances, with the bulk of these being taken on by the GP out of hours service. Information was shared on the admission avoidance/ virtual hub which was operationalised within a week and ran for 3 weeks. In Bury, of the 49 patients reviewed 25 avoided admission. It was suggested that further work is needed to capture the learning from this and to consider how to continue the work in some form. Current priorities in the UC programme were listed and LD then went on to cover the proposed areas of focus for phase 2 of the programme; she explained that some of these had emerged from work during phase 1. LD asked Board to approve the programmes of work in Phase 2. LD said that part of the learning from the programme had been that Urgent Care was much wider than the ED department at Fairfield General. Members reacted positively to the update and the work achieved. JS gave his personal thanks to LD and SM on an amazing piece of work, citing it as an example of how to work differently. He agreed that UC is wider than just the ED and noted the massive achievement in persuading GPs to accept deflected patients.

	JS said it was unfortunate that the virtual hub work had only lasted for 3 weeks and that more learning could have been gained if this had gone on longer. He said that the MH work had been very positive but that Estates is an issue. AS praised the UC work and the achievements made through joint working. She suggested a test of change at the ED front door using more experienced staff. LD explained that a number of tests of change had taken place and that knowledge of services outside the hospital, as well as remaining cost neutral, had been taken into account as part of this. AS referred to the workforce on line work and questioned whether this may give further scope for patient pathways. TR described the work as a phenomenal achievement and suggested that even more could be done to build on this work. CJ praised the utilisation of the wider workforce as part of this work and suggested this could be further developed as part of the workforce OD work. She offered to feed in to this work. KWJ gave her thanks to LD and SM and said that a separate conversation regarding phase 2 work is needed. She said that the UC work could act as an example of new ways of working and how the boards' work and roles and responsibilities fit into this. As part of the Estates work LD confirmed that she and SM are linked in with the NCA work on the master plan at Fairfield. She agreed that a further conversation around Phase 2 would be helpful. LD highlighted the work in the MH work stream, giving credit to MH colleagues. She said that this type of working had not been done elsewhere in GM.
8.	**Update on GP IT Futures work**
	An IT and Digital briefing had been shared with Board and SK joined the meeting to cover the main highlights on GP connect, Graphnet and oximetry at home work. With regards to GP IT Futures SK explained that EMIS is the preferred system, used by 85% of practices across GM. He said this would be a positive move for patients. KW praised the work undertaken by the Digital Team and listed some of the other programmes being worked on: • Vaccination work and Simply Book • Agile work with practices • GP Connect launched • Ask my GP work She said that funding is in place for 5 digital facilitators to support on-going programmes of work. Via the Chat facility JS said ZR and SK had done a really amazing job bringing GPs together and doing a fabulous job going through a really tricky consultation on the GP System of Choice. WB acknowledged this substantial body of work, referring specifically to the vaccination and risk stratification work streams. He said that developing systems where patients have more control over their care and the services around them would be a crucial element in this work.

9.	Closing Matters
	None discussed

Next Meeting	**Date: 16 March 2021, 1.30-3.30pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521