Strategic Commissioning Board

Agenda	
Date & Time:	7 June 2021, 16.30 -18.30
Venue:	Council Chamber, Bury Town Hall, Knowsley Street, Bury
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) 12 April 2021	Re	A	Chair	16.40
4.	Public Questions	V	C	Chair	16.45
5.	Chief Executive and Accountable Officer Update	V	I	Geoff Little	16.50
6.	SCB Membership	Re	C	Geoff Little	17.00
Strategy & Policy					
7.	Update on the White Paper/Integrated Care System (ICS) a) Update on GM ICS Transition b) Update on Bury Partnership Arrangements	Re	C	Geoff Little/Will Blandamer	17.10
8.	2021-22 Activity and Primary Care Workforce Plan Update	Re	I	Will Blandamer	17.20
Recovery & Transformation					
9.	Northern Care Alliance (NCA) - Urology Reconfiguration	Re	C	Will Blandamer	17.30
10.	Housing Strategy – Delivery Action Plan	Re	A	Geoff Little	17.40

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Item	**Description**	**Report (Re) Verbal (V)**	**Action**	**Presenter**	**Time**
Finance /Performance/Risk					
11. 11.1 11.2	Finance / Budget Update Integrated Commissioning Fund Bury CCG Transformation Funding	 Re Re	 A/C C	 S Evans/ Cllr O'Brien	18.05
12.	Performance Update	Re	C	W Blandamer	18.20
Information					
13.	Minutes of Meetings a) Bury System / Transition Board Minutes	Re	I	For information	—
Close					
14.	AOB and Closing Matters	V	I	Chair	18.25

Next Meetings in Public	**Strategic Commissioning Board Meeting (formal):** Monday, 2 August 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

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	07 June 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 7 June 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
June 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	
Will Blandamer	Executive Director of Strategic Commissioning	Ashton on Mersey Football Club (Trafford)			X		Director (Chairman)	2018		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Manchester Football Association (MFA)			X		Board Champion for Safeguarding	2018		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Fiona Boyd	Registered Nurse	DWF Law		X			Medical Assessor	03/08/2020		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		NHS England / NHS Improvement (Cheshire & Merseyside)			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.
Sam Evans	Executive Director of Finance						None declared	05/05/2021	Present	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 Healthcare.
		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.
Cllr Richard Gold	Councillor Bury Council - Communities	RIGOLD LTD	X				Director and Employee			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Richard Gold T/A Richard Gold Books	X	X			Employment			
		Transport for Greater Manchester Committee		X			Member			
		The Ephemera Society		X			Member			
		Holy Law South Broughton Congregation Synagogue		X			Member			
		Yeshurun Hebrew Congregation Synagogue		X			Member			
		Jewish Labour Movement NW Region (membership and education)		X			Member			
		Jewish Labour Movement		X			Member			
		Community Union		X			Member			
		Labour Party		X			Member			
		Prestwich Labour Party Branch		X			Member			
		Sedgley Branch delegate to Bury South Constituency Labour Party			X		Delegate			
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.
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		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		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 and majority shareholder	2014		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 and 50% shareholder	2018		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.
		PCP III Number 4 Limited	X				Director	Apr-21		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		PCP III Number 3 Limited	X				Director	Apr-21		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		PCP III Holdco Limited	X				Director	Mar-21		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
		Bury Council			X	Indirect	Daughter is an employee	2012		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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 Charlotte Morris	Councillor Bury Council - Culture and Economy	University of Salford	x				Employment			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meet
		Transport For Greater Manchester				Indirect	Spouse Employed			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meet
		Labour Party		x			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meet
		Unison		x			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meet
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.
		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 Syndrome 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
		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.

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 Andrea Simpson *(cont)*	Councillor	Ribble Drive Primary School		X			Governor			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Salford LMC Subcommittee		X			Neighbourhood lead for Swinton			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Village Greens	X				Shareholder			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
		Medical Defence Union		X			Member			General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cllr 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		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.

In Attendance - Non-Voting

Name	Current position (s) held i.e. Governing Body, Member Practice, Employee	Declared Interest- (Name of organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate Interest
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the Interest direct or indirect?		From	To	
Donna Ball	Bury Council Executive Director of Operations	Oldham Pathology (Pennine Acute)			X	Indirect	Husband works for Oldham Pathology	2010	2020	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
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 James Mason	Councillor Bury Council	Service Manager - DFS Trading	X				Employment			General arrangements for declaring Conflicts of Interest to be followed.
		Self employed - hairdresser				Indirect	Spouse			General arrangements for declaring Conflicts of Interest to be followed.
		Serving Freemason		X			Member			General arrangements for declaring Conflicts of Interest to be followed.
		Radcliffe First, registered political party		X			Group Leader			General arrangements for declaring Conflicts of Interest to be followed.
		Save Greater Manchester's Greenbelt		X			Chair			General arrangements for declaring Conflicts of Interest to be followed.
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.
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 Partnership	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.

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Agenda Item 3

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	07 June 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 12 April 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the Minutes of the Meeting held on 12 April 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 12 April 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	April 2021
Date of Issue	April 2021
To be Agreed	7 June 2021
Document Status (Draft/Final)	Draft
Description	Minutes of the Strategic Commissioning Board on 12 April 2021

Document History:

Date	Version	Author	Notes
	0.1	Philippa Braithwaite	Forwarded to Chair for review.
Approved:			
Signature:			..... **Dr J Schryer**

Strategic Commissioning Board Virtual Meeting

MINUTES OF MEETING
Strategic Commissioning Board Virtual Meeting 12 April 2021 16.30 – 18.30 **Chair – Dr Schryer**

Voting Members	
Dr Jeff Schryer	NHS Bury CCG (Chair)
Cllr Eamonn O'Brien	Leader, Finance & Growth, Bury Council
Cllr Jane Black	Cabinet Member Cultural Economy, Bury Council
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
Geoff Little	Chief Executive Bury Council & Accountable Officer NHS Bury CCG
Mr David McCann	Lay Member Patient & Public Involvement, NHS Bury CCG
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
Cllr Tamoor Tariq	Deputy Leader, Cabinet Member Children, Young People & Skills, Bury Council
Mr Chris Wild	Lay Member, NHS Bury CCG
Others in attendance	
Philippa Braithwaite	Principal Democratic Services Officer, Bury Council
Pat Crawford	Interim Chief Finance Officer, NHS Bury CCG
Jacqui Dennis	Director of Law & Democratic Services
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
Emma Kennett	Head of Corporate Affairs and Governance, NHS Bury CCG
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
Kath Wynne-Jones	Chief Officer, Bury Local Care Organisation

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/04/01	Decision	Noted the information.	

2.	Inclusion Update
2.1	The Deputy Chief Executive, Bury Council presented the report which detailed 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.
2.2	Progress had been very positive thanks to the work of the Inclusion Working Group. It was noted that a best practice guide to inclusion in digital working had been produced, and a detailed plan will be developed to tackle race inequality over the next 12 months.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/02	Decision	Noted this update.	
D/04/03	Decision	Endorsed the best practice guide for inclusion in digital working.	

3	Declarations Of Interest
3.1	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.
3.2	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.
3.3	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.
3.4	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**
3.5	There were no declarations of interest raised. • **Declarations of Interest from the previous meeting**
3.6	There were no declarations of interest from the previous meeting raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/04	Decision	Noted the published register of interests.	

4	Minutes of the last Meetings and Action Log
4.1	• **Minutes**

4.2	The minutes of the Strategic Commissioning Board meeting held on 1 March 2021 were agreed as an accurate record. • **Action Log** The following updates were provided in respects of the Action Log: • A/11/02 – The mental health paper was on the agenda for this meeting. • A/02/03 – Geoff Little advised the affordability of a Learning Disability Lead was being looked at as part of wider partnership arrangements and an update would be given at the first meeting of the municipal year. • A/02/04 – The financial trajectory and outcomes were included on the agenda for this meeting.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/05	Decision	Approved the minutes of the meeting held on the 1 March 2021	

5	Public Questions
5.1	There were no public questions raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/06	Decision	Noted the information.	

6	Chief Executive and Accountable Officer Update
6.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG provided an update on the latest CCG and Council developments. It was reported that: - • The rate of transmission per 100,000 had been decreasing over the past 10 days. It was still above national levels but was now below 50. • Successful vaccine rollout in the borough was ongoing, with all priority groups having received their first dose. The second dose was underway and advanced planning was in place for younger cohorts when the national supply was in place. • Bury was meeting the national target around hospital admissions, but capacity pressure remained from efforts to reduce waiting lists. • No variants had been observed in Bury so far, but this was being closely monitored. • Bury was focused on safely lifting restrictions, helping businesses to restart and residents cope with hardship. The community hubs were still operating but were now supporting those with financial hardship or those with positive test results, as the requirement for people to shield had ended.
6.2	The following comments / observations were made by Strategic Commissioning Board members: - • With regards to national fatality rates in the Jewish community it was noted that although data on religious groups wasn't available, locality data was held and was informing work in those communities to address concerns. • It was noted that supply of the vaccine was sufficient to deliver second doses. There were occasions where this might be outside the 12 weeks between doses

	but this was rare. For residents unsure of their status and whether they should receive a vaccine, they were advised to speak to their GP.
6.3	With regards to Hospital Discharge arrangements, Geoff Little advised that funding for community discharges from hospitals was due to cease in February but, after feedback from Bury and other Greater Manchester authorities, operational guidance had been issued advising funding was being continued and could be tapered out in a controlled way.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/07	Decision	Noted the update.	

7.	Update on the White Paper/Integrated Care System (ICS)
7.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG and the Chief Officer, Bury Local Care Organisation presented three joint reports on the developing arrangements for the Integrated Care System (ICS)
7.2	The Board received a report presented to the GM Health and Care Partnership Executive Board and the GM Health and Care Board which sought to reset a number of GM wider discussions on the future form and shape of the Greater Manchester Integrated Care System (GM ICS). Members discussed the report, making the following points: • Workshops would be held over the next month with two representatives for each Borough, including key providers, professionals and clinical leaders to represent a cross section of sectors, organisations and localities in GM. • It was noted that the task wasn't necessarily how to comply with the requirements of white paper, but instead to work out what was best for Bury and ensure the legislation was permissive of that. Although the White paper proposed two boards, it was hoped Bury could continue with a single operating model. • The timetable for establishment was clear, with proposals being submitted in spring 2021, shadow arrangements in place for late summer/early autumn, and legislation in spring 2022. • With regards to how residents would be involved it was noted that Bury's representatives at the workshops would bring their understanding based on local views, and that community and voluntary sector representatives were included in the workshops. Moving forwards, neighbourhood focus would be built into design with a grass roots system supported by the ICS. • Members discussed the bigger ask on communities and noted that more support and appropriate infrastructure was needed for volunteers to take on these responsibilities. Concerns were raised over the unknowns around governance and finance, and it was noted that key historical knowledge could be lost with staff changes.
7.3	The Board received a report which provided an update on progress establishing the previously agreed framework for the system, providing early consideration of the objectives and membership of the Bury Locality System Board and the Bury Integrated Delivery Collaborative Board, and describes the developing work of on building the capacity and capability of integrated neighbourhood teams in health and care. Members discussed the report, making the following points:

	• Innovation was needed to engage with residents in a different and meaningful way, making locality groups fit them and empowering them to tell us what they want. • It was agreed that the aim was to improve health over the course of a generation, not just seeking to deliver services but to address health through a holistic approach. • Concerns were raised over the current scattered and hierarchical clinical voice. A representative senate and a 'golden thread' was needed throughout governance to facilitate the right conversations at System Board. • It was noted that intelligence was needed to enable decision making at neighbourhood level, devolving power and budgets to resource communities effectively. • The Board were advised that much of that detail was still to be worked through as well as the governance behind devolving resources. Better understanding was needed of our staff resources, to ensure all managerial, clinical and professional expertise was being utilised. • The Board noted that final Terms of Reference would be developed and the LCO agreement expanded to reflect the new arrangements. These would then be ratified by the System Board before being taken through the existing governance arrangements of the Cabinet, Council and Governing Body. It was also noted that this would be a regular agenda item.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/08	Decision	Received and noted the reports.	

8.	Update on the Radcliffe SRF
8.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG presented a report on the regeneration of Radcliffe coordinated through the Radcliffe Strategic Regeneration Framework and its ambition to improve population health and well-being and reduce inequalities.
8.2	The following comments / observations were made by Strategic Commissioning Board members: • It was agreed that this would be a challenging project but was about far more than buildings, taking a holistic view of peoples' lives including housing, jobs, communities, and access to services. This view needed to suit not just those moving into Radcliffe, but to those already living there. • A need to do things differently was discussed, including the language used. The right infrastructure was needed to empower people to talk about aspirations for the area, through community champions with local understanding and existing contacts. • It was noted that the right metrics of success needed to be identified to enable meaningful monitoring and learning, which could inform future developments.
8.3	In terms of a model, it was noted that initial thoughts and proposals would be brought to the Board's next meeting.

ID	Type	The Strategic Commissioning Board:	Owner
A/04/09	Action	Noted the report and agreed that a paper on initial thoughts and proposals for the Radcliffe model would be brought to the Board's next meeting.	G Little

9.	MH Urgent Care by appointment
9.1	The Director of Community Commissioning, Bury Council presented the report which sought approval in principle 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.
9.2	Members discussed the evaluation report which demonstrated the rate of deflection away from A&E and the positive impact of this for both patients and services. It was noted that despite the system-wide benefits, savings made in one area didn't always feed back into the area responsible for that saving. The Board noted that this decision was in principle at this point, as it would be subject to the wider development of mental health 24/7 crisis offer in Bury and front-end Urgent Care redesign at Fairfield hospital.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/10	Decision	Noted the content of the report and attached evaluation report.	
D/04/11	Decision	Approved in principle the 12-month funding of £271,233 for the continuation of the UEC by Appointment service. This would be subject to the wider development of mental health 24/7 crisis offer in Bury and front end Urgent Care redesign at Fairfield hospital.	

10.1	Finance Quarter 4 report
10.1.1	The Interim Chief Finance Officer, NHS Bury CCG presented the report which provided an update on the Integrated Commissioning Fund (ICF) budget for 2020/21, forecast outturn for 20/21 at quarter 4, and incorporated a review of ICF achievements.
10.1.2	The ICF is currently forecasting an underspend of £1.3m. it was noted that there was 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 stemmed from unallocated COVID-19 grants.
10.1.3	The Board noted that a further report would be brought to the next meeting regarding discussions to find a longer-term solution for continuity of services. It was also noted that embedding the past year's achievements in collaboration, new ways of working, and effective partnerships represented a major step forward to developing new care models and approaches and by enhancing effective neighbourhood and locality working.

ID	Type	The Strategic Commissioning Board:	Owner
D/03/12	Decision	Noted that all Quarter 4 figures are provisional as Month 12 has not yet closed.	
D/04/13	Decision	Noted the increase in CCG allocations received since the Quarter 3 report to SCB and accept their allocation to the ICF.	
D/04/14	Decision	Noted the ICF forecast underspend at Quarter 4 of £1.3m (provisional) and the assumptions on which it is based.	

A/04/15	Action	Noted the need for a longer-term solution to support the services funded from Transformation and other short term funding solutions and that a further report would be brought to the next SCB meeting.	P Crawford
D/04/16	Decision	Noted the financial risks to Bury.	

10.2	**2021/22 NHS Operational and Financial Planning Guidance**
10.2.1	The Interim Chief Finance Officer, NHS Bury CCG presented the report regarding the NHS 2021/22 Priorities and Operational Planning Guidance, which set out the priorities for the year ahead against the challenges of restoring services, meeting new care demands and reducing 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.

ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/04/17	Decision	Noted the NHS 2021/22 Priorities and Operational Planning Guidance.	

10.3	**2021/22 ICF Indicative Financial Plan**
10.3.1	The Interim Chief Finance Officer, NHS Bury CCG presented the report which provided an early working position for the ICF budget. Whilst Bury Council's budget is approved, the CCG only recently received its notified allocation for the first half year to September 2021 (H1). 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).
10.3.2	It was note that demand for mental health services and acute care exceeds the budget allocated to the CCG and discussions were underway to identify a system-based solution and manage the totality of resources to ensure the best value for Bury.

ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/04/18	Decision	Approve the revisions to the proposed main purposes of the ICF.	
D/04/19	Decision	Considered and approve the factors to consider and the key deliverables.	
D/04/20	Decision	Noted the intended changes to the elements of the Pooled, Aligned and In-View Funds and agreed a 50/50 risk share, to be reviewed on a quarterly basis.	
D/04/21	Decision	Noted 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.	
A/04/22	Action	Noted that a further update on CCG financial plans will be brought to the next Board meeting.	P Crawford
D/04/23	Decision	Noted that further updates will be brought to SCB once 12-month CCG allocations have been	

		announced.	
D/04/24	Decision	Noted the uncertain CCG financial regime beyond September 2021.	

10.4 Council Social Care Provider Fees

10.4.1 The Director of Community Commissioning, Bury Council presented the report which detailed 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. It was noted that the Council had undertaken a process of engagement and negotiation with contracted providers of adult social care services to define both the fee proposals for 2021/22 and determine the final fee recommendations.

10.4.2 The recommended Adult Social Care Provider Fee Uplifts were:

Care Homes

	Weekly Fee Rate 2020/21	% Uplift	Increase (£)	Weekly Fee Rate 2021/22
Older Adults Residential Care	£502.95	0.9%	£4.77	£507.72
Older Adults Residential Dementia	£517.95	0.9%	£4.77	£522.72
Older Adults General Nursing	£502.95	3.9%	£19.77	£522.72
Older Adults Nursing Dementia	£532.95	6.4%	£34.77	£567.72
Adults Residential Care MH/LD/PD	£502.95	0.9%	£4.77	£507.95

Care at Home

	Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
Care at Home (Framework)	£16.13	2.3%	£0.37	£16.50
Care at Home Complex	£16.13	2.3%	£0.37	£16.50

Supported Living

	Hourly Fee Rate 2020/21	% Uplift	Increase (£)	Hourly Fee Rate 2021/22
Supported Living Waking Hours	£16.13	1.2%	£0.19	£16.32
Supported Living Sleep in rate	£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

10.4.3	In response to Board member comments, assurance was given that officers are working with providers and supporting them, with discussions regarding not only 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. Members noted that further work was being carried out on the Real Living Wage, market management to ensure sufficiency of social care, and the impact of increased insurance costs for care homes.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/25	Decision	Approved the proposed Adult Social Care Provider Fee Uplifts.	

10.5	**Sustainability of LCO management and clinical costs**
10.1	The Chief Officer, Bury Local Care Organisation presented the report which updated on current discussions to address the financial risk of prioritising funding for the transformation fund. It was noted that discussions were ongoing, and no solution had been reached as yet.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/26	Decision	Noted the content of the report.	

11.	**Performance Update**
11.1	The Chief Officer, Bury Local Care Organisation presented the report which set 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.

ID	Type	The Strategic Commissioning Board:	Owner
D/04/27	Decision	Received the update and noted the areas of challenge and action being taken.	

12	**Any Other Business and Closing Matters**
12.1	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/04/28	Decision	Noted the information.	

Next Meetings in Public	**Strategic Commissioning Board Meetings:** • Monday, 7th June 2021, 4.30 p.m., Formal Public meeting at Bury Town Hall (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 – April 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	Discussed at April meeting.
A/02/03	The affordability of a Learning Disability Lead be investigated in line with organisational governance arrangements.	G Little and W Blandamer		June 2021	Mr Little reported at the April SCB meeting that the affordability of a Learning Disability Lead was being looked at as part of wider partnership arrangements and an update would be given at the first meeting of the municipal year. Update – June 2021 – Mr Blandamer advised that the learning disability partnership arrangements are currently being reviewed. In the meantime a practitioners network had been created – which has been very well received and very well attended and has secured buy in to issues around LEDER practice improvement. We will review whether the need for the LD lead is still evident as the programme of work develops.

					This would be taken forward outside of SCB in line with organisational governance arrangements.
A/04/09	Agreed that a paper on initial thoughts and proposals for the Radcliffe model would be brought to the Board's next meeting	G Little		June 2021	This item will now be brought to the SCB in August with an update Mr Little will provide a brief update as part of the Chief Executive update at the June SCB meeting.
A/04/15	A further report regarding a longer-term solution to support the services funded from Transformation be brought to the next SCB meeting.	P Crawford		June 2021	Included on today's SCB Agenda
A/04/22	A further update on CCG financial plans will be brought to the next Board meeting.	P Crawford		June 2021	Included on today's SCB Agenda

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Agenda Item 6

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Recommend
Item No	06	**Confidential / Freedom of Information Status**	No
Title	Strategic Commissioning Board Membership and Voting		
Presented By	Geoff Little, Chief Executive and Accountable Officer		
Author	Lisa Featherstone, Deputy Director of Business Delivery		
Clinical Lead	-		
Council Lead	-		

Executive Summary

This paper sets out the revised membership and voting arrangements for the Strategic Commissioning Board in light of the recent changes to the Council Cabinet following the Local Elections in May 2021 and recent changes within the CCG. There is a need to ensure that the Board continues to operate efficiently and effectively in discharging the duties delegated to it from the Council Cabinet and CCG Governing Body.

The Strategic Commissioning Board has been established as a Joint Committee, under the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) to support the delivery of health and care integration in Bury.

Whilst developing the governance arrangements, including voting arrangements, a number of discussions were undertaken with the Cabinet, Council, Governing Body, CCG membership and NHS England.

The arrangements were originally approved by all parties consulted and an overarching governance paper was submitted to the Strategic Commissioning Board in October 2019, including the final Terms of Reference which set out the voting arrangements in respect to the SCB. This reflected no more than 7 voting members and 2 non-voting members from the CCG and 7 voting members from the Council Cabinet plus two (2) opposition party representatives in attendance.

Further changes were made to the membership of the SCB in both June 2020 and February 2021. In June 2020 the number of Cabinet Members was increased from 7 to 9 with an equivalent voting arrangement applied for the CCG and in February 2021 a cosmetic change to the roles within the CCG holding a vote was made.

Following the Local Elections 2021, the new Council Cabinet consists of 8 members (compared to the previous 9) and therefore it is proposed that the number of Governing Body votes is also reduced to 8 on the SCB to maintain the balance. A vacancy has arisen in one of the Clinical Director roles which provides a natural removal of one voting member.

When originally established, the SCB also included a non-voting member position for the largest opposition parties. As Radcliffe First has increased its membership, it is proposed that the number of opposition party representatives invited to the meeting is increased to 3.

No changes to quoracy are proposed as part of this report, which for information is set at:

- A minimum of 4 elected members (voting), of which 1 must be the Leader or Deputy Leader of the Council;
- A minimum of 4 Governing Body (voting) members, of which 2 must be practicing clinicians; and
- At least one joint Executive Officer.

These changes impact on the voting arrangements of the SCB, and whilst it is envisaged that all decisions will be made be consensus, appropriate provisions must be in place in the eventuality that a vote be required.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Supports the revised membership and voting arrangements for the Strategic Commissioning Board as set out in the paper and revised Terms of Reference;
- Recommend the draft Terms of Reference to the respective governance arrangements for formal approval.

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	☐

Implications						
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The SCB will support delivery of the health and Well-being Strategy through collective decision making to support the health and well-being of the patients, residents and population of Bury.					
How do proposals align with Locality Plan?	Establishing the OCO is explicit within the Locality Plan.					
How do proposals align with the Commissioning Strategy?	The SCB will support delivery of the Commissioning Strategy.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	The SCB will bring together the Council and CCG to ensure that future decisions are made jointly and for the benefit of the population of Bury					
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	The establishment of the SCB has been socialised with key stakeholders, including staff, elected members, clinicians and other interested parties over the last 6 months. This engagement has informed the shape and remit of the SCB, which has set out its membership and terms of reference in accordance with what is legally permissible under existing legislation.					

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

Strategic Commissioning Board
Review of Membership, Voting and Quoracy

1.0 Introduction

1.1 The Strategic Commissioning Board has been established as a Joint Committee, under the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) to support the delivery of health and care integration in Bury.

1.2 This paper sets out the proposed revised membership and voting arrangements for the Strategic Commissioning Board following the recent changes to the Council Cabinet

2.0 Background

2.1 In September 2015, NHS Bury CCG and Bury Local Authority signaled their ambition to work more closely to ensure better outcomes for the Borough of Bury through the most economic, efficient and effective use of the Bury pound to improve outcomes for the residents of the Borough.

2.2 The Terms of Reference for the Strategic Commissioning Board have previously been approved through the respective governance arrangements of each organisation with the first meeting of Board taking place in October 2019.

2.3 A paper setting out the Governance arrangements including voting arrangements was originally submitted to the Strategic Commissioning Board in October 2019. This included a proposal for no more than 7 voting members and 2 non-voting members from the CCG and 7 voting members from the Council Cabinet plus two opposition party representatives in attendance. These arrangements were also reflected within the Terms of Reference.

2.4 Further changes were made to the membership of the SCB in both June 2020 and February 2021. In June 2020 the number of Cabinet Members was increased from 7 to 9 with an equivalent voting arrangement applied for the CCG and in February 2021 a cosmetic change to the roles within the CCG holding a vote was made.

2.5 Following the Local Elections 2021, the new Council Cabinet consists of 8 members (compared to the previous 9) and therefore it is proposed that the number of Governing Body votes is also reduced to 8 on the SCB to maintain the balance. A vacancy has arisen in one of the Clinical Director roles which provides a natural removal of one voting member.

2.6 When originally established, the SCB also included a non-voting member position for the largest opposition parties. As Radcliffe First has increased its membership, it is proposed that the number of opposition party representatives invited to the meeting is increased to 3.

3.0 Membership and Voting arrangement of the Strategic Commissioning Board

3.1 The proposed changes to the Terms of Reference for Strategic Commissioning Board members as included at Appendix 1 of the report.

3.2 The proposed revised voting arrangements are also included at Appendix 2 of the report for information.

3.3 The SCB will aim to achieve consensus for all decisions and securing the support of both partners will be critical to the success of most of the decisions made. In exceptional circumstances where consensus cannot be reached, and should a vote be required, it will be by a simple majority of voting members present. If the vote is tied and a deadlock position is reached, the item of business will be referred back, with the minuted views of the Strategic Commissioning Board members, to the respective decision-making body from which the item of business is delegated.

4.0 Recommendations

4.1 The Strategic Commissioning Board is recommended to:

- Supports the revised membership, voting and quoracy arrangements for the Strategic Commissioning Board as set out in the paper and revised Terms of Reference;
- Recommend the draft Terms of Reference to the respective governance arrangements for formal approval.

Appendix 1: Strategic Commissioning Board Terms of Reference

Context

1. As part of the Bury Locality Plan for Health and Social Care Transformation 2017 to 2021 and to progressing the wider public service reform agenda there is a commitment to full alignment and integration between the Council and the Clinical Commissioning Group to form Bury Health and Social Care One Commissioning Organisation.

2. As part of this commitment the statutory bodies have agreed to form a single "Strategic Commissioning Board" in Bury to bring together the integrated governance of health and social care commissioning in its widest sense.

3. The following document sets out the terms of reference for the Strategic Commissioning Board (SCB).

4. Any changes to these Terms of Reference must be approved by the Council Cabinet and the CCG Governing Body

Statutory Framework

5. The SCB is not a statutory body. It is not intended to replace any of the existing statutory bodies in the locality; instead it is a joint committee of the two statutory organisations, Bury Metropolitan Borough Council ("the Council") and NHS Bury Clinical Commissioning Group ("the CCG"). The SCB will have overarching responsibility for all powers as have been delegated to it by the two statutory organisations (subject to any reserved matters) and set out in the associated Scheme of Delegation.

Role of the Strategic Commissioning Board

6. The SCB will be responsible for setting the principles and high-level strategic direction across the full responsibilities of health and care commissioning that is the responsibility of the two partners and will align wider Council, CCG and public services by inclusion so far as possible.

7. The SCB has been established to make decisions on the objectives, priorities, strategic design, commissioning and overall delivery of health and care services, including the oversight of their effectiveness, quality and performance.

8. In performing its role, the SCB will exercise its functions in accordance with duties delegated to it to support the delivery of the Bury Locality Plan for Health and Social Care Transformation 2017 to 2021, and its successor strategies and plans; including the Bury Strategy.

9. Members of the SCB have a collective responsibility for its operation. In undertaking its role, clinical and democratic accountability will be implicit within all decisions, as will respect for all professional areas of knowledge and expertise. Decisions will be based on achieving better outcomes and experience for the residents of Bury and those that use services within

the Borough, better quality and better value.

10. The ethos of partnership working will underpin the programme of work, recognising that on occasion, difficult decisions may be required to benefit the population of Bury.

11. The SCB will have responsibility for providing a Bury response to Greater Manchester commissioning matters.

Core Business

12. As the SCB will operate as a "place based", strategic, outcomes-based commissioner, the items of business for the SCB are likely to be:
    a) Understanding the aspirations, strengths and needs of Bury communities
    b) Leading collaboratively agreement of priorities for improvement
    c) Leading collaboratively the agreement of commissioning and enabling strategies and associated use of financial and other resources
    d) Enabling and supporting others to fulfil their roles within the system
    e) Providing oversight and gaining assurance in respect of outcomes, quality, performance and finance
    f) Providing leadership, oversight and assurance in respect of the development of an effective "One Commissioning Organisation"

13. The items of business for the SCB are unlikely to include detailed plans for operational service design and re-design.

Membership

14. The Strategic Commissioning Board shall consist of the following members:
    - Councillors – Cabinet Members of the Council to include no more than 8 voting Cabinet Members;
    - CCG Governing Body Members – no more than 8 voting , of which the majority will be clinicians;
    - The joint Chief Executive and Accountable Officer;
    - The joint Chief Finance Officer (including S151 responsibilities); and
    - The joint Executive Director of Strategic Commissioning.

15. In addition, other Officers and representatives will be invited to the SCB, and will be recognised as in attendance, enabled to participate fully in discussions to inform the decisions of the SCB, but will not hold voting rights. This will include, but is not limited to:
    - 3 opposition party representatives;
    - additional members of the CCG Governing Body (who are not members of the SCB)
    - additional members of the CCG/Council Joint Executive Team or any such equivalent successor team (who are not members of the SCB)

Chair

16. The SCB will be jointly chaired by the Council's Leader on behalf of the Council and the CCG Chair on behalf of the CCG, with chairing responsibility rotated between meetings.

17. In the event of the Chair of the SCB being unavailable for all or part of the meeting, the following deputising arrangements will apply:
    - The Deputy Council Leader will deputise for the Council Leader; and
    - The CCG Chair will nominate a deputy drawn from the CCG members of the SCB.

Quorum

18. The meeting will achieve quoracy if the following requirements are satisfied:
    - A minimum of 4 elected members (voting), of which 1 must be the Leader or Deputy Leader of the Council;
    - A minimum of 4 Governing Body (voting) members, of which 2 must be practicing clinicians; and
    - At least one joint Executive Officer.

Voting

19. It is anticipated that decisions will be made by consensus, however in the event that this cannot be achieved, a vote will be undertaken. Each voting member of the SCB will have one vote and a simple majority vote will be sufficient to carry the decision.

20. In the event that the vote is tied, and a deadlock position is reached, the item of business will be referred back, with the minuted views of the Strategic Commissioning Board members, to the respective decision-making body from which the item of business is delegated.

Deputies

21. Deputies are only permitted in respect to the Chairing of the SCB or Officer members.

22. With the exception of deputising arrangements for the Chair of the SCB, nominated deputies will not hold a vote nor will they count towards quoracy.

Frequency of meetings

23. The SCB will routinely meet at monthly times; a schedule of pre-arranged meeting dates will be distributed on an annual basis with a proposed annual calendar of business.

24. The meetings of the SCB shall be held in public:
    a) subject to any exemption provided by law

    b) the SCB may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by both the Public Bodies (Admission to Meetings) Act 1960 (as amended or succeeded from time to time) and the Local Government Act 1972.

Attendance

25. Members are expected to attend every meeting.

26. Where a member is unable to attend a meeting, apologies should be notified in advance to the Chair of the meeting.

Conduct of Meetings

27. The SCB will give no less than five clear working days' notice of its meetings.

28. The agenda and supporting papers will be published at least 5 clear working days in advance of the meeting, not including the publication day and the day of the meeting. Authors of papers presented must use the required template. Papers must be received by the committee secretary in line with the published deadlines unless, in exceptional circumstances, explicit agreement has been reached with the SCB Chair.

29. The SCB will be appropriately resourced to ensure the timely distribution of papers, production of minutes, action and decision tracking, and the maintenance of the formal record and documentation of the business of the SCB.

30. Presenters of papers can expect all SCB members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues arising since the time of publication which may materially influence the decision or actions of the SCB. SCB members and others in attendance may question the presenter.

Conflict Of Interest

31. As a statutory Joint Committee formed by the two statutory organisations, the SCB must comply with the standards set by the Local Government Act 2000 as set out in Part 5(a) of the Council's Constitution and Section 140 of the National Health Service Act 2006 (as amended) as set out in Section 6 of the CCG Constitution.

32. In addition, the Register of Interests will be maintained for the members of the SCB and published on the Council and CCG websites.

Reporting

33. A highlight report from the SCB will be submitted to the Governing Body and Cabinet meetings, drawing the attention of the respective Statutory Committee to any items where further action is required. The SCB minutes will be included as an appendix to this report.

Monitoring Compliance

34. Meetings of the SCB shall be conducted in accordance with the provisions of both bodies Constitutions, Standing Orders, Scheme of Reservation and delegation of the respective partners and the duties delegated.

35. The SCB shall submit an annual report to the Governing Body and Council, incorporating progress, reporting arrangements, frequency of meetings and membership attendance. A

summary of which will be included within the respective Governance Statements.

36. A review of effectiveness of the SCB will be undertaken at the end of the first year of operation and at further intervals as agreed appropriate.

37. The Terms of Reference of the SCB will be reviewed at least annually and submitted through the appropriate Governance arrangements for approval.

Appendix 2: Membership and Voting Status

Role	Current Post Holder	Membership Status	Voting Status	Deputy Permitted
Council Leader and portfolio holder for Finance and Growth	Cllr Eamonn O'Brien	Member	Voting	✓ (Deputy Leader)
Council Deputy Leader and Portfolio holder for Children, Young People and Skills	Cllr Tamoor Tariq	Member	Voting	
Council First Deputy and Portfolio Holder for Health and Wellbeing	Cllr Andrea Simpson	Member	Voting	-
Council Elected Member and Portfolio Holder for Environment and Climate Change	Cllr Alan Quinn	Member	Voting	-
Council Elected Member and Portfolio Holder for Communities	Cllr Richard Gold	Member	Voting	-
Council Elected Member and Portfolio Holder for Culture and The Economy	Cllr Charlotte Morris	Member	Voting	-
Council Elected Member and Portfolio Holder for Corporate Affairs and HR	Cllr Tahir Rafiq	Member	Voting	-
Council Elected Member and Portfolio Holder for Housing Services	Cllr Clare Cummins	Member	Voting	-
Council Opposition Member	Cllr Nick Jones	In attendance	Non-Voting	-
Council Opposition Member	Cllr Michael Powell	In attendance	Non-Voting	-
Council Opposition Member	Cllr Mason	In attendance	Non-Voting	-
CCG Chair (Clinical)	Dr Jeff Schryer	Member	Voting	✓

				(when Chair of Mtg)
Clinical Director	Mr Howard Hughes	Member	Voting	-
Clinical Director	Dr Cathy Fines	Member	Voting	-
Clinical Director	Dr Daniel Cooke	Member	Voting	-
Lay Member – Quality	Mr Peter Bury	Member	Voting	-
Lay Member - PPI	Mr David McCann	Member	Voting	-
Lay Member – Finance and Audit	Mr Chris Wild	Member	Voting	-
Governing Body Registered Nurse	Mrs Fiona Boyd	Member	Voting	-
Chief Executive and Accountable Officer	Mr Geoff Little	Member	Voting	✓
Executive Director of Finance	Ms Sam Evans	Member	Voting	✓
Joint Executive Director of Strategic Commissioning	Mr Will Blandamer	Member	Voting	✓
Governing Body/Director/Executive Members (not members of the SCB)				
Governing Body Secondary Care Consultant	Mr Peter Thompson	In Attendance	Non-voting	-
Director of Community Commissioning (DASS)	Mrs Julie Gonda	In Attendance	Non-Voting	-
Director of Public Health	Mrs Lesley Jones	In Attendance	Non-Voting	-
Deputy Chief Executive (Corporate Core)	Lynne Ridsdale	In Attendance	Non-Voting	-
Executive Director of Operations	Ms Donna Ball	In Attendance	Non-Voting	-
Executive Director of Children and Young People	Ms Sheila Durr	In Attendance	Non-Voting	-
Director of Nursing and Quality Improvement	Ms Catherine Jackson	In Attendance	Non-Voting	-

Other Colleagues (Advisory Only)				
Head of Communications, Marketing and Engagement	Mrs Karen Johnston	In Attendance	Advisory	-
Business Support Unit Representative	Mrs Emma Kennett	In Attendance	Advisory and Minutes	-
Business Support Unit Representative	Ms Philippa Braithwaite	In Attendance	Advisory and Minutes	-

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Agenda Item 7

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Consider
Item No	7a	**Confidential / Freedom of Information Status**	No
Title	Update on GM ICS Transition		
Presented By	Geoff Little, Chief Executive Bury Council & Accountable Officer NHS Bury CCG		
Author	Will Blandamer, Executive Director Strategic Commissioning, Bury CCG and Bury Council		
Clinical Lead			
Council Lead			

Executive Summary
The arrangements for the operation of the GM ICS from April 2022 (subject to legislation) are progressing and Bury representatives are fully participating in their development, through the GM provider collaborative, the GM Joint Commissioning Board, the GM Partnership Executive board, and other relevant forums. This paper summarises a number of the key strands.
Recommendations
It is recommended that the Strategic Commissioning Board note the content of the report.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being	Yes	☐	No	☐	N/A	☒

Implications						
requested?						
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	Yes					
How do proposals align with Locality Plan?	As set out in report.					
How do proposals align with the Commissioning Strategy?	As set out in report.					
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.		
Bury CCG Governing Body	26/05/2021	
Bury Locality System Board	20/05/2021	

Bury Health, Care and Well Being Partnership.

White Paper Transition Arrangements

Update on GM ICS Transition

Paper for;

- **Bury Locality System Board - 20th May**
- **Bury CCG Governing Body – 26th May**
- **Bury Strategic Commissioning Board – 7th June.**

Will Blandamer – Executive Director Strategic Commissioning – Bury CCG and Bury Council.

Background

The arrangements for the operation of the GM ICS from April 2022 (subject to legislation) are progressing and Bury representatives are fully participating in their development, through the GM provider collaborative, the GM Joint Commissioning Board, the GM Partnership Executive board, and other relevant forums.

This paper summarises a number of the key strands.

1. GM ICS operating model

1.1 GM Workshops and the Mike Farrar Report

A series of 4 workshops have been held over recent weeks involving representatives from all localities and all parts of the GM Health and Care Partnership. The workshops were chaired by Mike Farrar – former chief Executive of NHS North West. The report from the workshops is attached as Appendix 1.

There are some important principles to recognised in the report. This includes the following

1. Design principles and the 6 proposed areas of focus are good. The emphasis on preventative care and the contribution of primary care is particularly helpful. The 'stock' and 'flow' description of the different contributions of GM-wide provider collaboratives and localities in addressing planned care recovery and reform, though how these two work together in a positive way will be critical. It is good to see the report call-out the need to address unwarranted clinical variation.

2. The emphasis in building on the current spatial architecture (neighbourhoods, place, GM) is extremely helpful, as is the recognition of the need to plan and deliver services at different spatial levels. It is particularly helpful to see the emphasis on strengthening arrangements at a neighbourhood level.

3. The report emphasises the importance of provider collaboratives within each place, including acute providers, and the need to end the purchaser/provider split, which is consistent with our view.

4. The finance section is potentially open to different interpretations. Although no-one is going to disagree about a "blended approach", the flow of funding between GM and localities is still not clear though. The proposed commitment to "recognise and maintain, as a minimum, current arrangements where such money has been pooled with localities on a s75 arrangement" and the associated proposition to maintain levels of expenditure in community services is welcomed.

However, it is recognised that there are still some fundamental issues to address if the shadow arrangements by September 2021 are to be established and this will require continued dialogue. In particular there the report does not conclude key issues such as

- The governance and accountability arrangements at a GM level and how ensure place is reflected in GM level decision-making
- How the funding flows will work between the GM and locality system
- Formal programme governance arrangements and decision-making arrangements to establish the ICS, ensures timely and inclusive decision-making, with a transition timetable that enables effective shadow arrangements and the transition of the CCG staff and functions into the new arrangements

In addition, the report is not sufficiently strong on the necessity for clinical leadership (rather than just advice) at the level of both GM and particularly in the locality arrangements.

1.2 Next Steps to a GM operating model

In response to these issues and others, a brief report highlighting the steps to be taken to address some of the outstanding issue across the GM Health and Care Partnership has been produced and this is attached as Appendix 2. Key issues remain on matters of financial flow, decision making at spatial levels, the locality approach, the provider collaborative, the GM governance arrangements, and the Organisational Development Support Required.

Bury locality representatives have also articulated the need for further clarity on the future funding arrangements for current CCG clinical leadership and have escalated the query to the North West ICS transition group.

2. Workforce Communication

The following documentation has been developed by the GM ICS workforce transition group:

1) HR Transition principles
2) Employment Stability Principles
3) Equality Approach
4) Frequently Asked Questions
5) GM ICS update.

These documents are attached as Appendices. Items 4 and 5 have been circulated to all CCG and OCO staff in Bury, and a further all OCO/CCG staff briefing is being held on 3rd June by the Accountable Officer.

Greater Manchester - More than an ICS.....

Proposals for a new operating model for the GM health and care system

1. Context

This report was commissioned by the Greater Manchester Health and Social Care Partnership. Its' purpose is to advise the GM Partnership Board on the development of a new operating model* for the GM system. **The report is a part of the ongoing process for ultimately determining the model and reflects the outcomes of a major engagement exercise over recent weeks with key stakeholders and system leaders**. It also builds on a number of pieces of work that have been previously carried out or are currently in train. Finally, it sets out a number of next steps and suggested additional pieces of work.

1.1 Drivers of Change

There are four main drivers for why the GM health and care system wants and needs a new operating model

- whilst GM has made progress against its aim to improve the health and well being of its population, it has not been able to make as much progress as it wished to see against its four priorities of reducing health inequalities, meeting national constitutional standards, accelerating innovation and creating a financially sustainable health and care system

- Covid-19 has had a major impact in terms of the health of the mental, physical, social and economic health of the population. This has deepened the problems that the GM is facing in terms of poorer underlying health, longer waits, vulnerability in the social care sector, and increases in mental health problems especially amongst young people,

- Equally however Covid -19 has also driven a number of very positive new ways of working in particular: strong collective leadership by NHS and care providers; a greater emphasis on collaboration between health and care organisations; a different more engaged relationship between GM citizens and GM services; an acceleration of the digitisation of service delivery; and a strengthened sense amongst health and care leaders of a common purpose and constructive collective leadership behaviours

- The Government has signalled through a white paper its intention to establish statutory integrated health and care systems (ICS) which will require changes to the current system architecture. These will impact on GM, even with its devolution deal, and whilst there is a promise of permissiveness in terms of the means of implementation, there are likely to be a number of legal expectations on how the system operates and a stronger national direction over its priorities

1.2 Methodology

In order to develop a new model, there has been a rapid process of co design with health and care leaders across the system. This allowed the sharing of their analysis and wishes based on their experience to date of both successful and less successful progress. The report has been therefore been informed by

- a series of 4 design workshops involving over 150 health and care leaders from the GM system including political, managerial, clinical & professional, and community leaders

- a selected series of semi structured interviews with key opinion leaders in the system

*An 'operating model' is defined many times in the literature but as a general rule its definition centres on *'the process of how, by using people, processes and technology, the organisation delivers value described by its strategy'*

- previous work commissioned by the GMHSCP in addition to work from a number of organisations across GM to inform a revised operating model that described the spatial levels for organising the planning and delivery of care (GMSCP, CF 2021) and the evolution of commissioning (Deloitte 2017/18); and the model of spatial service organisation - West Yorkshire and Harrogate ICS (set out in the appendices)

1.3 The challenge of designing a new operating model - feedback from the process

Throughout the process of engagement, a number of challenges for GM leaders have emerged In proposing a new model. these largely centred on -

- lack of clarity of the GM priorities or expected outcomes going forward, in particular the balance between achieving national standards and priorities versus locally determined priorities and expected outcomes (without clarity it is hard to design an operating model to deliver them)

- differing views on what aspects of the model need to be fixed - for some this is technical and a matter of determining spatial distribution of service planning, for some it is about financial flows and accountability, whilst for others it is about behaviours and culture (in practice a new model needs to address and align all of these aspects)

- a recognition of the different starting points across the GM localities and whilst most leaders favour variability, there is a challenge to getting an operating model that recognises and enshrines these variations but also enhances a common sense of purpose

- a spectrum of views about the need to change aspects of the way GM works now - where for some their current locality model either works well or is believed simply to need more time to achieve its benefits, but there are others who wish to see a more fundamental reshaping of the operating model to enable faster transformation

- a presence of some deep seated mindsets within the leadership that reflects years of organisational thinking rather than system thinking and creates mistrust of sectors or organisations and accentuates a desire to build in restraints or control mechanisms

- a reduced level of confidence in the effectiveness of operating programmes at GM level since devolution driven by the perceived failure of some collective programmes to deliver the promised added value. This is often exacerbated by a mindset that views 'the level above' in the structure to be hierarchical rather than a sum of its component parts. (In practice GM is the ten localities, and the ten localities are their constituent neighbourhoods etc)

- inevitably there is a risk of a new operating model creating complexity which leaders wish to avoid, but they also recognise that undertaking functions such as priority setting, planning, and service delivery jointly does require reshaping or adding to the bureaucracy especially if joint decision making is to be transparent and subject to good governance rules (as the proverb says - *if you want to go fast - go alone; if you want to go far - go together*)

1.4 Design Principles

Throughout the process of engagement, there has been a large range of design principles shared with GM leaders, many of which stem from the original design principles for the current operating model (see appendices). Most of these are deemed relevant but there are a subset of principles supported by health and care leaders that have emerged as the major principles, for the new model to embrace.

- the new operating model must **be bold in enabling transformation** recognising that GM has much still to do on its journey; COVID has worsened the problems; some of GM's work has yet to bear fruit; GM is determined to tackle inequalities; GM has not been able to deliver consistently on national standards and this may threaten autonomy in the future model; GM residents still experience unwarranted variation in standards and processes of care including access standards

- the new operating model (including funding flows and accountability) must facilitate the **alignment of incentives** for each organisation and partnership to achieve the locality and GM priorities with **a greater emphasis at each level on reducing health inequalities**

- the new operating model requires **shared priority setting** that balances national and GM; and GM and locality priorities; **shared planning** between neighbourhood, locality and GM levels; **shared 'stewardship' of resources** at whatever level and whichever 'organisational bank' they sit; and **shared accountability** for delivering the key standards and priorities

- new forms of accountability that ends the purchaser provider split and **require care providers to be an integral part of shared leadership arrangements** at all levels

2.0 Proposed Approach - how the new operating model for GM will accelerate delivery of its overarching aim and accelerate the achievement of its priorities

2.1 What needs to be and will be different?

Taking the drivers, the challenges and the design principles emanating from the engagement into account, there is an emerging operating model that crucially builds on the existing system but places much greater emphasis on 6 major programmes of activity and focus -

1) maintaining physical, social and mental well being

- through the use of wider local authority and private sector expenditure (eg housing, jobs, retail, transport, education, police, leisure etc) to deliver the fundamental basics of health and well being - a home, a job and a family/social support system. This should pay particular attention to supporting children young people and families in their early years of life.

- through the NHS and care system building stronger links into the work of the Combined Authority and business community: alignment with the Mayoral programmes and drawing on the Marmot city region work,

- through the strengthening of the role that health and care organisations play as anchor institutions in particular, running a dedicated and shared programme to capitalise on the opportunities of creating employment/apprenticeships (with a heavy accent on D&I policies), local sourced procurement, and leadership of the sector's sustainable energy plans for example,

- each locality, working with its neighbourhoods, building and delivering a plan for community engagement and development through community groups, VCSE, patient groups, carer support

etc. This would align also with the opportunity to invest in community pharmacy, and PCN social prescribing programmes

- allocating resources differentially to individual neighbourhoods to recognise need and designing more accessible services that are culturally sensitive, targeted to reduce health and life inequality and work hand in glove with local welfare, employment and housing services

2) Creating more consistent evidence based preventive and proactive primary care

- GM has some country leading services but has some of the worst life expectancy. This means there should be a much greater focus on primary and proactive care to support the earlier identification and better management of chronic disease.

- The operating model must capitalise on the development of PCNs and structured working at the neighbourhood level. Through these structures there is now a clear opportunity to improve the service offer at this level by investing in programmes to reduce unwarranted variation, develop models of shared care with citizens, extend the use of personal health and care budgeting, train and educate carers, use digital and new forms of remote health and care monitoring

- Using the data (and investing in joined up data systems and software) to identify and stratify risk within the patient population on a real time basis in order to prevent deterioration of patients, hospital admissions and loss of independent living

3) Greater integration of the community based reablement, residential, rehabiliative, palliative and social care services (working to eliminate the traditional divide between hospital and out of hospital services)

- the development of provider alliances within localities can embrace the next stages on the journey to establish integrated community teams aligned to PCNs and neighbourhoods that can manage physical, mental and social health problems by offering holistic services

- using data sharing, streamline assessments, carer training and support, digital home monitoring, social care market management for example to deliver longer periods of independent living and speedier return to employment for GM citizens

4) Coordinating and improving the urgent and emergency care service response by mandating health and care providers to develop more coherent pathways of care and enabling patients to access the right level of care sooner

- using a clinically guided GM wide approach to develop the pathways between the local urgent care services such as GP OOH, 111, A&E and more specialist emergency care (such as for major trauma, HASUs)

- through empowering the Provider Collaborative (PFB) to play a greater role, working closely with the relevant locality/community based organisations and NWAS to organise and deliver a consistent approach to urgent care that ensures the appropriate levels of triage, treatment and transfer across urgent care and emergency sites

- using neighbourhoods and community groups to train more of the population in first aid

- through enabling the use of NWAS insights and data to predict and prevent acute and emergency episodes of care, whilst also targeting resources to known need demographically and geographically

5) Delivering more consistent planned care and delivering the planned care recovery programme

- through using the Provider Collaborative (PFB) to own the system wide planned care recovery programme, operating with a single PTL, as interpreted and delivered by their COO group, The Collaborative would work to access the ERF funding and directly addressing its criteria of targeting health inequalities, offering virtual outpatients, offering effective clinical validation, operating as a single system, and managing staff well being. This would help to deal with the *stock* of patients waiting for diagnosis and treatment

- through joint planning with localities and local provider alliances on managing the *flow* of new patients needing diagnosis and treatment. This might include access to specialist opinion sooner in the pathway, developing models for community diagnostics hubs and greater investment in primary care development

- through expanding a GIRFT or similar approach across GM to reduce unwarranted clinical variation and maximising existing bed and workforce capacity as a consequence. Using clinical networks to share learning and support training or colleagues where necessary.

- through joint service delivery between the constituent hospitals of the collaborative and local integrated community health and social care teams to facilitate discharge from hospital when clinically fit and using virtual wards and remote monitoring to accelerate acute care management and rehabilitation at home

6) Further developing GMS access to and delivery of world class specialised care and building a hugely capable innovation capability in HIM

- GM has a huge opportunity to develop its range and depth of specialised services to attract new investment and staff, in particular in light of the importance of the life sciences sector to a post Brexit UK.

- The work also of HIM is very impressive in comparison to other approaches within the NHS. This is a real asset for encouraging inward investments and partnerships but crucially for enabling the health and care system in GM to adopt leading edge technologies that will enhance the value of the GM pound and support improvements in outcomes for the GM population

- Work to create the first prototype virtual health and care system underpinned by integrated data flows, which would bring together the current range of best in class digitised point solutions into an end to end digitally delivered set of care pathways (from health and lifestyle apps, remote home monitoring, virtual out patients, remote diagnostics, virtual wards, flow management systems and assisted rehabilitation for example)

2.2 The architecture, spatial management and funding flows

2.2.1 General consensus on the architecture and spatial management

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

Equally there has been considerable work done on the spatial level at which service planning and delivery should be organised and undertaken (see appendix 2). In some specialities and conditions, such as mental health, these spatial levels have been taken to a more detailed and granular level with a clear explanation through the mental health THRIVE model for example as to how services and programmes could address the mental health challenge GM faces (appendix 3).

Philosophically this work also aligns with the adopted principle of leaders recognising what needs to be done once, what needs to be done 10 times consistently (ie in each locality) and what needs to be done 10 times on a bespoke basis

Again there is an agreement between leaders that these are evidence based models and should be adopted at the core of the operating model, These form the broad basis to underpin current planning assumptions but should now be taken and the spatial models crystallised with clinical input to gain assurance on the practicalities of managing clinical care pathways and locations to ensure that clinical co-dependencies are not overlooked and crucial services do not get fragmented or weakened as a consequence.

2.2.2 Specific comments on the consistency and detailed expectations of the architecture

There are however more specific thoughts on elements of the architecture and what expectations might be set on the commonality of developing the detailed arrangements

1) neighbourhoods need some form of management structure or group which aligns and builds on the PCN function (ideally PCNs and neighbourhoods would be geographically coterminous)

2) locality structures would feature a consistent locality model operating with -
   - A Locality Board (that can deliver accountability for decisions and budgets at place level) and includes LA political leaders/portfolio holders, and care providers (primary care, MH, social care and acute hospital care) as an integral element of the governance
   - A "place based lead" (accountable person to GM ICS for health and care)
   - An accountability agreement between partners in the locality and GM ICS
   - A mechanism for the priorities to be decided together in the locality and a process for determining consequent financial flows to providers or provider alliances
   - A system of clinical and professional advisory input
   - Provision of an appropriate organisational arrangement for employment of locality based ex CCG staff
   - An articulated relationship with their local Health and Well Being Board (the detail of which would be determined locally)

3) a means by which locally based providers work together in some locally determined form of alliance (but which 'typically' would be expected to include the acute services provider, mental health provider, primary care, neighbourhoods, VCSE, social care services). This alliance should be an integral element of the leadership group and engage fully in shared priority setting, shared planning and delivery of care, shared stewardship of the combined, pooled of aligned resources, and shared accountability for delivering the expected outcomes, They would also need to ensure that the group was informed on recognising the need for financial resilience in provider organisations whilst identifying clinical validated plans for improving the value of healthcare spending as part of any redistribution,

4) Provider Collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care as defined in the spatial model. The governance arrangements must enable the constituent organisations to hold/manage a shared budget and to address the associated shared risks and benefits. These must also support the shared learning and development of their constituent organisations.They would require additional resources and strengthened governance to underpin the Collaboratives' work if they are to manage key programmes of activity.

5) Capability at GM level to discharge the functions, governance and legal requirements of a statutory ICS (as constituted in the forthcoming legislation) whilst being consistent with the existing devolved GM structure and process. The engagement process referenced the need to address and agree the new governance structure at GM level but focused more thinking onto the operating model beneath this level and further work will need to be done on this once a new operating model has been agreed.

6) There will be management capability at GM level to discharge the ICS statutory functions, convene the constituent partners within GM as appropriate and agreed, organise and deliver GMS wide enabling functions and deliver the 'upwards, outwards and downwards' accountability for the agreed GM priorities and expected outcomes

7) A system of joint planning convened at GM level but with constituent localities and collaboratives fully engaged to identify the synergies and connections between allocated resources. This would support the ICS with calibrating allocations and ensure a seamless coherent deliver of programmes (eg connect the work on addressing both the stock and the flow of the planned care programme; join up cancer services delivery with cancer screening etc).

2.2.3 The funding flows of NHS money

There is much less consensus amongst leaders relating to the exact nature of the funding flows other than a very strong agreement that to get added value out of every pound we spend, to get best value out of any new money we have available, and to align any non-health and care spend with the collective pot, there needs to be shared stewardship of the money spent at each level irrespective of with which organisation it is banked.

This principle would apply between organisations in different sectors, between organisations within Collaboratives and between organisations engaged in enabling GM wide programmes.

At one level, this should mean that funding flows are immaterial however in practice there are underlying tensions and fears about the quantum of funding to each level, the alignment of primary care funding, the cohesion of the overall funding streams, the formula for differential allocation of resources against need in a plan to tackle inequalities, and in a few places mistrust of the hosting organisation acting in accordance with the principle.

Some leaders believe that the best and simplest way to allocate resources would be for all the money to go directly to Trusts who are bound by aligned incentive agreements to work collectively. Other leaders believe that the best and simplest way to allocate resources would be for all the money to go to localities with a commitment to pass through money to providers or provider alliances in a manner aimed at achieving local priorities whilst also recognising an agreed level of fixed and semi variable costs. There is also a desire to direct funding to GM wide provider collaboratives for specific programmes of work (in a manner currently operating for mental health specialised care).

Taking all of these issues into account the proposal would be for the operating model to

1) adopt a blended approach to funding flows of NHS money between direct allocation to Trusts, allocation to Collaboratives and to agreed NHS/LA arrangements in localities (and onwards through to local providers or provider alliances) with the exact calibration of quantum to be determined by the ICS NHS Board (as it becomes constituted within the new GM ICS governance structure)

2) recognise and maintain, as a minimum, current arrangements where such money has been pooled with localities on a s75 arrangement. This would also maintain the local level of expenditure from the CCG budgets for community services which would be considered and deployed as part of the Locality Boards stewardship.

3) maintain the current allocation of resources to the acute provider sector, especially in light of the huge backlog of patients waiting for diagnosis and treatment, but direct this through the PFB provider collaborative who would lead the delivery of integrated urgent care, manage the ‘stock’ element of a planned care recovery programme, address unwarranted variation and develop a specific anchor institution programme. This does not preclude providers agreeing through their locality boards to distribute any received resources into another area of the care pathway if they believe it could have a beneficial effect on the value of that resource (eg improving outcomes or managing demand)

4) allocate resources beyond the current level for specialised care to the two MH providers (acting as a specific Collaborative) to deliver the appropriate programmes of care as defined in the THRIVE model (see appendices). It would be important to ensure that any allocation of

resource to MH providers is aligned with other monies being spent in the locality in order to ensure that MH is an integral part of leadership boards or as an equal partner in any provider alliance groupings. This will enable them to work with other partners to deliver the benefits of holistic care and MH well being activity. In order to ensure the delivery of the LTP MH commitments, MH funding should meet the investment standards and given GM's history of underfunding against national benchmarks, with a strong steer to increase the levels of MH funding as a percentage of the total spend,

5) Locality leadership boards should allocate or delegate a shadow budget to each neighbourhood which could then be aligned by the neighbourhood management team with PCN and GMS funding.

6) The absolute quantum of primary care funding must be maintained as a minimum but there should be facility within the Locality Boards, (within which primary care would be an equal partner), to steer the specific activity and requirements placed on primary care practitioners by the locally determined primary care budgets (eg LES schemes etc - as opposed to nationally determined contractual requirements) in order to align these with the delivery of locally agreed neighbourhood objectives. If the neighbourhood is successful, in particular in managing demand and maintaining healthy communities, then there should be scope for additional investment and reward to create a virtual cycle of delivering improvement.

7) There should be an agreement on the establishment and funding for GM wide enabling programmes that would encompass functions such as Health Innovation Manchester, PCB GP Excellence programme, population health management, OD support, Information Management and technology, data and business intelligence, People and HR, estates (this is not an exhaustive list) and whether these are delivered by GMICS directly employed staff or Collaboratives, or by a lead organisation/locality on behalf of GM. Again the national guidance and spatial models indicate the programmes that should be organised on a GM basis but it is essential that these are tested against the principle of adding value and that constituent parties are confident of their delivery.

8) Allocation of money needs to be accompanied by deployment of staffing and the opportunity of reform means that there is a pool of people who could be effectively redeployed fo support the delivery of the new operating model. Once the model has been agreed there needs to be a clear programme to redeploy staff and budgets to the appropriate level or organisation in the GM system

3. Clinical Engagement

The reform of the system and the creation of a new operating model only makes sense if it is seen as enabling clinicians, professionals and practitioners to redesign care and to develop shared models of citizen engagement in health and care. There is a risk that the technocratic description of a new operating model will not signal the value or intent, and would be likely to pass most of our key staff by.

Therefore, it is essential that this work is

- aligned with the work of Tom Tasker on how to build clinical and professional engagement

- subject to a substantial communications and engagement exercise to explain the new opportunities and how GM is tending to accelerate its achievements of its aims and priorities

4) Establishing a new accountability process and culture

There is a real appetite amongst leaders to create a new process built on shared accountability, peer support and review, and performance improvement rather than old style performance management.

In order to achieve this, there will need to be a process through Locality and Collaborative Accountability Agreements for delivering the key GM, locality and programme objectives. The integrating care white paper signals the concept of earned autonomy but based on the consultation, the GM model might feature a greater focus on self assessment triggering support.

The crucial element is that locality boards providers of services (through alliances or collaboratives) are an integral element of the ICS and therefore accountability is to each other and not to a hierarchically positioned higher tier authority or agency. In parallel however, the ICS will need fo account to the NHS England Region for its achievements against national objectives and priorities and this requires collective ownership by all GM organisations also.

The GM operating model would feature

- a core principle of shared accountability (rather than a pure organisational focus), which could be manifest in Joint Committees, Committees in Common or aligned incentive contacts for example

- accountability agreements with NHS England with the potential of mirroring those in agreements with locality boards and provider collaboratives

- organisational contributions to the alliance or collective, governed appropriately and effectively as now by NED majority boards

- peer review and support

- escalation triggers in the event of failure to deliver within the agreement which would be agreed and reported with a view to securing help to recover

- light touch data reporting and monitoring against key priorities (sufficient however to allow the GM ICS to report upwards on key national priorities)

- an emphasis on continuous learning and development aligned to a people and talent management strategy

5) Establishing an OD programme

There is a very clear consensus that to make the new operating model work effectively will require a substantial programme of organisational development. This should work on establishing the capability and capacity to operate collaboratively as leaders and can focus its work on

- individual leaders including citizens as community leaders, GP and professional representatives

- groups such as joint committees, collaborative boards, PCNs, neighbourhood groups, locality boards and the GM board(s)

- individual boards

- system wide leadership groups that undertake key work programmes,

The OD programme would build on but enhance existing work and will require major investment

Leaders were clear that whatever the architecture it will be leadership behaviours and conduct, coupled with the ability of organisations to adjust their mindsets to a system orientation. The programme will include all four areas of managerial, clinical, political, non executive and professional leaders

6) Time frame for adoption and next steps

There is a widespread view that leaders want to see some momentum to adopt a new operating model as soon as possible. This would allow new locality and Provider Collaborative arrangements to be put into place or confirmed, if building on existing structures. There are however a number of areas of work in the operating model that haven't been addressed fully and need to be undertaken -

1) work on the precise nature of the GM ICS governance structure - how does the white paper impact on the current governance and how will the new structures discharge the national legally required functions? There is a need to do this work quickly in order to build confidence that the key roles of the ICS in particular, relating to priority setting and allocations are being discharged as a shared enterprise, with localities and providers an integral element of that

2) work to agree/confirm the GM enabling functions and their programme management

3) establishment of a wider task and finish group including clinical leaders to crystallise the spatial model using the technology of the THRIVE model to set out the planning levels for a number of key services such as the elements of the cancer and urgent care pathways

4) once the model is agreed there should be a dedicated programme management approach set up to ensure the model is implemented effectively and to the expected time frames

5) work on the detailed impact of the financial flows section of this paper to consider how best to create a simplified set of financial processes. This should be augmented by the use of financial modelling to allow leaders to understand and adjust for the consequences of sector and organisational investments, in particular to assess their impact and return in terms of value to the whole system.

Mike Farrar CBE, FRCGP, FRCP (April 2021)

Appendices

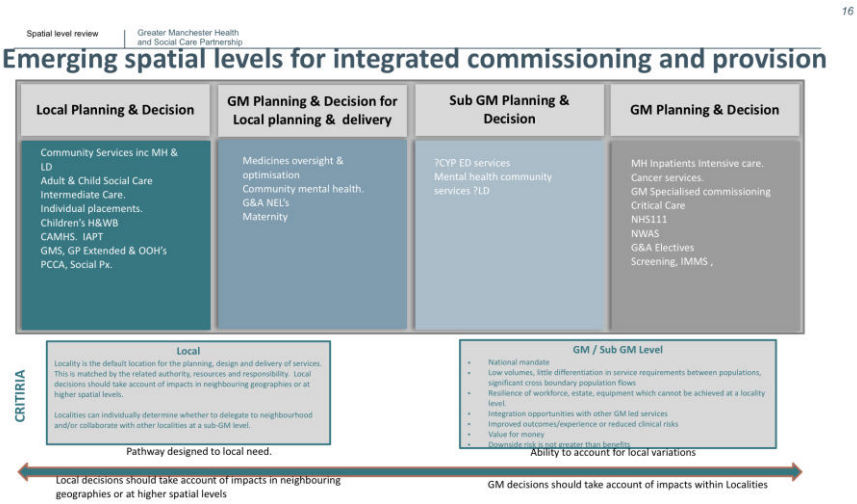
1) GMHSCP spatial model

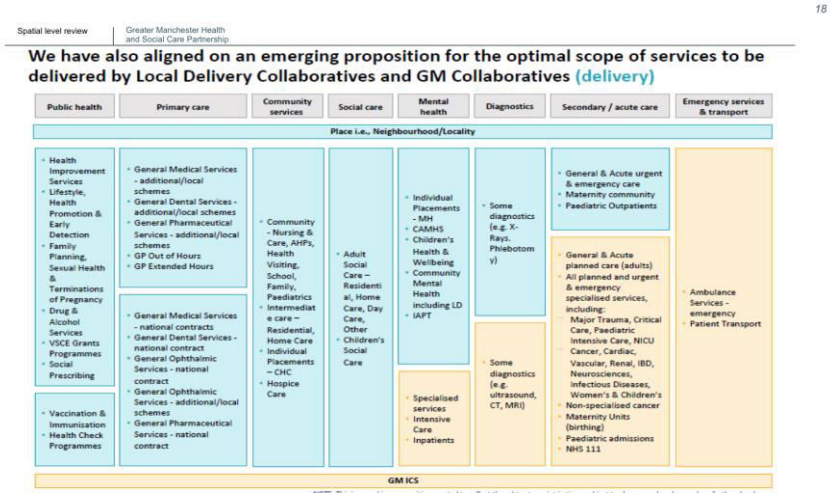
2) Carnall Farrar spatial model for planning and delivery

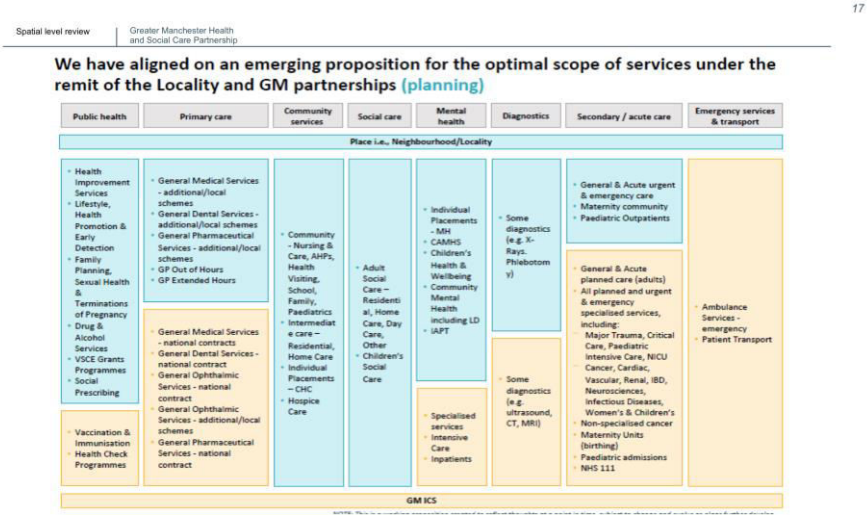
3) **West Yorkshire ideological spatial model**

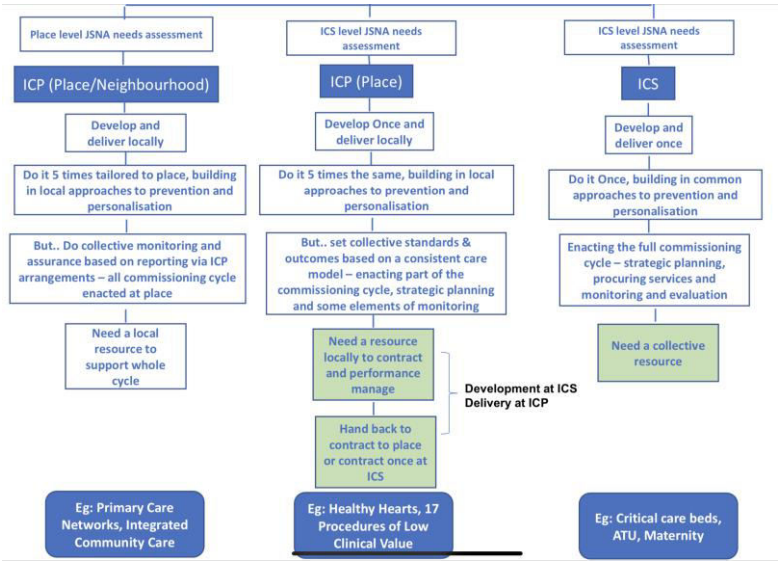
4) **GM design principles**

5) **Mental health THRIVE model**





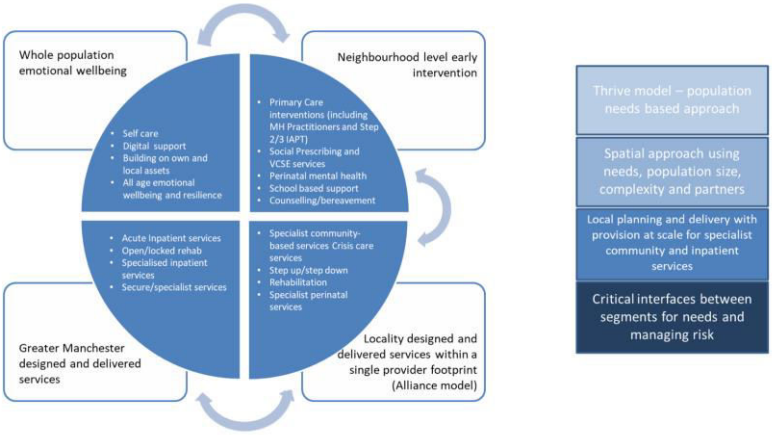




A GREATER MANCHESTER APPROACH TO IMPLEMENTATION

- Change is **done with, not to**, people.
- 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.
- Bringing those contributions together in **neighbourhoods with proactive primary care supported through PCNs**
- **Collaborating at scale** across Greater Manchester to deliver consistent standards of care.
- We expect to be **a place which innovates** and connecting our Universities, healthcare providers and industry base, 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.

Spatial level for design and delivery of all age mental health and emotional wellbeing services



GM – More than and ICS…. Next Steps

Following the presentation of the report from Mike Farrar to Partnership Executive Board on 30th April on the work undertaken to get us to the next stage in the development of an operating model for Greater Manchester (GM) and building on our first five years as a devolved system, the emerging programme plan has been updated and some of the more detailed work now required set out for agreement by the system.

There are areas of work that are well understood and progressing at pace – key elements of the People, Culture and Communications programme for example. Other aspects are only just getting off the ground or require further definition.

The recommendations in Mike Farrar's paper that need further clarification and development and need to take priority in resolution include:

- Finance
- Spatial Levels
- Locality approach
- Provider Collaborative
- GM Governance
- OD

Finance

FAC and FLG will take the lead in this work and will develop and recommend an approach to financial flows. Mike Farrar will work with both groups to develop final recommendations. It is acknowledged that the approach may need to evolve over the next two years, so although it needs to be ambitious, it is likely to be relatively simple initially as we move into system working.

Spatial Levels Analysis

As discussed at the workshops in April, agreeing where both planning and delivery of services will take place needs to be worked through in more detail. The model used by mental health which adopted the Thrive model will be used as the basis of the in-depth work which alongside spatial level, will need to set out how the agreed model will be delivered, by whom with what governance. The work will be co-ordinated by Mel McGuiness, Director of Commissioning from Bolton, and draw on provider, commissioner and primary care leaders to undertake the detailed work.

Alongside specific services, broader priorities will need to be looked at within a tight timescale. First priorities include:

- Urgent and emergency care
- Planned Care – both recovery and areas of concern eg breast services
- Mental Health

Locality Approach

Having agreed the key characteristics of locality working, each locality now needs to share their plans against the framework broadly articulated in Mike Farrar's paper.

- place-based leader – how will delegated responsibility be managed
- locality board – proposed role and form
- holding pooled budgets – who will act as 'banker'

- Relationship with GM ICS – how does the locality see accountability agreements working
- How will clinical and professional expertise be built into locality working and decision making

Provider Collaborative

Although GM is advanced in provider co-operation and working arrangements with Provider Federation Board bringing together acute and mental health trusts and linked to Local Care Organisations, the concept of a provider collaborative takes this model further. The GM Collaborative will require formal governance, the ability to manage a shared budget and take on formal accountability for delivery. PFB are working with Mike Farrar to develop their approach and will need to set this out as part of the GM Operating Model.

CCG Functions

If legislation is passed as intended, the 10 GM CCGs will cease at the end of March. All statutory accountabilities will need to be transferred to successor organisations and this technical piece of work needs to be undertaken consistently across all 10 organisations. Su Long is leading this work and will be running a workshop with key leads from across the CCGs, Shared Service and Partnership to get this underway.

GM Level Governance

The workshops helped take us further forward in agreeing a GM Operating model and ensured important engagement with stakeholders, but they did not come to any view on how we will work together at a GM level, the relationship between the ICS Team, Provider Collaborative, Combined Authority and other GM groups like Health Innovation Manchester and the VCSE. The supporting GM level governance (Partnership and ICS NHS Board) and relationship with localities needs to be worked through. Mike Farrar will be working with us to complete this work.

Organisational Development

A strong theme emerging from the workshops was the need to develop new ways of working, establishing a culture of trust and mutual support and strong engagement with stakeholders and the public.

Again, working with Mike Farrar and using the expertise we have in GM, we will develop a programme to support our move to shadow arrangements and final changes in April 21.

Timescales

GM will need submit set out our operating model and plan for implementation to the Region at the end of June. This will require focused activity to answer some of these more challenging questions.

By the 11th June we need to have a broad outline of the work completed allowing the second half of the month to bring all aspects together into one overall model and socialise with stakeholders.

Leads will need to develop a detailed timetable for each aspect of the work to pull into the programme plan.

Programme Oversight

The programme will run across the whole of 2021-22. As set out, the immediate focus will be on completing the work on the operating model with focus turning to implementation in the second half of the year when the Bill receives Royal Assent.

The programme plan will be developed further and support from the PMO team at the Partnership will provide the co-ordination of monitoring information and reporting required to ensure progress against the timetable.

A programme board will be established to oversee the work, chaired by the SRO.

Sarah Price, 13 May 2021

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Consider
Item No	7b	**Confidential / Freedom of Information Status**	No
Title	Update on Bury Partnership Arrangements		
Presented By	Geoff Little, Chief Executive Bury Council & Accountable Officer NHS Bury CCG		
Author	Will Blandamer, Executive Director Strategic Commissioning, Bury CCG and Bury Council		
Clinical Lead			
Council Lead			

Executive Summary

The Strategic Commissioning Board has previously received updates on the implications of the White Paper for the operation and development of the Bury partnership arrangements, and the operation of the GM Health and Care Partnership. The national context is that the legislation is anticipated in the early summer, with moves to transition to GM ICS arrangements in the autumn including the appointment of a Chief Executive and associated leadership roles for the GM ICS.

For Bury the focus has been on continuing with the journey of transformation, developing transition arrangements for the operation of the Bury partnership system. Our work with GM colleagues is to ensure that the emergent GM ICS operating model creates the opportunities and authority to maintain and quicken progress to a clinically and financially stable health and care system in Bury creating better quality outcomes for local residents.

This paper provides an update on all aspects of the transition work in the Bury System and in the local system, as a core briefing note into a number of Bury System meetings.
A summary table is provided confirming progress and next steps on each element of local transition.

This paper should be read in conjunction with a paper updating on the development of the GM ICS operating model (Agenda Item 7a).

Recommendations

It is recommended that the Strategic Commissioning Board note the content of the report.

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

Add details here.

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being 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:						

Implications						
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.		
Bury CCG Governing Body	26/05/2021	
Bury Locality System Board	20/05/2021	

Bury Health, Care and Well Being Partnership.

White Paper Transition Arrangements

Update on Bury Partnership Arrangements

Paper for;

- **Bury Locality System Board - 20th May**
- **Bury CCG Governing Body – 26th May**
- **Bury Strategic Commissioning Board – 7th June.**

Will Blandamer – Executive Director Strategic Commissioning – Bury CCG and Bury Council.

Background

Bury System meetings have previously received updates on the implications of the White Paper for the operation and development of the Bury partnership arrangements, and the operation of the GM Health and Care Partnership. The national context is that the legislation is anticipated in the early summer, with moves to transition to GM ICS arrangements in the autumn including the appointment of a Chief Executive and associated leadership roles for the GM ICS.

For Bury the focus has been on continuing with the journey of transformation, developing transition arrangements for the operation of the Bury partnership system. Our work with GM colleagues is to ensure that the emergent GM ICS operating model creates the opportunities and authority to maintain and quicken progress to a clinically and financially stable health and care system in Bury creating better quality outcomes for local residents.

This paper provides an update on all aspects of the transition work in the Bury System and in the local system, as a core briefing note into a number of Bury System meetings.

A summary table is provided confirming progress and next steps on each element of local transition.

This paper should be read in conjunction with a paper updating on the development of the GM ICS operating model.

Bury Health Care and Well Being Partnership Transition

The term "Bury Health, Care and Well Being Partnership" is used to describe the collective effort of all key stakeholders to a reformed health and care system in Bury – including NHS providers, Bury CCG, Bury Council, the voluntary and community sector, private providers, and patients and residents. Work is progressing across the Bury Health, Care and Well Being Partnership to create the conditions to maintain and quicken our transformation.

1. The Bury Locality Plan.

Overview

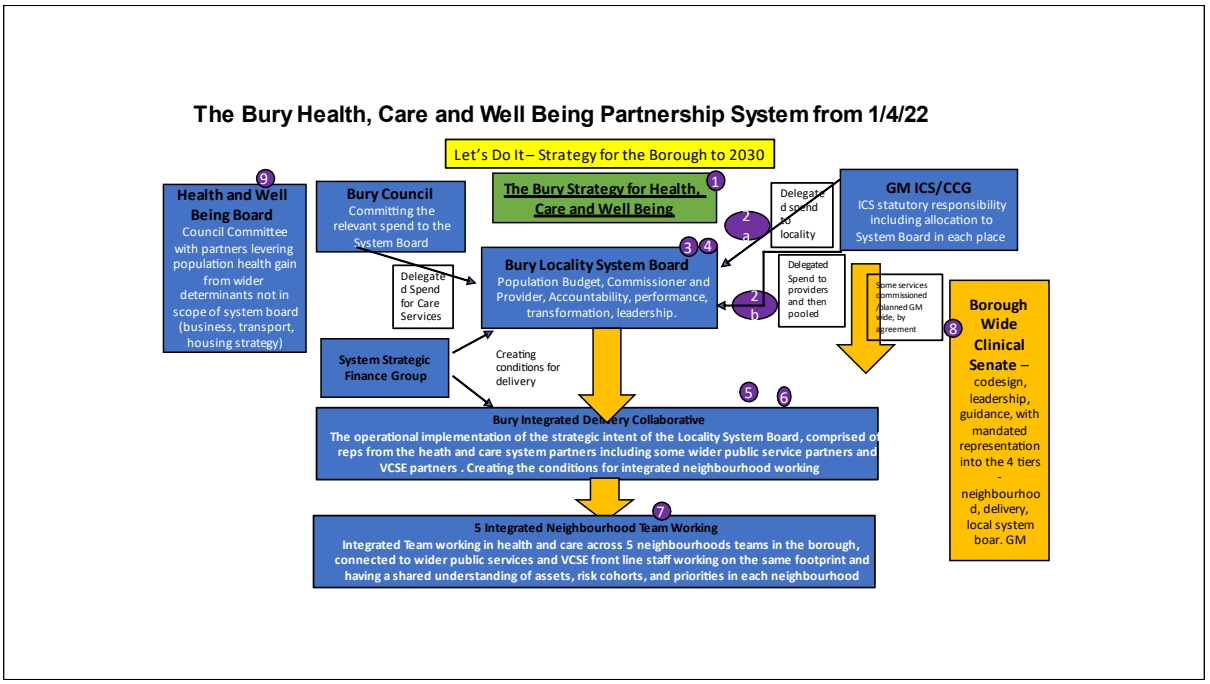
The Locality Plan is the strategy for the health and care system in Bury. It was developed in 2017 and refreshed in 2019. It is important through a period of turbulence to restate and reconfirm the core principles underpinning the transformation – to operate as a touchstone and to remind all partners of what we are trying to achieve and how. This is refresh – reflecting our learning from the Covid 19 pandemic and the new strategic context provided by Let's Do It – the strategy for the borough to 2030.

Progress

A first draft of the refresh has been shared with the IDCB for comment and circulated to wider stakeholders.

2. Building the new local partnership arrangements.

System meetings endorsed proposed new system partnership arrangements shown below, and progress is being made in this transition year and report to the Bury System Board as a Transition Board.



2.1 Bury Locality System Board

Overview

The current form of the Bury Locality System Board meets informally and will in time need to strengthen its governance to operate as the older of the integrated budget for the borough, including the Council, NHS Providers, and the GM ICS. To some extent the new system board replaces the current role of both the informal system board, and the Strategic Commissioning Board.

Progress.

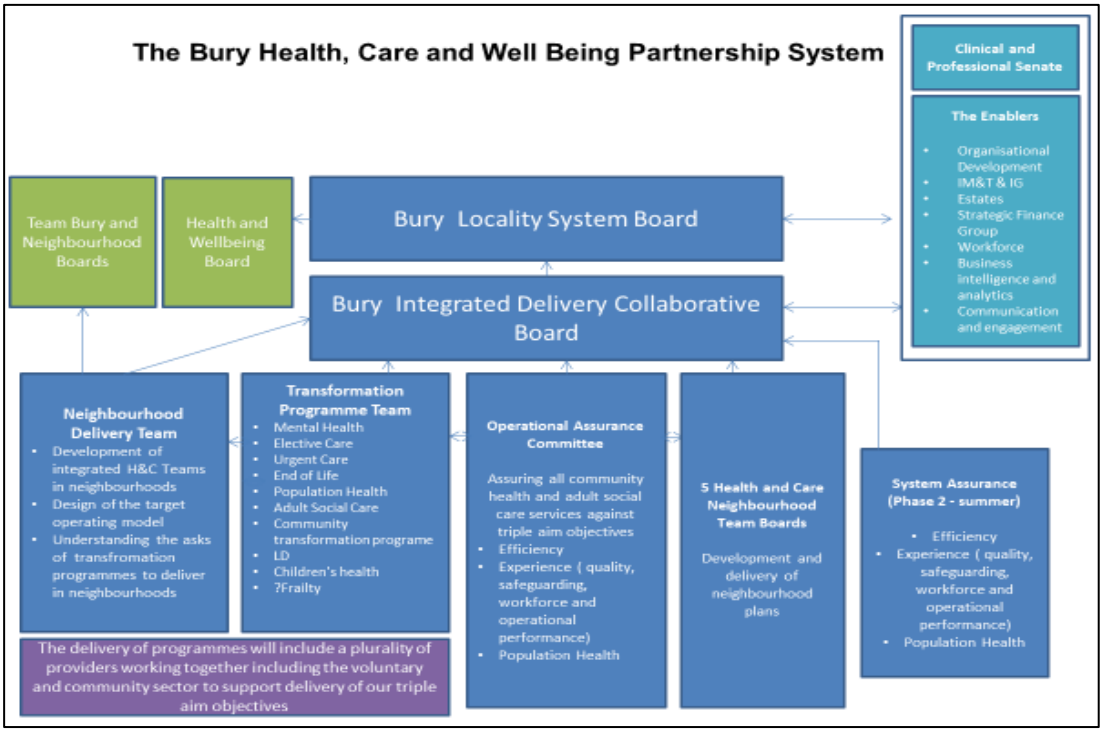
A terms of reference for the new System Board has been drafted and is attached for consideration. It is proposed we hold the first formal system board in transition in September 2021, and host CCG governing Body and SCB on the same day to address decision making in accordance with current duties.

2.2 Integrated Delivery Collaborative Board

Overview

The IDC Board builds on the success and partnership of the Bury LCO, and includes a wider representation of providers and the oversight of the whole of the operation of the health and care system. Its job is to create excellent partnership working in business as usual, and to drive the transformation programme of the partnership as whole on behalf of the System Board and in accordance with the principles of Locality Plan. The IDCB will be independently chaired, as the LCO was, for at least the duration of the transition to April 2022. It has a particular task to create the conditions for integrated neighbourhood leadership team working to thrive.

The role of the IDCB is summarised in this diagram.



Progress.

The IDCB has met once in shadow form as a 'soft launch', and workshops on values, behaviours,

the oversight of the transformation programmes, and the role of assurance and performance oversight

2.3 Integrated Neighbourhood Team Working

Overview
Building and operating integrated neighbourhood team working in each of 5 places, connected to the reform of public services on the same footprint, and infused a spirit of an asset based/ethnographic approach to communities and residents, is a cornerstone of the locality plan.

Progress.
The 5 neighbourhood teams are well established with managerial and clinical neighbourhood team based leadership. Further alignment of services into the 5 neighbourhood team model is progressing (e.g named connections to quality and safeguarding), and an underpinning neighbourhood team profile is in development. The neighbourhood delivery team steering group -reporting to the IDCB is finalising confirmation of vision, leadership team development, programmes of assimilation and alignment, outcomes measurement. The connection to community hubs, early help in children's services, and to wider public service teams on the same footprint is progressing. INTs are also represented through key reform programmes (e.g elective care) and in enabling frameworks (e.g estates

2.4 A clinical and professional senate for the borough

Overview.
The proposed senate will provide assured and mandated leadership to inform, lead, and advise reform and transformation across the borough – creating space for clinical and wider professional leadership from all organisations work effectively together.

Progress.
A draft terms of reference for the senate has been established and a workshop will be convened in June to finalise terms of reference and the operating model. An initial meeting will be convened in July. The work is sighted on the connection to the proposition for a GM wide clinical and professional senate.

2.5 Revised Health and Well Being Board

Overview
The health and well being essentially operating as a 'standing commission' on health inequalities and using the Kings Fund 4 quadrant population health system.

Progress.
The health and well being board has met in this mode now for 2 meetings. Further work to strengthen decision making and action orientation but partners are positive about the progress to date.

2.6 Strategic Finance Group

Overview
With the reduction of the focus on the commissioner/provider split, and the role of the new system board holding essentially a locality capitated budget, it is necessary to establish a Bury System Strategic Finance group including Council, CCG and NHS providers, to developed shared and transparent understanding of system and uni-organisational financial position.

Progress
This group is now meeting regularly.

3. Performance and Outcomes Framework

Overview
The operation of the health, care and well being partnership for Bury will require a single and recognisable performance and outcomes framework. This will be a triangular framework – at its apex identified a small number of key system indicators (e.g healthy life expectancy, non-elective admissions), and working through tiers of indicators and outcomes. It is dynamic – intending to show the effect of one indicator on others.

Progress
This is in development and the System Board of 20th May are receiving a demonstration of the work thus far from the integrated Business Intelligence Team

4. Patient voice and co-design.

Overview
There are a number of excellent examples of patient/resident codesign in transforming services – for example through the SEND transformation programme and working with residents with learning disabilities. It is also at the heart of the work of community hubs. This approach is not however systematically applied.

Progress
We have asked the new leadership team at Bury Healthwatch to work with us to develop some proposition for harnessing their expertise, connections, and experience in working with patents and relatives, and to develop a framework for engagement. Bury Healthwatch will work with other VCSE partners in this work. A paper is due for consideration by the System Board in June. We will in addition adopt a practice from the Bury LCO in bringing lived experience into the room of the work of the Integrated Collaborative Delivery Board.

5. Recovery and Transformation board

Overview
The recovery and transformation board, chaired by Howard Hughes as provided a focal point for the programme management of transformation programmes - on elective care , planned care, community services, end of life care, adult social care transformation etc. However, the meeting schedule itself was stood down during the pandemic from Christmas 2020 onwards.

Progress
We will reconvene the programme management arrangements as part of the Transformation Programme Team working reporting to the IDCB. Work currently undertaken to review and refresh charters, outcomes, and implementation plans across all programmes.

6. Workforce Support and Development.

Work is progressing with HR leads for Bury CCG and Council, and in the context of the developing GM ICS arrangements. In the absence of legislation and a national HR framework communication with CCG staff particularly at a time of relative uncertainty has been challenging. Key actions have been the following:

- Stocktake of all CCG staff contracts and employment arrangements to establish a clear baseline.
- Review of commissioned activity through GMSS
- Regular monthly all CCG/OCO staff briefings
- Reminder to all staff in the context of the wider Council and CCG approach to health and well being support, of the help and support available for all staff.

GM wide HR guidance is being circulated imminently, including FAQs, inclusion policy, staff sustainability policy, position statement on GM operating model development, and HR transition principles.

An area of common concern for all CCGs is the steps being taken to ensure the retention of clinical leadership expertise into the new system in the absence of the current arrangements through the CCG of Clinical Directors and Clinical Leaders. Work is being done locally to review the availability of clinical and professional leadership across all partners in the system and in the context of the establishment of the clinical and professional senate. However, the lack of essentially population based (rather than organisationally based) clinical leadership from senior CCG clinical leaders constitutes an enormous risk and has been escalated to the GM ICS arrangements.

The working assumption nationally, and in GM, is that most CCG staff will be employed by the GM ICS but deployed in localities to continue the work on local transformation. This will allow us to continue our transformation working – for example

- integrated teams in support functions like business intelligence, finance, comms etc,
- CCG commissioning capacity in primary care and secondary care building different working relationships with providers in the context of the transformation programmes described,
- expert CCG capacity in quality improvement, safeguarding working as part of whole system assurance processes
- corporate core capacity supporting the new partnership meetings established.

It is possible that in some areas there will be a GM wide ambition to centralise some CCG staffing deployment – where the current work on spatial levels of planning and delivery concludes that GM wide consistent approaches aggregation of expertise from individual CCGs. We will regard this as exceptional, as even in these circumstances the integration with local services remains crucial.

7. Place Based Lead.

Overview
The White Paper highlights a potential role for a 'place-based leader' – the person co-ordinating the partnership working in local systems. In Greater Manchester, it is also presumed (given the strong focus on the balance between the work of 10 localities operating within one ICS) that the GM ICS will seek named leadership in each of the localities with the responsibility for the locally devolved budget in the place.

There is not yet clarity on whether it would be expected the place-based lead, and the GM ICS lead in Bury, would be one and the same person.

Progress.
This has not been discussed in the Bury System and a fuller paper will developed on the options available, (including as a transitional arrangement pending the confirmation of GM ICS arrangements)

8. CCG Closedown

Overview
The System Transition plan agreed by the Bury System Board included an element to review the closedown arrangements of the CCG.

Progress
Guidance is awaited.

9. Working on the NCA Footprint

Overview
The 4 localities of Bury, Rochdale, Oldham, and Salford are bound together through the connection to the Northern Care Alliance footprint of delivery for a substantial volume of acute and community health services. It is important to create a mechanism for transaction business together where it relates to particularly acute reconfiguration and transformation on that footprint – for example in relation to proposal around urology, or community diagnostic hubs. At the same time, it is apparent there is a strong shared philosophy with NCA that priorities a locality focus (e.g through the borough specific 'care org' model of managerial and clinical leadership. There is also a strong focus on health inequalities.

Progress
The Carnall Farrar report scoped the opportunity of the locality focus but also the opportunity of the NCA footprint collaboration, and also the opportunity to influence GM wide ICS development. Further work with NCA colleagues is underway to describe a formalised programme of work and a partnership working arrangement.

10. Public Health National Transition

Overview
With the announcement of the abolition of Public Health England, the national public health leadership architecture is changing, and it is important to ensure the strong public health focus

locally.

Progress
An update paper is being considered at the System Board on 20th May.

Summary of Local Transition Arrangements

The following table provides a summary of the narrative above in section 2.

Action	Progress	Next Step
Refreshed Locality Plan	Drafted	For agreement
Locality System Board	Terms of Reference developed	Convene Shadow meeting Sept
Integrated Delivery Board	First meeting held in shadow form	Operating model workshops in development
Neighbourhood Team Development	Steering Group meeting	Development plan to be finalised
Clinical and professional senate	Broad system endorsement	Workshop to finalise working in June.
Revised Health and Well Being Board	Operational	Strengthened focus on outcomes
Strategic Finance Group	Operational	Further development of single transparent oversight of system
Performance Outcomes Framework	In development	Presentation to System Board May 2021
Patient Voice and Co-design	Healthwatch proposition in development	Presentation to System Board June 2021
Recovery and Transformation Board	Agreed to be Connected to the IDCB	Workshop to review whole programme connected to IDCB in June 21.
Workforce Support	On going	All CCG staff briefing 3rd June based on latest GM HR guidance
Place Based Lead Officer	Not discussed in Bury	For discussion – forum to be advised
CCG Closedown	Under Review	Awaiting national and GM guidance
Working on NCA wide footprint	Carnall Farrar report delivered	Develop programme plan
Public Health Transition	Update paper developed	For System Board May 2021

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Agenda Item 8

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Receive
Item No.	8	**Confidential**	No
Title	2021-22 Activity and Primary Care Workforce Plan Update		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

As part of the NHS planning process, the CCG formulates an activity and performance plan. This is submitted to the Greater Manchester Health and Social Care Partnership (GMHSCP) which combines submissions from all Greater Manchester (GM) CCGs and providers into a single GM system-wide plan. At the same time workforce plans are also submitted with a return relating to primary care workforce required from CCGs.

Development of the plans is an iterative process and draft plans were submitted to GM on 4th May 2021. The deadline for final plans to be submitted to GM was 25th May in advance of the national deadline of 3rd June. This gap allows time for GM to analyse plans and request further refinement if this is required.

National guidance requires specific activity and performance levels to be achieved during the year and it is also essential that plans are aligned across GM between providers and CCGs and that each organisation's plan also aligns to the locality finance plan.

In formulating the plan for 2021-22, the CCG liaised closely with both Northern Care Alliance (NCA) and other North East Sector (NES) CCG colleagues. Following submission of the draft plan, the CCG undertook further work to reconcile baseline data incorporating revised or new assumptions from key providers. All required changes were included within the final plan and the Governing Body in May granted retrospective authority to the Executive Director of Strategic Commissioning to sign-off Bury's plan.

This paper sets out the high-level requirements of the 2021-22 plan along with the assumptions applied in the final version. A summary of the primary care workforce return is also included. The Strategic Commissioning Board is asked to receive this information.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the updates relating to 2021-22 planning contained within this report.

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

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

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

1. Introduction

1.1. The purpose of this report is to provide an overview of the content of NHS Bury CCG's activity and performance plan for the 2021-22 financial year along with a summary of the intended growth in primary care workforce.

2. Background

2.1 Each year, NHS organisations are asked to submit operational plans for the next financial year, hereon in referred to as the 'planning round'.

2.2 For 2021-22, planning guidance was published during March 2021 to cover the period April to September 2021 and focuses on the following six priorities:

- Support staff health and wellbeing, taking 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.

2.3 To support the planning round, system-level templates are completed for activity, mental health, finance and workforce with an overarching narrative submission too. The focus of this report is the activity template (referred to as "the plan") and the primary care workforce plan. CCG and provider versions of activity and workforce plans are submitted to GMHSCP who collate into a single system-wide plan.

2.4 Across GM, it is essential that activity plans are aligned between CCGs and providers and also with finance plans too. To achieve this in Bury, assumptions have been agreed with the main acute provider, Northern Care Alliance, and with wider GM intelligence sought too. The main forums for this have been:

- NCA / NES CCG Technical Group and GM Technical group;
- GM Elective Recovery and Reform Operational Leads group;
- NCA / NES CCG Acute Recovery and Restoration group (ARRG);
- NCA / Bury CCG Locality group; and
- GM Assurance team via email queries.

2.5 Draft plans were submitted to GMHSCP on 4th May in advance of the national deadline of 6th May. The national deadline for final plans was 3rd June with submission to the GMHSCP having taken place on 25th May.

2.1. The following section of this report will summarise the requirements set out within the planning guidance along with the main assumptions applied to each of the main sections of the activity template. A tabular summary is also included at Appendix A. A further section then outlines the primary care workforce plan, the output of which is shared at Appendix B.

3. NHS Bury CCG Operational Plan for 2021-22

3.1 Due to the uncertainty about future COVID-19 transmission, most elements of the plan for 2021-22 relate to the first half of the year only, ie April to September 2021. It is expected that a second planning round will be instigated at a later date.

3.2 The plan is projected from a baseline position that uses 2019-20 data. However, due to the pandemic having commenced during March 2020, a calculation is applied to 'normalise' data for that month. Bury's approach was to calculate the growth from February to March 2019 and apply this to the February 2020 figures.

3.3 For some points of delivery (PODs), the CCG-generated baseline figures differ to those provided by NHS England (NHSE). This is not unusual and further work was undertaken to ensure the CCG had correctly interpreted the guidance. In all cases, the 2021-22 plan is based on the CCG generated baseline figures.

3.4 The NCA has commissioned KPMG to undertake some demand and capacity modelling and had expected the output of this to be reflected in the trust's final plan. The NCA did, however, advise that although the KPMG modelling will be used for internal purposes, it was not used to inform the plan.

3.5 Provider planning assumptions are crucial to CCG plans and detail was received from NCA and Manchester University Foundation Trust (MFT) and these were reflected in Bury CCG's plan. NCA assumptions were then applied to all other providers.

Elective POD Plans

- **Outpatients**:

3.6 For outpatient attendances, elective admissions and diagnostics, the planning guidance sets a requirement for systems to reach 70% of the 2019-20 baseline in April, 75% in May, 80% in June and 85% in July to September.

3.7 For outpatients, the Bury CCG plan reflects the 70% - 85% requirement. The guidance also sets a minimum level of outpatient attendances to be delivered as non-face to face. This minimum level is reflected in Bury's plan where the non-face to face level (41%) has been based on the proportion that NCA has included in its plan. MFT had indicated a lower proportion though linked this to recording and reporting issues rather than delivery, therefore once these issues are resolved the MFT percentage should increase too.

3.8 There is a requirement for outpatient transformation to take place and this ultimately will realise a growth in Advice and Guidance (A&G) requests and Patient Initiated Follow-up (PIFU) attendances. In advance of larger scale transformation taking place, the growth seen in A&G in recent months is shown to remain static in Bury's plan. Similarly, although PIFU has been initiated at NCA, this is currently on a small scale and therefore activity is very low. The CCG has therefore reflected the NCA plan of zero PIFU for the first six months. It is expected that growth would be seen in the latter half of the year once transformation schemes are progressed and this would then be reflected in both the CCG and NCA future plans. This approach also ensures alignment across NES CCGs.

- **Elective Admissions**:

3.9 For both elective PODs (day case and ordinary admissions), Bury's plan shows achievement of the 70% - 85% requirement.

- **Diagnostics**:

3.10 Activity plans are required for a specific subset of seven diagnostic test types and recognising that diagnostic capacity is critical to support elective recovery, guidance is for "recovery of the highest possible diagnostic activity volumes" in 2021-22. The methodology applied by the NCA has been reflected in the CCG plan. This includes capping activity at 100% of 2019-20 levels and also increasing activity for any tests that might fall below the specified percentage level.

3.11 Against the 2019-20 baseline, the result of the applied assumptions is that activity levels between April and September 2021 will range from 80% of the baseline for echocardiography to 97% for computerised tomography (CT) scans. Additional activity was included in the plan for echocardiography to ensure the required activity level could be reached.

3.12 The increase predicted in diagnostic activity reflects the increased capacity generated locally through out-sourcing, recruitment and, in some cases, additional scanners (eg a new CT scanner at NCA).

3.13 Diagnostics transformation will also be achieved through implementation of the Community Diagnostic Hub (CDH) model for which local planning has commenced.

Non-Elective POD Plans

- **A&E Attendances:**

3.14 The requirement is for activity to reach 100% of the 2019-20 baseline from April 2021 onwards and this has been reflected within both the CCG and NCA plans. Although attendances during 2020-21 reduced significantly during the pandemic, a month on month increase was seen with attendances during March 2021 being just a little below the baseline position.

3.15 In-year, the biggest change in A&E attendances is likely to be the split between the various attendance types which are coded as Type 1 through to Type 4, with the highest acuity being Type 1. Currently, the Fairfield General Hospital (FGH) Urgent Treatment Centre (UTC) attendances are coded as Type 1 though these will become Type 3 once the new UTC becomes operational and this will therefore impact on the split, most likely once plans for the second half of the year are required.

- **Non-Elective Admissions:**

3.16 The requirement is for activity to reach 100% of the 2019-20 baseline from April 2021 onwards and this has been reflected within both the CCG and NCA plans for both zero day and one+ day length of stay admissions.

Other Metrics / Activity Levels

- **Appointments in General Practice:**

3.17 The Long Term Plan (LTP) set a target for there to be 50 million more appointments in general practice by 2024 and the requirement for 2021-22 is for systems to demonstrate restoration to the 2019-20 baseline. The CCG's plan reflects the requirement though this is caveated by Ask My GP data not currently being included within the published data. It has been confirmed that this issue, which will impact all users of the Ask My GP software, has been escalated to NHS Digital.

- **Cancer Activity:**

3.18 There are two elements in 2021-22 for which CCG plans were required. The first, EB30, relates to outpatient appointments following a suspected cancer referral whilst the second, EB31, relates to the number of first treatments required following such a referral. In both cases, the requirement is for activity to be restored to the 2019-20 baseline level in addition to making up the shortfall of activity seen during 2020-21.

3.19 For EB30, the Bury plan requires 744 (+15.9%) more outpatient appointments between April and September 2021 than in the same period of 2019 whilst for EB31 the increase required is 84 more first treatments (+16%).

3.20 The methodology applied is aligned to that of the NCA and has been sense checked by the CCG's clinical lead for cancer. Data has shown that in each month since June 2020, suspected cancer referrals have been higher than in the equivalent month of the previous year and recent performance data has started to show an improvement in the number of patients seen within two weeks of their referral.

3.21 Oversight of cancer plans and performance is provided by the GM Cancer Alliance.

- **Learning Disability Metrics:**

3.22 The target in 2021-22 is for an annual health check to be completed for 70% of patients on the GP Learning Disability Register thus creating a target of 796 health checks for Bury based on a register size of 1112.

3.23 The plan requires a quarterly breakdown of projected health checks to be submitted. In previous years, the completion of health checks has tended to back-loaded, ie more completed in the second half of the year. For this reason, the proportion split seen in 2019-20 has been applied to 2021-22, resulting in a spread of 13.1% in Quarter 1, 15.3% in Quarter 2, 36.5% in Quarter 3 and 35.1% in Quarter 4.

3.24 The above plan has been shared and approved in principle by the CCG's Clinical Lead for Learning Disability services though the challenge this presents is acknowledged.

3.25 Plans are also required for the number of CCG-commissioned and NHSE-commissioned learning disability patients occupying inpatient beds.

3.26 During the pandemic, increased demand resulted in the number of both CCG and NHSE-commissioned inpatients exceeding the planned level set under the LTP. Discharge plans are underway for some patients and a realistic plan has been set that

shows a higher level of inpatients in the first half of the year with an expectation that this plan could reduce by year-end as discharge plans progress. This plan has been approved by the CCG's Director of Nursing and Quality Improvement.

- **2-hour Care Contacts:**

3.27 A plan is required that shows an increase in the number of referrals to the Rapid Response Team that are responded to with a care contact within two hours. Discussion has taken place with the Locality Care Organisation (LCO) and Rapid Response Team to arrive at a realistic increase. An average of the previous two quarters was used to provide a plan figure for Quarter 1 of 2021-22 with 10% added to each quarter thereafter.

4. Primary Care Workforce Plan

4.1 Workforce plans are required for a number of staffing groups that include: acute, community and ambulance; primary care; urgent community response; and mental health. CCGs are required to collate and submit the primary care element of this.

4.2 Roles within the plan are split between GPs, nurses, direct patient care roles (whether they be funded via the Additional Roles Reimbursement Scheme (ARRS) or not) and 'other' roles, eg administration or other non-clinical roles.

4.3 Across all groups, the data showed a workforce establishment of 477.22 whole time equivalent (wte) in 2020-21. Planned growth in 2021-22 shows this establishment increasing to 513.86 wte. This equates to a 7.7% increase with most growth expected in the ARRS funded direct patient care roles. In terms of a comparison against the actual number of staff in post at 31st March 2021, the plan represents an 18% increase. A breakdown of the plan by role type is included at Appendix B.

5. Conclusion

5.1 The CCG submitted its final activity and primary care workforce plans for 2021-22 in line with the timescale set by GM. As described earlier in this report, the activity plan was aligned as closely as possible with that of the NCA and other NES CCGs and has received input from CCG Clinical Leads, as appropriate.

5.2 There is opportunity for GM to provide feedback to CCGs and providers between the 25th May and the national submission date of 3rd June. At the time of this report, the CCG has not received feedback indicating amendment to the plan is required.

5.3 In time, further planning guidance is also expected to be published for the second half of 2021-22 and it is at this point that the impact of local transformation schemes, particularly in elective care and urgent care would be reflected in the CCG plan.

6 Actions Required

6.1 The audience of this report is asked to:

- Receive this report.

Susan Sawbridge
Head of Performance
May 2021

Appendix A: Summary of CCG Plan Assumptions for 2021-22

Indicator(s)	Basis of Plan	Concerns/Issues/Notes
All Indicators	Following investigation of differences between NHSE and CCG baselines in first submission, these were revised in line with NES colleagues and known issues. Some differences remain but generally smaller percentage variance and with CCG value higher than NHSE which will allow some leeway for under-performance in targets.	
Outpatients	Elective % targets	NF2F proportion based on NCA 41%. Smaller % seen in MFT assumptions but they are addressing known issues in recording NF2F.
Elective DC	Elective % targets	
Elective IP	Elective % targets	
A&E	100% of baseline	Possible change to Cat 3 in year at both NCA and MFT though this is likely to be in latter half of year.
NEL	100% of baseline	Covid levels estimated on last 6 mths 20/21
Diagnostics	Currently on run rate for Feb-21, as per NCA assumption. Except for Echos set at elective %s as would under-perform.	Due to the calculation of a run rate it is possible that monthly figures exceed 19/20 baseline levels. In this case we have capped at 100% of 19/20 as per NCA method.
A&G Requests	Run rate last 6 months, flatline projection, as per NCA assumption	May change as a result of outpatient transformation work but not before Q3/Q4.
PIFU	Set to zero as with NCA	May change as a result of outpatient transformation work but not before Q3/Q4.
GP Appts	Based on 100% of 19/20 baseline	Concern re recording of AskMyGp appts
LD Health Checks	796 (GM Target) for year, trajectory ramping to Q4 as per 19/20 model	Plan discussed and agreed with LD Clinical Lead
LD Inpatients	Trajectory set based on current position agreed by Director of Nursing & Quality	
SDEC Referrals	Confirmed that GM to complete	
2 hour care contacts	Q3/Q4 20/21 average taken as Q1 21/22 with 10% cumul inc by quarter	
Cancer 2WW/ 31 Day	19/20 plus shortfall in prev year	

	19/20 Activity	Est 20/21 Activity	21/22 Plan	% Var vs 19/20	% Var vs 20/21
Cancer 2WW	8952	7466	10430	16.51%	39.70%
Cancer 31 Day	1095	928	1274	16.35%	37.30%

Appendix B: NHS Bury CCG's Primary Care Workforce Plan for 2021-22

	Establishment	Baseline	Plan	Plan	Plan	Plan	Establishment
	2020/2021	Staff in post outturn	As at the end of June 2021	As at the end of September 2021	As at the end of December 2021	As at the end of March 2022	2021/2022
NHS Bury CCG	Year End (31st March 2021)	Year End (31st March 2021)	Q1	Q2	Q3	Q4	Whole Year
Workforce (WTE)	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Total by staff group							
GPs excluding registrars	105.34	95.50	101.16	103.17	103.17	104.59	104.59
Nurses	62.19	56.09	57.59	59.40	59.40	62.40	62.40
Direct Patient Care roles (ARRS funded)	15.00	15.00	18.00	46.00	46.00	46.00	46.00
Direct Patient Care roles (not ARRS funded)	43.56	41.30	44.01	44.22	45.02	45.02	45.02
Other – admin and non-clinical	251.13	227.74	249.15	250.81	251.55	255.85	255.85
Total Provider Workforce (WTE)	**477.22**	**435.63**	**469.91**	**503.6**	**505.14**	**513.86**	**513.86**

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Agenda Item 9

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Approve
Item No	9	**Confidential / Freedom of Information Status**	No
Title	Urology Services Across Bury, Oldham, Rochdale, and Salford		
Presented By	Will Blandamer, Executive Director of Commissioning Bury Council and Bury CCG		
Author	Mike Ryan, Head of Planning and Delivery, NCA North East Sector Commissioners		
Clinical Lead	Howard Hughes, Clinical Director		
Council Lead			

Executive Summary

A Greater Manchester (GM) Model of Care (MoC) for Benign Urology was developed through the GM Improving Specialist Care Programme. This hub and spoke configuration for the delivery of Benign Urology services has been endorsed by the Greater Manchester Joint Commissioning Board (JCB), though implementation has been delayed due to COVID-19.

As a result of the Pennine Acute Trust (PAT) transaction, in April 2021 responsibility for the provision of local Urology services in Bury, Rochdale and Oldham now rests with Salford Royal and will, on completion of the Transaction, formally transfer to NCA.

Colleagues from Bury, HMR, Oldham and Salford CCGs and the Northern Care Alliance (NCA) are jointly working together to improve local Urology services. This work is being overseen by a Programme Board, jointly chaired by two of the CCG Chief Clinical Officers.

This delivery model, which is designed to deliver high quality and accessible services for our patients, would see the establishment of a hub-and spoke model – connecting Salford Royal and Royal Oldham hospitals to locality based spokes, with most care delivered through locality based Urology Investigation Units (UIs).

This paper, which has been co-authored by the locality commissioners and the NCA, is seeking endorsement of the proposed pan-locality delivery model.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note the strategic direction of the Urology Reconfiguration Programme which is fully consistent with the Greater Manchester Model and the phased approach to mobilisation overseen by the Urology Reconfiguration Programme Board.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
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	☐

Implications						
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:						
Requirements re: consultation/engagement and impact assessments being considered by the Programme Board.						
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.		

Urology Services Across Bury, Oldham, Rochdale and Salford

1.0 Executive Summary

1.1 This paper will update Strategic Commissioning Board colleagues on the progress made in developing Urology Services.

1.2 Colleagues from Bury, HMR, Oldham and Salford CCGs and the Northern Care Alliance (NCA) are jointly working together to improve Urology services. This is being overseen by a Programme Board, jointly chaired by two of the CCG Chief Clinical Officers.

1.3 There are significant service resilience issues and unwarranted variation in Urology services within Greater Manchester (GM). In response to this, the GM Improving Specialist Care (ISC) programme developed a GM-wide Model of Care (GM MoC), which was subsequently endorsed by the GM Joint Commissioning Board (JCB).

1.4 The NCA provides most of the urological care for the populations Bury, Rochdale, Oldham and Salford. Working with local commissioners, a pan-locality delivery model has been developed which is fully aligned with GM ISC MoC.

1.5 This delivery model, which is designed to deliver high quality and accessible services for our patients, is described in more detail below but in essence would see the establishment of a hub-and spoke model – connecting Salford Royal and Royal Oldham hospitals to locality based spokes, with most care delivered through locality based Urology Investigation Units (UIs).

1.5 This paper, which has been co-authored by the locality commissioners and the NCA, is seeking that the SCB note the strategic development of the proposed pan-locality delivery model.

2.0 Background

2.1 A GM MoC for Benign Urology was developed through the ISC programme. This hub and spoke configuration for the delivery of Benign Urology services has been endorsed by the GM JCB, though implementation has been delayed due to COVID-19.

2.2 As a result of the Pennine Acute Trust (PAT) transaction, in April 2021 responsibility for the provision of local urology services in Bury, Rochdale and Oldham now rests with Salford Royal and will, on completion of the Transaction, formally transfer to NCA.

2.3 North Manchester General Hospital (NMGH) is currently the main delivery site for inpatient (IP) Urology services for Bury, Rochdale and Oldham, though – as part of the GM MoC – in the future this site will become a spoke, with IP activity undertaken at one of designated GM hub sites (of which there are anticipated to be five), with most IP activity flowing to Royal Oldham Hospital (ROH), Salford Royal Hospital (SRH) or Manchester Royal Infirmary (MRI).[1]

2.4 Currently 1 in 5 new patient pathways ends in a procedure and a minority of these require an IP stay. Around 80% of the IP activity undertaken at NMGH is from Bury, Oldham and HMR. At SRH the vast majority of IP activity is from the Salford locality.

[1] The other two hubs in GM would be Stepping Hill Hospital (Stockport) and Bolton Hospital).

3.0 The Proposed Pan-Locality Delivery Model

3.1 The proposed pan-locality delivery model is fully aligned to the approved GM MoC and will support the delivery of a single urology service across Bury, Rochdale, Oldham and Salford.

3.2 By delivering a more integrated model of care within each locality, only a small number of patients requiring an IP stay will need to move between sites, thus improving patient experience and continuity of care, reducing inefficiencies and maximising patient safety.

3.3 Key features of the pan-locality model are:

- A single comprehensive Benign Urology Service delivered across Bury, Rochdale, Oldham, and Salford.
- Hub-and-spoke delivery model –
  - ROH and SRH as inpatient hubs and Rochdale Infirmary and Fairfield General Hospital as spokes.
  - Virtual corridors running from Bury to Salford and Rochdale to Oldham.
- Single workforce within two integrated functional teams – NCA West & NCA East.
- Bury, Rochdale and Oldham IP activity currently undertaken at NMGH being aligned with the hub-and-spoke model but recognising that patients (and their GPs) will be free to choose their service provider.
- Expansion and enhancement of clinic & diagnostic capacity at each site in the form of UIUs - increasing local access to urology services.
- A full range of sub-speciality services (e.g. stone services, andrology etc.) will be offered, in line with the GM MOC.

3.4 A phased implementation of the pan-locality model is proposed, particularly recognising the dependency on estate developments (i.e. the delivery of the agreed capital development on the ROH site and the redevelopment of NMGH site).

3.5 The final end-state is delivery of the GM MoC. This will include decommissioning of PAT IP services at NMGH and the full establishment of both ROH and SRH as hub sites. It is anticipated that the most patients requiring an IP episode will be cared for at ROH, with some being cared for at SRH or MRI, depending on catchment areas.

4.0 Summary of Drivers for Change

4.1 The pan-locality delivery model is fully aligned to the approved GM MoC for Benign Urology and addresses the following drivers for change:

- Risks to service sustainability, ability to meet performance requirements (exacerbated by COVID), and inequalities in access. Implementation of the first phases of the pan-locality delivery model will begin to address these issues.
- Recommendations made in the national Getting It Right First Time (GIRFT) report for Benign Urology, largely relating to the reduction of unwarranted variation in both access and outcomes, and the future development of the urological workforce. The pan-locality delivery model addresses these issues.
- If a new delivery model is not implemented, there will be increased movements of patients between providers, impacting upon continuity of care.
- MFT's long term model sees no IP surgical activity being delivered at NMGH, reinforcing the need to establish a new model that delivers more care as close to home as possible.

5.0 Impact and Benefits

5.1 The pan-locality model will deliver high quality care for urology patients, address longstanding health inequalities, make the best possible use of available capacity, utilise new ways of working and increase the amount of care that is delivered locally.

5.2 The provision of UIUs in each locality will mean that several daycase and diagnostic procedures, where patients currently travel to an inpatient site, will be delivered closer to home. UIUs will also increase outpatient capacity in each locality. Discussions have commenced between Bury CCG Commissioners and NCA to scope the requirements for a UIU to support in the identification of suitable site(s) in the community from which to host the service. Access to diagnostics to support urology investigations will form part of the CCGs work to develop an overarching Diagnostic Strategy for Bury.

5.3 The provision of sub-speciality services will improve patient experience and outcomes.

5.4 Working as a single NCA-wide team will address long-standing sustainability issues, improve recruitment and retention of clinical staff, increase service resilience, and allow the development of pathways that will reduce unwarranted clinical variation.

5.5 The proposed hub-and-spoke arrangements would see Bury and Salford patients that are referred into the service having their IP episode at the Salford Royal hub site. Rochdale and Oldham patients referred into the service would be cared for at the ROH hub. Patients and GPs would, of course, continue to be able to choose other providers within GM.

5.6 This would mean that some patients who currently access IP services at NMGH may have to travel further e.g. patients in the south of Bury and Rochdale, though it is anticipated that as part of the GM MoC and MFT's plans there will not be an IP service on NMGH site.

5.7 An Equality Impact Assessment (EIA) was started by the GM ISC Programme board. This piece of work was paused as part of the COVID 19 response. At the time this document was approximately 70% complete.

5.8 Headline findings of the EIA so far include that the highest users of urology services are males aged 60+ and that distribution of 'BAME' to 'White British' patients for benign urology spells is reflective of the ethnic distribution of the wider GM population.

5.9 As part of the re-boot of the GM ISC programme the EIA document will be completed by the partnership. In addition, a local Bury specific EIA will be undertaken jointly through the Bury locality system.

5.10 Based upon 2019/20 data the number of elective episodes of care from each CCG area delivered at NMGH and therefore impacted by the GM MoC is as follows.

Bury CCG	HMR CCG	Oldham CCG	Salford CCG
776	822	813	No Change

6.0 Recommendations

6.1 Commissioners are asked to note the key design features of the pan-locality delivery model, which are fully consistent with the GM MoC, and the phased approach to mobilisation overseen by the Programme Board.

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Agenda Item 10

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Consider
Item No	10	**Confidential / Freedom of Information Status**	No
Title	Health and Housing: Update on the Bury Housing Strategy		
Presented By	Geoff Little, Chief Executive and Accountable Officer		
Author	Geoff Little		
Clinical Lead	Dr Jeff Schryer		
Council Lead	Councillor Clare Cummins, Cabinet Member for Housing Services		

Executive Summary

Safe, secure, affordable housing is critical in enabling people to work and take part in community life. The new Bury Housing Strategy recognises how important the right home is to having both good physical health and good mental health.

A workshop on housing and health was held with the Strategic Commissioning Board on 6 July 2020, with discussions from that session informing the development of the strategy. The draft strategy was subject to extensive stakeholder and public consultation for twelve weeks, with over 600 comments being generated and it was amended to reflect the feedback from the public. The Housing Strategy was approved by the Council's Cabinet on 26 May 2021 and this report details the health and housing specific parts of the strategy.

A strategic priority delivery plan has been developed which sets out the steps we will take towards more healthy housing, communities and places to take the pressure off our health systems, including through our One Commissioning Organisation and, by proactively addressing people's housing problems through our neighbourhood-based teams and homeless programmes.

Recommendations

It is recommended that the Strategic Commissioning Board:

Notes the update on the Housing Strategy and delivery of the strategic priority action plan.

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
The report links to the Locality Plan and the Let's Do It Strategy.	

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 new Bury Housing Strategy recognises how important the right home is to having both good physical health and good mental health.					
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	Yes	☐	No	☐	N/A	☒

Implications						
Assessment been completed?						
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**
Strategic Commissioning Board Workshop	06/07/2020	Discussions informed the development of the Housing Strategy.

1. Introduction

1.1 People are healthy when they are living well in their homes and neighbourhoods. The ability to secure a warm, safe home that is the right size and that meets particular needs at each stage of life in a neighbourhood we feel we 'fit' and with the support we need to live independently, is core to our happiness. It is the basis for good mental and physical health and a springboard to a good life at any age.

1.2 We want to drive up the number and quality of homes in the borough and to make sure that new homes are right for the location, offering people choice and helping our towns and neighbourhoods to thrive. The Housing Strategy sets out the steps we will take towards more healthy housing, communities and places to take the pressure off our health systems including through our One Commissioning Organisation and, by proactively addressing people's housing problems through our neighbourhood-based teams and homeless programmes.

1.3 A workshop on housing and health was held with the Strategic Commissioning Board on 6 July 2020, with discussions from that session informing the development of the strategy. The draft strategy was subject to extensive stakeholder and public consultation for twelve weeks, with over 600 comments being generated and it was amended to reflect the feedback from the public. The Housing Strategy was approved by the Council's Cabinet on 26 May 2021 and this report details the health and housing specific parts of the strategy.

Link to view the Housing Strategy
Link to view the Strategic Priority Delivery Plan

2. Healthy homes and households

2.1 Our vision in the Locality Plan is to improve health and wellbeing through working with communities and residents to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life. This means that people have good standards of living, a decent place to live and meaningful relationships with others as active members of society. The Housing Strategy aims to address health issues that are caused or exacerbated by unhealthy, unsuitable and unstable housing and unhealthy places, providing the right home environment enabling people to:-

- Manage their own health and care needs, including long term conditions.
- Live independently, safely and well in their own home for as long as they choose.
- Complete treatment and recover from substance misuse, tuberculosis or other ill-health.
- Move on successfully from homelessness or other traumatic life event.
- Access and sustain education, training and employment.
- Participate and contribute to society.

These can bring benefits to the wider health and care system, and can be a key factor in contributing to:

- Delaying and reducing the need for primary care and social care.
- Preventing hospital admissions.
- Enabling timely discharge from hospital and prevent re-admissions.
- Enabling rapid recovery from periods of ill health or planned admissions.

3. Integrating housing into the Bury neighbourhood model

3.1 There are many instances in which patients' or households' health problems are significantly exacerbated by their housing circumstances and where a change to their housing is needed to improve their health. Our new neighbourhood arrangements are the place where we are bringing together statutory services to respond to residents' health and social care issues through case management. Two programmes are relevant here: our new all-age early help teams and our integrated health and care teams, both of which will sit behind the community hubs. Key housing roles within these teams will provide direct access to housing experts who can broker a range of housing solutions for residents.

4. Targeting improvement of poor condition homes through neighbourhood profiles

4.1 The establishment of a 'data warehouse and engine room' will bring together and interpret data from a range of sources that shows where the biggest problems lie and the nature of those problems, as well as capturing trends. Data on Bury's house conditions, including owner occupied and private rented housing, will be brought into this data warehouse so that we can identify where unhealthy, unsuitable and unstable housing may be contributing to poor health and wellbeing. By disaggregating the data at a neighbourhood level and supplementing it with local intelligence, we will be able to determine who are those at most risk of accessing expensive care services, with a

view to targeting our resources at a sufficiently early stage so that demand on statutory services is reduced. Active case management through multi-disciplinary teams will continue to expand, to enable those most at risk to be identified and supported by health and care working together with other public services.

5. Minimising hospital stays, safe and secure discharge

5.1 Much of the Housing Strategy is aimed at providing enabling support that actively promotes wellbeing and prevents worsening of people's mental and physical health and enables them to live well within their own homes. We are also intending to take some specific actions at the interface with hospitals, both to avoid unnecessary and unplanned hospital admissions and to facilitate safe discharge. A hospital discharge protocol has recently been developed and introduced, with training for health and hospital colleagues. A project group is to be established which will ascertain the level of need for suitable step-down accommodation, with a protocol and clear pathways to be developed.

6. Mental Health

6.1 Housing is a central part of an effective recovery pathway for people with a serious mental health problem, as well as a key element in preventing ill health. We will seek out and examine best practice from other Council-NHS partnerships to identify the best forms of accommodation and tenancies to provide stability and support. We will work across the Council and CCG, including through the one public estates programme, to identify sites and bring forward funding to provide appropriate accommodation.

7. Addressing fuel poverty, helping people to keep their homes warm

7.1 The Council has taken action to reduce fuel poverty and help Bury residents to keep their homes warm over many years. The Council has facilitated the installation of energy efficiency measures in over 16,000 private sector homes attracting investment of over £12m, this has resulted in significant carbon savings and energy bill reductions. The Council is now exploring how ECO-funds can help our residents to stay warm. We are also engaged in a short Government-funded pilot programme to enforce the new minimum energy efficiency standards (MEES) in the private rented sector.

8. New homes for people with a physical disability

8.1 The Bury 2020 household survey has indicated that residents in 2,141 households (2.6%) require wheelchair adapted dwellings either now or within the next five years. Over the plan period, this number is expected increase by a further 132, resulting in an overall need for 2,274 wheelchair adapted dwellings. This will be achieved through the adaptation of existing properties and through newbuild. The Housing Strategy seeks to ensure that Bury's housing stock needs is accessible, which will be important for our ageing population and people with disabilities.

9. Housing Strategy: Strategic Priority Action Plan

9.1 The strategic priority action plan focuses on delivery of two specific priority areas which will have the biggest short to medium term impact on health and wellbeing for some specific groups in the borough, those being in addition to the wider population housing priorities such as affordable housing and improving energy efficiency.

Priority Area: Addressing the shortfall in housing provision for older people

Our Housing Needs Assessment is telling us that most people over the age of 65 want to continue to live in their current home, with support when needed. Finding new ways to support our expanding older population within their natural communities is a key focus for Bury and we have set the following objectives:-

- An evidenced based understanding of where the existing generation of older people and the next generation of older people are currently living in the borough; their health and aspirations for housing in old age over the next 25 years.
- Sites and buildings identified in the right locations for development and conversion/improvement to meet the local needs of the future older population of the borough.
- A programme of integrated commissioning for homes and services that support our older residential population.
- Increased housing choices for older people.

Priority Area: Increase housing options for specialist groups

Bury's aim is for everyone to live well within their homes and communities for as long as possible and to reduce the need for the more institutional settings such as care homes and specialist housing schemes, objectives include: -

- A finer grained evidenced based understanding of future needs including aspirations for supported housing over the next 25 years.
- Sites and buildings identified in the right locations for development and conversion/improvement to meet the needs of specialist groups including people with a learning disability.
- Increased housing choices for specialist groups including people with a learning disability.

10. Progress to date on the priority areas for health and wellbeing

10.1 An accommodation strategy/market position statement for people with social care needs, including older people and people with learning disabilities, is near completion. This will provide us with both current data and a future forecast of housing needs with an emphasis on neighbourhoods. This will be shared with registered housing provider partners to support future specialist housing development.

10.2 Work is also underway to review existing sheltered housing schemes for older people to allow us to improve existing housing stock for the future. Easy read versions of housing policies and documentation are being produced in partnership with voluntary, community and faith organisations. Registered housing provider partners are working with us regarding opportunistic developments.

10.3 Plans are in development to build on the site next to Peachment Place with supported living arrangements for people with physical or learning disabilities. Other sites are being reviewed for proposals of further developments.

11. Associated Risks

11.1 There are no risks associated with this report.

12. Recommendations

12.1 The Strategic Commissioning Board notes the update on the Housing Strategy and delivery of the strategic priority action plan.

Geoff Little, Chief Executive and Accountable Officer
g.little@bury.gov.ukj
June 2021

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Meeting: Strategic Commissioning Board			
Meeting Date	07 June 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	Yes	☐	No	☒	N/A	☐

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?						
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 childrens and adults mental health care along with an overview of the impact of the COVID-19 response to these areas as the locality moves through the COVID recovery phases.

2. Background

2.1. This paper is a summary of the information presented to the CCG's Quality and Performance Committee in May 2021 which related to the published position as at February 2021. However, where data for March 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 Following the reduction to NHS Incident Level 3 during March, to date the lockdown that began in January is being lifted in the phased manner outlined by the government with the most recent easing of lockdown having been enacted on 17th May.

3.2 Community transmissions and bed occupancy of COVID-19 positive patients continue to reduce with Fairfield General Hospital (FGH) bed occupancy standing at three on 13th May. A watchful eye is, however, being kept on the so-called 'Indian variant' of which there are reported cases within Bury.

3.3 In line with national planning guidance, the CCG submitted its draft activity plan for the first half of 2021-22 to the Greater Manchester Health and Social Care Partnership (GMHSCP) on 4th May, followed by the final plan on 25th May. GMHSCP will submit the final collated GM plan to NHS England on 3rd June.

3.4 Arrangements for the second half of the year will be confirmed once the future transmission of COVID-19 is better understood. A separate paper has been prepared for the Governing Body to enable sign-off of the CCG's plan.

3.5 Some national data collections remain paused for Quarter 1 of 2021-22. Of those submitted by the CCG, eg Personal Health Budgets and Wheelchair Waiting Times, the indication is that these are likely to be resumed in Quarter 2.

3.6 It has been confirmed that Bury's COVID-19 Management Service (CMS) will cease to operate on 30th June 2021. From that point on, patients requiring primary care support will be managed by their GP practice.

Planned (Elective) Care

3.6 Transaction of the North Manchester General Hospital (NMGH) site to Manchester University Foundation Trust (MFT) was completed by 1st April with the transaction of the remaining Pennine Acute Hospital Trusts (PAHT) sites to the Northern Care Alliance (NCA) scheduled to be completed by the end of September 2021.

3.7 The second and third in a series of workshops led by the Bury Elective Recovery and Transformation Group took place in April and May, respectively. The output from the second workshop enabled refinement of potential transformation schemes to be commenced during the third session. Several task and finish groups will now be established to progress delivery of quick wins and longer term developments.

3.8 In line with GM-level plans around the restoration of elective activity, trauma and orthopaedic (T&O) surgical cases are now being undertaken at the FGH site with those patients in greatest clinical need and those waiting the longest being prioritised. A small number of gynaecology and general surgery procedures also commenced at FGH in late-April alongside some paediatric Ear Nose and Throat (ENT) activity at Royal Oldham. Elective capacity will be expanded to other specialties in line with both the GM plans and the 'Green Floor' development at FGH.

3.9 A priority of the planning guidance for 2021-22 is for the restoration of activity to be accelerated and to implement outpatient transformation in a way that addresses health inequalities and manages those waiting the longest.

3.10 The waiting list increased further across February and March, finishing with 18853 incomplete pathways by year-end. This is 19.3% above the original target for the year though 2.4% below the level set in the Phase 3 plan. Across 2020-21, the largest increase in waiting list size has been in gastroenterology which has grown from 1183 patients waiting in January 2020 to 2423 by March 2021 (+105%). Other significant increases have been seen in gynaecology (+59.2%), T&O (+42.3%) and general surgery (+65.5%). Reductions against the January 2020 baseline are most notable in cardiology (-34.6%), dermatology (-22%) and thoracic medicine (-37.4%).

3.11 Specialty level developments continue at both a Bury and a GM level, for example, a new Referral Assessment Service (RAS) commenced recently in dermatology and implementation of a new glaucoma pathway continues in ophthalmology. The CCG is fully engaged with the GM elective work programme which has set T&O, ophthalmology, paediatrics, gynaecology, general surgery and ENT as priority areas for development. Oversight of this programme is via the GM Elective Care Reform Board.

3.12 By year-end, there had been 9314 breaches against the 52 week RTT standard, with 1697 new breaches reported in March 2021 (an individual patient may be counted multiple times if the breach spans more than one month). This position is 73% above the predicted level set in the Phase 3 plan. Gynaecology, gastroenterology and 'other' (includes colorectal) saw the biggest increases in March whilst a reduction was seen in T&O, ENT and Ophthalmology. For T&O and ENT, this may be a result of the elective surgery that has now restarted at the FGH site.

3.13 There has been recent improvement in Bury's diagnostic performance and although this remains significantly above the national target, the variance to performance at a GM or national level has now started to reduce. An improvement plan is, however, in place at

NCA and the trust is now reporting an improving picture with additional capacity coming on-line through a combination of out-sourcing, recruitment and an additional CT scanner. Plans are progressing within the locality with regard to the implementation of Community Diagnostic Hubs (CDH). Feedback from clinicians within Bury has been fed into the process for development of the CDH model.

Cancer Care

3.14 Recovery of suspected cancer referral levels is being sustained in Bury though variance continues between tumour groups with suspected lung cancer referrals remaining approximately 50% below the pre-COVID-19 level. E-Referral Service (eRS) data does, however, show lung referrals to have been higher in March 21 than at any point in 2020-21. The reduction in lung referrals is off-set by a similar increase in suspected gastrointestinal cancer referrals.

3.15 Planning requirements for 2021-22 are for an increase in initial outpatient appointments and first treatments to provide sufficient capacity to both recover and address the COVID-19 related shortfall alongside reducing the number of patients waiting beyond 62 days and 104 days for treatment.

3.16 GM CCGs have approved recurrent funding for existing transformation initiatives that ensure continuation of services aligned to operational planning guidance and service recovery. These include Best Timed Pathways (BTP), Prehab4Cancer and CURE.

3.17 In terms of performance against the NHS Constitution standards, the picture remains mixed though improvement is noted in the most recent data for March. For the two week wait (2WW) standard, performance in March 2021 was just below target and is the highest performance level seen since July 2020. At a tumour group level, achievement was noted for breast for the first time in several months and there was a further reduction in the number of skin breaches. Improvement in breast has been the result of recruitment to both locum and substantive Consultant posts alongside additional ad-hoc clinic provision. The breast service moved to Manchester Foundation Trust (MFT) as part of the NMGH transaction on 1st April 2021.

3.18 In dermatology, there has been significant improvement at NCA over recent months though this improvement is at some risk currently due to the increase in referrals seen recently in all CCG areas. A specialty level improvement plan is in place and progress against this is monitored via the NCA Cancer Improvement Committee. Ultimately, the NCA is aiming to expand the one-stop clinic model into community settings also.

3.19 The NCA improvement plan that was signed off during March 2021 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 and the most recent data shows a reduction in these numbers.

Urgent Care

3.20 Performance at PAHT against the A&E four hour wait standard remains below target though this is reflected across GM too. Data for February and March, however, shows a significant improvement in the number of 12 hour trolley waits, with zero breaches reported in March.

3.21 During March and April 2021, A&E attendances at the FGH site increased significantly, with an average of 197 attendances per day seen. This is now just 7.5% below the level seen in the same period of 2019-20. A&E attendances have increased at other GM sites too and this is currently receiving focus from the North West region. Work is ongoing within the locality to better understand the current position and there are plans to increase streaming capacity at the FGH site. Initially, the increase in attendances had a negative impact on performance at FGH though some improvement is now noted.

3.22 Implementation of the urgent care redesign programme in Bury continues with planning for Phase 2 underway. This will include the capital works required to develop a new purpose built Urgent Treatment Centre (UTC).

3.23 Renewed focus on discharge planning has resulted in improvements in patient flow and continued strong performance at PAHT is evident for patients with a length of stay of 7 days or more (stranded) and 21 days or more (super-stranded). National planning guidance for 2021-22 has confirmed that funding for discharge placements will continue for six months. Six week placements will continue to be funded during Quarter 1 with a reduction to four weeks in Quarter 2. A planning requirement for 2021-22 is for length of stay to continue to reduce, particularly for stays longer than 14 and 21 days.

3.24 Implementation of the Intermediate Care programme continues with notice having been served to the NCA on the service previously provided. The Locality Care Organisation (LCO) remains on target to implement the changes by summer 2021.

3.25 A Bury system-wide 'show and tell' event is being planned for June 2021 where information about current urgent care provision and updates on transformation scheme development will be shared.

Mental Health

3.26 Strong performance continues for both the Dementia Diagnosis and the Early Intervention in Psychosis standards.

3.27 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 six 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 large numbers. Digital therapy for IAPT continues via Silver Cloud for which waiting times are reportedly significantly shorter than for clinician-facing therapy.

3.28 A locality meeting is currently being set up to progress discussion around demand and capacity modelling within the IAPT service that takes the newer delivery methods into account.

3.29 A number of locally commissioned schemes to improve access to services have commenced in recent months. These include the urgent care by appointment for mental health scheme, the embedding of mental health practitioners within each of Bury's Integrated Neighbourhood Teams (INT), dedicated support to homeless people to support access to services and a Consultant Access Service which was launched during autumn 2020. Additionally, Bury's newly commissioned Community Crisis Service became operational during April 2021. This is a 12 month pilot operating across three

evenings and five days per week.

3.30 A requirement of the 2021-22 planning process is for all CCGs to meet the Mental Health Investment Standard (MHIS). There will also be service development funding that will flow in line with implementation plans.

3.31 Ramsbottom Ward at the FGH site is now confirmed to be single gender following the completion of a capital works programme though does at this stage remain mixed specialty, admitting patients with either an organic or functional diagnosis.

Maternity and Childrens Performance Measures

3.32 Following the significant increase in referrals to the Pennine Care Foundation Trust (PCFT) Healthy Young Minds (HYM) service between September and December 2020, a reduction was noted in January and February though this was then followed by a significant increase in March. Across Quarter 4 as a whole, referrals were 0.8% higher than in the same period of the previous year whilst referrals in Quarter 3 had been 35% higher than the previous year. 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 future demand. This includes the commissioning of a new advice line which will be operational for six months initially and which will sign-post CYP to relevant support.

3.33 Unusually, the standard for children and young people (CYP) accessing the Community Eating Disorder Service (CEDS) was not achieved in Quarter 3 though provisional data for Quarter 4 shows a return to 100% performance. All urgent cases referred across 2020-21 to date have been seen within the required one week timeframe.

3.34 With regard to the CYP Access Rate measure, provisional data for Quarter 4 suggests the annual target has not been achieved and this is likely to be confirmed once final data is published. This is, however, in the context of a much higher target for Bury in 2020-21.

3.35 For 2021-22, the metric is changing to include CYP with at least one treatment contact during the reporting period (this is currently two or more contacts). Confirmation of Bury's target against the revised measure is awaited.

3.36 A number of initiatives, both within the locality and across GM, remain in place to increase the options for additional support to CYP during the pandemic. These include text and online platforms about which the CCG's communications team continues to raise awareness of options available.

4 Actions Required

4.1 The audience of this report is asked to:

- Receive this report.

Susan Sawbridge
Head of Performance
May 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%	Apr-21	79.4%	77.7%	82.0%	85.4%
A&E 12 Hour Trolley Wait	0	Apr-21	34	21	116	523
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	Mar-21	2301	384	6327	38812
Super-Stranded Patients (LOS 21+ Days)	Null	Mar-21	869	123	2430	13418
Referral To Treatment - 18 Weeks	92.0%	Mar-21	62.1%	62.2%	64.1%	64.4%
Referral To Treatment - 52+ Weeks	0	Mar-21	29896	1697	61869	437329
Diagnostics Tests Waiting Times	1.0%	Mar-21	29.3%	36.6%	25.9%	24.3%
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93.0%	Mar-21	94.9%	91.5%	94.3%	91.3%
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93.0%	Mar-21	70.6%	60.2%	77.7%	76.9%
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96.0%	Mar-21	96.8%	98.1%	96.0%	94.7%
Cancer - 31-Day Wait For Subsequent Surgery	94.0%	Mar-21	94.9%	100.0%	90.4%	86.4%
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98.0%	Mar-21	100.0%	100.0%	99.6%	99.0%
Cancer - 31-Day Wait For Subsequent Radiotherapy	94.0%	Mar-21	100.0%	100.0%	99.9%	97.9%
Cancer - 62-Day Wait From Referral To Treatment	85.0%	Mar-21	72.1%	50.0%	73.0%	73.9%
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90.0%	Mar-21	72.6%	50.0%	75.8%	75.1%
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade	Null	Mar-21	83.7%	95.7%	84.6%	82.3%
Cancer - 104-Day Wait	0.0%	Mar-21	65	11	187	1476
Breast Cancer Screening Coverage (Aged 50-70)	70.0%	Aug-20	64.5%	63.9%	61.7%	63.7%
Bowel Cancer Screening Uptake (Aged 60-74)	60.0%	Aug-20	64.5%	63.9%	65.0%	66.1%
Cervical Cancer Screening Coverage (Aged Under 50)	80.0%	Dec-20	68.0%	70.2%	69.3%	68.1%
Cervical Cancer Screening Coverage (Aged 50-64)	80.0%	Dec-20	74.2%	74.5%	74.2%	75.0%
MRSA	0.0%	Mar-21	3	0	5	55
E.Coli	Null	Mar-21	122	6	364	3245
Estimated Diagnosis Rate for People with Dementia	66.7%	Apr-21	68.20%	74.2%	65.6%	61.7%
Improving Access to Psychological Therapies Access Rate	5.3%	Feb-21	4.19%	2.28%	3.71%	4.34%
Improving Access to Psychological Therapies Recovery Rate	50.0%	Feb-21	47.0%	49.4%	48.6%	50.6%
Improving Access to Psychological Therapies Seen Within 6 Weeks	75.0%	Feb-21	84.5%	62.5%	87.7%	92.3%
Improving Access to Psychological Therapies Seen Within 18 Weeks	95.0%	Feb-21	98.2%	100.0%	97.4%	98.7%
Early Intervention in Psychosis - Treated Within 2 Weeks of Referral	56.0%	Feb-21	78.8%	85.0%	54.4%	71.5%
First Treatment For Eating Disorders Within 1 Week Of Urgent Referral	95.0%	Feb-21	100.0%	100.0%	65.6%	72.7%
First Treatment For Eating Disorders Within 4 Weeks Of Routine Referral	95.0%	Feb-21	93.3%	100.0%	72.5%	74.6%
Access Rate to Children and Young People's Mental Health Services	34.0%	Feb-21	45.0%	47.8%	42.1%	40.2%
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	Feb-21	06:38	07:00	07:12	06:51
Ambulance: Category 1 90th Percentile	900	Feb-21	10:48	11:37	12:10	12:06
Ambulance: Category 2 Average Response Time	1080	Feb-21	19:04	18:58	21:04	18:19
Ambulance: Category 2 90th Percentile	2400	Feb-21	37:01	34:19	42:39	36:04
Ambulance: Handover Delays (>60 Mins)	Null	Mar-21	1.4%	1.9%	1.0%	1.9%
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 14/05/2021. Assurance>Greater Mancheser Constitutional Standards Summary/Constitutional Standards Summary

Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Information
Item No	13	**Confidential / Freedom of Information Status**	No
Title	Bury System / Transition Board Meeting		
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 the Bury Transition Board Meeting held on 15 April 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the Minutes of the Bury Transition Board Meeting held on 15 April 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 requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐

Implications						
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
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 Transition Board	15 April 2021	Minutes being submitted for ratification

Title	**Minutes of the Bury System/Transition Board** **15th April 2021**
Author	Lindsay Johnson
Version	1.0
Target Audience	Members of the Bury System/Transition Board
Date Created	
Date of Issue	
To be Agreed	20th May 2021
Document Status (Draft/Final)	Final

Document History:

Date	Version	Author	Notes
15/4/2021	1	Lindsay Johnson	Sent to Jeff Schryer for review
20/05/2021			Approved by System/Transition Board

Approved:	
Signature:	.....

Bury System/Transition Board

MINUTES OF MEETING
15 April 2021, 10.30 am – 12.30 pm Via Teams **Chair –** Dr Jeff Schryer

Present:

Dr Jeff Schryer, Chair Bury CCG
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)
Mr Chris O'Gorman, Independent Chair, LCO Board (CO'G)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH
Ms Julie Gonda, Director of Community Commissioning (DASS) (JG
Ms Mui Wan, Associate Director of Finance, Bury LCO (MW)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council
Ms Penny Martin, Interim Director of Operations, Bury Care Organisation (PM)
Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Ms Sheila Durr, Executive Director Children and Young People, Bury Council (SD)
Cllr Eamonn O'Brien, Leader of the Council (EO'B)
Ms Lisa Kitto, Interim Director of Financial Transformation (LK)
Ms Sian Wimbury,(for Keith Walker) Network Director of Operations: Mental Health, PCFT (SW)
Ms Pat Crawford, Interim CFO, Bury CCG (PC)
Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation (TR)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)

Others in attendance:
Mrs Lindsay Johnson, Committee Secretary, Bury CCG (Minutes)

Apologies

Apologies for absence were received from:
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council
Dr Kiran Patel, Medical Director, Bury LCO
Ms Lynne Ridsdale, Deputy Chief Executive, Corporate Core
Mr Ian Mello, Director of Secondary Care Commissioning, Bury CCG

MEETING NARRATIVE & OUTCOMES

1.	**Welcome and Apologies**
1.1	The Chair welcomed those present to the Bury System/Transition Board and apologies were noted as outlined above.
2.	**Declarations of Interest**
2.1	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.
2.1	There were no declarations of interest to record.

3.	**Minutes of Last Meeting (16 March 2021)**
3.1	The minutes of the previous meeting held on 16th March 2021 were reviewed. The minutes were approved as a true record.
4.	**Review of Action Log**
4.1	The Action Log was noted.
	TRANSITION PROGRAMME
5.	**Transition Update**
5(i)	**GM ICS**
5.1	A verbal update was provided by Mr Geoff Little on the GM ICS with the following key points highlighted to the System Board:- • Series of 4 workshops would be taking place for all partners across GM with Bury having 8 places available. Currently identifying individuals to attend the workshops representing Clinical Leads, Political Leaders as well as Commissioners and the CCG. Mr Little said it was essential to get the representatives right in attending the workshops. • The workshops were highlighted as being critical to ensure the designing of the ICS, in creating what is right for GM and what is right for the Bury Locality. Mr Little said it was important to ensure that we continue to move Bury forward on the devolution journey. • Mr Little commented also that the workshops would need to look at the following areas; allocation of functions, discussion around financial flows, governance and clinical leadership. • In terms of allocation of functions, detailed discussion should be around planning of those to identify where best these be located. • In terms of Financial Flows; it was reported that employment of staff would be part of the ICS and then be deployed back into the localities. Discussion would need to take place around delegation of funding into Bury ensuring the correct S75 agreement was in place for the pooled budget. • In terms of Governance, Mr Little highlighted that the White Paper refers to two boards and currently there is one board at GM at the moment. He said discussion surrounding this was essential as it was important that the 10 localities continue working with GM Partners as one system and therefore a two tiered approach may not necessarily be the right way forward. • In terms of Clinical Leadership; it was noted that work continues at GM level at the moment with a need to look at how Bury develops its own Clinical Senate from the Primary Care networks and at strategic level across the borough, along with a requirement to not lose the executive leadership also.
5.2	Mr Little concluded his verbal update advising that each workshop would be built upon and a combination of each workshop would then present a steer forward.
5.3	The agenda item was opened up for comments and questions.
5.4	The Chair referred to the employment of staff advising that he understood that the CCG Staff would retain their NHS Contracts and enquired therefore on where the discussions were happening around the equitable distribution of staff. He said that it was important to make sure that the allocation of staff back into areas (especially in relation to Bury) was equitable and/or if not identify the extra support needed.

5.5	Mr Little informed the System Board that a set of principles would need to be established to guide the workforce part of this change. Mr Little outlined that this would require good change management practice, listening to staff and being transparent in communications to design what is right for Bury. This would also allow the shaping of a structure and providing a change management function and integrated working.
5(ii) & 5(iii)	**Bury Update**
5.6	Ms Wynne-Jones gave an update on the Bury Locality Transition Programme and the Integrated Delivery Collaborative. Ms Wynne-Jones highlighted key points from both sets of slides issued in the pack.
5.7	**Bury Transition Programme** **System Governance Documentation** • First draft available of the Terms of Reference for the Bury Locality System Board. Ms Wynne-Jones explained Children's Representatives, Housing and Social Care Representatives were to be included and discussions were underway as to who the representatives would be. Ms Wynne-Jones said this was about the need to develop the right connections with the right people. • Locality Plan refresh is being led by Mr Will Blandamer and in terms of the alliance agreement with neighbourhoods, Ms Wynne-Jones advised that there would be a need to think about how they operate and their expectations around delivery outcomes. She said discussion was underway with IMT and Team Leaders on how this might develop.
5.8	**Establishing the Integrated Delivery Collaborative** Slide 2 was highlighted which described the Proposed Role of the Integrated Delivery Collaborative. The diagram outlined the following;
5.9	**A Focus on Neighbourhood Delivery** Ms Wynne-Jones said the key questions were around; what would be the ask from individual services to contribute to the neighbourhood delivery and how would we connect to the population in different ways?
5.10	**Development Priorities** It was noted that Mr Howard Hughes would be leading the workstream to drive the programmes of change and that discussions around frailty were taking place to see how this could be established as a programme.
5.11	**Integrated Service Delivery** The System Board was advised that this was about bringing everything into the scope of service delivery arrangements, delivering standards and how integration between teams would be carried out.
5.12	**System Assurance** This would be a programme of work being carried out in the Summer as well as linking into GM ICS.
5.13	**Clinical Senate** In terms of a Clinical and Professional Senate, Ms Wynne-Jones said that this was around supporting the Clinical and Professional Senate from a system board and collaborative perspective.

5.14	**IDC Board Proposal** This slide brought to the attention of the System Board, the information around the Board meetings and the new meeting structure, describing the content of how they would work.
5.15	**IDC Management Proposal** This slide outlined the changes to the management team and how it will be structured based on the new pillars of work. It outlined that membership would be expanded and would include OCO and Broader PR representatives.
5.16	The items were opened up for comment and discussion.
5.17	Mr Little referred to the neighbourhood working information and advised that a discussion had taken place at the Strategic Commissioning Board meeting on how there will be a focus on health and wellbeing in Radcliffe. Mr Little said we should now use our opportunities in Radcliffe to move into the right direction and as such said he would welcome further discussion around neighbourhoods.
5.18	Mr Little said it was also important to balance the budget this coming year and that focus needed to be translated into the programme of delivery. He said that development priorities will achieve larger savings in the current services and that the neighbourhoods focus is more around formal transformation change that will reduce increase in demand over time.
5.19	Ms Wynne-Jones outlined to the System Board that she and Miss Pat Crawford had discussed how the economics were to be managed at the Strategic Finance Group and how allocations would be managed across each area in order to maximise programmes of care and change. Ms Wynne-Jones confirmed that this was a detailed piece of work being carried out that would be brought back for further update.
5.20	The Chair said he welcomed the information as listed in the Neighbourhood Delivery, however said that it was also about how we ensure primary care, the clinical team and the council team work together. He also said there was an element of linking into communities and how people can inform their neighbourhood teams, the system and Bury the place. The Chair said this was a great piece of work and he was pleased to see progress.
5.21	In terms of the enablers, Ms Wynne-Jones outlined that this would be around using the existing forums that are in place; however there was a need to ensure that agendas, report mechanisms are in place in order to support the architecture.
5.22	Mr Little suggested that inequality perceived through Covid is considered also with more focus on some cohorts and parts of the borough (based on geographic deprivation) where this overlaps with communities. Mr Little was advised that as part of the neighbourhood agreement, work would be taking place looking at the inequalities across the dashboard and how that might translate to indicators. He was informed that although this was in its early stages, it was something that needed to be embedded as part of the neighbourhood agreement.
5.23	The agenda item was concluded and the System Board agreed therefore that as part of the Integrated Delivery Collaborative they would like to see an update paper update paper/presentation to submitted to their June meeting. The System Board agreed that the update paper would need to cover multiple areas such as; • Neighbourhood Team Expectations • How the different teams will be working together

	• Expectations across the system • How we develop a people voice
6.	**Clinical and Professional Senate**
6.1	Mr Hughes gave an update on Clinical and Professional Senate. He referred to the detail in the paper which advised that; the CCGs gave GPs control over local NHS spend and within Bury and as such this led to the creation of a Governing Body with an elected Clinical chair and four elected clinical directors. The role of these clinicians was to provide clinical leadership to the organisation and ensure that grassroots clinical insight helped drive forward change.
6.2	The paper also stated that a clinical cabinet was set up where the clinical leads came together with senior managers and some partners to make delegated decisions on commissioning priorities, approve strategies, peer review the work of the clinical leads and to provide wide ranging clinical advice to the system. The paper started to map out what it may look like, how it may work and at what level it would operate. It also explored how clinical influence and leadership could be maintained across the integrated delivery collaborative board and its subgroups.
6.3	Mr Hughes asked for guidance from the System Board in agreeing an interim senate and any other direction they wished to provide.
6.4	Mr Roberts informed the System Board that there was a lot of national focus on Clinical and Professional Senate and that a debate had also taken place with the NW Director of Nursing and College of Nursing surrounding this. Mr Roberts gave his support on the direction of travel as proposed in the paper. He did however refer to the Professional Senate Draft Proposed Membership and in particular to Nursing representatives. Mr Hughes outlined that discussions had taken place around matching clinical and professional input and those whom would fairly represent the roles at the Senate, he however agreed for further conversations to take place on this.
6.5	The Chair commented that there was a need to ensure there were different professions representing different backgrounds and that it was important to look at what skills were needed ensuring they were transferrable.
6.6	The meeting was informed that Ms Wynne-Jones, Mr Hughes, and Dr Kiran Patel were in active discussions around how the Senate would support delivery collaboration. Ms Wynne-Jones said it was important to get a balance of individuals and sectors as well as looking at the role of the GP and neighbourhood GP and how that relationship would connect to the Clinical Directors.
6.7	Mr Little commented that he was pleased to see the level of detail provided. He suggested that going forward, the right resources needed to be in place in order to support the level of leadership. In terms of local leadership, he said the clinical leaders need to be professionally informed in order to have the level of strategic leadership and decision making required.
6.8	Ms Darley commented that it was important that conversations take place around principle and inclusion and how individuals would be represented and to seek those opinions and feedback. Ms Jackson agreed and said the roles needed to be clearly defined and there was a need to build on the development of the talent pool in place as well as considering those that cannot apply due to the infrastructure in place currently. The Chair said this was a helpful point in relation to identifying the principles and that it was essential to bear in mind that the resources were sufficient and of the efficiencies needed against time and inclusivity.
6.9	Ms Wimbury commented that it was also important to get that voice for Mental Health and Mental Wellbeing as well as engagement within the 3rd sector. Ms Wimbury said it was essential to recognise that the patient voice for mental health was meaningful and current. Ms Gonda agreed and said there was the need for this to be balanced and suggested a review point be built in to take some feedback.

6.10	Mr O'Gorman suggested that part of the conversation should be around a network of professional leadership and professional relationships and how they link into the different parts of the system. Mr O'Gorman also gave support to wanting to get a system to work as described.
6.11	Mr Hughes that the Neighbourhood GP would be a good way of understanding the challenges faced. He said if the Senate is going to provide dovetail leadership with the System Board then there would be a need to understand the GP hierarchy. Mr Hughes also outlined that it was important to look at the workforce to ensure it was able to influence and deliver change across the Integrated Service Delivery. Mr Hughes said there was a need to identify leaders and understand if PCNs are delivering a separate agenda. In terms of Mental Health he confirmed that it was essential to encapsulate mental health as a speciality.
6.12	Ms Wynne-Jones highlighted to the System Board that this was going to be a really important development and piece of work between the System Board and Delivery Collaborative and that there was a need to plan in diaries and structure agendas to allow for those developmental conversations.
6.13	Mr Hughes concluded his update advising that some of the membership listed was an interim measure whilst this continued to work forward.
6.14	In terms of next steps it was agreed that Mr Hughes to bring back an update paper to the May System Transition Board meeting. The report should outline the following for the System Board Members to consider:- • Draft Interim Membership of the Senate • Progress update • Timeline mapping out the future
6.15	Mr Hughes proposed that local workshops take place in relation to the Clinical Senate and it was enquired whether any off line discussions could take place, looking at the future dates of the System Transition Board meetings and whether any of those could incorporate a workshop or become a workshop session. **Action for Mr Hughes to link in with Jill Stott with regard to the meeting dates. (ref A/04/01)**

SYSTEM BOARD

7.	**Palliative and EOL Care Update**
7.1	Lindsey Darley presented the Palliative and EOL Care proposed model of care.
7.2	The paper submitted provided an overview of the work done following the development of the Bury Palliative and EoL Care Framework 2019 – 2022 to review and develop proposals of the redesign of Bury's Palliative and End of Life Care system. It set out the proposed new model of palliative and end of life care and the workforce, information system, commissioning changes and investment required to deliver the model.
7.3	The paper also set out what will be different especially for people and their carers, and the outcomes that the new model of service delivered.
7.4	The main areas of the presentation slides were as follows:- • Design Process Management • Design • Diagnostic and Lived Experience Report Findings • Vision • NW EOL Palliative Pathway • Information around what will be different

	• Identification • Assessment and Care Planning • Communication and Coordination • Delivery of Care • Carer Support • Plan of Care for the last days of life • Bereavement Support • Specialist Tier • Core Workforce Tier • Universal Workforce Tier • Lived Experience Recommendations • Success Measures • Draft Performance Measures • Financial System Impact • Identified Financial Gaps • Mobilisation • Recommendations
7.5	In terms of the Financial Model provided in the pack, Ms Darley stated that the intention was to keep within the financial envelope.
7.6	The agenda item was opened up for discussion and comments.
7.7	Miss Crawford raised a general issue around Finance Governance and outlined that if there was a financial ask, she would like to see those in advance and further enquired what the governance approval would be and if this would be submitted to the Strategic Finance Group for approval? Ms Wynne-Jones advised that there was a need to review governance in relation to where businesses cases go for approval. Ms Jackson also highlighted that at the Urgent Care Clinical Group there was a paper submitted for a Paediatric Nurse Practitioner Post and as such she was not sure where those conversations and proposals were happening?
7.8	In terms of other programmes, it was noted that a stock take on all of programmes in May and June would be carried out which would identify what the success metrics were and the budgets that need to be lived within.
7.9	The Chair commented that clarity was required around the Governance aspect and as such it was agreed for Ms Wynne-Jones and Mr Blandamer to take away an action in regard to this.
7.10	The System Board reviewed and **agreed** the recommendations in the report as follows:- Recommendation 1 **– Endorsed** the new Palliative and End of Life care Model and the system move towards implementation within the current resource envelope. Recommendation 2 **– Supported** the development of the suggested success measures into key indicators within the System Apex report. Recommendation 3 **– Recognised** the key gap of a Palliative Care Consultant and **supported** the move to development of a business case in order to support funding of a Palliative care Consultant and medical Secretary support. Recommendation 4 **– Endorsed** the move to the proposed use of EARLY, GMCR and EPaCCS information systems, previously considered by Digital Board, within the existing local and GM funding arrangements.

	Recommendation 5 **– Endorsed** the move to the proposed use of IPOS through exploration with Health Innovation Manchester. Recommendation 6 **– Acknowledged** the resource impact through application of the Financial impact Framework described. Recommendation 7 **– Acknowledged** the interdependency with the planned CHC review. Recommendation 8 **- Recommended** Option 2 where Specialist Palliative Care contracts are devolved down to place level. Decisions about how and who would deliver each aspect of the service would be decided at this level.
8.	**Elective Care Update**
8.1	Penny Martin presented the Elective Care Update, Building Back Better.
8.2	The information provided outlined that COVID 19 had significantly impacted upon the delivery of acute services across the NHS. Despite Bury having high quality health services across primary, community, secondary care and the third sector the scale and the depth of the impact of COVID means that the current models of care can't address the problem and support the recovery required. The report confirmed that there had been exacerbation of pre-existing access and waiting time pressures and considerable increase in the time patients are waiting to receive non-urgent treatments.
8.3	The System Board were made aware that the NCA, Bury OCO and wider partners were driving forward a joint programme of work to radically change current ways of delivering acute care to patients and respond at pace. They noted that the key focus would be to address health inequalities and inclusion at a neighbourhood level.
8.4	In terms of Elective Care Performance, the System Board noted that the programme detailed the key principles along with looking at tackling inequalities within neighbourhoods and the Bury systemwide roadmap.
8.5	Ms Martin informed the System Board that the next key event was 26th April.
8.6	The Chair enquired where patients fit into the discussions. Ms Martin advised that there would be a clinical discussion whereby information such as that would need to surface for further discussion and consideration. She also said coproduction was essential and how it linked into local populations with the need to understand how this could be done in the right way. Ms Martin outlined that there was more work to do in relation to this.
8.7	Ms Darley confirmed that from a neighbourhood perspective the IMT Leads were engaged in this; however she gave a note of caution in relation to capacity of delivery through the neighbourhoods. In terms of frailty Ms Darley said there was a need to be mindful to not lose sight of frailty and frailty levels and scope this into earlier discussions.
8.8	The System Board welcomed a further update when required.
9.	**Bury Local Care Approach: Final Evaluation**
9.1	The report submitted formed part of an evaluation of the local care approach to health and social care in six localities of Greater Manchester: Bolton, Bury, Oldham, Rochdale, Trafford, and Wigan. The evaluation was commissioned by the six localities and the Greater Manchester Health and Social Care Partnership (GMHSCP) and is being conducted by a partnership of specialist organisations: Cordis Bright, PPL, Traverse and COBIC. Paper here for information. A lot of positive feedback that gives real evidence and strong foundation on what was built through integration and its journey.
9.2	The final summative report summarised findings from the three phases of evaluation of the local care approach in Bury. We highlight the evolution of the local care approach and its structures and examine what has been achieved.

9.3	The evaluation focused on the implementation of two core strands of the transformed community services offer in Bury: the **intermediate tier** and the **INTs**. Significant progress has been made in the development of both services, which have contributed to the following:
9.4	• **Development of integrated service pathways**, through the inclusion of a wide range of professionals within the neighbourhood multi-disciplinary teams (MDTs), including from mental health, pharmacy, and the voluntary sector, and the development of a single point of access to the intermediate tier.
9.5	• **Shift of balance of services delivered at home or in the neighbourhood**, rather than in hospital settings, a trend accelerated by COVID-19.
9.6	• **Increased role of prevention and early intervention**, with an emphasis on identifying cases before need escalates through risk stratification.
9.7	• **Increased focus on the wider determinants of health**, particularly in the MDTs due to the work of social prescribing link workers and links to public service reform hubs.
9.8	• **Increased use of asset-based and person-centred approaches**, for example through the introduction of a key worker in the INTs to work out what matters to patients.
9.9	The report provides a vast amount of detail covering the following areas for consideration:- • Bury Care Approach • Structures, Governance and Accountability • Leadership and relationships • Impact on Population • Impact on Workforce • Impact on Health and Social Care • Summary of Key Findings and Recommendations
9.10	The System Board reviewed the information and recognised this as being a good piece of work.
10.	**Risk Report**
10.1	The report provided an update in respect of the one strategic risk, which was captured on the Governing Body Assurance Framework (GBAF), and has been assigned to the Bury System Board for oversight. The report presents the risk position and status as at 31 March and the risk is detailed below:-
10.2	• **Service re-design processes, innovations and new approaches**
10.3	It was noted that this risk had been reduced to target level and in line with the Risk Management Strategy had been recommended for closure by the risk owner.
10.4	The report outlined that the March risk assessment saw the risk reduced to its target level of 8 by the specified timeframe. The likelihood of 3 (possible) has reduced to 2 (unlikely) as through the establishment of the OCO there's greater clarity and understanding of the organisation's stakeholders and communication channels. Additionally, there is a well-articulated 2030 Bury Strategy, a Communications Strategy, established networks and embedded team in place**.**

10.5	In terms of learning from the pandemic, engagement has increased with key stakeholders with improved communication channels being strengthened within the business networks and faith communities which reduced the risk of lack of engagement. All mitigating actions have been completed and gaps closed. This risk has therefore been recommended for closure by the risk owner.
10.6	The System Board reviewed the detail listed in the report and agreed the recommendations as detailed below:- • Received the Bury System Board Risk Register and • Reviewed the information presented.
11.	**Closing Matters**
	The Chair closed the meeting at 12.10 pm reporting that it had been a really helpful meeting with lots of discussion.

Next Meeting	**Date: 20 May 2021 by Microsoft Teams** **10.30 am until 12.30 pm**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

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