Strategic Commissioning Board

Agenda	
Date & Time:	6 September 2021, 16.30 -18.30
Venue:	In the Council Chamber at Bury Town Hall
Chair:	Cllr E O'Brien

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.	Declarations of Interest	Re	C	Chair	16.35
3.	Minutes of the last Meeting and Action Log • 7 June 2021	Re	A	Chair	16.35
4.	Public Questions	V	C	Chair	16.40
5.	Chief Executive and Accountable Officer Update	V	C	G Little	16.45
Strategy / Policy / Proposals					
6. 6.1 6.2 6.3	Integrated Care System Greater Manchester arrangements Locality Partnership arrangements Neighbourhood (INTs)	 Re Re Re	 A A A	W Blandamer /G Little	16.50
7.	Proposal to manage funding requests to NHS Bury CCG for spot purchases of services	Re	A	H Hughes	17.00
8.	Review of Armed Forces Covenant	Re	A	S McVaigh	17.10
9	Care at Home Contract Award	Re	A	W Blandamer	17.20
10.	Designated Beds – Shared Provision	Re	A	A Crook	17.30
Recovery & Transformation					
11.	Integrated Delivery Board	Re	C	W Blandamer	17.40

Key	A – Approval	R – Recommendation	C – Consideration	I – Information	
Item	**Description**	**Report (Re) Verbal (V)**	**Action**	**Presenter**	**Time**
12.	Elective Care	Re	C	W Blandamer	17.50
13.	Mental Health	Re	A	I Mello	18.00
Finance / Performance / Risk					
14.	GM Contracting Principles and Extension of Bury Contracts	Re	A	S Evans	18.10
15.	Integrated Commissioning Fund	Re	I	S Evans	18.20
16.	Risk Report	Re	C	S Evans	18.30
Information					
17.	• Bury System/Transition Board minutes from 20 May 2021 and 17 June 2021	Re	I	Information	——
Close					
18.	AOB and Closing Matters	V	I	Chair	18.35

Next Meetings in Public	**Strategic Commissioning Board Meeting (formal):** Monday, 4 October 2021, 4.30 p.m., Formal Public meeting via Microsoft Teams
Enquiries	Emma Kennett, Head of Corporate Affairs and Governance Email: emma.kennett@nhs.net

Agenda Item 2

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	06 September 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 C Fines, 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 6 September 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
September 2021

Declaration of Interests Register - Strategic Commissioning Board

Name	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments
		Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Voting Members									
Will Blandamer, Executive Director of Strategic Commissioning - **Voting Member**	Ashton on Mersey Football Club			X	Direct	Chairman	2018	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Manchester Football Association			X	Direct	Board Champion for Safeguarding	2018	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Fiona Boyd, Governing Body Lay Nurse - **Voting Member**	Tameside Hospital (Seconded to)		X		Direct	Head of Nursing Urgent Care	Sep-19	Sep-20	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Heywood Middleton & Rochdale CCGT (substantive)		X		Direct	Quality & Safety Lead	Apr-13	Jul-20	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	NHS England / NHS Improvement (Cheshire & Merseyside)		X		Direct		Sep-21	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	DWF Law		X		Direct	Medical Assessor	Aug-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Peter Bury, Lay Member Quality and Performance - **Voting Member**	Labour Party		X		Direct	Member	1979	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury College		X		Direct	Member of Board of Governors	2008	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Member	1974	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Clare Cummins, Bury Council, Councillor - **Voting Member**	Mental Health – Deputy Manager	X			Direct	Deputy Manager			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	ADT	X			Indirect	Spouse / Civic Partner is a Salesperson			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour party				Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Election Campaign – Ramsbottom								Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Branch & Labour Group								Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Sam Evans, Executive Director of Finance - **Voting Member**	None declared					Nil Interest	05/05/2021	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cathy Fines, Clinical Director - **Voting Member**	Bury GP Federation	X			Direct	Practice is a member	2013	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Tower Family Health Care	X			Direct	Member practice is part of Tower Health Care	2017	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Horizon Clinical Network	X			Direct	Practice is a member	2019	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Central Manchester Foundation Trust			X	Indirect	Husband is employed		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Richard Gold, Councillor Bury Council - **Voting Member**	RIGOLD LTD	X			Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Richard Gold T/A Richard Gold Books	X			Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	GM Police, Fire & Crime Panel		X		Direct	Cabinet Appointment			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	The Ephemera Society		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Holy Law South Broughton Congregation Synagogue		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Yeshurun Hebrew Congregation Synagogue		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Jewish Labour Movement NW Region		X		Direct	Membership and Education			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Jewish Labour Movement		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Union		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Cllr Richard Gold, Councillor Bury Council - **Voting Member** *(cont)*	Prestwich Labour Party		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury South Consistency Labour Party			X	Direct	Sedgley Branch Delegate			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Brookvale Care Home			X	Indirect	Parent is Vice Chair of Trustees			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Howard Hughes, Clinical Director - **Voting Member**	Prestwich Pharmacy LTD	X			Indirect	Spouse is Director	1996	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Prestwich Pharmacy LTD	X			Direct	Director	1996	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Greater Manchester Mental Health Foundation Trust			X	Indirect	Sister is performance Manager	2014	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hughes McCaul LTD (Dormant Company)	X			Indirect	Spouse is Director	1995	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hughes McCaul LTD (Dormant Company)	X			Direct	Director	1995	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Geoff Little, Chief Executive for Bury Council & Accountable officer Bury CCG - **Voting Member**	Ratio Research			X	Indirect	Close family member is an employee	Apr-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
David McCann, Lay Member - **Voting Member**	Praxis Real Estate Management LTD, Manchester	X			Direct	Director and General Legal Counsel	2011	Present	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			Direct	Director	2014	Present	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			Direct	Director and majority shareholder	2014	Present	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			Direct	Director and 50% shareholder	2018	Present	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			Direct	Director	Oct-19	Present	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			Direct	Director	Oct-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Praxis Residential Limited	X			Direct	Director	Oct-19	Present	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			Direct	Director	Nov-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Praxis Group Limited	X			Direct	Director	Oct-20	Present	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			Direct	Director	Feb-20	Present	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			Direct	Director	Mar-21	Present	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			Direct	Director	Mar-21	Present	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			Direct	Director	Apr-21	Present	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			Direct	Director	Apr-21	Present	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			Direct	Director	Mar-21	Present	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	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Charlotte Morris, Councillor Bury Council - **Voting Member**	University of Salford	X			Direct		Jun-17	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Font Communications			X	Indirect	Partner Employed	Sep-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unison		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Eamonn O'Brien, Bury Council Leader - **Voting Member**	Bury Council - Councillor	X			Direct	Councillor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Cllr Eamonn O'Brien, Bury Council Leader - **Voting Member *(cont)***	Young Christian Workers – Training & Development Team	X			Direct	Development Team			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Prestwich Arts College		X		Direct	Governor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury Corporate Parenting Board		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	No Barriers Foundation		X		Direct	Trustee			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	CAFOD Salford		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Prestwich Methodist Youth Association		X		Direct	Trustee			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Alan Quinn, Councillor Bury Council - **Voting Member**	Bury Council	X			Direct	Councillor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	BAE Systems - Military Aircraft	X			Direct	Skilled Aircraft Fitter			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Harrogate and District NHS Foundation Trust			X	Indirect	Daughter in Law employed			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Mid York NHS Trust			X	Indirect	Son employed			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Citizens Advice Bureau			X	Direct	Spouse Advisor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Greater Manchester Waste Disposal Authority		X		Direct	Member/Council Representative			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	City of Trees		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	University of Manchester		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Co-operative Party		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	North West Rivers - Floods & Coastal Committee		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	GM Green City Partnership (via the Waste Authority)		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	The Down Syndrome Association			X	Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Uk Government in Switzerland (permanent UK Mission to the UN Geneva)			X	Indirect	Daughter is an employee			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Tahir Rafiq, Bury Council, Councillor - **Voting Member**	Juris Solicitors	X							Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hollins Grundy Primary School		X			Governor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hollins Institute Educational Fund		X			Trustee			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Law Society (England & Wales)		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Law Society (Ireland)		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Punjab Bar Council Pakistan		X			Member/High Court Advocate			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Cllr Tahir Rafiq, Bury Council, Councillor - **Voting Member *(cont)***	Unite the Union		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	KM Solicitors LTD	X							Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Legal Property and Consultancy	X							Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Tamoor Tariq, Bury Council, Councillor - **Voting Member**	Bury Council - Councillor	X			Direct	Councillor	May-10	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Health Watch Oldham	X			Direct	Manager	Aug-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	St Luke's Primary School			X	Direct	Chair of Governors	Sep-18	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	The Derby High School			X	Direct	Governor	Apr-18	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Community Member	May-12	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member	Jun-07	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Domestic Violence Steering Group				Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Greater Manchester Police and Crime Panel				Direct	Chair			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Safety Partnerships				Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Andrea Simpson, Councillor Bury Council - **Voting Member**	Silverdae Medical Practice	X			Direct	Practice Manager			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Parrenthorn High School			X	Direct	Governor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Ribble Drive Primary School			X	Direct	Governor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Union		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Union			X	Indirect	Spouse is a Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury Council	X			Direct	Councillor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Salford LMC Subcommittee			X	Direct	Neighbourhood Lead for Swinton			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Village Greens	X			Direct	Shareholder			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Medical Defence Union		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Joe Hague Photography			X	Indirect	Spouse is Owner			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Chris Wild, Lay Member - Audit and Finance - **Voting Member**	Northern Industrial Generation Limited	X			Direct	Shareholder/Director	Jun-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Secure Generation Limited	X			Direct	Shareholder/Director	Nov-15	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Efficient Generation Limited	X			Direct	Shareholder/Director	Nov-15	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	McNally Wild Limited	X			Direct	Shareholder/Director	Jul-14	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Capitas Finance Limited	X			Direct	Shareholder/Director	May-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Lower 48 Energy Limited	X			Direct	Shareholder/Director	Jul-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Close Brothers PLC	X			Direct	Retained Advisor	Sep-14	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Chris Wild, Lay Member - Audit and Finance - **Voting Member** *(cont)*	Bury College			X	Indirect	Wife Employed	Feb-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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In attendance									
Donna Ball, Executive Director of Operations, Bury Council - **Non-voting**	Oldham Pathology (Pennine Acute)			X	Indirect	Husband is and Employee			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Catherine Jackson, Executive Nurse - **Non-Voting**	NCA			X	Indirect	Husband is a Director at the NCA.			General arrangements for declaring Conflicts of Interest to be followed.
Lesley Jones, Director of Public Health, Bury Council - **Non Voting**	Bury Social Care Provider			X	Indirect	Daughter is employed	Oct-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Nick Jones, Bury Council - N**on-Voting**	Arum Systems Ltd (Arum)	X				Account Director			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Elms Bank			X		Governor			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Conservative Friends of Israel			X		Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	PLC Flats Management Limited	X				Director			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	RNLI					Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Anglo-Swedish Association					Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Friends of the British Overseas Territories					Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury North & South Conservative Association		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	the Conservative & Unionist Party		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Conservative Councillors Association		X			Member			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr James Mason, Councillor, Bury Council - **Non-Voting**	DFS Trading	X			Direct	Service Manager			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hairdresser			X	Indirect	Self Employed - Spouse			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Serving Freemason			X					Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Radcliffe First		X		Direct	Registered Political Party			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Save Greater Manchester's Greenbelt		X		Direct				Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Michael Powell, Bury Council, Councillor - **Non-Voting**	St Thomas Primary School –	X				Teacher employed by Stockport Council	Nov-19		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Elms Bank School –	X				Spouse / civic partner: teacher employed by Oak Learning Partnership	Sep-17		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Liberal Democrats		X			Member	Jan-12		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	National Education Union (NEU)		X			Member	Sep-17		Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Milton St John's Primary School	X				Teacher employed by Tameside Council	Sep-17	Aug-19	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Lynne Ridsdale, Deputy Chief Executive, Bury Council - **Non Voting**	Together Trust		X		Direct	Trustee	Jan-20		General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Emma Kennett, Head of Corporate Affairs and Governance - **Non-voting**	None Declared					Nil Interest			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Karen Johnston, Head of Communications, Engagement and Marketing - **Non-voting**	None Declared					Nil Interest			Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

Name	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments
		Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Peter Thompson, Secondary Care Consultant - **Non Voting**	Field of obstetrics	X			Direct	Performs legal work	Jun-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Shrewsbury and Telford Hospitals ,Maternity Services	X			Direct	Work as a Consultant Obstetrician	Sep-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

Agenda Item 3

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	06 September 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 C Fines, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author	Emma Kennett, Head of Corporate Affairs and Governance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

The attached minutes reflect the discussion from the Strategic Commissioning Board held on 7 June 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the Minutes of the Meeting held on 7 June 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	☒

Implications						
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒

Implications	
Additional details	

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

Title	**Minutes of the Strategic Commissioning Board Meeting on 7 June 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	June 2021		
Date of Issue	June 2021		
To be Agreed	6 September 2021		
Document Status (Draft/Final)	Draft		
Description	Minutes of the Strategic Commissioning Board on 7 June 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 Meeting 7 June 2021 16.30 – 18.30 **Chair – Dr J Schryer**

Voting Members	
Dr Jeff Schryer	NHS Bury CCG (Chair)
Mr Will Blandamer	Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG
Mrs Fiona Boyd	Registered Lay Nurse of the Governing Body, NHS Bury CCG
Dr Daniel Cooke	Clinical Director, NHS Bury CCG
Ms Sam Evans	Executive Director of Finance, Bury Council & NHS Bury CCG
Cllr Richard Gold	Cabinet Member Communities, Bury Council
Mr Geoff Little	Chief Executive Bury Council & Accountable Officer NHS Bury CCG
Mr David McCann	Lay Member Patient & Public Involvement, NHS Bury CCG
Cllr Tahir Rafiq	Cabinet Member Corporate Affairs & HR, Bury Council
Cllr Andrea Simpson	First Deputy Leader, Health & Wellbeing, 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
Julie Gonda	Director of Community Commissioning, Bury Council
Emma Kennett	Head of Corporate Affairs and Governance, NHS Bury CCG
Cllr James Mason	Council Opposition Member, Bury Council
Cllr Michael Powell	Council Opposition Member, Bury Council

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	**Declarations Of Interest**
2.1	The Chair reported that the CCG and Council both have statutory responsibilities in relation to the declarations of interest as part of their respective governance arrangements.
2.2	It was reported that the CCG had a statutory requirement to keep, maintain and make publicly available a register of declarations of interest under Section 14O of the National Health Service Act 2006 (as inserted by Section 25 of the Health and Social Care Act

	2012). The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.
2.3	The Chair reminded the CCG and Council members of their obligation to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Strategic Commissioning Board.
2.4	Declarations made by members of the Strategic Commissioning Board are listed in the CCG's Register of Interests which is presented under this agenda and is also available from the CCG's Corporate Office or via the CCG website.
2.5	• **Declarations of interest from today's meeting** The Deputy Leader, Cabinet Member Children, Young People & Skills, Bury Council declared a personal interest owing to his employment at Healthwatch Oldham. It was noted that this was included on the Declaration of Interest Register.
2.6	• **Declarations of Interest from the previous meeting** There were no declarations of interest from the previous meeting raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/02	Decision	Noted the published register of interests.	

3	Minutes of the last Meetings and Action Log
3.1	• **Minutes** The minutes of the Strategic Commissioning Board meeting held on 12 April 2021 were agreed as an accurate record.
3.2	• **Action Log** The following updates were provided in respects of the Action Log: • A/04/09 – Noted that a paper on initial thoughts and proposals for the Radcliffe model would be brought to the Board's meeting in August.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/03	Decision	Approved the minutes of the meeting held on the 12 April 2021	

4	Public Questions
4.1	There were no public questions raised.

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

5	Chief Executive and Accountable Officer Update
5.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG provided an update on the latest CCG and Council developments. It was reported that: - • The rates of the Delta variant of Covid-19 were rising across the North West and Bury was working to support people through this next wave, with an increased

	effort to communicate and engage with residents to ensure safety measures were being adhered to. • Work was underway to increase levels of testing and vaccinations. Testing on site in schools and colleges was expected in the coming weeks and additional vaccines had been successfully distributed in pop-up centres, although more was required to close the gaps in neighbourhoods with low take-up. • The first half of the year had been modelled, with work regarding the backlog of cases for elective care and increased demand into primary care, rollout of improvements to mental health services, pressure on the acute sector, and work to manage the budget deficit. • Members noted that the government had not been forthcoming with enhanced support, despite requests. Although Bury continued to manage the crisis with existing resources, it was agreed that it would be worthwhile to see the revenue cost if no additional support was given.
5.2	The SCB extended their thanks to everyone involved with the vaccination programme, including clinicians, volunteers, and the senior management team.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/05	Decision	Noted the update.	

6	SCB Membership
6.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG presented a report which set 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. It was noted that each side would now have eight voting members (down from nine), and that the number of opposition party representatives be increased to three. No changes to quoracy were proposed.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/06	Decision	Supported the revised membership and voting arrangements for the Strategic Commissioning Board as set out in the paper and revised Terms of Reference and recommended the draft Terms of Reference to the respective governance arrangements for formal approval.	

7.	Update on the White Paper/Integrated Care System (ICS)
7.1	The Chief Executive, Bury Council & Accountable Officer, NHS Bury CCG and the Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG presented two joint reports on the Greater Manchester Integrated Care System (GM ICS) Transition and Bury Partnership Arrangements.
7.2	Members discussed the reports in detail, making the following points: • With regards to an accountability framework, the aspiration was for a focus on peer challenge and support, similar to Local Government arrangements, alongside a top down system of assurance. • There was a need to link forthcoming changes in with the challenges identified over the past years, particularly the lessons learned through responding to

	Covid, which exposed inequalities in not only the virus but the ability to respond with services. • Members discussed the importance of people engagement and the need to ensure these systemwide changes were made relevant to and understood by local people. This wouldn't be limited to engagement with the hubs, as proactive engagement with residents and people with lived experience was needed; not just codesign but working with people across the system, empowering them to go out to their communities and speak with people, to reach those who didn't normally engage. • The structure of the new Boards and their Terms of Reference were being developed but wouldn't be established until the governance and decision making implications had been fully realised. It was noted sign-off would come before this Board and was expected for the September meeting.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/07	Decision	Received and noted the reports.	
A/06/01	Action	Noted sign-off would come before this Board and was expected for the September meeting	W Blandamer

8.	2021-22 Activity and Primary Care Workforce Plan Update
8.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG presented a report which set out the high-level requirements of the 2021-22 plan along with the assumptions applied in the final version. Members discussed the report and noted this had been 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.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/08	Decision	Received the updates relating to 2021-22 planning contained within this report.	

9.	Northern Care Alliance (NCA) - Urology Reconfiguration
9.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG presented a report co-authored by locality commissioners and the Northern Care Alliance (NCA), which provided an update on the strategic direction of the Urology Reconfiguration Programme.
9.2	Members discussed the report, querying the lack of detail particularly with regards to an end-to-end clinical pathway and what can be done in the community, and expressing their reservations regarding mobilisation without this information.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/09	Decision	Noted 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.	

10	Housing Strategy – Delivery Action Plan
10.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG presented the report which set out an update on the Housing Strategy and delivery of the strategic priority action plan.
10.2	Members discussed the report, in particular the importance of transition planning for families or elderly residents, and the unknown effect long Covid might have on the demand for accessible housing.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/10	Decision	Noted the update on the Housing Strategy and delivery of the strategic priority action plan.	

11.1	Integrated Commissioning Fund (ICF)
11.1.1	The Executive Director of Finance, Bury Council & NHS Bury CCG presented the report which provided an update on the ICF budget. For 2021/22 the net ICF expenditure budget was £520m, a consolidation of the 3 budgets (Pooled, Aligned and In-view). For ease and to enable consistent reporting across the integrated organisation, the CCG had assumed the same level of funding and expenditure for the second half of the year as the first. While the financial framework for the second half of the year was unknown, significant efficiencies were expected.
11.1.2	The Board noted that within the ICF were challenging savings targets. For expenditure incurred through the CCG, planning identified a full year savings target of £4.2m of which £0.9m had been identified in the CHC directorate, with schemes for the remaining £3.3m still to be worked up. For expenditure incurred through the Council, proposals on efficiency savings of £4m and service reductions of £4m on top of a £12m planned use of reserves was required to balance the budget.
11.1.3	Members discussed the report, noting that Bury was benefitting from the GM system's peer challenge approach, and that efficiencies were being driven forward while the capacity was there. Outcomes of the programme were monitored as well as the financial aspects and would be brought to the Board in August.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/11	Decision	Noted the opening ICF budget based on approved Council and CCG budgets.	
D/06/12	Decision	Approved the pooled budget element of the ICF.	
D/06/13	Decision	Noted the uncertain CCG finance regime beyond September.	
A/06/02	Action	Noted the outcomes of the programme were monitored as well as the financial aspects and would be brought to the Board in August.	S Evans

11.2	Bury CCG Transformation Funding
11.2.1	The Executive Director of Finance, Bury Council & NHS Bury CCG presented the report which provided a position statement on the £19.5m non-recurrent transformation funding received in 2016, including the use from 2016 to March 2021 and those schemes still in operation, how they are currently being funded and the need to find a

	funding solution for them. It was noted that a follow-up paper would be brought to the Board in August.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/14	Decision	Noted the content of this report and the financial risks to the Bury system.	
D/06/15	Decision	Noted the Council is holding a reserve of £0.75m from 2020/21.	
D/06/16	Decision	Noted the CCG £4.5m additional allocation to the Pooled Fund in March 2021 includes £2.5m of transformation funds.	
D/06/17	Decision	Noted GM is holding £1.2m for 2021/22, due to be paid if Covid funding stopped at the end of quarter 1. Given half year (H2) allocations the position needs to be clarified, as this funding could potentially go some way to bridging the gap in H2.	
D/06/18	Decision	Noted the need for regular updates to ensure ongoing accuracy and completeness of the information provided and to evidence the success of the transformation programme and related schemes.	
D/06/19	Decision	Noted the need for a recurrent funding solution/agreement during 2021/22 for the underlying deficit full year effect costs of £5.7m (Programme 3, 6 and LCO costs).	
D/06/20	Decision	Considered the need for an assessment of the realisable benefits for those schemes that have ceased in March 2021.	
A/06/03	Action	Noted that a follow-up paper would be brought to the Board in August.	S Evans

12.	Performance Update
12.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG 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.
12.2	Members discussed the report, noting that penalties had been suspended for the year but incentives were still offered. With regards to areas of concern, it was noted that despite a robust plan for elective care, the scale of the task was still challenging. Mental health was another area of concern, with the effect from the pandemic yet to be fully realised. It was noted that services had been put in place for lower levels of intervention but more was needed for complex cases. It was agreed that this be brought to a future Board meeting for discussion.

ID	Type	The Strategic Commissioning Board:	Owner
D/06/21	Decision	Received the update and noted the areas of challenge	

		and action being taken.	
A/06/04	Action	Agreed that complex mental health needs be discussed at a future Board meeting.	W Blandamer

13	**Minutes of Meetings - Bury System / Transition Board Minutes**		
13.1	Minutes of the Bury System/Transition Board meeting held on 15th April 2021 were noted.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/06/22	Decision	Noted the minutes.	

14	**Any Other Business and Closing Matters**		
14.1	The Chair summarised the main discussion points from today's meeting and thanked members for their contributions. As this was her last Strategic Commissioning Board meeting, the Board expressed its thanks to Julie Gonda, Director of Community Commissioning, Bury Council, for her high-quality work, her integrity, honesty, and her innovative role in joint working, and wished her the best for the future.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/06/23	Decision	Noted the information.	

Next Meetings in Public	**Strategic Commissioning Board Meetings:** • Monday, 2 August 2021, 4.30 p.m., Formal Public meeting (Chair: Cllr E O'Brien / Dr J Schryer) ***NB*** **– Meeting was cancelled.**
Enquiries	Emma Kennett, Head of Corporate Affairs and Governance emma.kennett@nhs.net

Strategic Commissioning Board Action Log – June 2021

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

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		August 2021	This item will now be brought to the SCB in August with an update.
A/06/01	Noted sign-off of ICS documentation would come before this Board and was expected for the September meeting.	W Blandamer		September 2021	Suite of papers included on agenda for September SCB meeting.
A/06/02	Noted the outcomes of the ICF programme were monitored as well as the financial aspects and would be brought to the Board in August.	S Evans		September 2021	August meeting was cancelled. Item now scheduled for SCB in September.
A/06/03	Noted that a follow-up paper on CCG Transformation Funding would be brought to the Board in August.	S Evans		October 2021	August meeting was cancelled. Item now scheduled for SCB in October.
A/06/04	Agreed that complex mental health needs be discussed at a future Board meeting.	W Blandamer		October/November 2021	Item scheduled for future SCB meeting.

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Approve
Item No	6.1	**Confidential / Freedom of Information Status**	No
Title	GM ICS Transition		
Presented By	Will Blandamer – Executive Director Strategic Commissioning		
Author	Will Blandamer – Executive Director Strategic Commissioning		
Clinical Lead	Dr Schryer – CCG Chair		
Council Lead	Cllr Simpson – Exec Member Adult Care and Health		

Executive Summary

The GM ICS arrangements are developing and this paper provides an update on a number of key aspects of the work.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Endorses the documentation as indicated.

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:	Yes
The risk of business continuity around the ICS transition arrangements.	

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

Implications						
will be affected been consulted ?						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Fully aligned					
How do proposals align with Locality Plan?	Fully Aligned					
How do proposals align with the Commissioning Strategy?	Fully Aligned					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	Creates the conditions To continue our work on the integration of health and care services, and the focus on inequalities and population health gain.					
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	Yes	☒	No	☐	N/A	☐

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

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SCB Paper – Update on GM ICS Arrangements

Will Blandamer

Draft 2 – 20th August

Appendix 1 – GM Transition Programme

Appendix 2 – GM Governance Arrangements

Appendix 3 – GM Locality Programme

Appendix 4 - GM Financial Flow Proposals

Appendix 5 - GM ICS People and Culture Workstream Update

Appendix 6 – GM Clinical and Professional Senate

Background.

The SCB has been updated on the development of the GM ICS arrangements at regular intervals and at the SCB Development Session in June. The GM ICS development arrangements are firming up and this paper provides the SCB with an opportunity to review the latest key GM wide documentation.

This paper should be read alongside the related paper on the development of the Bury partnership arrangements, and the paper on the neighbourhood team working arrangements.

It will be recognised that the national appointment for the Chair and for the Chief Executive of the GM ICS (and other ICSs) is underway now and they will no doubt work with all partners and influence the final shape of the GM ICS arrangements.

Updates.

1. **Appendix 1 – GM Transition Programme**

   This paper describes the overall shape of the GM Transition programme. Bury is represented in most transition programmes and the transition programme itself is reported to the GM Partnership Executive Group attended by Geoff Little.

   Recommendation: SCB is recommended to note the programme.

2. **Appendix 2 – GM Governance Arrangements**

   This paper describes the proposed GM Governance arrangements. The key task has been to balance the requirement of an NHS Board, with the long-standing wider partnership arrangements of the way GM has worked since the health and care devolution agreements. The proposals have been considered by the GM Joint Commissioning Board, CCG Accountable Officers Group, the Provider Federation Board, meeting of senior political and managerial leadership of councils, and the GM Partnership Executive Board. There is a some

view that the proposals are with the grain of the GM approach and that the Joint Planning and Delivery Group and the informal Executive group can maintain the wider partnership focus. However at the GM Joint Commissioning Board on 17/8/21 considerable concerns were expressed around the lack of focus and influence of the localities on the proposed arrangements.

Recommendation: SCB is invited to consider the GM Governance Arrangements

3. Appendix 3 – The Locality Approach in GM

This paper, describing the key priority of a locality approach in GM as a precondition to addressing opportunities for integrated services and population health and wellbeing interventions, has been an important contribution to the thinking in the GM ICS development. It has been approved by all parts of the GM health and care system.

This paper has particularly been important to in clarifying expectations of the future role of CCG staff. It says that while employment will TUPE to the GM ICS the 'bulk' of staff will be deployed locally. This commitment has formed the centrepiece of staff briefings in recent weeks.

Recommendation: SCC is recommended to note the contents of the Locality Approach paper and endorse the approach.

4. Appendix 4 - GM Financial Flows Proposals

This paper describes the current thinking on the financial flows from a GM ICS to providers and localities. This is a draft slide deck due for further development and refinement in meetings in late August and early September and is presented here to secure an opportunity for the SCB to comment.

Key question for the SCB may include:

- Clarification on the mechanism of flow of GM ICS funding into the locality board, to be place alongside Council funding to make the integrated budget for the place
- Risks and opportunities of the flow of GMICS funding directly to providers and into localities
- Ensuring the GMICS funding associated with its own infrastructure support and sustain local capacity to deliver the local partnership arrangements

5. Appendix 5 – GM ICS People and Culture Workstream Update

This paper is an update on the principles and process for the people and culture transition workstream.

Recommendation – the SCB is recommending to note the work

6. Appendix 6 – GM Clinical and Professional Senate proposals

This paper proposes the development of a clinical and professional senate for the GM ICS. It mirrors the proposals for a similar function in Bury.

Recommendation – SCB is recommended to note the proposals.

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GM ICS Transition Work Programme

The GM Statutory ICS Transition programme, oversees the creation of the statutory ICS and has two phases:

(1)Design phase - to September 2021 and (2) **Implementation phase** – September 2021- April 2022

And 14 programmes..

Workstream	System lead
GM Operating Model	Sarah Price (GMHSCP
Establishing the GM ICS	Sarah Price (GMHSCP) and Eamonn Boylan (GMCA)
The locality approach	Geoff Little (Bury CCG)
CCG safe transition of functions	Su Long (Bolton CCG)
GM and locality spatial levels	Su Long (Bolton CCG)
Financial framework and funding flows	Steve Wilson (GMHSCP/GMCA and Ian Williamson (MHCC)
People and culture	Janet Wilkinson (GMHSCP) and Craig Harris (Wigan CCG)
GM Provider Collaboratives	Tracey Vell (GM Medical Executive/HInM) and Martyn Pritchard (Trafford CCG)
Place-based Provider Collaboratives	Karen James (T&G IC NHS FT), Geoff Little (Bury CCG) and Tracey Vell (GM Medical Executive/HInM)
Clinical and care professional leadership	Tom Tasker (GM Medical Executive/Salford CCG)
Population health	Joanne Roney (MCC) and Jane Pilkington (GMHSCP)
Developing the GM Strategic Plan	Warren Heppolette (GMHSCP)
Health innovation, data and digital	Ben Bridgewater (HInM)
Communications and engagement	Claire Norman (GMHSCP/GMCA) and Craig Harris (Wigan CCG)

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Greater Manchester Health and Social Care Partnership Executive Board

Date: 29 July 2021

Subject: Proposed Greater Manchester Governance

Report of: Sarah Price, Interim Chief Officer, GMHSC Partnership

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PURPOSE OF REPORT

The purpose of this paper is to set out the emerging proposals for the governance model and architecture of the new Greater Manchester health and care system.

These proposals have been developed by the governance task and finish group, supported by Mike Farrar who has been working with GM as we move towards the establishment of the GM Integrated Care System (ICS). Wider system engagement through workshops held during June have also played an important part in developing the proposals.

REQUESTS OF PEB

The GMHSC Health and Care Board is asked to:

- Approve and adopt the proposals for Governance set out in the report
- Support the ambition to establish these arrangements in shadow form from 1 October 2021

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GMICS Emerging Governance Proposals

July 2021

Purpose

The purpose of this paper is to set out the emerging proposals for the governance model and architecture of the new GM health and care system. These proposals have been developed by the governance task and finish group and informed by a paper produced by Sir Richard Leese that was submitted to the Partnership Executive Board in June.

Design Principles and Requirements

The proposed approach is designed to enable GM to meet its strategic objectives (tackling inequality, guaranteeing constitutional healthcare standards, innovation at pace and scale and creating a comprehensive sustainable system). In doing so, it also meets five essential requirements -

1) GM health and care system proposed governance **must offer the continuity of purpose, ethos and culture that have underpinned the GMS devolution deal** in the previous five years of its ten year journey

2) GM health and care system is required **to meet the national policy requirements and priorities** of the forthcoming legislation on integrated care; and **the principles of good governance**

3) GM health and care system governance must be designed to **enable the oversight and delivery of the aims and intentions of the new GM operating model** (recognising its architecture and its incentives)

4) the proposed governance arrangements should further develop the commitment in the operating model ***to a shared approach to its key functions**** by establishing **the crucial principle of shared governance.** This will serve to create the necessary commitment of constituent organisations to taking responsibility for delivery of the system's aims and avoid the GM ICS (Boards and Executive functions) being seen and felt as a separate entity (there is a strong desire to avoid an 'us and them' culture)

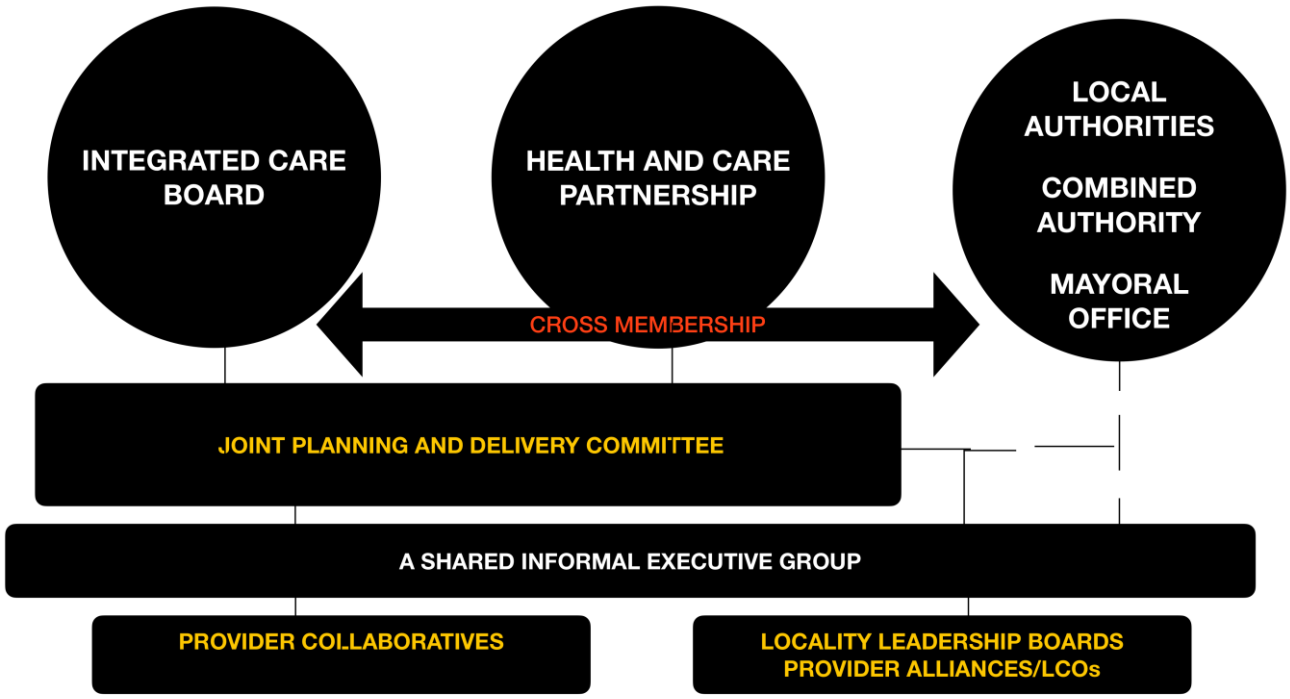
5) the proposed arrangements are built to respond to the challenge issued at the design workshops of **keeping it simple and reducing bureaucracy**. Hence meetings are dovetailed and designed to be coherent in terms of inter-connectedness and will operate with delegated powers and clarity of roles and functions. (See the meeting schedule section later)

As these principles are informing a new set of arrangements it is proposed to keep them under review as the new system beds in, with a more formal review set up to take stock prior to the ICS becoming a legal statutory entity on April 1st 2022 (subject to legislation).

Proposals

The new arrangements are designed to meet the principles above by

- Creating **a new Health and Care Partnership (HCP) which is central** to setting priorities and preserving the culture and ambitions of GM devolution. This replaces the current Partnership Board
- Establishing **an Integrated Care Board (ICB) to deliver the legal national requirements and functions** including allocation of, and accounting for NHS resource; and fulfilling primary care and specialised commissioning functions
- Creating **a Joint Planning and Delivery Committee (JPDC) that replaces PEB and JCB** and ensures/oversees joined up service planning and delivery between the GM enabling programmes, locality programmes (LA and health), Collaborative programmes and adjacent programmes (eg Mayoral office, Health Innovation Manchester, Marmot City Region etc)
- Establishing **a shared executive group (SEG) that meets weekly to coordinate executive delivery** on an ongoing basis and support the work of the three structures above
- Building on **the key delivery vehicles of Locality Boards/Alliances working through their constituent neighbourhoods** and **Provider Collaboratives** taking responsibility for programmes requiring a wider GM footprint to achieve their objectives
- Being **consistently underpinned by expert clinical and care professional advice** through lead professionals, advisory groups and forums, and adoption of a clinically and professionally empowering culture to enable service transformation and population health improvement. These mechanisms are not listed here but will be present in practice to support all the governance arrangements



Detailed Governance Functions

The GM governance model encompasses these **key collaborative governance mechanisms** with the stated intention of them operating coherently to oversee the planning and delivery of services and programmes.

The structures are part of a governance system organised in such a manner not to duplicate but to undertake the collective roles and functions of priority setting, pooling and alignment of budgets, stewardship of budgets, delivery of services and the accountability for achieving objectives.

The proposal would be **to establish the following in shadow form as of October 2021 with a review** and any adjustments made prior to formal adoption from April 2022.

1) Integrated Care Board

Function

- Fulfil all the NHS statutory functions for the ICB as set out in the 2021 Health and Care Bill including setting strategy to achieve national priorities (as set out by DHSC/NHSE in Planning and Priorities Guidance) and GM priorities (as proposed by the GM HCP and built on Locality and Provider Collaborative priorities) , allocation of NHS resources to support this strategy, oversee the commissioning or primary and specialised care, ensuring the component programmes and organisations fulfil their collective and individual responsibilities for delivering their contribution to the GM aims as agreed in the planning process.

Membership (12 members)

- 1 x Independent Chair
- 2 x Independent NEDs
- 1 x Chief Accountable Officer
- 1 x Medical Director
- 1 x Nursing Director
- 1 x Chief Finance Officer
- 3 x Partner Directors as specified (1 x LA; 1 x Primary Care; 1 x NHS Provider)
- 1 x VCSE Representative
- 1 x Chair of HCP (ex-officio)

Board of 12 Directors with ability to have observers in attendance (eg GMCA CEO)

Ability to delegate any, or all, functions
- priority setting to HCP
- planning and delivery to Joint PDC

Ability to establish joint committees (eg with Localities and Provider Collaboratives)

Ability to establish functional committees (eg Audit, Remuneration, Finance etc)

Meets 8 times per year (see meeting schedule in section below)

2) **Health and Care Partnership**

Function

- fulfil all, if any, statutory functions for the HCP as set out in the Health and Care Bill 2021; takes responsibility for setting priorities, informing and being informed by national and local priorities; provides a forum for wide engagement

- liaises, where appropriate, with Local Health and Well Being Boards on understanding locality needs, priorities and strategies

- has the power to establish wider working parties or engagement mechanisms (eg BAME forum, Inequality assembly, Younger People's Forum etc)

- With the ICB, replaces HSC Partnership Board

Membership (numbers tbd)

- Chaired by GMCA Health and Care Portfolio Holder
- Representatives from all constituent parties (eg Trusts, LAs, VCSE, local Primary Care forums/boards, academics, private sector, etc)

- Mixture of elected members, NED, lay members with executive directors, officers and lead clinical and care professionals
- Healthwatch and patient groups

- Meets 4 times per year, aligned with business planning and priority setting process (see meeting schedule in section below)

3) Joint Planning and Delivery Committee

Function

- operates with delegated responsibility to oversee the detailed **joint planning and delivery** process which will ensure that Locality programmes, Provider Collaborative programmes and GM enabling programmes work coherently. The process will coordinate the spatial levels for delivery of the programmes and the consequent financial flows set out in the GM operating model
- **strong focus on delivery of national and locally determined standards and outcomes**
- considers, determines and resolves operational issues associated with the delivery of the GM strategy
- has informal routes through Chair to political leadership
- advises ICB and HCP on potential priorities
- reports into ICB for formal decisions that have not otherwise been delegated
- liaises directly with LAs, GMCA, and Mayoral Office to align operational planning and delivery across the £7bn health & care spend with £15bn non health and care spend
- aligns the direct commissioning functions transferred from the CCG or NHSE/I (eg spec com, primary care etc) to ensure alignment of these budgets/programmes with other key programmes
- **replaces PEB and JCB**

Membership (23 members)

- 1 x Chair is GMCA health and care portfolio holder
- 1 x ICB Chair
- 3 x Provider CEOs (PFB Chair, MH Lead CEO, LCO Lead CEO)
- 1 x PCB Chair
- 10 x Locality Representatives (individuals to be determined by each locality but could potentially be the Chair of the Locality Boards as a default option)
- 4 x ICS officers (CAO, CFO, MD, ND)
- 1 x CEO GMCA
- 1 x VCSE Representative
- 1 x CEO Health Innovation Manchester

In attendance - specific attendees with distinct backgrounds, if not covered through locality representatives; and clinicians by invitation for key items

4) Shared Executive Group

Function

Brings together the key executive leaders on a weekly basis under the chairing of the ICS CAO. **Not a formal decision making group, but one that can fulfil the key role of ensuring coherence in the implementation of strategy**. The group will help steer the implementation process and serve to fix elements or programmes that are under performing. Sets agenda for Board, Partnership and Committee meetings and commissions papers.

Produces an action note rather than formal minute.

Membership

- to be determined by ICS AO, but not a formal membership list, much more about a fluid group depending on the nature of the work in hand.

5) Locality Leadership Boards

Function

- Responsible for setting local priorities, pooling and aligning NHS and social care spending, allocating budgets to local providers or local provider alliances, ensuring delivery of key programmes set out in the GM Operating Mode, liaison with GM enabling programmes and Provider Collaboratives.
- working closely with local HWBs on priorities and strategy
- subject to local scrutiny
- supporting, developing and embracing neighbourhood working as a key element of their strategy and integrated programme delivery
- aligning non health and care spend to deliver a health and care dividend
- can operate as a joint committee with ICS to allow for pooled budget

Membership

- to be determined locally but may be helpful to mirror the model options set out in the GM operating model
- will need an appointed ICS place based lead

6) **Provider Collaboratives**

Function

- take responsibility for leading (predominantly urgent care and elective care programmes) and partnering in the delivery of key programmes on behalf of the GM

ICS. In particular, to help GM achieve progress towards the national constitutional standards and priorities (including in cancer, mental health and physical health care)

- signals appropriate resource allocation to each Trust to deliver their collective clinical strategy
- liaison with locality boards and GM enabling programmes
- undertake programmes to standardise care, optimise workforce and sites; deliver technical efficiency and productivity improvement for existing quantum of resources spent
- has the ability to convene wider provider groupings where relevant to the GM aims (eg health and criminal justice issues etc)

Membership

- PCB - As now but may be reviewed as the system and responsibilities develop
- PFB - Executive Group - membership and structure as per recent agreements
- PFB - Chairs Group - meets quarterly
- PFB - All decisions made and accountable via individual Trust Boards steered by PFB Executive Group and Chairs to ensure visibility, and public/partner scrutiny

Schedule of Meetings

	Jan	Feb	Marc	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
ICB	X	Devel	X	X	X	Devel	X		X	Devel	X	X
HCP		X			X				X			X
JPDC	X	X	X	X	X	X	X	X	X	X	X	X
SEG	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx

Notes

ICB (Integrated Care Board)

- Meets 8 time per year formally at the beginning of each month
- Has 3 Optional Development Sessions a year (strategic session with no expected papers for decision) - can invite wider attendance
- Meets nationally prescribed membership (with GM additional membership, as set out above)
- REPLACES the GM Partnership Board

HCP (Health and Care Partnership)

- Meets 4 times formally per year, at the beginning of the month in question, and dovetailed with the NHS ICS Board
- Has larger membership drawn from the full range of stakeholders

JPDC (Joint Planning and Delivery Committee)

- Meets monthly in the middle of each month dovetailed with ICS Board and HCP
- Takes direction, informs and statutorily reports into NHS ICB
- Minutes also go to CA
- Has a standing membership drawn from ICSB, HCPB, LA and Mayoral Office
- REPLACES Partnership Executive Board and JCB

SEG (Shared Executive Group)

- Meets weekly
- Is an informal meeting but with action notes taken
- Has a small core membership but with ability to bring in additional input on a fluid basis

RECOMMENDATION - Taken together these proposals are recommended for adoption by the GM Health and Care Partnership Board

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NEXT STEPS IN PROGRESSING THE LOCALITY APPROACH IN THE GM ICS

Context

1. Colleagues have raised concerns that the ICS transition programme presents itself as incredibly complex and is able to be tracked and understood by too few people. That is a risk to the model overall if it doesn't achieve the simplicity for colleagues to lead, shape and participate effectively.

2. The true headlines of the GM ICS transition can be simplified as improving the health and wellbeing of all the residents of Greater Manchester and achieving equity through our work to:
   - **Complete the journey to place based working** – refresh the locality plans; confirm the approach to local governance and place and neighbourhood based provider collaboration; provide clarity to locally deployed staff.
   - **Create a new model of GM collaboration** – achieve a mature system governance model built on districts and GM functions operating to confirmed common purpose; achieve empowered provider collaboration; improve our approach to delivery and the execution of standards; establish shared capacity to connect the system
   - **Enable the transformation** – developing the population health system; secure the methods to deliver innovation and digital and data transformation; support and develop our people and culture building an inclusive and equality based workforce; confirm the financial framework; and maximise the best use of public estate.

3. GM has spent 5 years travelling in this direction and the destination has not changed although we have learned lessons along the way and have challenged ourselves when we haven't made the progress we would have wished. It is critical to bring that learning and clarity to the model and to recognise that the development of that model is completing a journey in GM and not starting one. We can confirm how much of that journey has already been completed; how much is actually enabled by the Bill; how much remains to be done; what of that work must be completed before April 2022; and what, of that remaining work, should be the focus for the period beyond April 2022.

4. That doesn't mean no change of course. We retain our belief in place based working, delivery and connection in neighbourhoods, integrating public service and bringing resources together in the interests of residents we jointly serve. The ways we do that will develop. As CCGs go and those commissioning skills informing population health approaches will be more connected to providers, and PCNs, to social care and wider public services. Boundaries between providers will reduce as colleagues collaborate in neighbourhoods and localities and across GM. We will tackle unwarranted variation, but not through unnecessary and distant centralisation, but by concerted action driven by common purpose and the commitment to common standards.

5. This note suggests some tangible developmental steps aiming to bring greater clarity to the locality approach in particular. It was initiated through wider discussion with existing accountable place leads at Director and Chief Officer level. It recognises, however, the context of parallel discussions relating to the governance of the model, the spatial levels considerations and the development of the GM level model. To that end further discussion with colleagues through the Transition Programme Board, Primary Care Board, Provider

Federation Board and the LCO Chief Officers network will be essential in helping progress the actions suggested here so this note can developing into a way forward for the full ICS system as a whole.

Confirming what we have already agreed

6. We are clear on the architecture:

The Locality Model

locality structures would feature a consistent locality model operating with -

- **A neighbourhood approach** with integrated working, connecting to PCNs and to communities and the full range of local partners
- **A Locality Board** (that can deliver accountability for decisions and budgets at place level) and includes civic, clinical, care professional, provider and VCSE partners as an integral element of the governance
- A "**place based lead**" (accountable person to GM ICS for health and care)
- Appropriate **accountability agreements** between partners in the locality and clear **delegations** to enable place based delivery
- 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 care professional leadership** input
- Provision of an appropriate organisational arrangement for the **deployment of locality based ex CCG staff**
- An articulated **relationship with their local Health and Well Being Board**
- 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, general practice and wider primary care, community services, VCSE, social care providers). 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.

The GM Arrangements

GM collaboration would similarly confirm clear features including:

- **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.
- 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.

- 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
- 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).

7. The outputs of the work to date and the headlines from the spatial levels work appears to confirm that perhaps 80% of the actions and approach are clear and broadly agreed. This should be affirmed to allow us to apply early certainty on the scope of place based working, people deployment and headline funding flows. If we can isolate the 20% specific focus and attention can be given to it whilst mainstream developments are able to be progressed.

Taking a bottom up approach

8. In developing Taking Charge we took an early decision to develop Locality Plans and deliberately avoided seeking to overlay a GM blueprint. These plans were developed by health and local government working together in each of our ten districts and were the bedrock of GM Health and Care Strategy and of the devolution Memorandum of Understanding.
9. We have neighbourhood models, underpinned by local care organisations or other provider alliances and supported by integrated governance and pooled resources in all ten districts. They are developed to different degrees but they exist.
10. Each locality has been refreshing and updating its locality plans in the context their integration journey to date, learning from the pandemic and ambitions for the future. These represent key opportunities to inform the detail of the locality approach
11. **We should invite updated and refreshed locality plans from each locality and look to have them confirmed by the end of August. The brief for that task should be co-designed with local leads and should facilitate and inform alignment with GM recovery plans and longer term strategic planning objectives**. Those plans should confirm the operating model for each Place covering:
    - Their vision and objectives and approach to transforming the health of their residents
    - The organisation of integrated delivery through the local care organisation or provider alliance
    - How this operates at the neighbourhood level
    - How it will be governed through the local system Board
    - Their model of leadership and capability building in the triumvirate of political, clinical and provider leadership with officer support
    - The model of public engagement and participation
    - The approach to achieving equity and inclusion

- How it will lead in meeting the key challenges we have already recognised:
  - Creating and improving health – tackling the social determinants, addressing inequality, inspiring and supporting community action
  - Creating more consistent evidence based preventive and proactive primary care
  - Completing the integration of services and removing the historic barriers between primary, social, community, VCSE and secondary care services, across physical and mental health
  - Addressing variation in standards, access and quality of care

- How it will collaborate to support transformation across GM
  - Coordinating and improving the urgent and emergency care service response
  - Delivering more consistent planned care and delivering the planned care recovery programme
  - Further developing GM's access to and delivery of world class specialised care and building a hugely capable innovation capability in HIM
  - Development of its approach to equity and inclusion

12. It feels essential to have, right now, a clear and confirmed leadership constituency to drive the locality approach. For the process of transition that should relate to those with responsibility for:
    - The interim, immediate: who is responsible for the wind down of the CCG, transfer of CCG staff and functions
    - The interim, immediate: who is responsible for
        a. reporting the locality Transition arrangements and progress into GM
        b. being linked into the GM transition work via the GM ICS transition Board - and report back to the respective locality Transition Board.

Recognising dependencies whilst maximising clarity for localities and their teams

13. We should avoid being hamstrung by details which may still need to be clarified and act according to where broad certainty is already available. We should immediately utilise the significant areas of consensus already evident from the spatial levels work and apply that agreement to bring greater certainty to the scope of place based working. this is necessary in 2 key areas:
    - **People**
      - **We should confirm and communicate the expectation that CCG staff will transfer employment to the GM ICS and that the bulk of CCG staff (including those in joint roles with the Council and those in SLAs) will be deployed back to the locality**.
      - **We should recognise the 10 accountable leads for transition leads immediately and work with them on <u>all</u> aspects of the locality approach**.
      - **We should invite those locality leads to work with local provider partners and local authority partners to support deployment to appropriate place based roles.**
      - **For those colleagues supporting, or proposed to support GM functions the H&SCP and GMSS should work with PFB, PCB, GMCA and the LCO network to confirm shadow deployment arrangements from 1 October and begin to run the system in a way that we expect it to operate next year**
      - There will be some exceptions to that, although they will be the minority and will be identified in the spatial planning work. The exceptions will largely to be determined

by the work on 'spatial levels' currently being developed – where it is recognised that for a relatively small number of services and functions the correct spatial level for planning, and sometimes delivery, will be a GM wide footprint, either as part of the ICS itself or as part of the Provider Federation Board.

- Where staff are deployed back in the locality there is not intended to be any organisation change that moves us backwards from our integrated arrangements. We would broadly expect that where there are currently integrated functions between councils and CCGs and many would continue. And we would expect each locality to be developing the work of its integrated provider/LCO/place based provider collaborative – a characteristic of which is that it brings together providers from a range of organisations and they work together as if one team even where there employing organisation is different. Partners in localities will work together to secure alignment in the deployment of teams in line with their shared objectives in the locality plan
- Different localities in GM are developing slightly different models of provider collaboration – for example where lead provider organisations are taking on employment of what is currently CCG expertise. There is no expectation that these arrangements are in place from 1/4/22, although they may be in some places as determined within localities.
- For many current staff in CCGs across the conurbation, the work in building partnerships and transforming services will feel very similar on 1/4/22 to that of 31/3/21.

- **Resources**
  - We should confirm the headlines of the spatial levels work to confirm the NHS services to be planned and coordinated at place and support transparency on the spending made at place level.
  - The flow of money associated with the bulk of current resources associated with CCG staff costs should continue to flow into the purview of the locality board. The exceptions, again, will be identified in the spatial planning work
  - The locality board is where NHS partners and the local authority are meeting and together holding a large pooled budget for the district which as at least the size of the current section 75 agreement.
  - We would expect any variation from previous CCG budgets is by exception and able to be explained (for example because it is collectively agreed that it relates to functions and services delivered once across GM).

Summary of proposed actions

A. **We should confirm the expectation that CCG staff will transfer employment to the GM ICS and that the bulk of CCG staff will be deployed back to the locality. Where that is not the case we should confirm that quickly.**
B. **We should recognise the 10 locality leads for transition immediately, recognising the existing accountabilities for 2021-2022, and work with and through them on <u>all</u> aspects of the locality approach.**
C. **We should invite those locality leads to work with local provider partners and local authority partners to support deployment to appropriate place based roles.**
D. **For those colleagues supporting, or proposed to support GM functions the H&SCP and GMSS should work with PFB, PCB, GMCA and the LCO network to confirm shadow**

deployment arrangements from 1 October and begin to run the system in a way that we expect it to operate next year

E. We should invite updated and refreshed locality plans from each locality and look to have them confirmed by the end of August. The brief for that task should be co-designed with local leads and should facilitate and inform alignment with GM recovery plans and longer term strategic planning objectives.

F. We set a timeline for shadow locality Boards to be in place by 1 October

G. We should confirm the headlines of the spatial levels work to confirm the services to be planned and coordinated at place and support transparency on the spending made at place level

WARREN HEPPOLETTE

JULY 2021

GM ICS Funding Flows

August 2021

Context

- This draft has been developed by FAC and discussed and will be agreed by FAC and then FLG and the GM ICS Transition Board as the basis for initial discussions with colleagues in GM as part of the ongoing development of the GM ICS

- The funds flow must be preceded by, and be seen in the context of plans for governance and spatial levels of activity and decision making, as part of the workstreams overseen by the GM ICS Transition Programme Board, PEB and emerging governance

- The draft has no formal status at this stage and no decisions have been made. A worked up proposal is planned for the FLG on 24th August and then the Transition Board on 26th August

- The next worked up proposal will be developed from the current draft, comments received during August, national guidance, legal proposals and the outputs from other workstreams

- Many views from stakeholders have already been incorporated but groups are continuing to provide constructive input and this work will need to be re-visited in the light of other outputs, particularly from the Spatial Levels and Financial Strategy work.

- Whilst the financial flows are important, the system also needs to develop a robust financial strategy and medium term financial plan. This work will start in September.

Introduction – What we know…

- We expect approximately 2/3 of GM NHS Funds to come into the GM ICS Board from NHS E. However, the other 1/3 will be received directly by NHS Providers, e.g. from HEE for training posts or for specialist services, and the funds flow for these is TBC.

- The GM system is starting from a position of a significant recurrent financial gap, which was estimated to be at £650m (based on H1 planning). Over recent years this has been managed through non-recurrent solutions and re-prioritisation of funding. Permanent solutions will be needed through improved delivery of recurrent savings from all parts of the Health and Care system.

- We expect contract funds to flow directly, once, from the GM ICB to acute and community and mental health trusts, primary care providers and independent sector. We expect this to be nationally mandated. In the first year at least we expect each individual trust to receive a direct contract and funds. It is possible over time for provider collaboratives, e.g. PFB or PCB, to collectively receive some funds for GM wide programmes.

- The Locality System Partnership Boards will have wide representation and be the decision making body for Locality responsibilities. The Locality System Board will collectively determine the pooling arrangements, the success of these groups will be based upon the strength of the trust and relationships within the Locality

- We know that we will be allowed to determine the financial governance and flows within the GM ICS subject to agreeing clear lines of accountability along with our ability to provide financial reporting and meet NHS financial governance

What is Financial Flows?

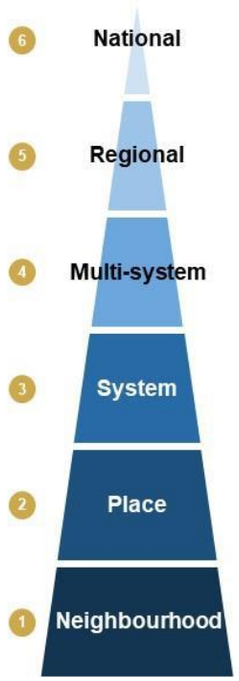
Financial Flows work describes

- Where financial decisions are made – in line with other GM ICS development work on spatial levels work and governance
- How funds / allocations will move around the system

There are a number of things it will not describe:

- The Spatial Levels work will define the responsibilities of GM and of Localities in designing and managing service pathways and funding. Initial guidance from National Provider Collaborative guidance is shown on the next slide
- The Financial Strategy will describe our approach to Budget setting, savings delivery and how we address health inequalities
- The Governance work will define the pooling and decision making arrangements in each Locality and explore how these will fit with current Section 75 arrangements

Spatial Levels



Services	Predominant collaboration partners	Collaboration arrangements	Activities
• Life sciences • Highly specialist services	• Specialist providers • Research universities • Industry	• AHSCs, AHSNs • Public-private partnerships	• Services need to be planned and coordinated on a broader footprint than a single ICS, working with neighbouring ICSs, other providers and national commissioners. • Provider collaboratives might span levels 4 and 5 but even when they are not, they must be sighted on decisions relating to the delivery of services at levels four to six in order to understand and calibrate the use of its collective resources for the delivery of all provider collaborative priorities. • Linked to commissioning of 999, 111 and IUC over multi-ICS as a Lead Provider model
• Highly specialist services • Specialised services	• Specialist NHS providers across a large geographic footprint	• Specialist clinical networks • Provider collaboratives	
• Specialist and specialised services • Community and mental health • Access to UEC	• Providers working over multiple ICSs	• Specialist clinical networks • Provider collaboratives	
• Elective and non-elective secondary care • Inpatient, crisis and specialist mental health, learning disability and autism • Community	• Providers working across an ICS • Providers with patient flow into an ICS	• Provider collaboratives	• Services in Level 3 are primarily delivered on an ICS footprint. • These services therefore particularly lend themselves to planning, coordination and delivery through a provider collaborative.
• Community health • Community mental health • 'Front door' acute • Social care	• Providers • GPs • LAs • Voluntary sector	• Place-based partnerships • ICP contracts	• Services in levels 1 and 2 are likely to be planned and coordinated at borough (place) level and delivered at neighbourhood or borough level, depending on the service in question. The primary "vehicles" for collaboration in these layers are place-based partnerships (of which the members of provider collaboratives are key partners). • Provider collaboratives play a role in areas where they can add value for at scale collaboration, across multiple places. but they should not duplicate work within each place.
• Primary care • Public health and wellbeing • Prevention • Community health • Social care	• Providers • GPs • LAs • Voluntary sector	• Primary Care Networks (PCNs) • Integrated multi-disciplinary teams	

- This is taken from the NHS E/I guidance on provider collaboratives, "Working together at scale"
- There is an ongoing GM piece of work on Spatial levels which will determine the decision making responsibilities of each part of the system

Locality Strategic Partnership Boards

We expect Localities to be able to influence service delivery through decision making at the Locality Partnership Boards over the pooled funds.

"Pooled" *services and budgets are where one organisation holds funding from a number of different sources to commission/deliver a single integrated service.*
"In Sight" *budgets are those reported alongside pooled budgets because improved understanding of the investments, cost pressures or savings will aid understanding of how best to deploy the pooled budgets.*

- Section 75 legal agreements can help systems deliver a common goal by merging funding from different sources and allowing the most appropriate vehicle to be utilised. The act of pooling budgets does not in itself deliver savings or improve outcomes. But it can remove barriers to achieving those goals.

- Section 75 agreements across GM have a range of approaches across different aspects :
    - Which organisations are party to the Section 75 agreement
    - Which services and budgets are pooled
    - How overspends are dealt with
    - Which organisation hosts the pooled budget

  Currently undertaking baseline work to capture the variation in agreements across GM and yet to describe where consistency of approach will be needed

- The nature of Section 75 agreements and the role that different partners play within the arrangements are likely to be evolve significantly in the future. In particular, Providers have historically not been signatories in most Localities in GM.

GM Integrated Care Board (A)

- All NHS funding must be received into the GM ICB and it holds the statutory authority and responsibilities for the ICS, with delegation to other bodies made from here.

- The GM ICB will be supported by the future governance model as agreed including the Health and Care Partnership and the Joint Planning and Delivery Committee

- The Finance Strategy will set out our approach to budget setting, responsibility for delivery of savings and how we address health inequalities. This will balance the need to fund the costs already in the system and fairly address the System Financial Gap estimated to be at £650m (based on H1 planning)

- NHS Funding to be allocated across Localities, Providers and GM Central functions. In line with our agreed principles we need to start with funding the costs structures that we already have in place.

- The GM ICB will formally set out the responsibilities expected accountabilities and NHS funding agreements through contracts (for provider organisations) and accountability agreements (for Localities). There will be one such agreement for each organisation encompassing all historic funding streams and responsibilities.

Local Strategic Partnership Board (F)

We expect that the Local Strategic Partnership Board will operate as a Joint Committee arrangement (although there may be other options as this has not yet been agreed across GM) with the GM ICB and other Locality partners and be responsible for driving improvements for the health of the local population. The role of the Locality Strategic Partnership Board in relation to Finance and Financial Governance is:

- It has a mechanism for engagement with all Locality stakeholders and clinical disciplines, including all wider primary care disciplines

- It has delegated authority from the GM ICB and ensures terms of accountability agreement with GM ICB are met (e.g. delivery of financial targets)

- It may oversee the financial performance of those services agreed to be "Pooled" and "In Sight". The cash will follow the route specified in the accountability agreement which could be pooled through GM ICB, NHS Provider or Local Authority – subject to the necessary transparency, reporting and financial governance. Further national guidance is expected in this area.

- It makes decisions on changing the utilisation and/or deployment of local resources, taking into account the impact of those services and budgets which are "In Sight" but not pooled

- It is the mechanism through which Localities make decisions on delivery of savings plans and agree local investments, respecting how each Locality agrees the balance of responsibilities held by the system and by individual organisations

Provider Trusts (B) + GM Central Functions (C) + Primary Care core contracts (D) + GM ICS Localities (E)

There will only be one contract per organisation, although depending on the outcome of the Spatial Levels work, this may encompass services for which decisions are made in different places.

- "NHS Provider Trusts", box (B), are currently expected to continue to operate as separate legal entities, but with co-operation and joint decision making on specified areas through provider collaboratives, e.g. the GM NHS Provider Federation. It is expected that NHS Provider Trusts will take on an expanded role for combining and managing existing sub-contracts and leading Locality Provider collaboratives.

- The "GM Central Functions" box (C) represents all staff and operating budgets, both for those functions which will be undertaken at GM level and for those functions which will be deployed back into Localities. These would not be pooled or delegated to Localities.

- The "Primary Care Core Contracts" box (D) represents the GP Practices, Dentists, Community Pharmacies and Optometrists. This includes all funding streams, both "core" and "additional" – although work is ongoing to categorise the funding streams and consider how these flows will operate in future. Use of the 'Additional' funding to be agreed at LSPB.

- The "GM ICS Localities" box (E) represents all other contracts and budgets which will be managed through the Locality Strategic Partnership Board

GM ICS REVENUE FUNDING FLOWS
DECISION MAKING AND CASHFLOWS – DRAFT

SPEC COMM, HEE & OUT OF AREA FUNDING

A

GM INTEGRATED CARE BOARD – ALL ALLOCATIONS

B

NHS PROVIDER TRUSTS

GM ICB contracts/works with each Provider Collaborative and contract directly (once) with each individual Provider

* ACUTE & COMMUNITY
* MENTAL HEALTH

C

GM ICB FUNCTIONS

INCLUDING ASSOCIATED RUNNING COSTS

D

PRIMARY CARE

GM ICB contracts/works with Provider Collaborative and contracts directly with each individual Provider

ALL FUNDING 'CORE' AND 'ADDITIONAL' PAID DIRECT TO PROVIDERS. USE OF THE 'ADDITIONAL' FUNDING TO BE AGREED AT LSPB.

E

GM ICB LOCALITY DELEGATIONS

Services and budgets agreed to be delegated to Locality level for decision making

Encourage collaboration across Localities on pathways and contracting to ensure consistency of offer to residents and workforce

Section 75 could be Hosted by any mix of GM ICB, Local Authority or an NHS Provider Trust

** As part of agreed integrated local care organisation arrangements*

F

LOCAL STRATEGIC PARTNERSHIP BOARD
(Operating as a Joint Committee)

ALL LOCAL RESOURCES IN SIGHT THROUGH S75 POOLED/ALIGNED BUDGET ARRANGEMENTS BETWEEN RELEVANT KEY PARTNERS

LOCAL AUTHORITY DELEGATED FUNCTIONS & ASSOCIATED BUDGETS

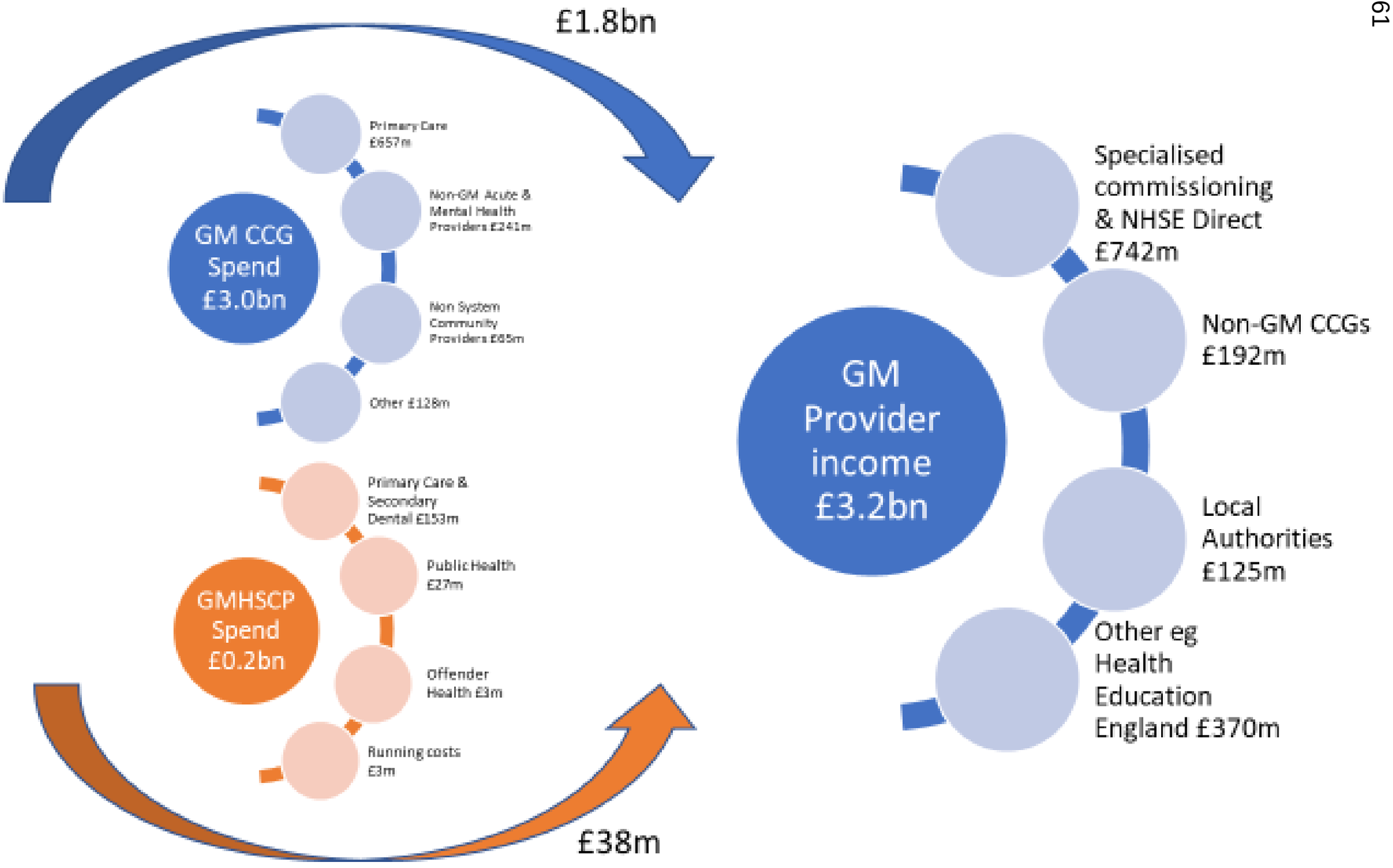
ENSURES SOCIAL CARE AND WIDER DETERMINANTS OF HEALTH AND POPULATION HEALTH MANAGEMENT IS AT THE HEART OF LOCAL DECISION MAKING

Flow of funding / allocations
Alignment of funding
S75 pooled funding opportunities

LOCAL SUPPORTING GOVERNANCE ARRANGEMENTS

THE WHOLE SYSTEM IS THE INTEGRATED CARE ORGANISATION

GM NHS H1 funding (ie half-year)



Key messages

- Financial Flows describes the places financial decisions are made and the way cash moves in the system

- Financial Strategy describes the way that the GM ICS will set budgets, deliver savings and address health inequalities. This work will start in September

- Outcome of the Spatial Levels work will determine the decision making to be undertaken at GM ICB, Local Strategic Partnership Boards and in the GM Provider collaboratives.

- GM ICS has an overall System Financial Gap estimated to be at £650m (based on H1 planning). The H2 Planning guidance will require us to develop and deliver recurrent savings programmes.

Next Steps

- This draft has been considered in a wide range of groups and the views of those groups incorporated into this updated version
- It is only able to serve as a simplification of the eventual financial governance – which will also be subject to local nuance
- This work will need to move into a more detailed stage of development once the outputs of the Spatial Levels work is available to give greater specificity to the ideas set out here
- These slides will be presented at the GM ICS Transition Programme Board on 26th August

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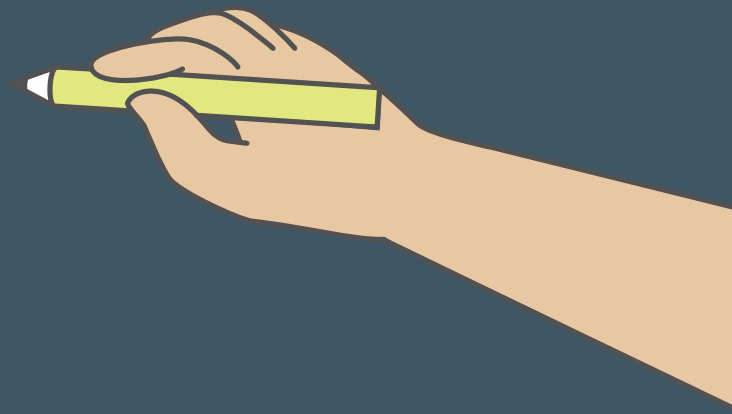
Greater Manchester Health and Social Care Partnership

GM ICS DEVELOPMENT PEOPLE AND CULTURE WORKSTREAM INFRASTRUCTURE REVIEW



AUGUST 2021

GMCA GREATER MANCHESTER COMBINED AUTHORITY

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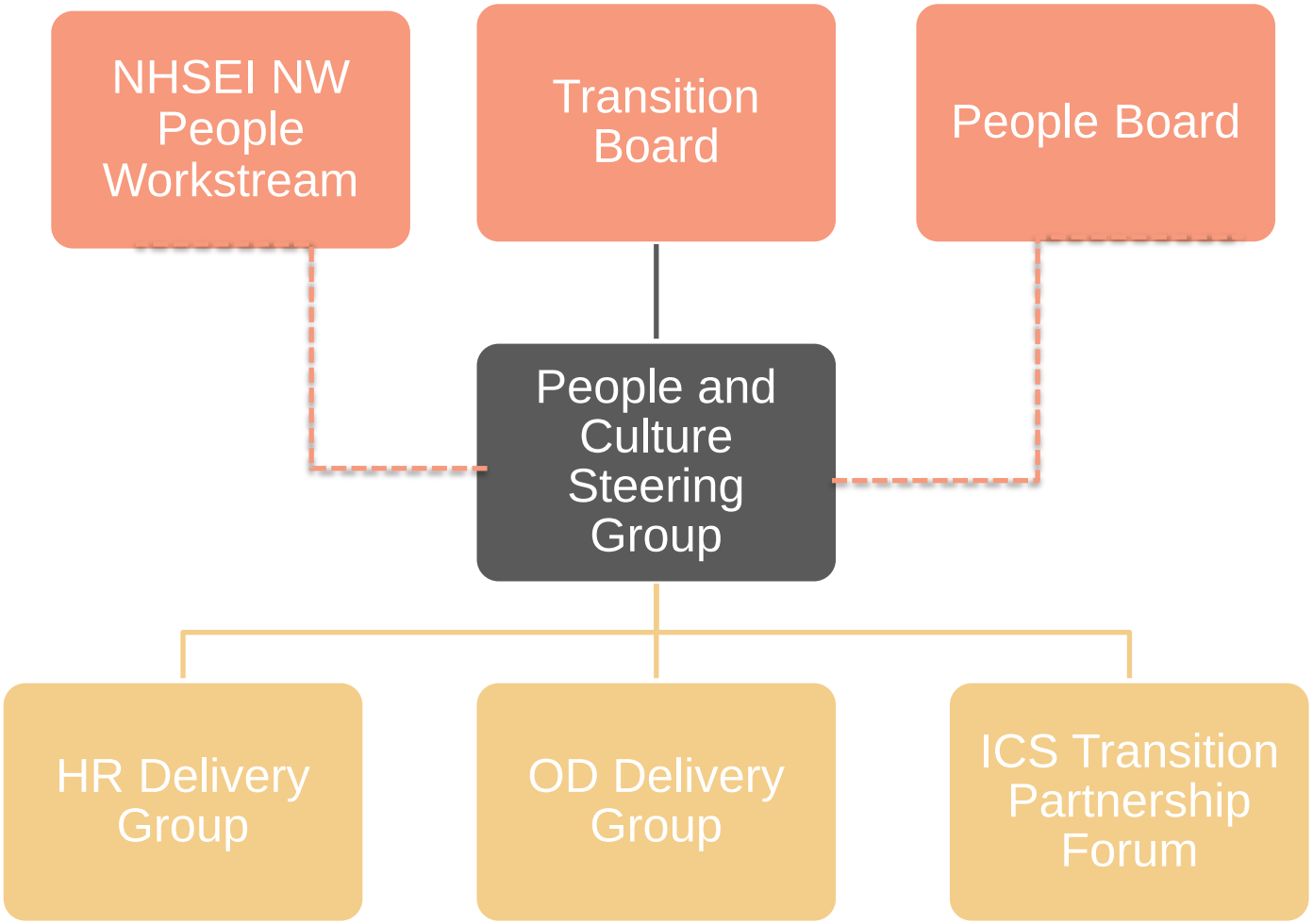
PROGRAMME INFRASTRUCTURE



GM ICS PEOPLE AND CULTURE STEERING GROUP

PURPOSE, ROLE AND WAY OF WORKING

The GM **ICS People and Culture Steering Group** will oversee the delivery of ICS objectives related to workforce / people within GM in line with regional and national timescales in a way appropriate to GM context that takes full consideration of local consultation and engagement. Working between National, regional and Local colleagues to clarify the process to be followed, timescales and specific responsibilities at Local, Regional and National Level.

The GM **ICS People and Culture Steering Group** will achieve this by:

1) Develop a People Plan and function for the Greater Manchester Integrated Care Board (Organisational)
2) Supporting the safe transition of our people to the new ICS structure
3) A whole system People Plan for Greater Manchester

GM ICS PEOPLE AND CULTURE STEERING GROUP

PURPOSE, ROLE AND WAY OF WORKING

The GM **ICS People and Culture Steering Group** will:

- **Track progress of Workforce key metrics / milestones** to ensure that specific actions are delivered and we focus on the overall aims of the change programme, including sustainable change and taking our people with us. Where necessary the group will prioritise the most important actions to be delivered against given timeframes.
- **Identify and monitor GM workforce risks and concerns**, ensuring mitigation and escalation where necessary.
- **Identify and channel resources**, as appropriate to deliver the transformation.
- **Determining the approach within GM (in accordance with any North West/national guidelines) for affected staff** and ensuring there is a support package for staff who are affected by the change process.
- **Oversee engagement with trade unions at GM level**
- **Ensure that any GM legal and HR challenges are addressed,** in partnership with regional and national colleagues, supporting people within GM to adapt to the changes and ultimately to think, work and behave differently.
- **Provide assurance** to the Transition Board that all sender organisations are able to meet the workforce requirements of the **readiness to operate checklist** to establish the ICB on the 1 April 2022.

- **The GM ICS People and Culture Steering Group will provide assurance to the Transition Board** and sender organisations and provide updates to the GM people board and NW workstreams throughout the process.

- **The GM ICS People and Culture Steering Group will set the tone, role modelling the People Promise** and key principles of partnership and inclusion.. All members should model the behaviours and culture set out in the People Plan, noting that throughout this change process it is key that staff feel valued.

GM ICS DEVELOPMENT PEOPLE AND CULTURE STEERING GROUP

MEMBERSHIP, QUORACY, AND FREQUENCY

Role	Name
Chair/SRO ICS People & Culture Workstream	Janet Wilkinson & Craig Harris
ICS People and Culture Programme Director	Jane Seddon
OD Programme Director	John Herring
Nominated Sender Exec Lead (with local workforce accountability)	X 12
EDI Specialist	Sharmila Kar
NHSEI	Andrea Anderson
Director of Communications	Clare Norman
Transition Comms Lead	Anna Cooper-Shepherd
Project Manager	Eram Hussain
Specialist Input	By invitation
Secretariat	Pam Sambrook
Staffside representative	TBC

Quoracy:	At least 5 members of the group including the chair or a nominated deputy
Frequency:	Monthly with informal check-ins
Deputies:	Expected in the case of non attendance of key representatives.
Review:	As required

NATIONAL ENGAGEMENT PRINCIPLES

CORE PRINCIPLES:

The overarching principles that apply throughout the transition period and which were agreed in partnership with national trades unions are:

People Centred Approach - in line with the People Promise

- Thinking about the needs of patients and the impact on our people as a first step and amending plans if necessary
- Taking a supportive talent-based approach with colleagues impacted by the changes
- Seeking to provide stability of employment/ engagement
- 'One NHS Workforce' inclusive change approach supported by the employee commitment
- Working in partnership with trade union colleagues

Compassionate and Inclusive

- Openness and transparency of process and actions
- Taking action to increase the diversity of the new ICS workforce and particularly the leadership
- Co-creation at the appropriate level
- Individual behaviours
- Supportive Change Approach

Minimum Disruption

- Taking the minimum position to enable the change to happen and setting the direction for future evolution by the new ICS NHS Bodies
- Keeping policy as simple as possible and testing thinking against these principles
- Working together to avoid unnecessary duplication of effort and achieve greatest value - based on the principle of subsidiarity
- Implementing the employee commitment

Subsidiarity

- Functions and accountability move based on the principle and where the work should be carried out to ensure the enablement of continuous improvement and partnership responsibility to the ICS ambitions, through a population health management approach across all functions
- People follow the function in line with the employee commitment for people below board level
- Organisation design at national and regional level should mirror the legislative approach and be as minimally prescriptive as possible

WORKING IN PARTNERSHIP WITH TRADE UNIONS

The ambition is for Trade Unions to be consulted at a national, regional, ICS and employer level

ICS

In anticipation of becoming an employer ICS's are encouraged to establish a partnership arrangement which enables effective employer partnership working with local trade union representatives.

Employer

There are legal requirements involved in consulting on these changes as well as locally negotiated HR and change policies and best practice principles for a change of this scale. Effective consultation and partnership working at employer level will be vital to ensure organisations successfully manage the risks and challenges associated with the transition.

Organisations involved in the transition, in partnership with their relevant trade union representatives will therefore:

- be responsible for the effective management of the transition at local level;
- be conversant with any relevant policies, procedures and guidance, including and nationally agreed guidance;
- agree locally how national guidance will be communicated and translated into CCG and/or system level HR plans;
- avoid local disputes by using the range of partnership working arrangements available.

It is recognised that due to the size of their organisations some CCGs do not have local union representatives. In such circumstances the relevant area or regional Trade Union representatives should be engaged and consulted to agree appropriate representation and consultation forums are available and established during the transition process

WORKING IN PARTNERSHIP WITH TRADE UNIONS

In partnership with our union colleagues the following infrastructure is proposed to ensure robust partnership working is taking place across Greater Manchester:

- A union representative to have a seat on each workstream group to codesign and inform the ICB and the closedown of sender organisations.

- ICS Transition Partnership Forum to be established to effectively support staff, whether directly employed, assigned, or seconded to functions that will be impacted by organisational change arising from the 2021 Health and Care Bill, by minimising uncertainty and maximising employment stability, limiting employment changes and working to the principles of simple, local and evolution.

ICS Transition Partnership Forum – Draft Terms of Reference

- Have a clear focus on equality, diversity and inclusion and maximise opportunities to enhance diversity at a system level.
- To clarify which people are in scope for the transition and share data on that group and the sender organisations.
- Define what is meant by ‘board level’.
- De-risk change for staff through protections to terms and conditions.
- Facilitate a strong staff and employer/ICS voice in the transition process.
- Provide a forum for candid conversations where members can raise issues arising at a local or system level in confidence.
- Co-produce organisational change workforce related documentation to facilitate consistency of approach across Greater Manchester
- To understand the transfer mechanism and ensure correct legal and organisational change processes are followed, for example staff consultations.
- Communicate relevant messages on the transition process.
- Support timely and effective partnership working to support the implementation of transition arrangements.
- Ensure a consistent and coordinated approach in delivery of workforce change between the ICS, place, and organisational levels.
- Work together to identify opportunities for improving employment practices that the creation of the new statutory bodies provides.
- Consider the impact of the implementation of non-legislative arrangements.
- Support the ICS to create their own internal partnership structures and have them up and running from day one, sharing good practice and learning.
- To ensure sender organisations are fully represented and feedback is provided at a local level particularly where the sender organisation does not have a local representative.

SUGGESTED MEMBERSHIP

Role	Name	Responsibilities
Joint Chair	Lead AO & James Bull (Unison)	Accountable officers to chair on behalf of accountable officers for all sender organisation with delegates responsibilities.
Executive Lead for People and Culture	Janet Wilkinson	
ICS People and Culture Programme Director	Jane Seddon	
OD Programme Director	John Herring	
Local union representatives from sender organisations	TBC	Local representatives are accountable for liaising locally within their organisation partnership forum and/or with the workforce to enable them to have clarity of local issues, ICS development and feedback back progress at a organisational level.
Regional union representatives	TBC	Regional representatives are accountable for liaising locally within their buddy organisation with the workforce to enable them to have clarity of local issues, ICS development and feedback back progress at a organisational level.
EDI Specialist	TBC	
Transition Comms Lead	Anna Cooper-Shepherd	
Project Manager	Eram Hussain	
Secretariat	Pam Sambrook	

Greater Manchester Health and Social Care Partnership Executive Board

Date: 24 June 2021

Subject: Clinical & Care Professional Leadership

Report of: Dr Tom Tasker, Chair Salford CCG and Chair, GM Medical Executive

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PURPOSE OF REPORT

This paper outlines the role and contribution of clinical and care professional leadership in system working. It confirms the principles and application of effective clinical and care professional leadership and proposes a means of establishing and supporting that leadership at the heart of the GM Integrated Care System.

KEY ISSUES TO BE DISCUSSED

The proposal confirms a significant consensus on the value and principles of clinical and care professional leadership and also on the key areas of activity for that leadership to support GM level working.

The paper proposes a Clinical and Care Professional Forum. The forum would not seek to replace existing groups and networks that exist, but instead, be proactive in helping those existing arrangements connect better with each other; be a route to that incredible range of clinical and care professional networks; innovate in how clinical and care professionals connect and network; be a means of drawing novel multi-disciplinary groups together to problem solve and participate in joint work.

The paper also recognises that locality level clinical and professional leadership arrangements are developing in each part of GM. There is significant benefit in connecting the place based and GM level arrangements. How that happens will be one focus of the future work.

The paper then sets out some key elements of the further detailed arrangements including representation in formal governance, alignment to statutory accountabilities, alignment to key work programmes and GM bodies, and ensuring the proper breadth of participation across the GM care system.

REQUESTS OF PEB

The GMHSC Partnership Executive Board is asked to:

- To confirm the principles of clinical and care professional leadership (s 3)
- To confirm the ways of working and how we apply clinical and care professional leadership (s 4)
- Confirm support to the further detailed work (s 8) to fully establish the model.

CONTACT OFFICERS:

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

BRINGING TOGETHER CLINICAL & CARE PROFESSIONALS IN THE GM INTEGRATED CARE SYSTEM

A Proposal & Discussion Paper Arising from the Workshop Series

1.0 CONTEXT

On 11 February 2021, the Department of Health and Social Care published the White Paper "Integration and innovation: working together to improve health and social care for all", which sets out legislative proposals for a Health and Care Bill. The White Paper brings together proposals that build on the recommendations made by NHS England and NHS Improvement in *Integrating care: next steps to building strong and effective integrated care systems across England* .

The White Paper references "Clinical and Professional Leadership" but does not go into significant detail. This paper offers a proposed way forwards for the GM system in this area.

2.0 KEY CONSIDERATIONS

Integrated care is about giving people the support they need, joined up across local councils, the NHS, the VCSEs and other partners. It removes traditional divisions between hospitals, family doctors and community support, between physical and mental health, and between NHS and council services and other sectors. In the past, these divisions have meant that too many people experienced disjointed care or lack of care.

Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and addresses health and social inequalities.

An important part of the vision is that decisions about how services are arranged should be made as closely as possible to those who use them and/or need them. For most people their day-to-day health and care needs will be met locally in the town or district where they live or work. Partnership in these 'places' is therefore an important building block of integration, often in line with long-established local authority boundaries. However, the system also needs to recognise that some services will need to be designed around communities of identity and experience not geographies alone

What do we mean by Clinical & Care Professionals?

- The term 'clinical and care professional' in this paper refers to a wide range of disciplines across health, local government and the voluntary, community and social enterprise (VCSE) partners. It includes nurses, allied health Professionals (AHPs), doctors, therapists/ counsellors, pharmacists, dentists, optometrists, public health, healthcare scientists and social workers delivering care to all age groups across community services and primary care, secondary care, mental health, specialist regional / national services and also includes those delivering indirect care to patients and carers e.g. Pathology.
- We recognise that a comprehensive leadership approach bringing together expert management, authentic lived experience, civic leadership and clinical and care professional leadership is necessary. This paper does not underplay any of those critical elements but does focus on the specific contribution of clinical and care professional leadership.

How did we produce this paper?

- A group of multi-professional clinical and care professional colleagues representing a cross section of sectors, organisations and localities in GM met as a task and finish group for 3 facilitated workshops and then a final meeting to discuss the proposal in more detail. The discussion explored the why, what and started to think through the how for clinical and care professionals influencing and working with the emerging GM ICS. Key principles, functions and ways of working have been explored in detail.
- The group was mindful of the development of clinical and care professional leadership arrangements in place and wishes to offer assurances that this work will seek to complement and improve the connections between those fora and networks and not replace any of them.

What does this proposal broadly outline?

Throughout all the discussions held over the last few months, there was a strong consensus both within the clinical and care professional community and beyond that the GM ICS must have clinical and care professionals at the heart of it; that clinical and care professionals are viewed very much as the engine room – driving forwards strategic development as well as implementation and delivery.

This proposal attempts to bring it all together – not seeking to replace or undermine existing structures which have clinical and care professional leadership at its heart e.g. Primary Care Board, Hospital Directors of Nursing - but instead look to how we can better co-ordinate our efforts, reduce silo working and maximise the benefits and support to each other and the wider system.

Our vision is:

- That clinical and care professionals will automatically have a seat at the top table in terms of the GM ICS governance. We would want this representation to be appropriate, but we are not yet in a position to describe the preferred membership until the wider piece of work around the GM ICS governance has been undertaken.
- The relationship between clinical and care professional leadership in place and GM must be complementary and effectively linked together.

- We are proposing to create a “Clinical and Care Professional Forum” which will enable a broad church of representative leaders to come together to develop a shared vision and set of priorities for the GM ICS in collaboration with other system partners; one that would achieve better co-ordination across our constituent professional groups and representative bodies and maximise our output in terms of service development; workforce engagement; deployment of research and innovation opportunities and professional leadership support and development. With this new forum, we are not seeking to replace or undermine any existing structures but instead maximise our potential.

Why Does Clinical and Care Professional Leadership Matter?

- The quality of care people receive depends first on the skill, compassion and dedication of clinical and care professionals. The more engaged those staff are in the shaping and coordination of services, and the decisions which affect those services, the better the outcome for patients and clients will be.
- Clinical and care professional leadership does not develop or emerge by chance. We need to be purposeful in ensuring that talent is identified, fostered and supported. We have a huge amount of untapped clinical and care professional leadership – we want to emphasise the identification, nurturing, support and mentoring of these staff, and ensuring that clinical leadership positions are highly sought after, and immensely rewarding.
- We want to capture and support that drive for greater consistency in the care and support patients and residents receive. We can help to identify unwarranted variation whilst strengthening, sharing and replicating best practice and work collaboratively to address this as a system. We are also well placed to focus on reducing health inequalities
- As we integrate care, and work as a system, clinical and care professional leadership will increasingly straddle divides across traditional care boundaries. That will mean leading across pathways, indeed across systems, and be supported to look beyond individual specialties, sectors and organisations.
- There is immense value in clinical and care professional leadership being fully embedded at every level of the GM system.
- Clinical and care professional leaders should be seen as part of the engine of our system and integral to prioritisation and decision-making.
- The leadership should reflect the diversity of the workforce itself and of the communities we serve.
- Clinical and Care Professionals can help other leaders (such as managers and politicians) in understanding effective use of finance and pooled budgets in terms of effective and efficient service delivery based in evidence.

Case Study

The Greater Manchester Mentally Healthy Schools & Colleges Programme was developed to provide support in school and college settings, to help children and young people to look after their emotional health and wellbeing and to provide specialist support where needed. In addition to training young people as mental health champions, the programme has given teachers the advice, training and support they need to help pupils as well as a simpler, easier way to refer into Child and Adolescent Mental Health Services (CAMHS) where needed.

This initiative was strongly driven by our clinical and care professional leaders from the Strategic proposal to the delivery model and implementation and the success of the programme , evidenced by the mental health outcomes and confidence of schools and pupils was significantly enabled by this leadership being multi- professional and across all sectors , breaking down many of our previous barriers.

Three cohorts of schools and colleges (totalling 125 settings) were in receipt of the programme between 2018 and 2021.
The partnership model was unique in the UK, spanning statutory and VCSE organisations working in alliance. Front line clinical and care professionals from across sectors designed and implemented this innovative programme.

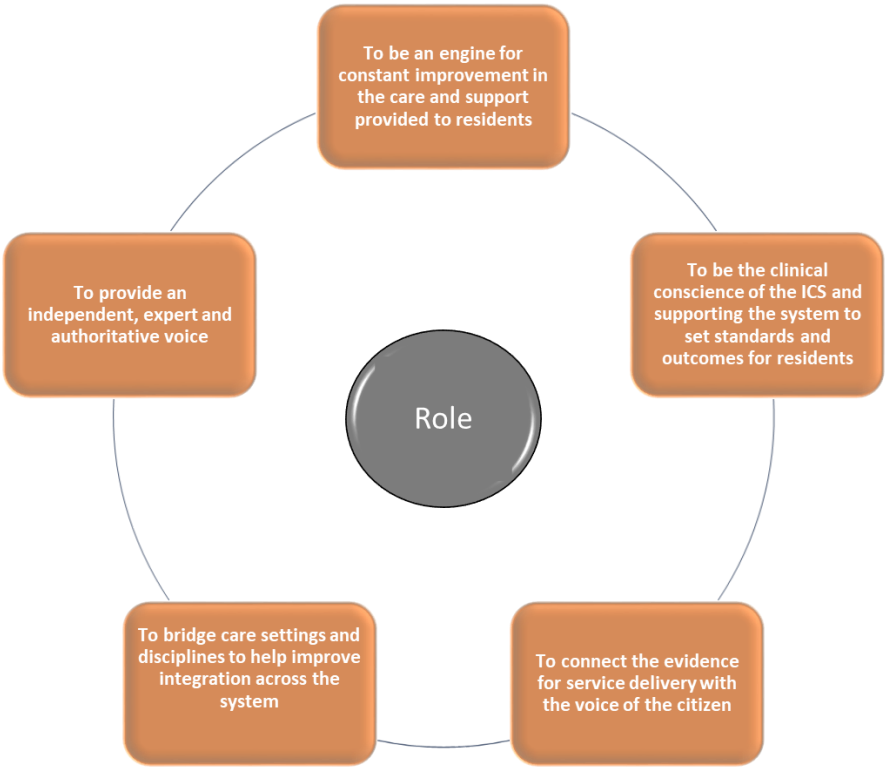
The delivery partners for this programme were:

- **Alliance for Learning**: Youth Mental Health First Aid England training programmes
- **Place 2 Be**: Mental Health Champions, Consultations & One to One Psycho-Social Support
- **42nd Street**: One to One Psycho-Social Support
- **Youth Sport Trust**: Active in Mind Athlete Mentors, Young Mental Health Champions and

- Physical and Emotional Curriculum Training
- **MFT:** Providing specialist clinical oversight

The impact of the programme has been very positive with longer term benefits and changes as a result of being one of the schools/colleges in the programme. It has given the respective schools and colleges a platform for focusing on mental health and wellbeing. For example, one respondent stated that "*MH is now at the forefront of school improvement*." another said they "*have made wellbeing a Key Priority*" and another said it has been "*a great start and allowed us to begin to shape our mental health provision."* The benefit to students was stated by one, "*students have welcomed a more open approach to mental health*." whilst staff benefits from the training were also acknowledged, *"Staff feel more confident in all aspects of mental health".*

3.0 THE ROLE OF COLLECTIVE CLINICAL & CARE PROFESSIONAL LEADERSHIP



4.0 OUR SHARED PRINCIPLES[1]

[1] Adapted from the work commissioned by NHS England and NHS Improvement (NHSEI) and undertaken through the NHS Confederation to support the development of national guidance which will drive the way in which clinical and care professional leadership will be established in an ICS.

5.0 WAYS OF WORKING – HOW WE APPLY CLINICAL & CARE PROFESSIONAL LEADERSHIP

Across GM, at both place and system level, clinical and care professionals should be central to the following key functions:

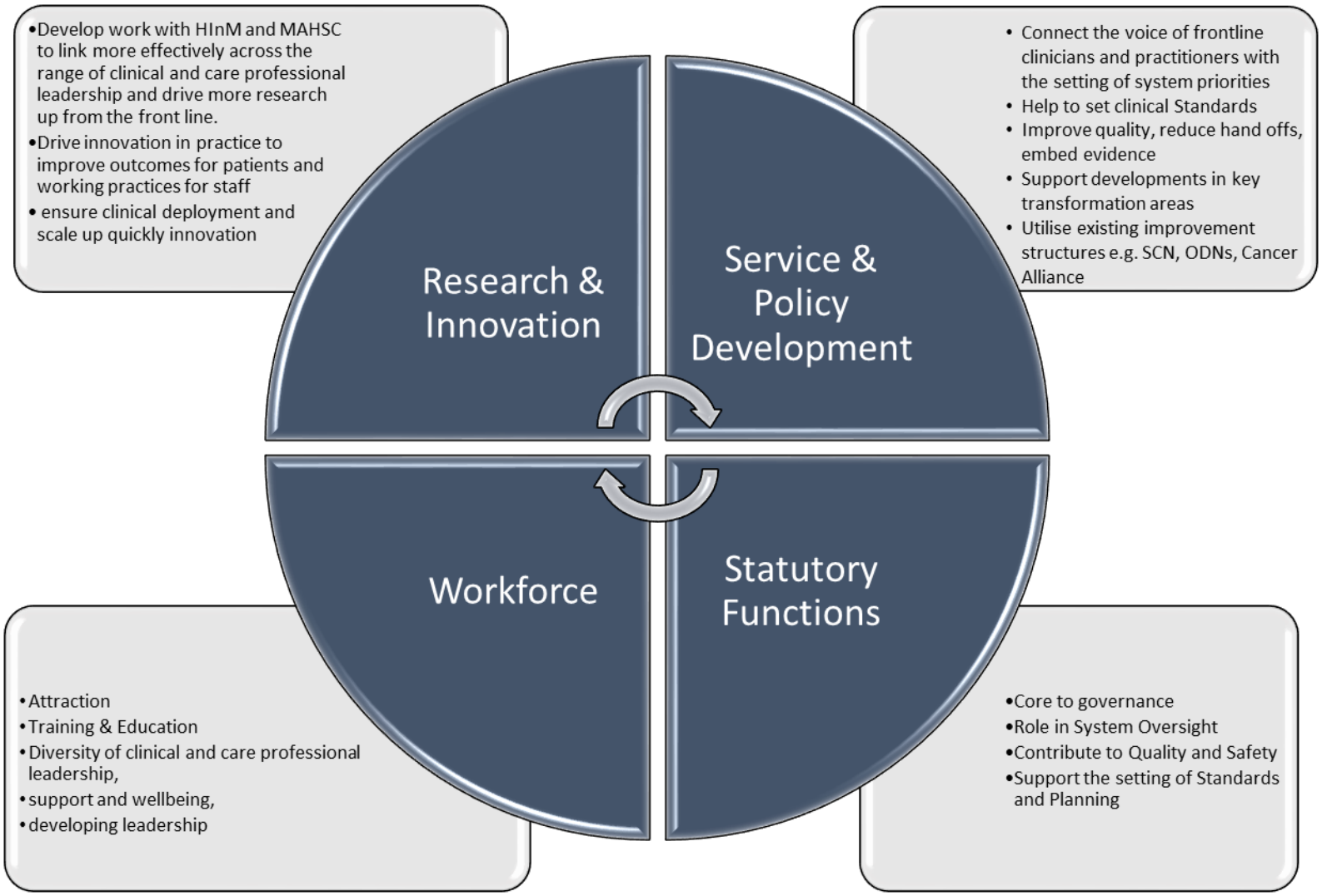
- Service and Policy Development, Quality Improvement, and integration from population health to tertiary care
- Ensuring that the context of a person's life is understood in the planning of their care – empowering the citizen, utilising their strengths and assets and those in their community, balancing social and preventative interventions and capturing lived experience
- Ensuring equity for the whole population through determined focus on inequalities
- Co-produce the setting of Standards and Outcomes with colleagues from across the wider system
- Population Health Management – shaping approaches to risk stratification, population segmentation and care model development
- Leadership in research & innovation and the opportunities for clinical deployment at scale
- Providing support and leadership in Quality Assurance and Safety as part of a system wide approach (Place and GM)
- Professional leadership support and development
- We will inform and support the **safe transition of CCG quality and statutory functions** (such safeguarding, Continuing Healthcare, SI panels, Coronial processes, SEND, oversight of CQC inadequate providers and CQC improvement action plans and the proposed host commissioner function for independent hospitals etc) into the new structures for place and GM system.

Clinical & Care Professional Leadership in Place

- The benefits of bringing clinical and care professionals together will be best realised at "place" level among those people looking after the same population, and this should be recognised in the developing locality structures.
- Place-based working will be the cornerstone of integrated local systems. Our future ways of working in localities will establish **Place Based Boards** to provide strategic oversight of all health and care in the place, to improve place-based population health management and health improvement. In each locality **place-based provider collaborations** will integrate care
- The participation, incorporation, and representation of clinical and care professional leadership is essential to the success of these structures. We support the establishment of **clear arrangements for clinical and care professional leadership in each place**. The relationship between place-based clinical and care professional leadership and that at GM will be pivotal to ensure we are well connected, and that we avoid duplication of effort.

GM System Clinical & Care Professional Leadership:

The group's discussions identified 4 key areas where clinical and care professional leadership should be active at a GM level:



6.0 ESTABLISHING A GM CLINICAL AND CARE PROFESSIONAL FORUM

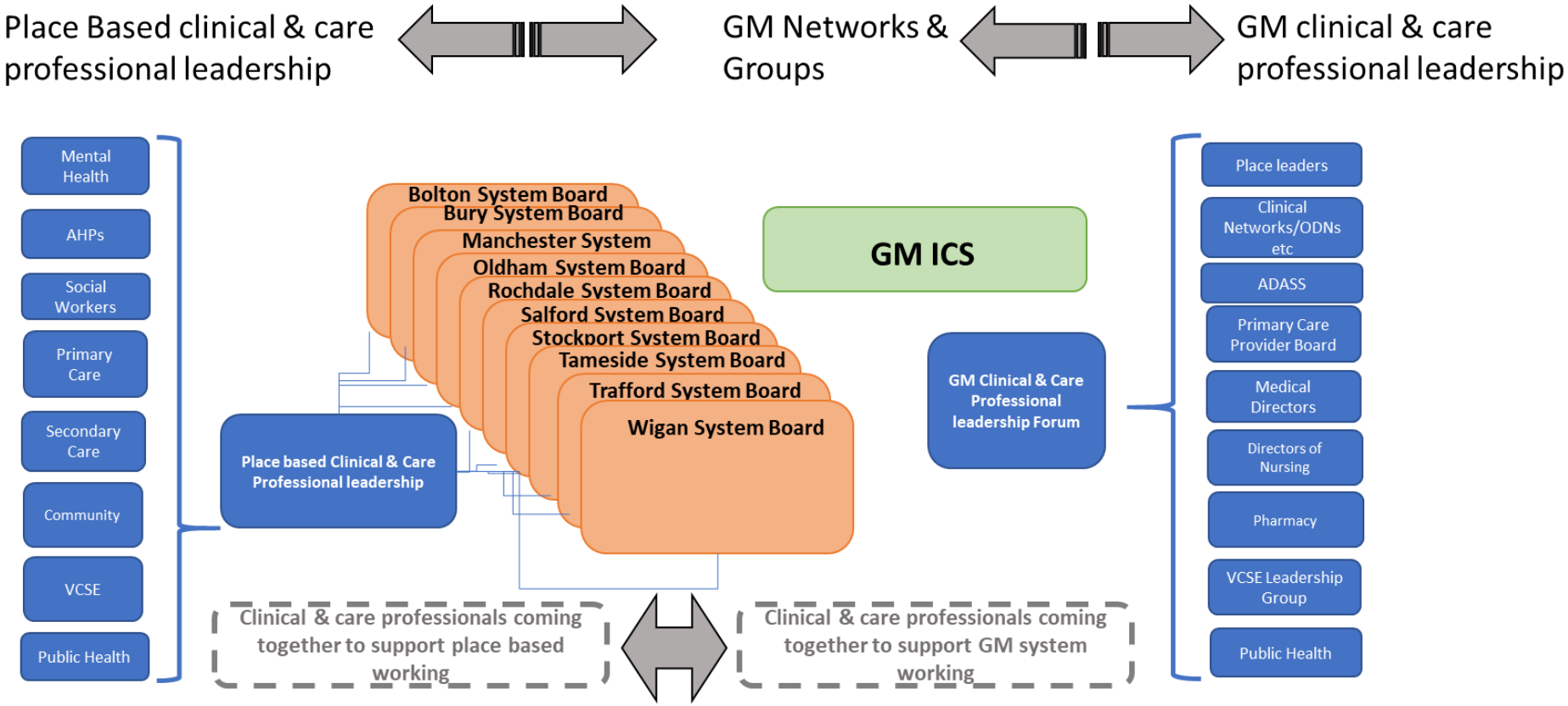
- We have emphasised how clinical and care professionals must be a cornerstone of place based leadership arrangements as well as how those leaders can operate collectively to inform and support system working at the GM level.
- Whilst the coordination and establishment of clinical and care professional leadership locally is a matter for each place, there would be an expectation that it was able to be clearly described and accessed and responds to the principles we have collectively agreed. The group also feel that there should be a significant degree of consistency across place-based arrangements to optimise the voice of clinical and care professional leaders in local systems.
- We wished also to confirm a structure for a wider GM network, **a Clinical and Care Professional Forum**[2].
- The forum will not seek to replace existing groups and networks that exist, but instead, what it can do is be proactive in helping those existing arrangements connect better with each other; be a route to that incredible range of clinical and care professional networks; innovate in how clinical and care professionals connect and network; be a means of drawing novel multi-disciplinary groups together to problem solve and participate in joint work. The forum would be of added value to the system, and have an important place, but as yet, undetermined in the wider GM ICS. It would not just be a "talking shop".
- The Forum would provide the mechanism to:
  - Ensure we can **draw on the widest range of talents** in the system to engage in decision making, priority setting, service transformation, research, strengthening our evidence base and quality improvement
  - Support strategic planning through development and communication of **shared common purpose** and prioritisation
  - **Ensure the voice of clinical and care professional leaders is connected** and audible and that emergent priorities benefit from the unique cross fertilisation afforded by this wider group.
  - Ensure GM working is driven by **direct engagement to, and connection with, frontline clinicians** in terms of developing clinical priorities.
  - Offer a **clinical and care professional opinion to the GM system** to inform approaches to service development, performance, quality, and access challenges. Potentially unlock key system challenges, independently of sector and organisation.
  - **Further support the deployment of research and innovation** – working with colleagues from MAHSC and Health Innovation Manchester, there is scope to improve further colleagues' knowledge of the current research and innovation agenda, encourage wider participation and influence both the focus and the breadth of the agenda, as well as deployment opportunities.

[2] The term Clinical and Care Professional Forum is a working title which may change as the detail of the proposed model and its ways of working are developed. The objective is that it will reflect dynamic, agile and innovative approaches to connecting colleagues and their participation and interaction to the range of activities.

- **Participate in workforce and leadership development** – connecting to the GM People Board where possible and through supplementary arrangements where necessary. Critical to this is the ability to develop the workforce in an integrated way. The objectives include:
    i. Attracting clinicians and care professionals to work in Greater Manchester as 'the' place to work.
    ii. Attracting people from our local communities into clinical and care professional careers
    iii. Enabling and encouraging diversity amongst the leadership of our clinical and care professional community, both in terms of diversity of role and diversity of people
    iv. Providing support to one another and the wider clinical and care professional community to be the best we can be in a sustainable way
    v. Improve the links to our academic institutions through the connection with the GM People Board.

7.0 CLINICAL AND CARE PROFESSIONAL LEADERSHIP IN PLACE AND ITS CONNECTION TO THE GM ICS

- During the development of this proposal, many colleagues from across the clinical and care professional community and beyond have challenged us on how this might start to piece together – the key relationship being between clinical and care professional leaderships in place as well as those in GM
- Of course, clinical and care professional leadership in place will need to be representative of the broad church and be inclusive of as many professional leaders as possible
- At a GM level, representatives of place-based leadership will need to align to, and be connected with, the many GM sectors and networks.
- Illustrated below is a diagrammatic representation of how this **MAY** look. Please note that this is only an outline suggestion at this stage and will need further development as per Section 8 "Making It Happen".
- Kindly note that this diagram is not intended to disrupt current relationships e.g. between Directors of Nursing and Medical Directors, nor between Primary Care Board and localities – instead it is a simple overview of how it may all fit together in the new GM ICS. All groups, sectors and organisations will stay be able to interface and work together as they currently do.


Place Based clinical & care professional leadership
GM Networks & Groups
GM clinical & care professional leadership
Mental Health
AHPs
Social Workers
Primary Care
Secondary Care
Community
VCSE
Public Health
Bolton System Board
Bury System Board
Manchester System
Oldham System Board
Rochdale System Board
Salford System Board
Stockport System Board
Tameside System Board
Trafford System Board
Wigan System Board
GM ICS
Place based Clinical & Care Professional leadership
GM Clinical & Care Professional leadership Forum
Place leaders
Clinical Networks/ODNs etc
ADASS
Primary Care Provider Board
Medical Directors
Directors of Nursing
Pharmacy
VCSE Leadership Group
Public Health
Clinical & care professionals coming together to support place based working
Clinical & care professionals coming together to support GM system working

8.0 MAKING IT HAPPEN

The paper identifies a number of key areas, drawing together the output of discussions to date and invite colleagues from across the health and care system to reaffirm those as follows:

- To confirm the principles of clinical and care professional leadership (s 3)
- To confirm the ways of working and how we apply clinical and care professional leadership (s 4)

If colleagues are supportive of the above, that will allow us permission to move to the next steps outlined below in order to make this happen. Listed below are a number of key areas essential to the ambitions the group has described, which will require further detailed work over the next 3 – 6 months:

- The need to describe a shared perspective on place based clinical and care professional leadership as a required feature of locality working and how this integrates into the wider ICS leadership.
- To set out a more detailed proposition on the development of the GM Clinical and Care Professional Forum. This should include how it will be representative of, and connect to, the breadth of clinical and care professionals across GM; how it is structured, supported and resourced, and its role in the GM ICS. It will need to ensure it is effectively connected with its constituent professional and organisational groups.
- The need to ensure clinical and care professionals are appropriately represented in key GM ICS governance structures e.g. GM ICS NHS board and wider GM partnership board.
- In the GM ICS there will be a number of accountable clinical roles – specifically around medical and nursing responsibilities. We will need to clarify the role and future intentions of the GM Medical Executive and the GM HSCP Nursing Team and the leadership arrangements therein.
- To make links across the range of GM networks to coordinate ODNs, SCNs, Cancer Alliance, HInM etc
- To initiate work with the GM VCSE Leadership Group to ensure the sector is fully engaged and invited to consider and describe its own perspective on the clinical and care professional contribution of the VCSE and its means of joining the proposed Forum.
- To collaborate with the wider system to understand which spatial level (GM, locality, other) work and accountability should appropriately sit
- Consideration needs to be given to how we move this paper forward and the next steps as outlined above – in particular getting the right level of resourcing and appropriate breadth of personnel involved from across the clinical and care professional system.

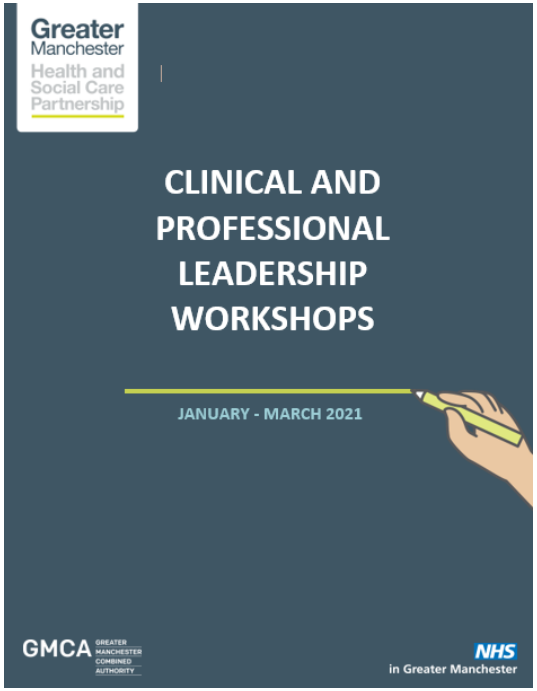
11th June 2021

Appendix one – Workshop Group Membership:

Name	Designation	Organisation
Mohsan Ahmad	General Dental Practitioner / Chair	GM LDN
Jolaade Anjurin	Principle Social Worker (Adults)	Manchester City Council
Kate Arden	Director of Public Health	Wigan Council
Helen Barlow	Deputy Director (Nursing)	Greater Manchester H&S Care Partnership
Alan Barrett	Consultant Clinical Psychologist	Pennine Care NHS Foundation Trust
Paula Breeze	OT / GM AHP Workforce Programme Lead	Manchester Foundation Trust
Emma Brown	Principle Social Worker (Adults)	Trafford Council
Chris Brookes	Consultant (A&E) / Deputy CEO Northern Care Alliance / GM Medical Exec Lead (Acute Care)	Salford Royal FT / GMHSCP
Julie Cheetham	Deputy Director (Improvement)	Strategic Clinical Networks (GMHSCP)
Jacqueline Coulton	Chief Nurse	NHS Trafford CCG
Jane Eddleston	Consultant in Intensive Care Medicine / GM Medical Exec Lead (Acute Care)	Manchester Foundation Trust / GMHSCP
Peter Elton	Clinical Director	Strategic Clinical Networks (GMHSCP)
Warren Heppolette	Exec Lead for Strategy	Greater Manchester H&S Care Partnership
John Herring	Strategic Lead for OD and System Leadership	Greater Manchester H&S Care Partnership
Catherine Jackson	Director of Nursing and QI / Nurse Practitioner	NHS Bury CCG / LCO
Luvjit Kandula	Pharmacist / Director of Pharmacy Transformation	GM LPC

Clare Parker	Exec Director of Nursing, Healthcare Professionals & Quality Governance / Deputy Chief Exec	Pennine Care NHS Foundation Trust
Dharmesh Patel	Optometrist / Chair	GM Optometry Provider Board / Primary Eyecare Services
Ashwin Ramachandra	GP/clinical Chair	Market Street Medical Practice / NHS T&G CCG
Sandeep Ranote	Exec Medical Director MH & Integrated Care / Exec Medical Lead Mental Health / Visiting Professor	WWL NHS FT / GMHSCP / University of Salford/Chester
Lesley Royle-Pryor	Community Nurse / Chief Nurse	Bolton GP Federation
Tom Tasker	GP/ Chair / Chair of GM Medical Exec	St Andrews Medical Centre / NHS Salford CCG / GMHSCP
Steve Taylor	MH Nurse / Chief Officer / MD	Rochdale Care Organisation
Tracey Vell	GP, Clinical Director / Medical Exec Lead Primary care	Health Innovation Manchester / GMHSCP

Appendix two – Workshop write-ups



1 Clinical and Professional Leaders

2 Clinical and Professional Leaders

3 Clinical and Professional Leaders

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Approve
Item No	6.2	**Confidential / Freedom of Information Status**	No
Title	Bury Partnership Arrangements		
Presented By	Will Blandamer – Executive Director Strategic Commissioning		
Author	Will Blandamer – Executive Director Strategic Commissioning		
Clinical Lead	Dr Schryer – CCG Chair		
Council Lead	Cllr Simpson – Exec Member Adult Care and Health		

Executive Summary

This document confirms the partnership arrangements to be developed that have previously been agreed, and provides a suite of documents that support those arrangements to progress as soon as possible and by October 2021 in line with GM Expectations.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Endorses the documentation as indicated.

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:	Yes
The risk of business continuity around the ICS transition arrangements.	

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

Implications						
from the proposal or decision being requested?						
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Fully aligned					
How do proposals align with Locality Plan?	Fully Aligned					
How do proposals align with the Commissioning Strategy?	Fully Aligned					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	Creates the conditions To continue our work on the integration of health and care services, and the focus on inequalities and population health gain.					
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	
	implications.

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.	01/07/2021	SCB Development Session

Bury Locality Partnership Arrangements.

Paper for the System Board on 19th August,

to be subsequently revised for consideration by the

Strategic Commissioning Board on 6th September

Will Blandamer – Executive Director of Strategic Commissioning

Draft 3 – 20th August

(Draft 2 -agreed at the System Board on 19th August)

Appendix 1 - Locality plan

Appendix 2a – Draft Locality Board Terms of Reference

Appendix 2b – Place Based Lead

Appendix 3 – Integrated Delivery Collaborative Board Terms of Reference

Appendix 4 – Terms of Reference for the Health and Well Being Board

Appendix 5 – Clinical and Professional Senate Development and Transition

Appendix 6 – Towards a GP Collaborative for Bury

Appendix 7 – Terms of Reference for the Locality Strategic Finance Group

Appendix 8 – Towards a System Wide Locality Quality, Safeguarding and Performance Group

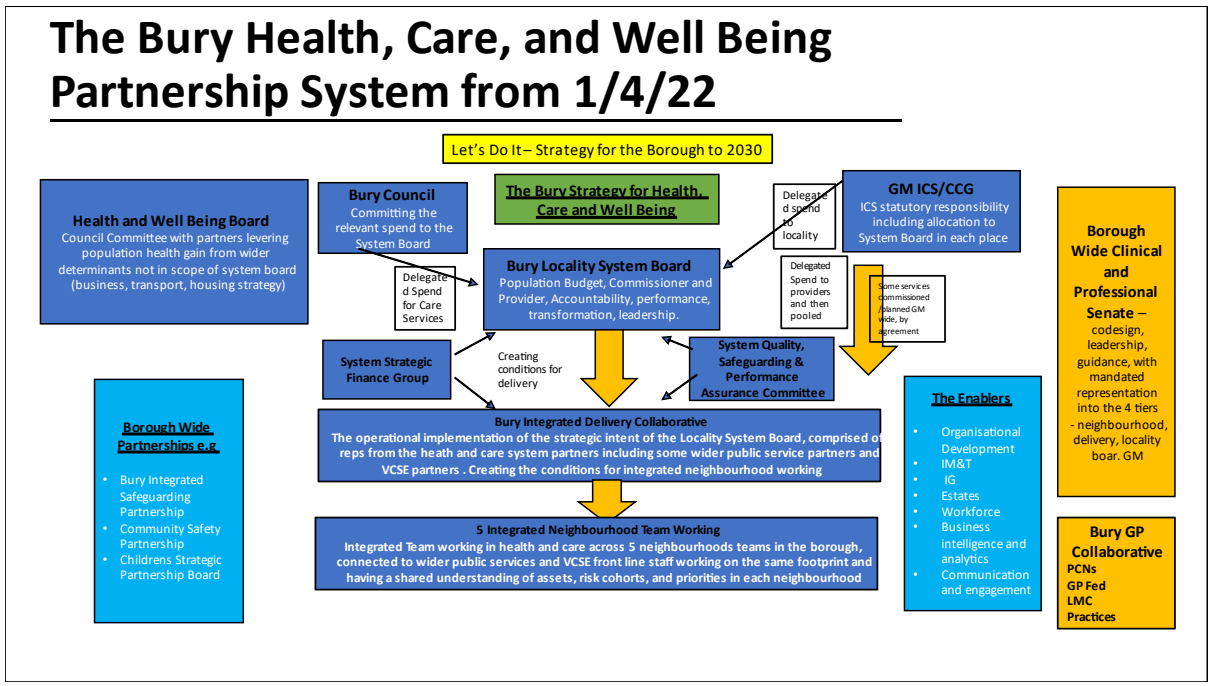
A. Background.

The SCB Development meeting received and reviewed a suite of documentation describing the development of the partnership arrangements in Bury in the light of the ICS development. The SCB made several useful suggestions and amendments, and this formal SCB meeting is invited to formally endorse the proposals. It is intended to have all aspects of the partnership system in Bury operating at least in shadow form by October 2021 in line with GM wide expectations.

SCB will note that the Bury System Board meeting of 19th August received this paper and all appendices and approved all, with only minor amendments.

B. Partnership Arrangements - Update

The following diagram, and its earlier iterations, have guided the development of the new partnership arrangements in Bury.



1) Locality Plan – The Strategy for Health Care and well Being

The refreshed locality plan (Appendix A) was approved at the SCB development session in July and the Bury system Board in July. It will be noted that Bury is ahead of the ask of GM for all localities to refresh their locality plan. We will continue to develop and refine the locality plan over time. The attached document includes recommended text from the GM Childrens Board on the high-level principles for integrated children's health and care services.

Recommendation: The SCB are asked to endorse the amended refreshed locality plan.

2) The Locality System Board ('Locality Board')

A draft term of reference for the Locality Board was presented to the SCB Development Session in June. A request was made to strengthen the clinical leadership, particularly nursing, with a seat on the locality board. A further amendment has been made to recognise the need for representation on the board of representation from major NHS Foundation Trusts other than NCA.

The locality board cannot operate in full form until the exact nature of the financial flows and accountability agreements are made as part of the GM operating model. The locality board cannot replace the statutory responsibility of the Governing Body and the Strategic Commissioning Board until 1/4/22. However, it is proposed to convene a first meeting of the shadow locality board in October – to run adjacent to the SCB. This transition period will allow the new membership to meet and develop a shared understanding of the future role of the locality board, and to receive updates of the work of the Integrated Delivery Board.

The combination of the locality board and the Integrated Delivery Board means we can stand down the current System Board.

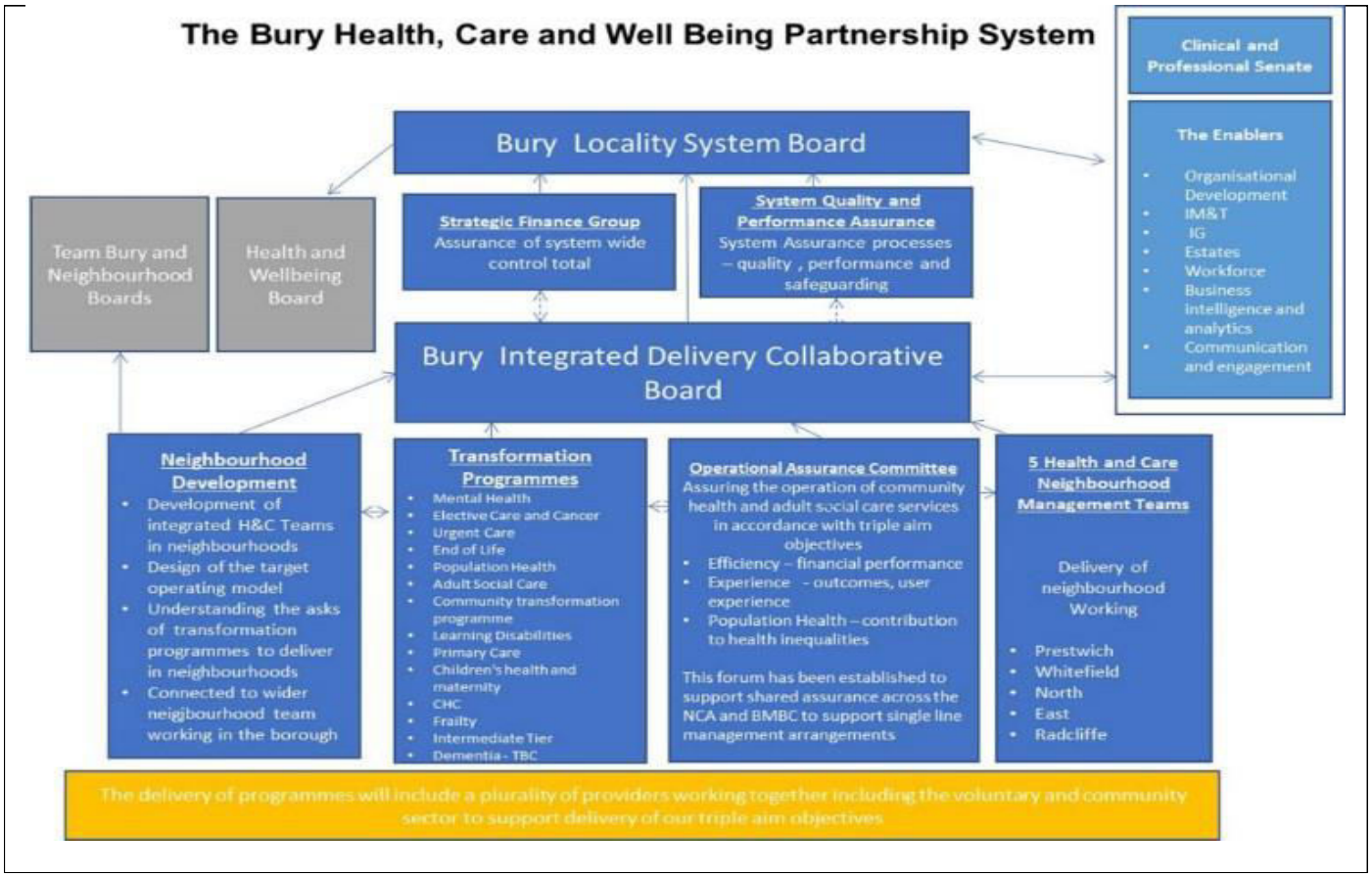
Recommendation: The SCB is asked to comment on the terms of reference including membership for the shadow locality board to operate from October 2021 but note further versions may be required as the precise obligations in terms of an accountability agreement with GM are confirmed. The SCB is invited to note the System Board approved this paper and has elected to cease meeting.

The terms of reference identifies the place-based lead as a key member of the System Board. The SCB development session received the attached paper (Appendix 2b) confirming the place-based lead for Bury.

Recommendation. The SCB is asked to approve the proposal of the place-based lead for Bury, and to note that the System Board endorsed this paper.

3) Integrated Delivery Collaborative Board

In the June System Board meeting, and the July SCB Development session the establishment of the Integrated Delivery Collaborative board was noted. The diagram below shows further detail of its work.



The IDCB is concluding its developmental phase and will begin to operate more fully – in relation for example to the check/challenge/support to the portfolio of transformation programmes.

Recommendation: The Terms of reference of the IDCB are endorsed.

4) The Health and Well Being Board

The health and well being board is a council committee and the terms of references are considered at each annual meeting. The health and well being board has changed its terms of reference to become a standing commission on health inequalities and deploying the Kings Fund model of 4 quadrants of a population health system to drive its agenda. This meeting is working effectively using the terms of reference.

Recommendation: The SCB is invited to endorse the terms of Reference of the Health and Well Being Board agreed at the Council meeting, and to note this was endorsed at the System Board meeting.

5) Clinical and Professional Senate

A proposition for the establishment of a clinical and professional senate for the borough has been developed. It describes two elements – a strengthened network of clinical and professional leadership in the borough, and at the heart of that network a clinical and professional senate steering group. Appendix 5 provides the latest description of a clinical and professional senate.

It is proposed to formalise the transition group for the clinical and professional senate, based on the proposed membership. The transition group will continue to develop the proposition with the objective of forming the clinical and professional senate in shadow form from January 2022.

Recommendation. The SCB is invited to support the development of the clinical and professional senate and the establishment of the transition group, and to note the System Board endorsed the proposal.

6) GP Collaborative

A paper describing the potential development of a GP collaborative for Bury is attached as appendix 6. This is an initiative being co-developed by the CCG with GP Federation and the LMC.

Recommendation: The SCB is invited to support the process outlined and to receive a further proposal following a sequence of conversations with the GP Community in Bury, and to note the System Board endorsed the direction of travel.

7) Strategic Finance Group

The Strategic Finance Group for the Bury Health and Care System supports the Bury Locality Board to discharge its responsibility to manage the integrated budgets (pooled and aligned

and in view) in a way that has NHS providers and the Council working transparently together to spend the Bury pound as effectively as possible.

The Group will also support the IDCB in working with transformation programmes to effectively manage the delivery of anticipated reductions in demand and cost.
This meeting is established and is developing maturity. The terms of reference were developed in April and are due for review to reflect the new architecture described in this paper.

Recommendation. The SCB is invited to endorse the terms of reference of the strategic finance group, to note the System board endorsed the same, and to receive a further updated version of the Terms of Reference in due course.

8) System Quality, Safeguarding and Performance Committee.

This meeting will support both the Locality Board and the Integrated Delivery Board in ensuring a that quality and safety and performance operate as 'golden threads' from the Locality Board to neighbourhood working. In transition phase this meeting will grow out of the existing CCG quality and performance committee and the chair has supported the approach. Work continues to align quality reporting arrangements with providers.

The System Board considered the need to reflect risk identification and management in the new partnership arrangements and further work will be undertaken on this.

Recommendation. The System Board and SCB is invited to note the progress towards establishing the System Quality, Safeguarding and Performance Committee, and to support the transition of the CCG quality and performance committee into the new arrangements (subject to completion of statutory CCG duties until 31/3/22.)

C) Partnership Arrangements – Transition.

There are local advantages to moving quickly to develop the shadow arrangements as soon as possible – while we are in transition there is some overlap and duplication of meetings and a lack of clarity around routes of reporting and decision making. In addition, there is a GM expectation of operating the shadow arrangements from October.

It should be very clear that the arrangements proposed reflect the operation of the system in shadow form. There is not a change to the formal lines of accountability – for example in relation to the statutory duties of the Governing Body of the CCG or the delegated authority from Governing Body and Cabinet to the Strategic Commissioning Board – until 1/4/22.

a. Establish the shadow Locality Board from October.

b. Limit the business of the Strategic Commissioning Board and the CCG Governing Body to those tasks that only the SCB and Governing Body can do in relation to the discharge of their statutory obligations. A forward plan for required decisions will be finalised, and the current version of the forward plan for both is attached as Appendices A and B for information.

c. Continue the operation of the IDCB, from September operating fully in relation to the oversight of its own subgroup including transformation programmes

d. The operation of the locality board and the IDCB means it is not necessary to have the current System Board and the last current System Board was agreed by the System Board to be August 2021.

e. Convene a first meeting of the Clinical and Professional Senate steering group in September, as described in the paper, to operate as a design and transition group, with the intention the senate operates in shadow form from January 2022

f. Progress the transition of the CCG quality and performance group to the System wide Quality, Safeguarding and Performance Group by October 2022.

Recommendation: The System Board and SCB are invited to endorse the proposed transition to new shadow arrangements as above and as described in the rest of this paper.

Appendix A

GOVERNING BODY FORWARD PLAN TRACKER

NB Work is required to understand the timeline of decisions required by the Governing Body in relation to the closedown of the CCG.

DATE	NAME OF DOCUMENT/REPORT	AUTHOR
22-Sep-21	Chief Officers Report	Geoff Little
22-Sep-21	Quality Update	Catherine Jackson
22-Sep-21	Safeguarding Dashboard	Cathy Fines
22-Sep-21	Monthly Finance Report	Sam Evans
22-Sep-21	Budget/Financial/Savings Plan	Sam Evans
22-Sep-21	Performance Report	Will Blandamer
22-Sep-21	GBAF	Lynne Ridsdale
22-Sep-21	Corporate Risk Register	Lynne Ridsdale
22-Sep-21	SCB Minutes (Information Section)	Chair
22-Sep-21	ICS proposals / next steps / engagement	Will Blandamer
22-Sep-21	Finance, Contracting & Procurement Committee Chairs Report	Chris Wild
22-Sep-21	Quality and Performance Committee Chair's report	Peter Bury
22-Sep-21	Audit Committee Chair's Report	Chris Wild
22-Sep-21	Workforce Race Equality Standard (WRES) report	Geoff Little
22-Sep-21	Policies - Conflicts of Interest, Whistleblowing and Gifts and Hospitality	Chris Wild
22-Sep-21	PCCC Chair's report	Peter Bury
27-Oct-21	**Development Session - propose cancel or use slot for shadow/transition purposes**	
24-Nov-21	**Formal Meeting - Propose step down - EPRR Core Standards item (consider alternative route/retrospective approval for this item so meeting slot can be used for other purpose**	
22-Dec-21	**Propose cancel or use slot for shadow/transition purposes**	
26-Jan-22	Chief Officers Report	Geoff Little
26-Jan-22	Safeguarding Dashboard	Cathy Fines
26-Jan-22	Quality Update	Catherine Jackson
26-Jan-22	Monthly Finance Report	Sam Evans
26-Jan-22	Budget/Financial/Savings Plan	Sam Evans
26-Jan-22	Performance Report	Will Blandamer

26-Jan-22	GBAF	Lynne Ridsdale
26-Jan-22	Corporate Risk Register	Lynne Ridsdale
26-Jan-22	SCB Minutes (Information Section)	
26-Jan-22	Quality and Performance Committee Chair's report	Peter Bury
26-Jan-22	Finance, Contracting & Procurement Committee Chairs Report	Chris Wild
26-Jan-22	Audit Committee Chair's Report	Chris Wild
26-Jan-22	PCCC Chair's report	Peter Bury
23-Feb-22	**Development Session - propose cancel or use slot for shadow/transition purposes**	
23-Mar-22	Chief Officers Report	Geoff Little
23-Mar-22	Safeguarding Dashboard	Cathy Fines
23-Mar-22	Quality Update	Catherine Jackson
23-Mar-22	Monthly Finance Report	Executive Director of Finance
23-Mar-22	Budget/Financial/Savings Plan	Executive Director of Finance
23-Mar-22	Quality Report	Catherine Jackson
23-Mar-22	Performance Report	Will Blandamer
23-Mar-22	Equality Report	Geoff Little
23-Mar-22	GBAF	Lynne Ridsdale
23-Mar-22	Corporate Risk Register	Lynne Ridsdale
23-Mar-22	Chairs Reports - Audit Committee, Q&P	Peter Bury/Chris Wild
23-Mar-22	SCB Minutes (Information Section)	
23-Mar-22	PCCC Chair's report	Peter Bury

Appendix B

SCB FORWARD PLAN TRACKER

DATE	NAME OF DOCUMENT/REPORT	AUTHOR
6th September 2021	**SCB Formal Meeting (Rearranged from August 2021)**	
06-Sep-21	ICS (Greater Manchester, Locality Partnership and Neighbourhood)	Will Blandamer/Geoff Little
06-Sep-21	Chief Officers Update	Geoff Little
06-Sep-21	Financial/Budget Update	Sam Evans
06-Sep-21	Risk Report	Lynne Ridsdale

06-Sep-21	IFR/EUR Proposals	Howard Hughes, Maxine Lomax, Nasima Begum
06-Sep-21	Integrated Pooled Budget Year End Report	Sam Evans
06-Sep-21	JCB Minutes from 20th July 2021	Information
06-Sep-21	Elective Care	Cath Tickle/Will Blandamer
06-Sep-21	Maternity Review paper	David Latham / Will Blandamer
06-Sep-21	Mental Health - look in more detail at what the issues are for complex cases	Will Blandamer
06-Sep-21	Transformation funding follow up paper	S Evans
06-Sep-21	Armed Forces Covenant Refresh	S McVaigh
06-Sep-21	SEND JSNA	Will Blandamer
06-Sep-21	Care at Home Contract Award	Will Blandamer
06-Sep-21	Lived Experience/Patient engagement	Will Blandamer
06-Sep-21	Integrated Delivery Board (Overview)	Will Blandamer
06-Sep-21	Designated Beds - Shared Provision	Will Blandamer
4th October 2021	**SCB Formal Meeting**	
04-Oct-21	Chief Officers Update	Geoff Little
04-Oct-21	Financial/Budget Update	Sam Evans
04-Oct-21	Performance Update	Will Blandamer
04-Oct-21	Risk Report	Lynne Ridsdale
04-Oct-21	ICS Update (to include Structure of new ICS Boards etc)	Will Blandamer
04-Oct-21	Radcliffe SRF - proposals for the Radcliffe model	Geoff Little
04-Oct-21	EIA for the Northern Care Alliance - Urology Reconfiguration	NCA/Will Blandamer
1st November 2021	**SCB Development Session - Propose use for other transition purpose**	
11/01/2021		
11/01/2021		
11/01/2021		
11/01/2021		
11/01/2021		
6th December 2021	**SCB Formal Meeting**	
06-Dec-21	Chief Officers Update	Geoff Little
06-Dec-21	Financial/Budget Update	Sam Evans
06-Dec-21	ICS update	Will Blandamer
06-Dec-21	Performance Update	Will Blandamer
06-Dec-21	Council/CCG Risk Report	Lynne Ridsdale

10th January 2022	**Development Session - Propose use for other transition purpose**	
01/10/2022		
01/10/2022		
01/10/2022		
01/10/2022		
01/10/2022		
7th February 2022	**SCB Formal Meeting**	
07-Feb-22	Chief Officers Update	Geoff Little
07-Feb-22	Financial/Budget Update	Sam Evans
07-Feb-22	ICS update	Will Blandamer
07-Feb-22	Performance Update	Will Blandamer
07-Feb-22	Risk Report	L Ridsdale
7th March 2022	**Development Session - Propose use for other transition purpose**	

Refreshed Bury Locality Plan

The Bury Strategy for

Health, Care, and Well Being

Draft Version 6

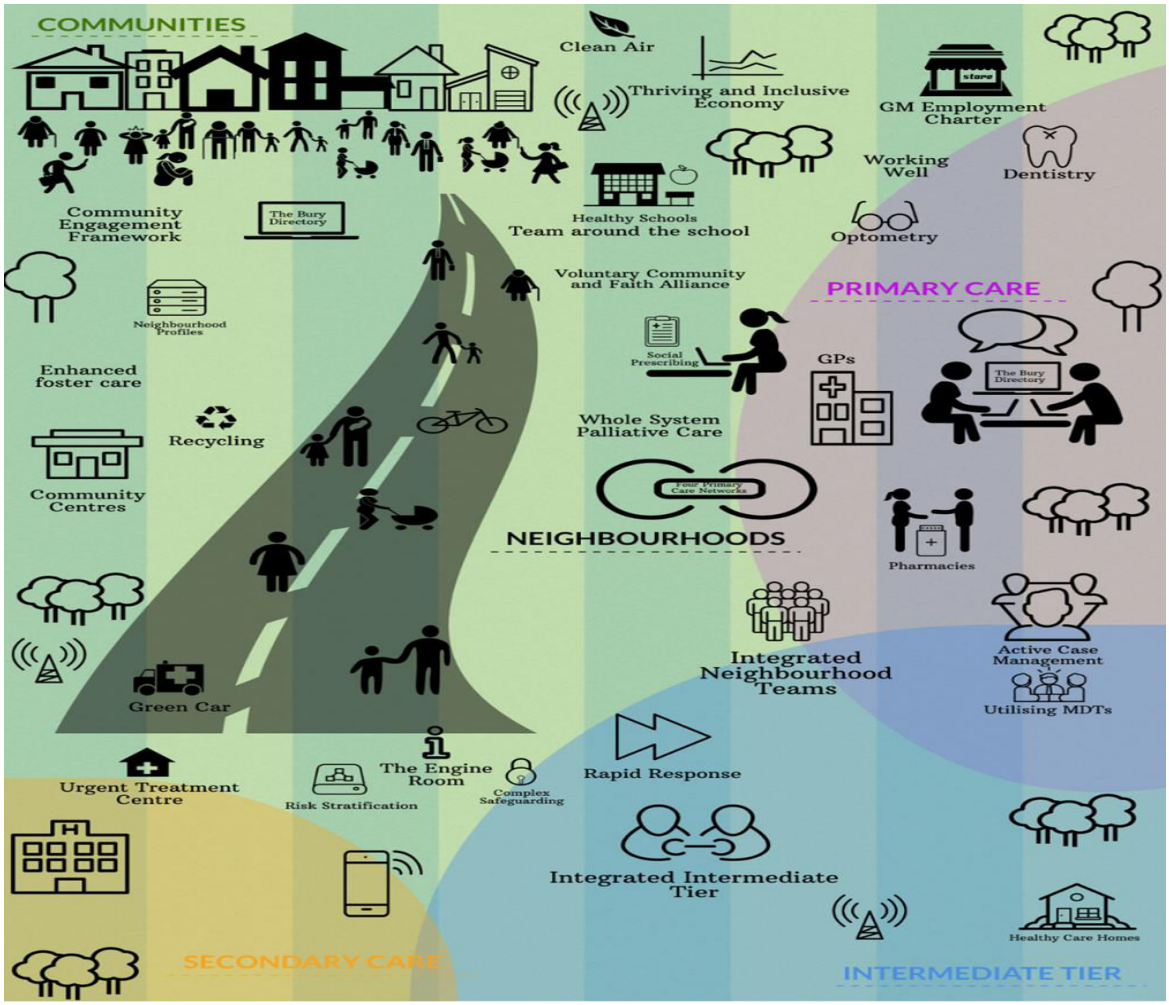
Endorsed at System Board 20/8/21

For approval at SCB

Will Blandamer

6/8/2021

For Review January 2022



Executive Summary

Significant progress has been made in transforming the operation of the health, care and wellbeing system since the first Bury Locality Plan in 2017, and since its refresh in 2019. However, the context of the work of partners has changed considerably because of Covid 19, and the emergent new partnership arrangements as a consequence of the DHSC White Paper of March 2019 and subsequent legislation. We also have the benefit of the Let's Do It strategy for the borough – the strategy for the place until 2030.

'Form follows function' – and as we progress new partnership arrangements and priorities to respond to the changed context it is imperative to restate and reconfirm the vision, the priorities, and the way we anticipate working together to support better outcomes for Bury residents.

This is a refreshed and concise Bury Locality Plan for the Health, Care and Well Being. It is intended to operate as touchstone – or a north star - as we recover from the pandemic and move into a period of organisational uncertainty. It reminds us, that securing better outcomes, addressing health inequality, improving access to and the quality of services received, and supporting residents to be well, independent, connected to their communities, and in control of the circumstances of their care and lives is the basis for our transformational ambition.

Contents

A. Background

1. In 2017 partners in the health and care system in Bury agreed a strategy for health, care and wellbeing. It was called the 'Bury Locality Plan', and each of the 10 Districts in Greater Manchester had a similar document as part of the wider GM Health and Care Devolution arrangements.

2. The 2017 Bury Locality Plan set out an ambitious programme of work, focusing not only on new models of joined up health and care delivery, but also on the wider ambition to improve population health and reduce inequalities. The plan recognised that achievement on health inequalities was also dependent on work with other public services, and work to support residents to be independent of services as far as possible and connected to their communities. The plan also developed a framework for potential investment from the Greater Manchester held Transformation Fund – to help establish new ways of working and to cover some 'double running' costs. Importantly, it indicated that without concerted and system wide action the size of the financial gap in the health and care system was predicted to be £76m in 2022.

3. In 2019 the Locality Plan was refreshed. The refresh recognised considerable progress – in beginning to build neighbourhood teams for health and care staff in each of 5 places, in building the partnership of providers as a 'local care organisation' (LCO), in standing up some borough wide transformation programmes (e.g in Urgent Care), and in the work tackling entrenched health inequalities in the borough. It referenced the work being done to substantially improve the working relationships between Council and CCG in the borough through the proposed establishment of the One Commissioning Organisation (OCO). The OCO changed some line management arrangements into integrated team and was also an ethos of collaboration in commissioning between Council and CCG – joint appointments, an integrated (pooled and aligned) budget, and the establishment of the Strategic Commissioning Board – where decisions from Council Cabinet and CCG Board were delegated for shared and joint decision making by clinical and political leadership.

4. The 2019 Locality Plan was comprehensive in describing a range of new programmes and initiatives. And it constituted a step change in integrated commissioning arrangements through the OCO, and a new forum for partnership and collaboration and delivery through the LCO. It also acknowledged some areas where progress from the 2017 plan was not as advanced as hoped, and it recognised the anticipated 2022 financial gap was now £85m.

5. Nevertheless the 2017 Locality Plan and its refresh in 2019 were pivotal in the Bury Health and Care System. They created ambitious transformation programmes in the delivery of health and care, they focused strongly on improving population health as a means of improving outcomes and contributing to the financial sustainability of the system. They constituted a step change on our journey of integration. And they confirmed a commitment to building and developing neighbourhood teams of health and care staff. They also recognised that simply re-designing the way health and care services are provided isn't enough – we need to engage with people and communities in a different way, support residents to be in control of their lives and in control of the way health and care services are organised around them.

B. Context

6. Much of the locality plan refresh of 2019 stands true today. But the context for a strategy on health, care and wellbeing in 2021 for Bury has changed fundamentally for the following reasons:

    a. The global Covid 19 pandemic in 2020-2021 has been an appalling tragedy for so many people and families, and the consequences in terms of health, and the economy will be felt for years to come. However, it is also true that the response to the pandemic has taught us much – it has starkly exposed health inequalities particularly by ethnicity as well as socio-economic deprivation, it has required a community-based response, it has demonstrated the best of how a health and care system can work together effectively, it has seen rapid deployment of technology, and it has reminded us of the important role of social care provision as part of an integrated system.

    b. The focus of the NHS in response to the pandemic has of course been the urgent care system, but the consequence has been an enormous backlog of elective/planned care that needs to be addressed. There is also likely to be a hidden cost in terms of health inequalities– lost opportunities to prevention harm or to intervene earlier (for example in cancer diagnosis). Finally, we are likely to see a growth in demand for services, particularly in mental health, as consequences of the pandemic itself, and as a consequence of the very severe economic position currently being experienced.

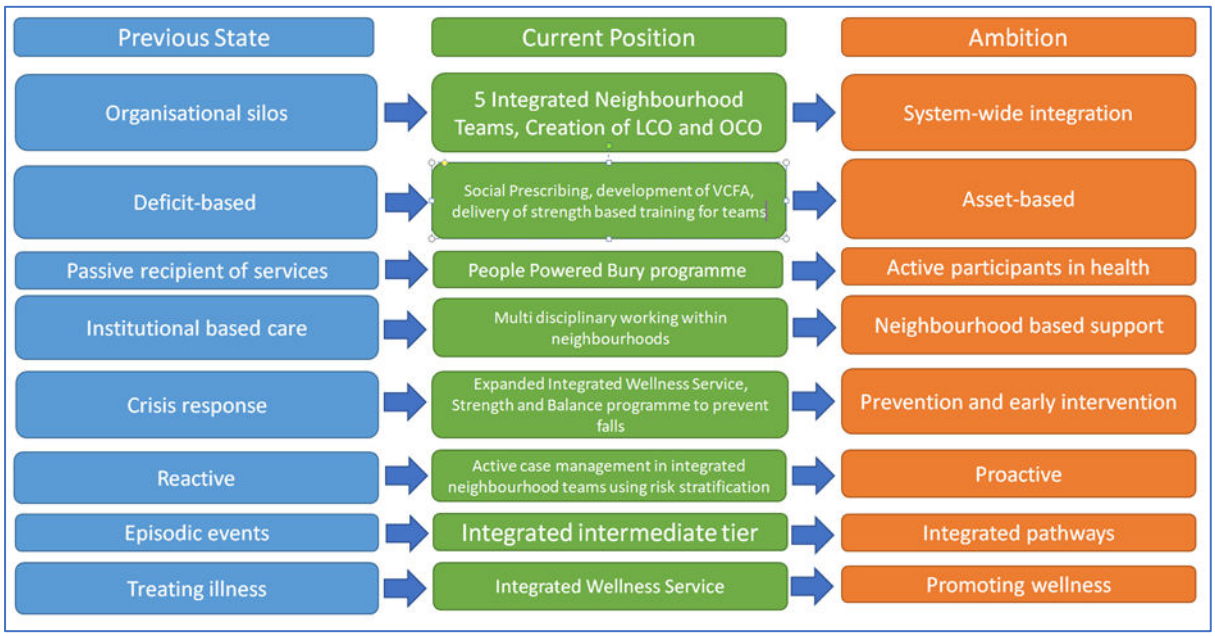
    c. The NHS White Paper of March 2021 has signalled a shift in the focus of the system – from competition to collaboration in the NHS, to a focus on 'place', to a blurring of the commissioning/provision distinction. It signals the end of CCGs from 31/3/22 to be replaced by a GM Integrated Care System operating across Greater Manchester and in each of the 10 places. At the time of writing, we are awaiting the subsequent legislation.

    d. The financial position of the health and care system predicted in the locality plan of 2017 and its refresh in 2019 is becoming evident. For the year 21/22 both Council and CCG remain very financially challenged – the Council due to significantly reduced income due to the pandemic, and both council and CCG facing significant demand growth.

    e. Very positively, Bury Council and CCG have worked with partners to produce 'Let's Do It' – the Strategy for the borough until 2030. It has a focus on combining economic ambition with a relentless focus on tackling the inequalities in health and life chances that hold many residents and communities back in making a full and positive contribution to the future of the borough and being in control of the circumstances of their lives. Let's Do It provides a clear strategic framework within which our sectoral strategy on health and care can sit, and mutually reinforce other strategies around economic ambition, climate change, wider reformed public services, and community vibrancy and connectedness.

C. Progression of the Health and Care System

7. In addition to the changing context, it should be recognised that the locality plan refresh of 2019 anticipated a progression in our collective thinking about priorities and objectives. It described moving from a state of organisational silos and crisis response, through to a system displaying more joined up working as exemplified by the OCO and LCO. It also describes the future – system wide, integrated, preventative, connected to communities and neighbourhood team based.



8. Of course, progress across these three 'states' isn't linear, and there are examples of where our current practice and working arrangements are ahead or behind the 'current position'. The 2019 set out the progress since 2017 and conditions to move beyond to fulfil the overall ambition. But this diagram is prescient – if the first locality plan of 2017 responded to the characteristics of the 'previous state', and the locality plan refresh of 2019 created the conditions for our 'current state' then this 2021 locality plan refresh is intended to recognise the new context and circumstances and move to realise the characteristics of 'ambition'.

9. The diagram above could be updated to reflect an additional dimension that has become apparent during Covid and has increasingly informed our response to pandemic – on issues of inequality and inclusion. The Let's do It strategy has escalated our collective ambition on addressing health inequalities, and all partners are working on a stronger inclusion focus.

- **Previous state – one model for everyone**
- **Current position – improved understanding of different populations needs**
- **Ambition – services that are designed to meet all populations**

D. The purpose of this 'Locality Plan for Health Care and Well Being' Refresh.

10. 2021/22 will be a tumultuous year as we seek to continue to transform and progress the health, care and well-being system.

    - Emerging from the command structure of the pandemic and addressing increased demand and system pressures – the enormous challenge of elective care and demand for mental health services for example

    - Developing shadow operating arrangements for the new partnership arrangements in Bury and understanding our part of the Greater Manchester Integrated Care System from 1/4/22.

    - Coping with the significant financial challenges affecting both council and CCG/local NHS.

    - Ensuring that the health and care System can play its full part in the ambition for the borough described in 'Let's Do It'.

11. It is important during a time of such change and as we are designing a new partnership system, that we remember that 'form follows function'. We should remind ourselves of the vision we have for the system, the guiding principles, the way we want to work, and the priorities that we have. And that we use this opportunity to 'refresh' our ambition in a way that cements all partners to common goals and priorities. Once this 'function' is re-described, we can push on and develop the partnership arrangements we will use to deliver it.

E. "Let's Do It" – the Strategy for the Borough to 2030 (February 2021)

12. This document is a refresh of our strategy for health and care and well being in the borough. It sits in the context of the overall strategy for the borough – "Let's Do It". Delivering the strategy for the borough to 2030 requires a mutually reinforcing alignment of several different strategic frameworks reflective of different sectors, for example on economic growth, on housing strategy, on employment training and skills, and on the reform of wider public services. Let's Do it also described the way we want to work - Local, Enterprising, Together, and Strengths based. All of these contribute to, for example, health inequalities, and the effective operation of the health and care system has an important contribution to make to the achievement of other strategic intent.

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

    - **Let's** This is a framework for joint endeavour. It proposes a partnership involving everyone in our six towns and the communities within them, aimed at creating the right conditions for people to make better lives for themselves. It is a plan to co-design our own futures and those of our communities. Bury is a proud Borough made up of six individual townships and distinct community groups including those of faith. This strategy seeks to recognise and develop the unique identities of each of our towns and individual communities and faiths but working towards one overarching ambition for the whole place.

    - **Do** This is a call to action. The truth is that without everyone's participation this strategy won't work. We all have a role to play, and we must give permission and the right delivery structures for individuals, communities and neighbourhoods to act towards building kinder, more resilient communities. We know that at times it can be daunting to bring about change so this plan also contains some key behaviours that will serve as a guiding light to us all. We have made specific proposals for how we will work together and the key things we will commit to delivering over the next two years.

    - **It** The 'It' in 'Let's Do It' means having a shared focus on what we want our Borough and its residents to be in ten years' time. Doing 'it' means recovering in a way that achieves our vision of tackling deprivation and inequality whilst securing economic recovery and ultimately securing ambitious growth. Our definition of success will be equal life chances for all our residents across every township and at a level which surpasses the England average. All residents in the Borough will have a healthy life expectancy with the current gap between our Borough and the England average closed by 2026. We will be known as public service thought leaders, working system-wide to tackle the determinants of a quality life. 'It' is the vision which we are going to create together, and that means we need it to include everyone's voice.

F. Financial Strategy

14. The previous iterations of the locality plan highlighted significant financial pressures of the Bury health and care system, reflective of Council budget, CCG budget, and that of NHS provider organisations. In February 2020/21, pre the COVID-19 pandemic, the CCG had a forecast deficit of £20m, the council had a savings plan of £5.2m with no planned use of reserves to achieve break even and deficits at Pennine Acute (including North Manchester General Hospital) and Pennine Care deficits was £80m and £10.8m respectively. In order to allow NHS organisations to focus on the COVID-19 pandemic an alternative funding methodology was used for the whole of 2020/21. All NHS organisations received sufficient funding in the first 6 months to cover the costs of delivering services and thereby allowing them to break even financially. In the second 6 months each system (and for Bury we are part of Greater Manchester) received a financial allocation that was broadly based upon the first half of the years core budgets, with reduced Covid costs in which they had to manage financially and break even. There were significant non recurrent allocations in 2020/21 that are not available in their entirety or at all in 2021/22, as the impact of COVID-19 reduces.

15. At the time of writing (June 2021) the NHS budget for the CCG and providers is only confirmed for the first half of 2021/22 (H1). The CCG allocation for H1 is broadly based on the allocations for the second half of 2020/21 financial year and includes a requirement for all CCGs to break even. Payments to NHS providers have been nationally set based upon 2020/21 plus inflation. The minimum investment standards for Mental Health, Community Services and Primary Care remain in place. The impact of these asks and the local funding pick up of formerly GM transformation funded schemes leads to a requirement to deliver £2.1m of efficiency savings for H1 2021/22 for the CCG. This is reduced from £4.8m due to there being no requirement to deliver a contingency (£0.9m) in H1 and the CCG receiving a share of GM growth monies (£1.9m). Nationally set inflation and growth values, built into the allocation, are lower than those required locally and this is a contributory factor within the efficiency requirement.

16. For both Salford Royal and Pennine Acute (excluding North Manchester General Hospital, as that transferred to Manchester Foundation Trust on 1st April 2021) the recurrent efficiency target for 2021/22 currently stands at £55m (4.4%). Of the £55m, £4.9m is allocated to Bury Care Organisation (BCO), excluding estates, facilities, procurement and other corporate functions. At June 2021 BCO have identified c£4.1m of schemes, which when risk adjusted equates to £2.5m. The NCA have submitted a breakeven H1 plan for 21/22. The H1 deficit position stood at £120m, offset with £107m system top up. Leaving a £13m efficiency target in H1, however the internal target remains £28m (£56m target for full year) in order address the underlying recurrent deficit.

17. PCFT has submitted a breakeven H1 plan for 2021/22. The annual deficit for the Trust is £19.1m before the application of top up funding. The H1 deficit is £9.4m. The Trust was allocated £8.6m in top up funding and applied a stretch efficiency target of £0.8m to breakeven.

    The 2021/22 efficiency target for the Trust was set at c£5m, which equates to c2.5%. The £0.8m efficiency for H1 is in addition to this target. £1.4m of recurrent savings are planned to be delivered from the corporate redesign programme with £1.1m of plans still to be finalised. £2.5m of savings are planned on a non recurrent basis.

18. The Council 2021/22 budget was approved at the full Council meeting of 26th February 2021. The Council's budget faces significant financial risks, with £8m of efficiencies and budget reductions and the use of £12m of reserves to deliver a balanced budget. The reliance on reserves in this and future years impacts on the Council's financial resilience and sustainability and will need careful monitoring and managing.

19. The CCG and the Council have, since 2019/20 had a pooled budget arrangement regulated via a section 75 agreement. This pooled budget is part of a wider Integrated Care Fund (ICF), with current assumptions relating to the ICF, (assumptions being necessary due to the unknown nature of CCG budgets for the second half of 2021/22), suggesting overall expenditure budget of £520m split between the 3 budgets as:

    - pooled budget £330m – all health, social care and health related functions it is possible and the SCB has deemed it appropriate to pool.
    - aligned budget £150m – all health, social care and health related functions that cannot be pooled or the SCB has deemed it not appropriate to pool.
    - In-view budget £40m – those budgets for which Bury incur cost and services, but decisions are made by an external body.

G. Our refreshed plan for Health, Care and Well Being – Objectives

20. 'Let's Do it' provides a permissive and supportive context for the transformation of the operation of the health and care system, and our work on reducing health inequalities. It..
    - has reducing inequalities as a prime objective.
    - focuses on the circumstances of the lives of residents and communities and recognises that its in relationships and connections that health and well being thrives.
    - recognises that supporting residents to be in control of their lives is central to wellbeing.
    - recognises that people's lives and hopes are not determined by their connection to public services but joined up public services are important to create the conditions where it is possible for prevention of harm and early intervention to reduce dependence on high cost public services is possible.
    - celebrates and promotes the diversity of the borough, and the importance of the pride that residents feel in their communities and in their connections to each other.
    - and finally, is it ambitious and challenging – that there is an unprecedented opportunity to "build a fairer society with no-one left behind by tackling our climate emergency, social inequality and unequal access to opportunities".

21. In this context the objectives of a refreshed locality plan for the health, care and wellbeing system are as follows:

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

18. We will continue to measure our overall success against four overarching outcomes for the Locality Plan:

    1. A local population that is **living healthier for longer** and where healthy expectancy matches or exceeds the national average by 2025.
    2. A **reduction in inequalities** (including health inequality) in Bury, that is greater than the national rate of reduction.
    3. A local health and social care system that provides high quality services which are **financially sustainable and clinically safe.**
    4. A greater proportion of local **people playing an active role in managing their own health** and supporting those around them.

H. Our refreshed plan for Health, Care and Well Being – The Way We Work

22. In pursuit of these objectives, we will work together as a system in the following way:

- strengthen the focus on wellbeing across all our services from primary care through to hospital-based care, and in social care provision, including greater focus on prevention and population health.

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

- deliver effective & efficient integrated health and social care across the borough, and in particular build the capacity and capability of 5 integrated neighbourhood teams in health and care – working with other public services on the same footprint

- consider how the 'anchor institutions in health and care' use social value to tackle the inequalities around us and create lasting benefits for the people of Bury, improve the local economy, whilst positively contributing (or at least minimising damage) to the environment.

- ensure equality, diversity and inclusion are reflected in our leadership and guide our priorities and all areas of our work

- ensure that the lived experience of Bury residents and patients is informing and guiding the design and delivery of services, and that the health and care system listens more carefully to those who use its services, and positively creates opportunities for 'co-design' and 'co-production'.

- harness the breakthrough opportunities of digital technology for enhancing existing services and crafting novel services to give better outcomes to citizens and improved value for money.

- secure clinical & financial sustainability across the whole of the health and social care landscape.

- work to proactively identify cohorts of vulnerability and risk – for example identifying those residents at a higher risk of unplanned hospital admission and seek to support those residents and families to change remain well and independent.

- contribute to economic growth and connect people to growth and maximise impact from health innovation and digital.

- work constructively with partners in Bury, and across 'sub regional footprints' (for example the footprint of the Northern Care alliance which includes Salford, Bury, Rochdale and Oldham),

- work positively and constructively with the development and design of the Greater Manchester Integrated Care System due for fully implementation in April 2022.

- Recognise the environmental consequences of our actions, and work as part of the borough strategy around carbon neutrality

23. In addition, the way we work will be informed by our deep understanding of the circumstances of peoples lives and their ambition for their health, wellbeing, and receipt of health and care services. In the previous locality plan, these ambitions were described in a series of 'i-statements' that were developed in consultation with residents in the borough. Residents described a health, care and wellbeing system where...

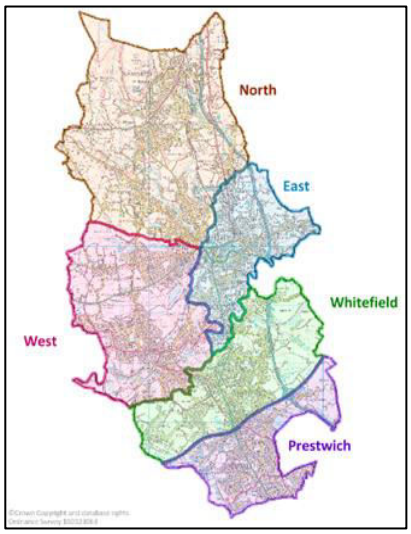
24. We have several excellent examples of co-design and co-production of transformed services that reflect these "I statements" with residents, carers and patients, for example in the SEND transformation programme, and in our work with residents with learning disabilities. However, we recognise that much can be done in the way we involve and engage people in the way services are organised around them. We will work the voluntary and community sector and will ask Healthwatch Bury to co-ordinate and challenge the way we transform service, including mechanism for structured engagement with those living with long term conditions.

25. We particularly recognise the challenge on health inequalities and inclusion that have been highlighted by the Covid 19 pandemic. The Council and CCG and wider health and care partners will work to ensure an inclusive approach and voice for those communities that may not previously have been heard, and the full implementation of the Council and CCG inclusion strategy (2021)

I. The Way we work – Neighbourhood Team Working

26. The 2019 locality plan proposed the establishment of neighbourhood team working in the health and care system working on 5 spatial footprints in the borough. The intention was to create for front line staff the opportunity to know each other, work with each other, reduce duplication and 'hand offs', and have a shared understanding of particular vulnerability and harm in the area, as well as a shared understanding of the assets of communities.

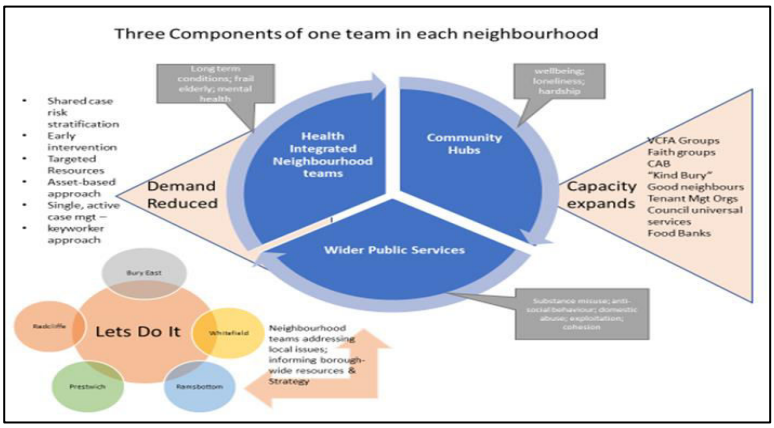
27. Integrated Neighbourhood teams (INTs) were created, providing unified management or a coordinating focus across community health services, adult social care and more recently community mental health services, and connected to communities. INTs have focused initially on delivering Active Case Management – proactively identifying residents at risk of future lost independence (for example unplanned admission to hospital) and working together to alter the course.



28. We intend to build on this excellent start and ensure that neighbourhood team working in health and care becomes a default setting across the breadth of the transformation programmes we have. We expect more services and staffing to be aligned into the model of neighbourhood team working and building a wider cohort of cases to deploy the benefits of neighbourhood team, and in so doing creating opportunities for staff in neighbourhood teams to work together more effectively, and for neighbourhood teams to take greater power to organise and control services that reflect the priorities of the communities they work with.

29. We particularly will work to ensure that the 5 integrated neighbourhood teams are working in as asset-based way -recognising the talents and hopes of residents, patients and carers, and the asset of local communities. We will also require the enabling groups, particularly IM&T, Estates, and workforce development to work to support the capacity and capability of neighbourhood team working.

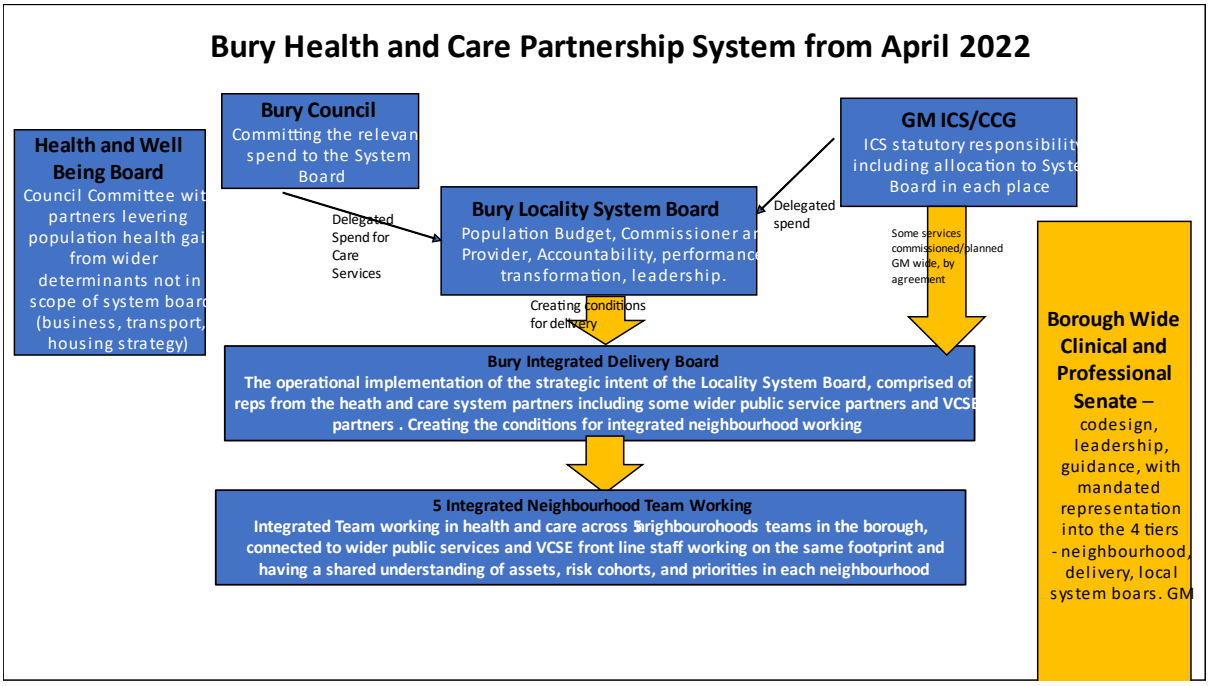
30. Neighbourhood team working in health and care is one part of a wider ambition in "Lets Do It" to build integrated teams of public services, working with communities differently. The other two parts – the work of community hubs, and the work to organise wider public services like GMP. DWP, housing providers, schools etc. This allows us to recognise the contribution many other partners play to both health and wellbeing, and to the demand for health and care services.



J. Our Partnership Arrangements for the Bury Health, Care and Well Being System

31. We are in a transition year 21/22 as we await clarification of the GM Integrated Care System arrangements. Nevertheless, it is important that we use this time to build a set of partnership arrangements for the Bury health care and wellbeing system that create the conditions for us to achieve our ambition, as well as being as far as possible 'future proof' in terms of the operation of the GM ICS.

32. A pictorial representation of the proposed new partnership arrangements is below.



33. The partnership is Bury is referred to as the "The Bury Health, Care and Well Being Partnership) and the key elements of this partnership system are as follows:

- A Locality Board – made up of representatives of NHS providers, the Council and the Voluntary Sector and others – setting strategy, managing performance and delivery, and holding an integrated budget between Council and the NHS (providers and GM ICS) working effectively as a capitated budget for the system.

- The Health and Well Being Board – formally a committee of the Council but with wider representation and operating almost as a standing commission on health inequalities and driving towards the full achievement of a population health system

- An Integrated Delivery Collaborative Board – an opportunity for all key partners and stakeholders to come together and drive the implementation of all aspects of reformed and transformed heath, care and wellbeing arrangements in the borough.

- 5 Integrated Neighbourhood Teams in health and care (and connected to wider neighbourhood teams including community hubs and other public services) serving the populations of Prestwich, Whitefield, Radcliffe, Bury town, and Ramsbottom/Tottington.

- A Clinical and Professional Senate – bringing together professional and clinical leadership from all organisations in the borough and ensuring mandate representation into the spatial levels of working described. It is important this drive and leads transformation.

34. In support of this architecture there will be several enabling functions to support the system working as effectively as possible. This includes:

    a. **A strategic finance group** – professional financial leadership from all relevant organisations understanding the position of each organisation and the mutual dependence between organisation to ensure system wide sustainability

    b. **A strategic estates group** – ensuring a 'one public estate' approach to the best utilisation of available estate, to ensuring that estate development is consistent with the objectives in this plan and creating the estates conditions to support integrated neighbourhood team delivery.

    c. **An IM&T programme** – developing opportunities for integrated patient and residents' records and data flows in support of better clinical and professional decision making, and exploring opportunities for residents to be in control of their own records

    d. **Workforce and Organisational Development programme** – identifying opportunities for system wide approaches to workforce recruitment, retention, and development in a way consistent with transformed health care and wellbeing partnership objectives.

    e. **Comms and Engagement –** bringing together communication and engagement specialists across health and care organisations and with the voluntary sector to listen effectively and amplify messaging where appropriate and consistent with the objectives here.

35. The governance and partnership arrangements are important to provide clarity on leadership, vision, and accountability. But our learning from Covid has been to recognise that empowering decision making, more agile working, reducing barriers between organisations, building quality working relationships, and have a shared ambition is hugely important to the achievement. Partners in the Bury Health Care and Well Being partnership will continue to build working relationships based on trust, mutual support, recognition of mutual dependence, and partnership.

K. Our Transformation Programmes

36. This refreshed locality plan has described our vision for the Bury health, care and well being system, and the way we intend to work together – for example in neighbourhoods, with an asset-based approach, and with a focus on inequality. In this context we have the following programmes of transformation that will provide focus to our joint work.

- **Urgent and Emergency Care** – to progress the 'phase 2' of our transformation of the operation of the urgent and emergency care system in Bury – focusing on ensuring residents are seen appropriately and in a timely manner, bringing more certainty to the operation of the system, moderating the season challenges in demand, reducing demand through focus on prevention and early intervention, strengthen discharge arrangements from hospital services. This more planned flow of urgent care will also support the achievement of challenging waiting time target for urgent care

- **Learning Disabilities** – working together and with residents and carers to transform the circumstances and opportunities of those with learning disabilities, maximising independence, and supporting more joined up and integrated services working across the life course.

- **Elective care** – working with Northern care Alliance and other providers of services to transform the way elective care services are organised – moving from traditional outpatient's services, supporting GPs with advice and guidance, supporting patients to initiate follow up appointments as required, ensuring patients are as fit and well as possible for elective surgery, and addressing the very challenging waiting list issues caused by the pandemic.

- **Cancer Services** – ensuring the whole cancer pathway – from prevention, early intervention, screening (and reviewing opportunities for community-based screening), GP access, 2 weeks wait for specialist cancer opinion, and where necessary into medical intervention is as effective as possible

- **End of Life Care Pathway** – a whole system partnership review of how effectively partners work with patients and families to support a dignified and pain free death where possible in a place of their choosing – often at home rather in hospital.

- **Primary Care** – our primary care system, particularly GP services, have been under significant pressure during the pandemic but have responded magnificently, for example in embracing new technology and in PCN delivery of the vaccination programme. There are also opportunities with a new focus on primary care networks

- **Mental Health** – Bury has an excellent mental health strategy - "ithrive" – and significant progress has been made in developing new models of service delivery across all 4 quadrants of that framework. But further work is required to hasten the pace of reform and development, from a focus on well being through to the availability of specialist services. In addition, there needs to be a specific recognition of the challenge to childhood mental health and well being as a consequence of covid, and an increasing demand for services.

- **Community Services** – Community health-based services – for example community nursing services and community therapy services, have been cornerstones of our covid 19 response and we will work to reflect on progress made in terms of connection to neighbourhood teamwork, and to learn from best practice nationally to further strengthen he community health services arrangements.

- **Adult Social Care** – Adult Social care provision is inherent to many of the other programmes, but we have (through the council budget strategy) articulated a range of transformation initiatives, around asset-based working, technology deployment, new models of housing provision, strengthen partnership working private providers of in home and care homes services.

- **Childrens health and care**. Equally, children's services are to be found throughout many of the transformation programmes above. But there are important transformation programmes to be connected – from the outcome of a recent review of maternity services, through to the ongoing work on SEND, on addressing the growth in demand for children's mental health services, for the focus on 'starting well'. In all of this we will recognise the crucial role schools and pre-school services play, and we will connect work on children's health and care reform to the work of the wider borough Childrens Strategic Partnership Board. We will look to the neighborough model as the basis of our integration approach, with a focus on early help, prevention, early intervention, and also as a focus on the first 1000 days. We will also focus on targeted, holistic support for our vulnerable children and young people, including Looked After Children, Care Leavers, SEND and youth offending.

- **Public Health Improvement Programme.** A framework to co-ordinate the implementation of key public health priorities including the Bury Food Strategy, the physical activity strategy, the sexual health strategy, good work charter, NHS health checks and other key interventions.

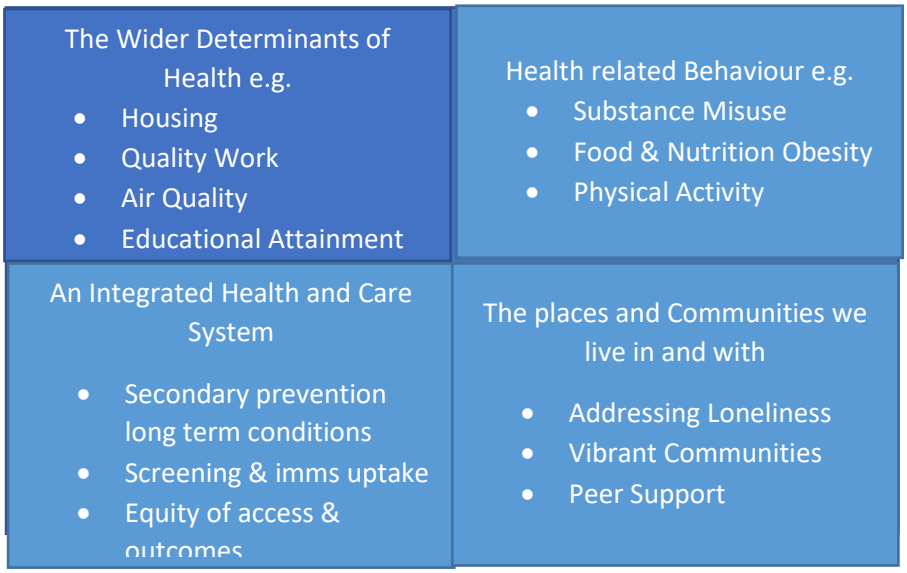
37. The programmes above are intended to transform the way key services work. There are, in addition, very many important programmes of work that reflect a business as usual – our work on safeguarding arrangements with partners and in the context of the Bury Integrated Safeguarding Partnership, or work on Continuing Health Care. All our work together will be infused with the principles described in this document.

L. A Population Health System Approach in Bury

38. This refreshed Locality Plan – like its predecessors - has at its core the ambition to fundamentally improve population health and wellbeing, and to reduce health inequalities. This is important to ensure Bury residents can lead the lives they want, but also to create a financially sustainable health and care system that is characterised by prevention of poor health, and early intervention, rather than reactive and costly service provision.

39. To do so requires us to lever health and gain and equality out of all levers available to us. In this we have recast Bury Health and Well Being Board to focus on developing the population health system as its unique role in the partnership arrangements. It will provide the necessary leadership, vision and grip on the step change in population health and well-being required. Importantly it will provide a focal point for our work on addressing pernicious health inequalities in the borough – in circumstances where we know progress in improving life expectancy has stalled and there is evidence of rising health inequality – almost certainly to be exacerbated by the consequences of the pandemic.

40. A framework for the work of the Health and Well Being Board on the population health system is the Kings Fund (2019) four quadrants diagram.



41. The Health and Well Being board will therefore operate as effectively a 'standing commission' on health inequalities and population health and will explore how to maximise the impact of interventions across all 4 quadrants. It will work closely with 'Team Bury' – the multi-agency leadership team for the borough reflecting public service, business leadership, and the voluntary and community sector – and will focus specifically on the work on health inequalities and wellbeing.

42. In undertaking its work, the health and well being board will have regard to the Independent Commission on inequalities in GM (2021), and the GM wide Marmot Review (2021) into health inequalities.

M. The Bury Health, Care and Well Being Partnership Locality Plan – Next Steps

37. This document has restated our vision, priorities, and way of working as a Health, Care and Well Being System. It is produced at a time of significant change and uncertainty and is intended to guide our work on establishing new partnership arrangements and programme leadership.

38. The important next steps in implementing this strategy are as follows:

    a. To use the period 21/22 to transition to a new partnership system including
        i. Establishing a clinical and political senate
        ii. Creating the new System Board with the capability of managing jointly a substantial integrated budget
        iii. Establishing the effective operation of the Integrated Delivery Collaborative
        iv. Building the capacity and capability of the 5 neighbourhood teams in health and care, and connecting to community capacity and wider public services operating on the same footprint
        v. Further develop the role of the Health and Well Being Board as a standing commission on health inequalities.
        vi. Clarifying the nature of the financial flows and accountability to the GM ICS

    b. To reset and drive forward the key transformation programmes described operating as system wide and whole system programmes and as a golden thread between the system board, the delivery collaborative and neighbourhood working.

    c. To maintain a focus on system wide financial sustainability and holding to account the transformation programmes for the delivery of improved outcomes and reduced costs.

The Bury Health, Care and Well Being Partnership

Bury Locality System Board

Draft Terms of reference

Draft Version 8 -24/8/21

Draft Version 7 – 20/8/21

(Draft Version 5 considered by SCB Development Session 5/7/21)

(Draft Version 6 approved by System Board 19/8/21 with minor amendments)

Will Blandamer

For Review January 2022

1 Purpose

1.1 The Bury Locality System Board ("Locality Board") has been established to provide strategic direction to the Bury Health, Care and Well-being Partnership , to manage risk and to support the Bury Integrated Delivery Collaborative for the performance of the bury health and care system. The Bury Locality Board will undertake its duties in the context of the agreed Strategic Plan for Health, Care and Well-being for the Borough – the Locality Plan. The primary purpose of the Locality Board is to set the Strategic Direction for the reform and transformation of the operation of the health, care and well being system in Bury, and to manage an integrated budget for the place (including a pooled fund) between Bury Council and the NHS.

2 Status and authority

2.1 The Bury Health, Care and Well-being Partnership is formed of the parties, who remain sovereign organisations, to provide strategic coherence, shared ambition, and operational delivery of the health and care system in Bury, in pursuit of better outcomes for residents and a financially sustainable system. The Bury Health, Care and Well-being Partnership is not a separate legal entity, and as such is unable to take decisions separately from the parties or bind its parties; nor can one or more party 'overrule' any

other party on any matter (although all parties will be obliged to act in accordance with the ambition of the Strategic Plan for Health and Care in the Borough.

2.2 The Bury Health, Care and Well-being Partnership establishes the Bury Locality Board to lead the Bury Health, Care and Well-being Partnership on behalf of the parties. As a result of the status of the Bury Health, Care and Well-being Partnership , the Locality Board is unable in law to bind any party so it will function as a forum for discussion of issues with the aim of reaching consensus among the parties. However the Locality Board will have responsibility via the Section 75 agreement for the operation of the Integrated Budget for the borough, the scope of which is to be determined but will not be less than the scope of the Integrated Care Fund held by the Strategic Commisssiong Board for the period 2021/22.

2.3 The Locality Board will function through engagement between its members so that each party makes a decision in respect of, and expresses its views about, each matter considered by the Locality Board. The decisions of the Locality Board will, therefore, be the decisions of the parties, the mechanism for which will be authority delegated by the parties to their representatives on the Locality Board.

2.4 Each party will delegate to its representative on the Locality Board such authority as is agreed to be necessary in order for the Locality Board to function effectively in discharging the duties within these terms of reference. The parties will ensure that each of their representatives has equivalent delegated authority. Authority delegated by the parties will be defined in writing and agreed by the parties and will be recognised to the extent necessary in the parties' own schemes of delegation (or similar).

2.5 The parties will ensure that the Locality Board members understand the status of the Locality Board and the limits of the authority delegated to them.

3 Responsibilities

3.1 The Locality Board will:

3.1.1 Ensure alignment of all organisations to the Bury Health, Care and Well-being Partnership vision and objectives, as described in the Locality Pan for Health, Care and Well Being , ensuring the delivery of the triple aim of improved population health, improved experience, and financial sustainability

3.1.2 Jointly manage the Bury Health, Care and Well Being Locality Integrated fund – established to reflect the scope of services agreed to be managed at a locality level between the Council and NHS and in accordance with the GM ICS accountability agreements, and doing so on the basis of 'formally pooled, aligned and in view'.

3.1.3 Ensure the Bury Health, Care and Well Being Partnership delivers on the NHS obligations under the terms of the GM ICS Accountability Agreement with Bury.

3.1.4 Secure the delivery of the portfolio of transformation programmes reported through the Integrated Delivery Collaborative Board and as described in the Locality Plan.

3.1.5 Ensure the Bury Health, Care and Well Being Partnership works as part of the Wider Team Bury approach and in the context of the Lets Do It Strategy for the borough, and secures support of all partners including other public services, the business community, and the voluntary sector in addressing health inequalities and population health.

3.1.6 Ensure that all partners are actively working to promote the capacity and capability of integrated neighbourhood team working in each of the 5 neighbourhoods teams in Bury, and doing so in a way consistent with the principles and values of the Locality Plan – a persona and community asset based approach.

3.1.7 Promote and encourage commitment to the integration principles and integration objectives amongst all parties.

3.1.8 Formulate, agree and ensure that implementation of strategies for achieving the integration objectives and the management of the Bury Health, Care and Well Being System partnership.

3.1.9 Discuss strategic issues and resolve challenges such that the integration objectives can be achieved.

3.1.10 Ensuring the work of the health, care and well being partnership in Bury has the voices of patients and residents, and the learning from lived experience, at the heart of the transformation programmes and service delivery.

3.1.11 Respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Bury Health, Care and Well-being Partnership or any parties to the extent that they affect the parties' involvement in the Bury System Partnership.

3.1.12 Agree policy as required.

3.1.13 Agree performance outcomes/targets for the Bury Health, Care and Well-being Partnership such that it achieves the integration objectives

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

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

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

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

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

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

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

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

4 Accountability

4.1 The Locality Board is accountable to the each of the parties to the Locality Board. The Locality Board is also accountable to the GM Integrated Care System (GM ICS), through an accountability agreement, for the delivery of NHS standards and for the GM ICS budget that is part of the Integrated Fund. The Bury Locality Board is therefore accountable to the GM ICS Board, and there will be Bury System representation on the GM ICS Board.

4.2 The minutes of the Locality Board will be sent to the parties within 10 working days

4.3 The minutes will be accompanied by a report on any matters which the chair considers to be material. It will also address any minimum content for such reports agreed by the parties.

5 Membership and Quoracy

5.1 The Locality Board will have 15 voting members, 3 non voting members, and a number of officers will attend to advise as required. The voting members reflect senior clinical, political, managerial, and NHS non-executive leadership from across the Bury Health, Care, and Well Being partnership

Voting Members

Political Representation (3)
- Leader of the Council
- Executive Member of the Council Adult Care and Health
- Executive Member of the Council for Children and Young People

Non Executive NHS Leadership (3)
- Independent Chair of the Integrated Delivery Collaborative Board
- Non Executive Director from an NHS provider (tbc)
- Non Executive Director of GM ICS (a representative CCG Non Executive in the interim)

Clinical Representation (4)

- Senior Clinical Leader in the Borough (as determined by the Clinical Senate via an election process – to be a GP) (Chair of the CCG in the interim)
- Medical Director from NCA (Bury)
- Medical Director of the Integrated Delivery Collaborative Board
- Senior Nurse Lead for the Borough (as determined by the Clinical Senate) (Director of Nursing and Quality – CCG, in the interim)

Managerial Leadership (5)

- The Chief Executive of the Local Authority/Place Based Lead for the GM ICS (subject to agreement that these roles are one and the same)
- Strategic Finance Group Chair – Joint Exec Director of Finance (S151 officer of the Council)
- Chief Officer NCA -Bury Care Org.
- Representative (tbc) Pennine Care NHS Foundation Trust
- Representative (tbc) Manchester Foundation Trust

Non Voting Members

Routinely attending (4)

- Chair of Bury VCFA
- Chair of Bury Healthwatch
- Executive Director of Health and Care – Bury Council
- Chief Operating Officer - IDCB

In attendance as required (3)

- Director of Childrens Services
- Director of Adult services
- Director of Public Health
- Representative NHS provider finance rep

5.2 Other Persons may attend the Locality Board as agreed by the Board. This will include the Chair of each of the System Enabling Groups – the Strategic Estates Group, the Workforce Group, and Digital Transformation Group, and others.

5.3 The Locality Board will be quorate if two thirds of its voting members (10) are present, subject to the members present being able to represent the views and decisions of the parties who are not present at any meeting. Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Deputies must be able to contribute and make decisions on behalf of the party that they are representing. Deputising arrangements must be agreed with the chair prior to the relevant meeting.

5.4 The Locality Board will be chaired by the Leader of the Council, the Senior Clinical Leader from the Clinical Senate, Chairing of meetings will be on an alternate basis and/or in the absence of one of the named chairs.

6 6. Representation of the Bury Locality Board on the GM ICS Board

6.1 to be confirmed

7 Conduct of business

7.1 Meetings will be held ***on a Monthly Basis***

7.2 The agenda will be developed in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place 5 working days before the meeting is scheduled to take place. In the event members wish to add an item to the agenda they need to notify the meeting administrators who will confirm this with the chair accordingly.

7.3 In line with statutory requirements and the discretion of the chair, business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

7.4 At the discretion of the chair a decision may be made on any matter within these terms of reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision will be as valid as any taken at a quorate meeting but will be reported for information to, and will be recorded in the minutes of, the next meeting.

8 Decision making and voting

8.1 The Locality Board will aim to achieve consensus for all decisions of the parties.

8.2 To promote efficient decision making at meetings of the Locality Board it will develop and approve detailed arrangements through which proposals on any matter will be developed and considered by the parties with the aim of reaching a consensus. These arrangements will address circumstances in which one or more parties decides not to adopt a decision reached by the other parties.

9 Conflicts of interests

9.1 The members of the Locality Board must refrain from actions that are likely to create any actual or perceived conflicts of interests.

9.2 The Locality Board will develop and approve a protocol for addressing actual or potential conflicts of interests among its members (and those of the Bury Integrated Delivery Collaborative). The protocol will at least include arrangements in respect of declaration of interests and the means by which they will be addressed. It will be consistent with the parties' own arrangements in respect of conflicts of interests, and any relevant statutory duties.

10 Confidentiality

10.1 Information obtained during the business of the Locality Board must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g., Performance management, securing competitive advantage in procurement).

10.2 Members of the Locality Board are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Bury System Partnership. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

10.3 Given that some LA decision making will go through the Board the provisions of the Local Government Access to Information legislation will apply.

11 Support

11.1 Governance/administrative support to the Locality Board will be provided as agreed by the Partnership.

11.2 The programme structure and supporting work groups will be developed and agreed as part of the Locality Board work plan.

12 Review

12.1 These Locality Board terms of reference will be formally reviewed annually.

Bury Health, Care and Well Being Partnership

Place Based Lead for Bury for the Health, Care and Well Being Partnership

Will Blandamer – Executive Director, Health and Care
25/6/21
Draft Version 3

1. The Design Guidance for Integrated Care Systems was published on 16th June 2021. It provided some high-level principles for the operation of Integrated Care Systems (subject to legislation) from April 2022. Of particular interest is the relationship between the ICS and places, and the relevant section of the guidance is extracted as Appendix 1.

2. The document states that…*"as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health."*

3. The document also recognised the need for a place based leader in the context of the ICS arrangements, stating for example .. "*The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.*

4. The extent to which the place based lead role and the GM ICS role for a place is vested in the same person is of course a matter for the incoming GM ICS leadership to consider in partnership with other key stakeholders. However a defining principle of the work to establish the governance arrangements across the GM ICS is that they must offer the continuity of purpose, ethos and culture that have underpinned GMs devolution deal and the journey of integration in each of 10 places.

5. In Bury there has been significant progress on integration between commissioning partners, bringing together political and clinical leadership to oversee integrated budget and aligned strategic intent, building integrated support functions (in finance, BI, comms etc.). there has also been significant progress in building new models of integrated provision and strengthened partnership working across the system. Our new partnership architecture consolidates and amplifies that into a comprehensive model of integrated arrangements – operating through the locality board, and the integrated delivery collaborative, and emerging models of neighbourhood team leadership.

6. We would seek therefore to ensure that the arrangements for a GM ICS lead in Bury build on the ethos of collaboration, and in particular we do not see a named place base lead for the Bury partnership, and then another person with the GM ICS lead for Bury. This should be something we seek to influence through the emergent GM ICS operating model development.

7. In the meantime, a number of districts in GM have already sought to confirm the name of the place based lead for the district health care and well being partnership. This clarity is important at a time of transitional uncertainty.

8. To consider the role of a place-based leader in the borough we should reflect on the options for place based leadership contained in the design guidance. These are as follows:

    i. consultative forum, informing decisions by the ICS NHS body, local authorities and other partners
    ii. committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources
    iii. joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation
    iv. individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
    v. lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

9. These options are considered below.
    i. Option 1 above does not reflect the aspirations of partners in Bury – the Locality Board must operate as more than a consultative forum – it must hold an integrated budget between council and NHS partners not less than the current scope of the section 75 agreement, create the conditions for the integrated delivery collaborative to thrive, and be accountable to both Council and GM ICS.
    ii. Option 2 looks an NHS centric focus for a place-based leader and would take Bury backwards in terms of the integration with local authority leadership and the wider ambition for the borough articulated in Let's Do It.
    iii. Option 3 looks closest to the ambition for the Locality Board and described in our locality plan.
    iv. Option 4 is possible, reflecting as it does that the GM ICS lead for the borough is also the place based lead
    v. Option 5 is being pursed in some parts of GM characterized by a largely 1-1 relationship between the hospital and the council/place, but is not otherwise a preferred model for partners across GM, particularly where the acute footprint spans multiple districts.

10. Options 3 and 4 are therefore of interest as long as they are with the grain of our integrated care journey. The core proposition of this paper is that person filling the role of Chief Executive of the Council and Accountable Officer for the CCG is recognisable to the system as the place leader for health, care and well-being, and also best able to co-ordinate the delivery of the obligations described.

11. The recommendation of the paper is therefore to;

1) to influence the development of the GMICS operating model to ensure the place-based lead and the GM ICS lead for the place is vested in the same person in Bury, and to take executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority ?

2) To agree that the post of CE of the Council and the post of Bury Place Based Lead for the ICS being held by the same person

Appendix 1

Extract of the ICS development framework – June 2021

Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community. There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold.

All systems should establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership.

The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

i. consultative forum, informing decisions by the ICS NHS body, local authorities and other partners
ii. committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources
iii. joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific

functions/services/populations to the joint committee in accordance with their schemes of delegation

iv. individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies

v. lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

Schedule X

BURY HEALTH, CARE AND WELL-BEING PARTNERSHIP

Bury Integrated Delivery Collaborative

Integrated Delivery Board

Terms of reference

Endorsed System Board 19/8/20
For Review SCB 6/9/22
Owner – Kath Wynne Jones

1. Purpose of the Board

The purpose of the Integrated Delivery Board is direct and govern the work of the Integrated Delivery Collaborative such that it successfully and effectively

- Provides high quality integrated care and support at neighbourhood and borough level to the people of Bury, providing excellent patient experience and outcomes

- Transforms health and social care services in line with the principles, standards and outcomes set by the Bury System Board and the Greater Manchester Integrated Care System, making best use of every pound invested in Bury's health and care services

- Support improvements in population health, wellbeing and outcomes and addresses inequalities in health across the borough.

2. Principles

The principles by which the Board shall operate are as follows:

- Decision-making always will be in the best interests of the Bury population including those from diverse backgrounds and or with protected characteristics whose health and wellbeing will be the main priority of the parties to the Agreement underpinning the Integrated Delivery Collaborative

- Services will be designed and delivered without exceeding the financial resources available for the purpose and with a focus on reducing inequalities

- Notwithstanding the pre-eminence of organisational members' contractual, regulatory and statutory accountabilities, achievements and failures will be collective to the parties, and not to the individual organisations which constitute the Integrated Delivery Collaborative.

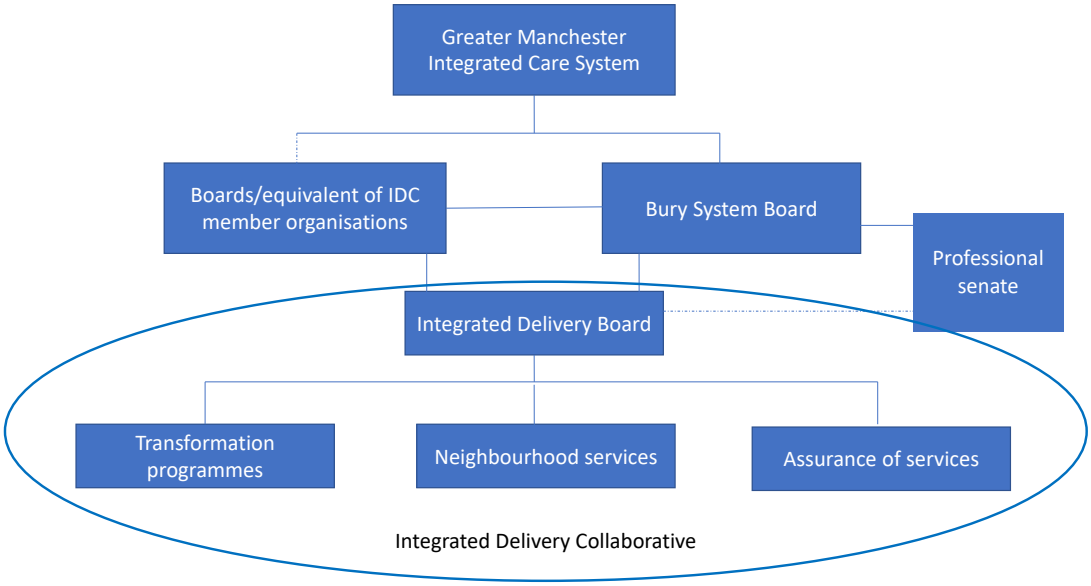
- Financial sustainability and the sustainability of the services which make up the health and social care system as a whole is essential to the success of the

Integrated Delivery Collaborative and expectations of the Collaborative will be agreed in that context

- All parties will share relevant operational, financial, clinical, professional and workforce information with other parties on an open and transparent basis subject only to the statutory obligations placed on them, e.g., by the Data Protection Act 1998 and the General Data Protection Regulations

3. Powers

The parties to the Mutually Binding Agreement have delegated specific powers to the Integrated Delivery Collaborative, and reserved specific matters. (The Board of the IDC is responsible for exercising these powers, to fulfil the agreed objectives and outcomes set out in the annual plan.



4. Responsibilities

The responsibilities of the ID Board shall be:

a) Promote and encourage commitment to the integration principles and integration objectives amongst all parties.

b) Implement strategies agreed by the Bury System Board to achieve the integration objectives.

c) Identify and escalate to the Bury System Board strategic issues and resolve challenges such that the integration objectives can be achieved.

d) Implement decisions on the System Board in response to changes in the operating environment, including in respect of national policy or regulatory requirements, which affect the health and care system in Bury as appropriate

e) Manage the performance of the health and care system in Bury, accounting to the System Board in this respect.

f) Identify and manage the risks associated with the health and care system in Bury, integrating where necessary with the parties' own risk management arrangements.

g) Ensure that risks identified as a result of decisions made by the IDC are managed effectively.

h) Implement arrangements through which the health and care system in Bury accounts to relevant regulators and other stakeholders through whatever means are required by such regulators or are determined by the System Board, including, to the extent relevant, integration with communications and accountability arrangements in place within the parties.

i) Address any actual or potential conflicts of interests which arise for members of the Bury Integrated Delivery Board or within the health and care system in Bury generally, in accordance with a protocol to be agreed between the parties (such protocol to be consistent with the parties' own arrangements in respect of declaration and conflicts of interests, and compliant with relevant statutory duties).

5. Membership

The membership of the ID Board shall consist of three categories of members:

a) **Voting members representing each partner organisation.**

Voting member should be a Board or equivalent level director from member organisations and shall be known as the ID Board directors.

The ID Board directors shall be:

IDC member organisation	ID Board Director job title	ID Board Director name (May 2021)
BARDOC Ltd	Chief Executive	Vicky Riding
Bury GP Federation	Chief Officer	Tbc
Bury Metropolitan Borough Council, Directorate of Health and Social Care	Executive Director of Commissioning	Will Blandamer
Bury Voluntary, Community and Faith Alliance	Chief Officer	Sajid Hashmi MBE
Northern Care Alliance NHS Group	Chief Officer, Bury Care Organisation	Tyrone Roberts
Pennine Care NHS Foundation Trust	Executive Director of Operations	Keith Walker
Persona Care and Support Ltd	Managing Director	Kat Sowden
Bury Primary Care Networks	Clinical Director	Dr Victoria Moyle
Bury GP Neighbourhood Lead	?	?

Each ID Board director shall have a nominated deputy who may attend on behalf of the ID Board director only when they are unavailable.

The nominated ID Board deputy directors shall be:

IDC member organisation	ID Board Deputy Director job title	ID Board Deputy Director name (May 2021)
BARDOC Ltd	Deputy Chief Executive	Dr Zahid Chauhan OBE
Bury GP Federation	Deputy Chief Officer	Paul Juson
Bury Metropolitan Borough Council Directorate of Health and Care	?	?
Bury Voluntary, Community and Faith Alliance	Chair	Andy Hazeldine
Northern Care Alliance NHS Group	Deputy to Chief Officer	Deputy to Chief Officer
Pennine Care NHS Foundation Trust	Network Director, Bury	Sian Wimbury
Persona Care and Support Ltd	Director of Finance	Bernard Noblett
Bury Primary Care Networks	?	?
Bury GP Neighbourhood Lead	?	?

b) Professional and technical members whose role is to advise the Board on key areas of its responsibility and/or to secure assurance from the Board that duties and functions delegated to the Board are being executed appropriately.

Professional/technical role	Name
Director of Adult Social Services (DASS)	Julie Gonda
Director of Nursing and Therapies	Tyrone Roberts
Director of Finance	Chair of Strategic Finance Group
Medical Director	Dr Kiran Patel
Bury Council Director of Public Health	Lesley Jones

c) Stakeholder members

Stakeholder members shall be as follows:

Stakeholder member	Name
NHS Bury CCG Clinical Chair	Dr Jeff Schryer
NHS Bury CCG Director of Quality	Catherine Jackson
NHS Bury CCG Clinical Director	Howard Hughes
Bury Council Assistant Director of Public Sector Reform	Vicky Clark
Bury Council/NHS Bury CCG Director of Secondary Care Commissioning	Ian Mello
Director of Strategy, Northern Care Alliance NHS Group (host)	Jo Purcell

Chief Officer, Healthwatch	Adam Webb
Assistant Director, Adult Social Care, Bury Council	Adrian Crook
Director of Community Services, Northern Care Alliance NHS Group	Nina Parekh
Chief Executive, Six Town Housing	
Greater Manchester Integrated Care System representative	
Director of Children's Services, Bury Council	
Representative, Bury social care providers	

d) Executive members

Executive Officers of the IDC, as follows, shall be in attendance:

a) Chief Officer

b) Director of Transformation and Delivery

c) Director of Finance

d) Associate Director of Finance

e) Governance Manager

e) Co-opted members

At its discretion, the ID Board may co-opt non-voting organisational representatives to the Board where to do so will assist the Board in advancing its purposes.

Co-opted members for the year 2021/22 shall include:

None specified

6. Meetings

The ID Board shall meet twice monthly and may call extraordinary meetings in addition to ordinary meetings as required.

7. Voting

Each member organisation shall have one vote, to be cast by their Director or Deputy Director. Voting will take place on matters that are within the powers of the Board.

Whilst it will be the intention of the ID Board to make decisions by consensus, where voting takes place a simple majority will be necessary to secure a decision.

Where relevant, the disputes procedure, set out in the Mutually Binding Agreement at Section XX, may be used by parties voting in the minority.

8. Quoracy

Board meetings will be quorate when each member organisation is represented either by their nominated Director or nominated Deputy Director.

Non-attendance by both a nominated Director or Deputy Director (twice or more per quarter) may lead to that party being excluded from the IDC.

9. Chairing

The Board shall be chaired by an Independent Chair, who shall be selected by the member organisations from time to time and engaged on terms agreed by those member organisations.

The Independent Chair shall not have a vote.

In the event of the absence of the Independent Chair, e.g., owing to leave, the Board shall nominate a deputy chair to chair the Board.

10. Accountability

The ID Board shall be accountable to:

- The Bury System Board for the delivery of its annual plan, whose priorities, outcomes and standards shall be set by the System Board

- The Boards or equivalent of the parties to the IDC for the exercise of delegated powers and the effective operation of the IDC

All staff within in scope services shall be responsible to the Board through the Chief Officer and in line with the agreed workforce protocol

11. Conduct of business

a) The agenda will be developed in discussion with the chair. Circulation of the meeting agenda and papers via email will take place three working days before the meeting is scheduled to take place.

b) In the event members wish to add an item to the agenda they need to notify the administrative support to the meeting who will confirm this with the chair accordingly.

c) At the discretion of the chair business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

d) At the discretion of the chair a decision may be made on any matter within these terms of reference through the written approval of every member, following circulation to

every member of appropriate papers and a written resolution. Such a decision will be as valid as any taken at a quorate meeting but will be reported for information to, and will be recorded in the minutes of, the next meeting.

12. Conflicts of interests

The members of the Bury Integrated Delivery Board must refrain from actions that are likely to create any actual or perceived conflicts of interests.

The Bury Integrated Delivery Board will adopt and comply with the protocol for addressing conflicts of interests as approved by the System Board.

13. Confidentiality

Information obtained during the business of the Bury Integrated Delivery Board must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g., Performance management, securing competitive advantage in procurement).

Members of the Bury Integrated Delivery Board are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Bury health and care system. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

14. Review

These terms of reference shall be reviewed in March 2022.

The Bury Health, Care and Well Being Partnership

Bury Health and Well Being Board

Terms of reference

Note

- Terms of Reference endorsed April 2017
- Refreshed October 2020 following September 2020 meeting that refreshed the focus of the meeting towards a focus on the population health system and the implementation of the Kings Fund 4 quadrant model (2018)
- Approved at the November 2020 Health and Well Being Board
- Approved at the Council Meeting June 2021

1. VISION

The Health and Wellbeing Board will work with partners and communities and residents to galvanise all effort to improve health and wellbeing, and reduce health inequalities to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life.

The Health and Well Being Board recognises the Bury 2030 ambition to significant reduce internal health inequality (measured by life expectancy and healthy life expectancy) in the borough, and between the borough and the England average, by 2026.

2. MEMBERSHIP

Membership of the Health and Wellbeing Board will be made up of leaders across the NHS, Social Care, Public Health, Wide Public Services and other services directly related to Bury operating as a Population Health System

Core voting members:

- Cabinet Member, Health and Wellbeing (Chair)
- A nominated representative from the voluntary sector
- Cabinet Member, Children and Young People
- Additional Labour Cabinet Member
- Shadow Cabinet Member, Health and Wellbeing
- Executive Director, Children, Young People and Culture
- Executive Director, Communities and Wellbeing
- Director of Public Health
- Two nominated representatives from the Clinical Commissioning Group
- A nominated representative from Bury Health watch
- A nominated representative from the Community Safety Partnership.

- A nominated representative from Greater Manchester Fire and Rescue.
- A nominated representative from Northern Care Alliance
- A nominated representative from Pennine Care NHS Foundation Trust.

The Board may also decide to co-opt/invite by invitation additional members to advise in respect of particular issues. These may include representatives from:

- Lead Member for Public Health
- Six Town Housing
- NHS England;
- North West Ambulance Service;
- GM Police;
- Clinicians;
- Coroner;
- other provider organisations/government agency/representatives from the Charity sector.

The Health and Wellbeing Board can, once the board is established, in agreement with full Council, appoint additional members to the Health and Wellbeing Board (Section 194, Health and Social Care Act).

3. FUNCTION

The Health and Wellbeing Board will be a strategic forum to ensure a coordinated commissioning and delivery across the NHS, Social care, public health and other services, directly related to health and wellbeing.

The Health and Wellbeing Board will determine, shape and implement key priorities and integrated strategies to deliver improved health and wellbeing outcomes, for the whole of the population of Bury.

The Health and Well Being Board will undertake its ambition for population health improvement and a reduction in health inequalities, using the Population Health System Model for the Kings Fund (2018). In particular the agenda will reflect the 4 quadrants.

- Wider Determination of Population Health
- Behavioural and Lifestyle determinants of health
- The effect of place and community on health and well being
- the operation of the health and care system, and wider public service reform, in pursuit of population health gain

4. KEY RESPONSIBILITES OF THE BOARD

- To provide Strong Leadership and a governance structure for local planning and accountability of Population Health and Care related priorities and services.

- To assess and understand the needs and assets of the local population and lead the statutory integrated strategic needs assessment (JSNA).

- Agree annual strategic priority outcomes for JSNA needs assessments, ensure plans are in place and actions and recommendations are monitored and followed up.

- To promote integration and partnership working and build strong stakeholder relationships across areas through promoting joined up commissioning plans across the NHS, social care and public health.

- To develop a Joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care, public health and other services the Board agrees to consider.

- To review major service redesigns of health and wellbeing related services provided by the NHS and Local Government. Providing critical challenge and strategic steer

- Receive exception reports, manage risks and resolve issues from other strategic groups, challenge performance and provide strategic steer where relevant. To challenge and support joint commissioning and pooled budget arrangements, where all parties agree this makes sense.

- Oversee effective and appropriate community engagement, involvement and consultation with regards to health and wellbeing priorities, to ensure strategies and service redesign reflect the views of local people, users and stakeholders.

- Provide overarching communication for regional and national agendas, co-ordinate responses.

- Ensure overarching actions to reduce health and social inequalities.

- Any other function that may be delegated by the Council under Section 196 (2) of the Health and Social Care Act 2012.

5. MEETINGS

The Health and Wellbeing Board is a Committee of the Local Authority.

The Health and Wellbeing Board will meet every six weeks.

The **date and timings** of the meetings will be fixed in advance by the Council, as part of the agreed schedule of meetings.

Additional meetings may be convened at the request of the Chair, and with the agreement of the Council Leader.

The meeting will be Chaired by a Member of the Health and Wellbeing Board duly appointed by the Council. The Vice Chair will be the Executive Director, Communities and Wellbeing. The Chair and Vice Chair would be appointed annually; the appointments would be ratified by Council. **In the absence of the Chair or Deputy Chair** - A replacement Chair will be elected for the duration of the meeting from the Core Membership. This will normally be the Lead Member for Public Health

A **quorum** of four will apply for meetings of the Health and Wellbeing Board including at least one elected member from the Council or one representative of the Clinical Commissioning Group or a nominated substitute.

Members will adhere to the agreed principles of the Council's Code of Conduct. It is expected that members of the Board will have delegated authority from their organisations to take decisions within their terms of reference.

Declarations of Interest – Any personal, prejudicial or pecuniary interests held by members should be declared in accordance with the Councils Code of Conduct on any item of business at a meeting, either before it is discussed or as soon as it becomes apparent. Interests which appear in the Council Register of Interests should still be declared at meetings, where appropriate.

Decisions are to be taken by **consensus**. Where it is not possible to reach consensus, a decision will be reached by a simple majority of those present at the meeting. Where there are equal votes the Chair of the meeting will have the casting vote, there will be no restriction on how the Chair chooses to exercise his/her casting vote.

The Executive Director of Adult Care will act as the **lead officer**. Lead officer responsibilities will include ensuring that agendas are appropriate to the work programme of the Health and Wellbeing Board.

Workload – Work Programme to be determined annually by the Board. The Board must also have regard to any issue referred to it by the Health Scrutiny Committee, Council and its leadership, or the Executive Director Adult Care.

The agenda and supporting **papers** shall be in a standard format and circulated at least five clear working days in advance of meetings. The minutes of decisions taken at the meeting will be kept and circulated to partner organisations as soon as possible. Minutes will be published on the Council web site.

Access to Information – It is important to ensure that all councillors are kept aware of the work of the Board and a copy of the minutes will be circulated to all Bury Councillors. The Board shall be regarded as a Council Committee for Access to Information Act purposes. Freedom of Information Act provisions shall apply to all business.

All meetings will be held in **public** with specific time allocated for public question time.

The Board will retain the ability to **exclude representatives** of the press and other members of the public from a defined section of the meeting having regard to the confidential nature of the

business to be transacted, publically on which would be prejudicial to the public interest (Part 5A and Schedule 12A, Local Government Act, as amended).

Non members of the Health and Wellbeing Board may be co-opted onto the Board as a non voting member, with speaking rights, with the agreement of the Chair.

Meetings will be **clerked** by a representative of Democratic Services.

The Board will oversee and receive reports from a set of sub groups which will focus on the delivery of key targeted areas of work. The sub groups will report directly to the Health and Wellbeing Board. Provisions that apply to the HWB would also apply to any sub groups of the HWB.

The HWB must be mindful of their duties as prescribed in the Equality Act 2010 and the Data Protection Act 1998:
The Equality Act 2010, requires specified public bodies, when exercising functions to have due regard to eliminating conduct prohibited by the Act and advancing equality of opportunity.
The Data Protection Act 1998 makes provision for the regulation of the processing of information relating to individuals.

REPORTING STRUCTURES

The Health and Wellbeing Board has a direct reporting link to Council.

Although Health and Wellbeing Boards are not committees of a Council's Cabinet, the Council may choose to delegate additional functions to the Board. The Discharge of these functions would fall within the remit of scrutiny but the core functions are not subject to call-in as they are not Cabinet functions.

The Health and Wellbeing Board would consult and involve the Health Scrutiny Committee in the development of the JSNA and the Joint Health and Wellbeing Strategy. The Chair of the Health and Wellbeing Board will attend the Health Scrutiny Committee, as required.

The Health and Wellbeing Board will not exercise scrutiny duties around health and social care, this will remain the role of the Health Scrutiny Committee as defined in the Health and Social Care Act and related regulations.

Clinical and Professional Senate for Bury

Proposal and Next Steps

Authors: **Howard Hughes, Kiran Patel, Will Blandamer**

Version: **V4 – 220th August 2021**

Version 3 endorsed by the System Board on 19/8/21

Version 4 includes proposed membership of clinical and professional senate transition group to January 2022.

Next Steps

To form the basis of the terms of reference for the first interim meeting of the clinical and professional senate to be convened in September 2021.

1. Background.

The introduction of CCGs gave GPs control over local NHS spend. Within Bury 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.

The CCG also appointed a number of clinical leads with specific portfolios (e.g., Urgent Care, Planned Care, long term Conditions, Mental Health, IM+T, Learning Disabilities, Medicines Optimisation, Cancer, Palliative Care and End of Life) and these leads headed multidisciplinary managerial and clinical meetings to develop priorities and work plans

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.

It is felt that this clinical infrastructure provided considerable added value to the work of the CCG and it is recognised that, with the imminent development of a GM ICS and of local system Locality Boards, there is a danger that this clinical leadership and insight might be lost. This risk is mitigated by the confirmation in the ICS Design Framework employment guarantee guidance (16th June) that CCG clinical leadership is included in the 'employment promise'. Nevertheless, the loss of the CCG means a loss of connection to a borough wide organisation for expert clinical leadership, where the CCG has provided a route for clinical consensus, agreement and implementation.

There is also a recognition that the clinical leadership described above was not system owned. It was largely, and understandably, primary care led, and commissioner focussed.

2. Current Context

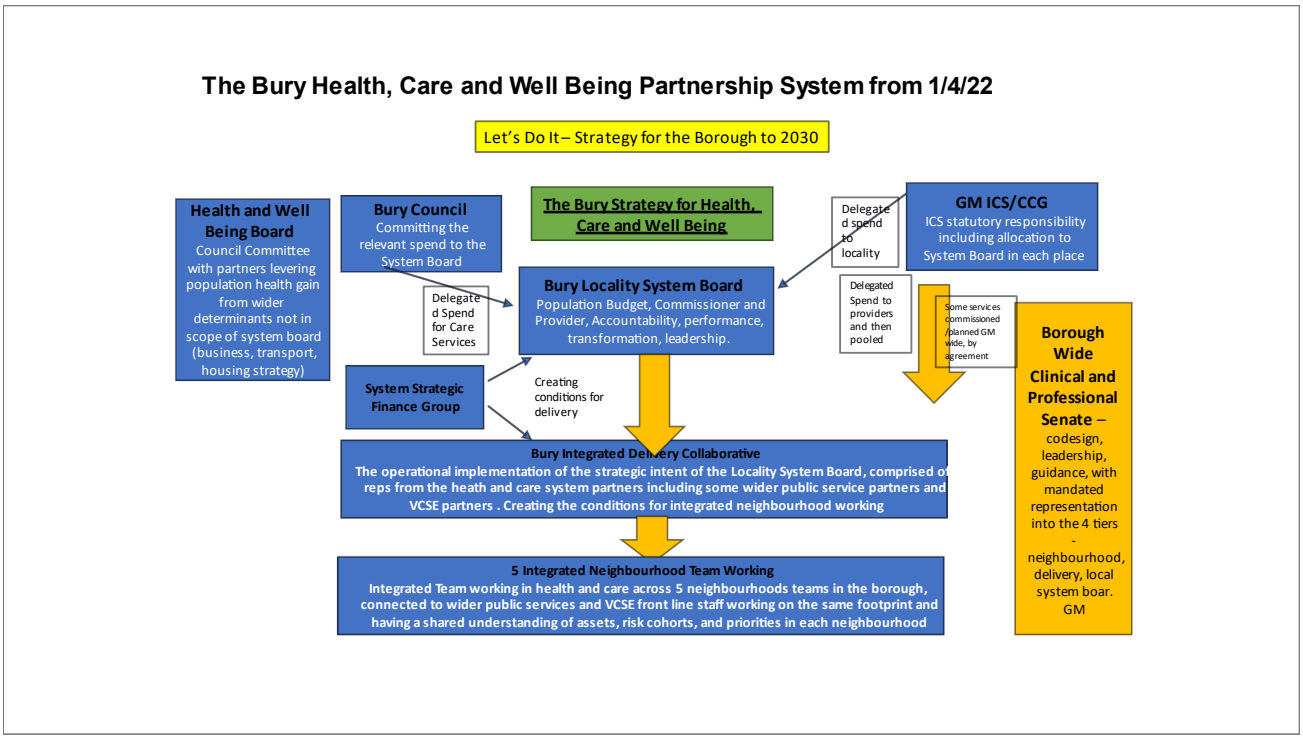
Subject to legislation expected in July 2021 the CCG will be disbanded from April 2022. This creates a risk that the considerable progress in ensuring clinical leadership is driving transformation and reform in the Bury partnership system could be lost.

System leaders in Bury have been clear that a form of clinical leadership needs to be retained within Bury following the implementation of the proposed GM system changes and this leadership has loosely been described as a 'Senate'.

System leaders in Bury have also recognised social care working is key to the delivery of health and social care and that there is an opportunity to focus on clinical and professional leadership.

There is broad support therefore for the development of a Clinical and Professional Senate for the borough reflecting not only GM ICS perspectives but creating opportunity for new models of clinical partnership across sectors – between primary care and secondary, between sectors, and with a wider professional perspective.

The position of a Bury Clinical and Professional Senate in relation to the new partnership arrangements in the borough to be in operation from April 2022 is described below. The box is intended to demonstrate that clinical and professional leadership needs to inform all 'tiers' of the partnership arrangements in the borough and to the GM tier



This paper begins to map out what that may look like, how it may work and at what level it will operate. It also explores how clinical influence and leadership can be maintained across the integrated delivery collaborative board and its subgroups

3. Clinical and Professional Senate Role:

The Clinical and Professional Senate will operate at two levels -that of a network for all clinical and professional leadership in the borough, and then a formal board or steering group to manage the business of the Senate and ensuring clinical and professional leadership is driving transformation of the Bury Health, Care and Well Being System.

3.1 The Clinical and Professional Senate as a network

The Senate needs to operate as a vibrant network of clinical and professional leadership in the borough. It needs to be inclusive, engaging, and a generating a sense of belonging and team working in the Bury System, collectively leading and informing transformational programmes of change. And it needs to have sufficient capacity to support the business of the Senate and the clinical and professional leadership teams in the borough. Such capacity can connect different aspects of the clinical and professional leadership architecture across the borough – e.g the work of the primary care and secondary care interface group, the work of principal social workers in adults and children's. The network of clinical and professional leadership in the borough can be supported to collectively understand and engage on the transformation programme of the borough and can create mechanisms for shared learning and best practice.

3.2 The Clinical and Professional Senate 'Board.

The clinical and professional senate will need a 'board' or 'steering group', composed of elected or mandated senior front-line clinicians and professionals and its primary roles will be at a strategic and oversight level. In practice this means that it will provide a Bury system professional voice to GM, either directly or through the system board or other GM professional groups.

The chair of the 'board' or 'steering group' of the clinical and professional senate will have a place on the Locality Board – setting the health, care and wellbeing strategy for the borough, managing the integrated fund, and supporting and holding to account the integrated delivery collaborative board for the operational delivery of the integrated system.

It is also envisaged that the senate would provide professional leadership to the integrated delivery collaborative board and the work groups below that including specialty and neighbourhood working.

This leadership would be by co-designing system wide delivery and nomination of appropriate professionals and by supporting the professionals involved in that work by peer review.

The role of the board is to provide a consensus of clinical and professional opinion, to provide support to clinical and professional leadership, and to drive the operation of the wider network.

More details on the proposed roles in the Board of the Clinical and Professional Senate can be found in Appendix 1.

4. Clinical and Professional Senate Membership:

All clinicians and professional leaders in the borough would be regarded as 'members' of the Senate. Work will be undertaken to ensure the Senate reaches all in scope practitioners.

In terms of the board of the Clinical Senate, it is proposed that the membership will represent all aspects of the Bury system and that each member will represent a clearly identified part of the clinical and professional community and that he or she will be responsible to ensuring that their views are represented and that they are aware of the outcomes of meetings.

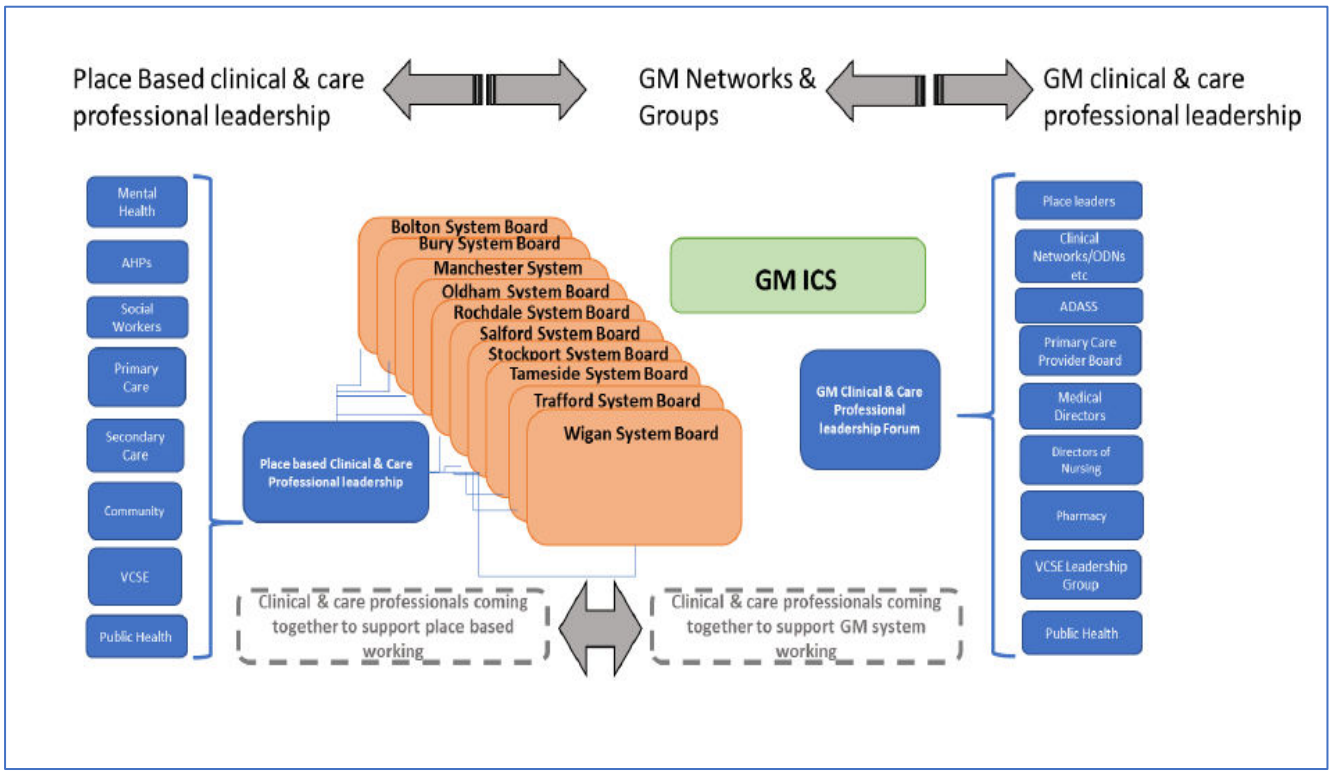
In practical terms this means that each member will be mandated by the section of the community they represent. This will be by election or another fair and agreed process, drawing on the managed network of practitioners established.

The sections represented may be neighbourhood, specialty or professionally based.

Proposed membership can be found in appendix 2

5. GM Clinical and Professional Senate

The proposals for a clinical and professional senate in Bury, and the rationale for doing so, are mirrored for the GM ICS as a whole. The picture below describes the potential operation of a GM Clinical and Professional Senate. Appendix 3 provides the latest paper of the terms of reference for the GM Clinical and Professional Senate, and it is likely we can draw on the document to populate our terms of reference in Bury.



6. Next Steps

The Bury System Board/System Transition Board of May 2021 proposed the following steps in relation to establishing the System Board.

1) Convene meeting of key stakeholder to review and amend this paper and develop terms of reference – June 2021. This meeting is due on 29th June
2) Convene a transition meeting of the Bury Clinical and Professional Senate meeting from September 2021, to meet on 2 or 3 occasions.
3) Convene a more formal shadow clinical and professional senate for the month of January 2022, in preparation for the full operation of the senate from April 2022.

Appendix 1

Clinical and Professional Senate Proposed Roles

1. To advise, shape and provide clinical and professional leadership for the Bury System Board
2. To help ensure the Bury Integrated Delivery Board has appropriate clinical and professional representation and leadership
3. To help ensure the 5 Integrated Neighbourhood teams have appropriate clinical and professional representation and leadership
4. To help ensure specialty or pan-Bury work that takes place outside the neighbourhood teams has appropriate clinical and professional representation and leadership
5. To provide a clinical and professional voice from the borough to GM clinical and professional senate
6. To represent the views of the system-wide clinical and professional community
7. To hold its members to account for the fulfilment of their role
8. To help disseminate the decisions, actions and questions of the System Board and GM to the wider clinical community
9. To provide a forum where leaders can seek wider advice and support for work they are undertaking in neighbourhoods or within specialties
10. To provide support and guidance to the work of the System Assurance and quality arrangements
11. To ensure the System Board is supported in its work in reviewing the performance and outcomes framework
12. To work with the Strategic Finance Group for the borough particularly on issues of Cost Effectiveness

Aims:

To have a bottom-up approach to clinical engagement, empowerment and dissemination.

To thus empower leaders to truly represent the clinical community through mandate and understanding.

To thus develop a powerful clinical voice which truly leads change and delivery

Need to understand interaction with patient and public voice and safeguarding

Appendix 2

Clinical Senate Proposed Membership – draft for discussion

	Member	Representing/Mandate from
Transformation Leads (to include elements of business as usual)	Professional Lead (Elective Care incl Cancer, EOL, Community Services)	System wide professionals working within elective transformation and BAU
	Professional Lead (Urgent Care incl Frailty, Intermediate Care)	System wide professionals working within EC transformation and BAU
	Professional Lead Mental Health (Incl Dementia)	System wide mental health professionals
	Professional Lead (LD)	System wide LD professionals
	Professional Lead (Children and Maternity)	System wide professionals working within Children's ana maternity transformation and BAU
Professional Leads	CCG Chair	CCG Clinical Leads
	Professional NCAG Representative	NCAG
	Elected GP representation	Primary Care GPs
	Community Nursing Lead	DNs and wider community nursing team
	Community AHP Lead	Community AHPs
	Community Non-Medical Primary Care Lead	Local pharmacists, optometrists and dentists
	Senior Children's Social Worker Lead	Childrens social care workers
	Senior Adult Social Care lead	Adult social care workers

	Nursing Home Lead	Private and LA Nursing home staff
	Public Health Consultant	Public Health
	Integrated Delivery Collaborative Medical Director	
	Secondary Care Medical representative	Secondary Care Medical clinicians
	Secondary Care Nursing representative	
	Secondary Care AHP representative	
	Secondary Care MH representative	
	Quality Lead	

Towards a GP Collaborative in Bury?

Will Blandamer

9/8/21

Background.

The loss of the CCG presents a challenge to ensure a voice for GP Leadership in the borough. While there is confidence that the emergent clinical and professional senate can secure mandated representation for clinical leadership into the locality arrangements, and indeed the GM partnership arrangements, there are concerns that GP leadership voice is diminished.

CCG clinical leadership has met with the GP Federation leadership and representatives from the Bury and Rochdale LMC to consider this issue. The general themes were

1) The significant pressure in primary care currently
2) The opportunity afforded by the Primary Care Network establishment and further development
3) The role and function of the neighbourhood clinical leads, and the clear ambition around the development of neighbourhood team leadership
4) The loss of the CCG as a GP membership organisation – although positive recent news in terms of the inclusion of clinical leads as part of the ICS employment promise
5) The role and voice of the LMC
6) The new leadership team of the GP Federation – chair and chief officer designate
7) The connection to the GM Primary Care Board (and expectation of the GM primary care board on the establishment of GP Boards in each district)

The meeting considered that while coming from different perspectives we share a common ambition which is to secure the leadership voice and influence of GPs into the Bury GM Partnership arrangements post – as providers into the Integrated Delivery Board and Locality Board, and through the development of the clinical and professional senate.

A number of other places in the country are establishing GP collaborative arrangements – respecting the unique contribution of each aspect of the GP community – the role of the LMC, the role of primary care networks, the role of the GP Federation for example – but creating an opportunity to work together. An example from Herefordshire is attached as Appendix 1.

Next Steps

A series of 'conversations' with the GP community is commencing, co-hosted by the CCG, GP Federation, and LMC. The first conversation is at an LMC event on 11th August, the second at the GP members strategic meeting on 6th September, and the third at the GP Federation on 10th October. We will together collate the outcome of the conversation and determine the next steps.

Appendix 1

Herefordshire General Practice Leadership Team

Who are we?

- PCN Clinical Directors
- GP Federation leaders
- LMC Secretary, and
- CCG Director of Primary Care

What is our role?

- **SUPPORTING General Practice resilience and sustainability**
- **providing CO-ORDINATED LEADERSHIP and being the VOICE OF GENERAL PRACTICE at Place and ICS level**
- **SUPPORTING PCN DEVELOPMENT & DELIVERY via a 'Network of Networks'**
- **overseeing DELIVERY of CLINICAL SERVICES via our Federation: 'GP 24/7'**
- **developing LOCAL SOLUTIONS to local problems**
- **providing a POINT OF ACCESS through which our partners can link to General Practice**

Working together to provide a single co-ordinated approach

How we work

Weekly meetings, Tues 9-11
Dedicated time for **system partners to join** us every other week
Key decisions & actions captured and available
Transparent about any conflicts of interest

We are committed to:

Engaging & communicating with GP practices and system partners

Ensuring what is **right for patients** is at the heart of decision making

Being the voice of Herefordshire General Practice

Providing **Clinical Leadership**

Collaborating and **championing the role of place** #OneHerefordshire

Collaborating with GP Colleagues across the ICS via the ICS GP Provider Forum

Respecting LMC responsibilities, with LMC being our critical friend

Co-producing local GP **contractual requirements** with ICS colleagues

Herefordshire General Practice
Taurus Healthcare

NHS
Bury
Clinical Commissioning Group

TERMS OF REFERENCE BURY SYSTEM BOARD – STRATEGIC FINANCE GROUP (*3rd iteration*)

Review September 2021

Terms of Reference Document Control Sheet

MEETING	Bury System Board Strategic Finance Group
ESTABLISHED BY/REPORTING TO:	Bury System Board
AUTHOR	Pat Crawford **Interim Chief Finance Officer, Bury CCG**
REVIEW DATES	March 2021 April 2021
ASSOCIATED DOCUMENTS	Bury System Board Terms of Reference Bury Locality Plan
RELATED COMMITTEES/GROUPS	**The System Board** is a whole health and care system partnership board for the borough – developing leadership commitment and clarity around a common vision and strategy and transformation programme. The **Strategic Commissioning Board** (Council and CCG) considers the joint commissioning consequences of the agreed strategy in terms of prioritisation and available finance. The **Health and Well Being Board** focuses on the population health system for Bury. The **LCO Board** is a partnership of providers ensuring the delivery of services is integrated. This Board is evolving into the Integrated Delivery Collaborative. The **Recovery and Transformation Group** reports to the System Board – driving forward the implementation of the programme. This Strategic Finance Group reports to the Bury System Board with a focus on the business and resource requirements, financial consequences and financial risks of decisions made by the Board and/ or its representative Boards. and Groups.

Document Control	
Document Name	Bury System Board – Strategic Finance Group Terms of Reference
File Name	
Version/Revision Number	2nd Draft

Version Control

Version Ref	Amendment	Date Approved
1. 2. 3.	Document Author Pat Crawford. SFG meeting 16.03.21. SFG Meeting 13.04.21	March 2021 April 2021 April 2021

1.0 Purpose

The refreshed Bury Locality Plan (2019-2024), set within the context of the reform of wider public services, reaffirms a vision to enable people to be active participants in their own well-being, to build and contribute to thriving communities and to reduce demand for statutory services. There is recognition that system wide transformation is needed to support delivery of this vision at the same time as addressing significant pressures which challenge the ongoing delivery of safe and sustainable services.

The **Bury System Board** brings together key Partners across the Bury health and care system with the intent to collaborate to bring about system wide change to achieve clinical and financial sustainability. The agreed goal will be to improve the life chances, independence and wellbeing for the Bury population, by maximising the use of the 'Bury Pound'. The impact on Partners in respect to Bury decisions which change the current delivery of services and flow of resources will be recognised to ensure there continues to be a stable delivery system in Bury to achieve improvements to the health and well-being of our population.

These **Terms of Reference (ToRs) relate to the Strategic Finance Group** of the System Board, which will lead the programme of work relating to undertaking an economic assessment and evaluating the impact of proposed changes to services. More specifically, the services falling under this remit are health, adult social care, children's social care, public health and other public service budgets.

The strategic finance group will be responsible for bringing together all key stakeholders to oversee and agree on the financial and resource requirements and outcomes and the overall affordability of proposals presented to the System Board, including how they will be funded, whilst also ensuring effective use of combined resources and system financial sustainability.

2.0 Functions

The core functions of the Strategic Finance Group will be to:

i) Ensure overall financial sustainability of the Bury Health and Social Care system within a context of reducing resources.
ii) Provide financial leadership to enable the transformation of health and social care in Bury at the same time as addressing significant financial pressures.
iii) Deliver a balanced health and care system, which closes the financial gap, whilst meeting rising demand, addressing health inequalities and promoting the ethos of self care.

3.0 Objectives

i) Ensure transparency and consistency in reporting of each organisation's underlying and in year financial position across the locality.
ii) Maintain a current baseline plan and forecast of health and care resources.
iii) Produce a medium term financial strategy (MTFS) and plans for the locality that identifies options to close the financial gap.
iv) Make recommendations to bring the system into financial balance and drive towards a sustainable surplus/ reinvestment position.
v) Facilitate/ support the LCO transformation programme and redesign of services.
vi) Provide support to ensure delivery of the work of the System Board by ensuring deployment of financial resources to meet the Board's objectives.
vii) Work together to ensure the most advantageous financial flows for current and future years, using flexibilities available within organisations financial regimes.
viii) Identify routes to bring more resources into the locality.
ix) Develop an economic model that identifies the impact on activity and resources

by service and organisation to support the development of robust Business Cases for new investment/ disinvestment.

x) Ensure effective utilisation of combined resources to optimise use of the Bury £.
xi) Oversee the identification of service improvement and savings opportunities and realisation plans.
xii) Ensure effective targeting of LCO resources to meet the changing needs of the population in an equitable manner.
xiii) Provide strategic financial leadership, develop frameworks for and agree services to be operationally managed through the ICF and Pooled Fund.
xiv) Determine and agree financial relationships between the partners.
xv) Consider/ propose alternative contractual, business and provider models.
xvi) Explore new payment and incentive models and financial levers for change to ensure collaborative investment in service changes that benefit Bury residents whilst improving the 'system' financial position.
xvii) To interact effectively with other change programmes affecting the LCO (eg GM ICS, provider transactions that impact on the LCO).
xviii) Ensure effective management of financial risks.
xix) Lead on financial engagement with external financial scrutiny bodies.

4.0 Membership

4.1 The Group is made up of representatives of the Bury system health and care Partners. Membership will comprise the following post holders:

Members
- Executive Director of Finance – Bury Council & Bury CCG
- GM ICS representative
- Finance Director – Northern Care Alliance
- Finance Director – Pennine Care
- LCO Representative
- PCN Representative
- VCFA Representative
- Executive Director of Strategic Commissioning – Bury

In attendance
- Deputy Chief Finance Officer – CCG
- Deputy Chief Finance Officer – Council

4.2 Briefed Deputies with delegated authority to act as permitted to cover unavoidable absences. The Chair's Secretary is to be notified before the meeting if a Member intends to send a Deputy.

4.3 The Group shall be entitled to invite other managers or subject matter experts, with the Chair's permission, to attend for specific items to support the Group's decision making.

4.4 Chair
The Chair shall be the Executive Director of Finance Bury Council and Bury CCG, or nominee in the event that the Chair is unable to attend the meeting.

4.5 Quoracy
A minimum of two representatives comprising
- one of the S151 Officer or GM ICS representative, and
- one provider.

4.6 Frequency
The Board shall meet monthly, as a minimum, with monthly meeting dates circulated in advance for each financial year.

5.0 Accountability and Reporting

The Strategic Finance Group is accountable to the Bury System Board.

The Bury System Board is accountable to Partner organisations represented on that Board.

The Bury System Board will report on key decisions to the Strategic Commissioning Board, the LCO Board, and the Health and Wellbeing Board.

6.0 Conduct of Meetings

6.1 The agenda and supporting papers will normally be sent out 5 working days in advance.

6.2 The Board will be supported by the Chair's Secretary who will be responsible for the production of minutes, action logs and decision tracking and maintenance of a formal record.

6.3 Presenters of reports can expect Group members to have read their papers and should keep to a short summary which outlines the purpose and key issues.

6.4 At the start of each meeting, the Chair will invite Group Members to declare all interests in relation to the current agenda and any conflicts of interest which may have arisen since the previous meeting.

6.5 The Chair shall decide, taking advice as required, on the materiality of each conflict and whether the conflicted party should participate in the discussion and/or vote, if one is required. The decision shall be documented in the minutes together with their reason.

6.6 Behaviours
The expected behaviours of Group Members and key features are that we will have honesty, openness and trust at the heart of our discussions. We will play to our collective strengths with a "can do" attitude.

Disagreements will be resolved in a courteous manner with challenges managed in a mature way without blame. We will develop a reflective culture, learn lessons and most importantly work as a system to improve outcomes for our population.

7.0 Review

These Terms of Reference shall be reviewed annually, with the first review at September 2021.

BURY HEALTH, CARE AND WELL BEING PARTNERSHIP

Report to: Bury System/Transition Board	
Meeting Date: 15.7.2021	
Title of Report: **Bury System Quality, Safeguarding & Performance Assurance Committee Proposals**	
Purpose of report: (Please Tick)	
Decision **Discussion** ☐	**Review of Performance** ☐ **Urgent operational issue** ☐

1. Executive Summary

The purpose of this paper is to share with the IDC Board the thinking around fully integrated system assurance for the quality and safety of Health and Social Care services.

The paper has been prepared following conversations with key local and GM Health and Social Care stakeholders and Bury Health Watch.

The paper describes the rationale and principals of working collaboratively across the system to deliver the borough's statutory responsibilities and ensure services are safe and of a high quality. Furthermore, the principals will ensure partners are able to work in a timely and responsive way to put in place change that will address issues and make improvements for local people.

2. Introduction

Why is system assurance important?

For the people who use NHS services, the NHS Constitution reiterates that the NHS aspires to deliver the highest standards of excellence and professionalism [1]. Additionally, the commitment to the quality of care is one of the seven constitutional values set out in the document. Similarly, the principals that underpin the support people in receipt of Social Care services describe high quality services working together for the well-being of individuals [2].

During the years since the publications of several key public inquiries into patient safety, for example the Francis Inquiry [3], the Kirkup Review[4] and the Berwick Report[5] and others there have been developments in systems and processes to improve patient safety and crucially for organisations to learn and embed improvements so that people have a good experience of their health services. Over time the same principals have extended into community services

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[3] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
[4] https://www.england.nhs.uk/wp-content/uploads/2021/03/Independent-Investigation-into-East-Kent-Maternity-Services-Terms-of-reference.pdf
[5]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

and into Social Care settings. Launched in 2019 is a new safety strategy - The NHS Patient Strategy - safer culture, safer systems, safer patients which builds on the learning so far and references medicines safety, safety in mental health settings and in services for older people[6]

During the transition from CCGs into Integrated Care Systems (ICS) it is important that we do not lose focus on the safety of services for our Bury population. We must as a system ensure that the learning from previous years on what good looks like is embedded and that we remain a listening system, vigilant to failings and passionate about making things better for people in health and social care that will in turn improve the outcomes for those living in the Bury borough.

3. Opportunities

A fully integrated local Health and Care system provides a new beginning for working differently for the benefits of population as set out in the white paper 'Integration and innovation: working together to improve health and social care for all'[7]. As such, system assurance and improvement will be collaborative rather than having a Commissioner / Provider split, we will work in a joined-up way where all partners understand what works well and where the focus needs to be to improve.

The key change for Integrated Care Systems is that assurance and learning is from a patient / public perspective rather that individual organisations so that the system improves for people and services work jointly. Place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. In Bury we have started on this road through co-production work, improved engagement and viewing success through the lens of people's lived experience and this is built into our long-term strategy.

The NHS guidance (June 2021) Integrated Care Systems: design framework[8] begins to describe the governance between the GM ICS and localities and includes accountability and assurance stating the ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's

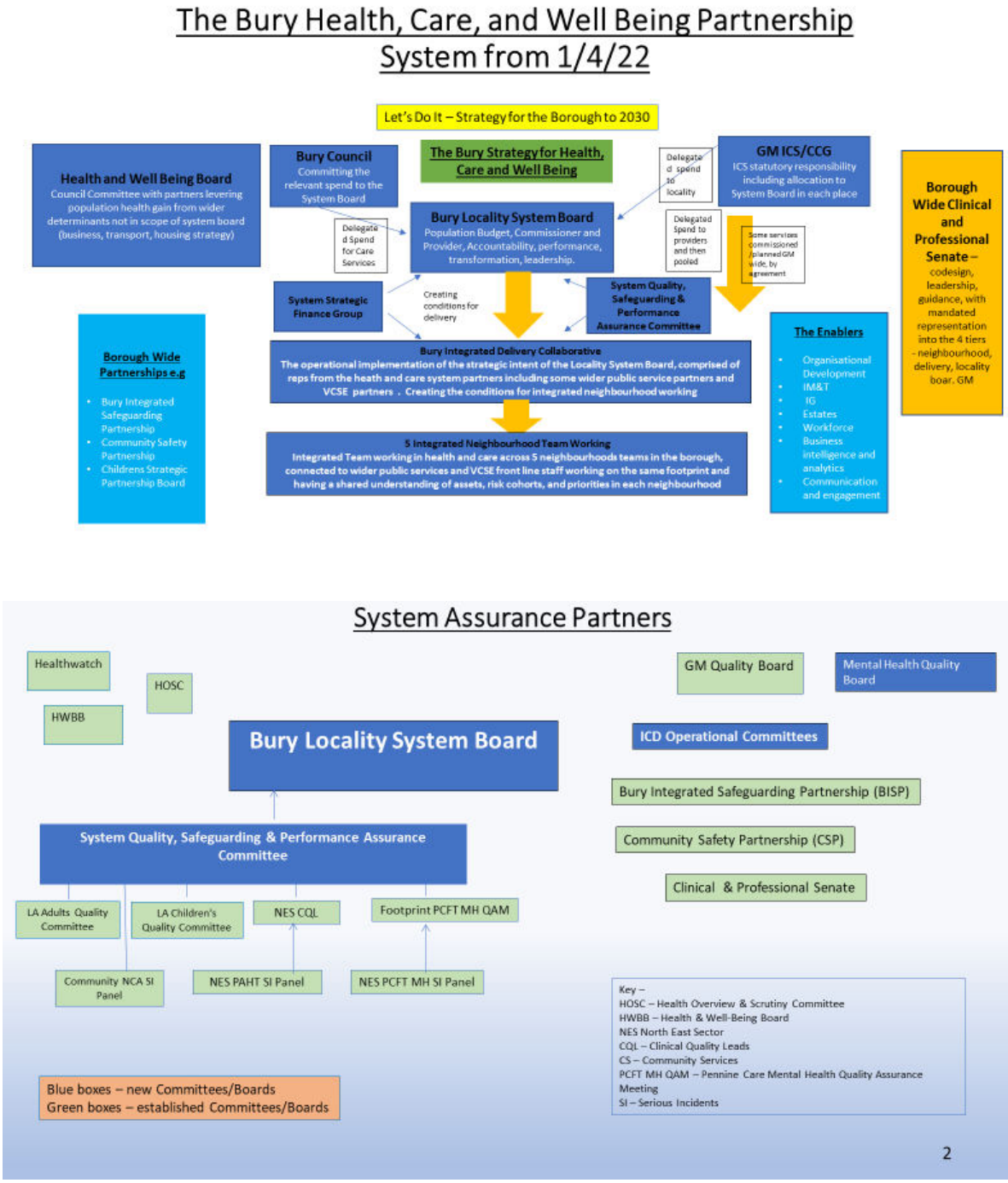
[6] https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf
[7] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version
[8] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

objectives. With this guidance we can begin to develop our local assurance model that will support the GM ICS but will ensure locally we can describe the quality of the local offer.

4. **Principals of the local System Quality, Safeguarding & Performance Assurance Committee**

- ✓ All Health and Social Care partners will support the development of a System Assurance Committee to assure the system once and irradicate duplication.
- ✓ The Committee will ensure statutory functions are delivered whether locally or at the GM ICS; including compliance with wider organisations e.g. NICE, CQC, Ofsted. This will not replace organisations legal duties as independent entities.
- ✓ The Committee will review system performance (likely national datasets), local performance and quality performance.
- ✓ The Committee will ensure sufficient health & care services are in place and influence local commissioning of services.
- ✓ The Committee will ensure value for money and benchmarking to influence local commissioning.
- ✓ The Committee will focus on quality from a lived experience perspective and actively seek the views of the local population on the services they access.
- ✓ The Committee will welcome an integrated approach to assurance with equal focus on all Health and Social Care services rather than focussing on the largest organisations & national KPIs.
- ✓ The Committee will provide assurance to the IDC Board and the Bury System Board as required.
- ✓ The values and behaviours of all stakeholders will adhere to those expected of people in public life, particularly openness and honesty to ensure there is a consistent and true account of the quality of services locally and the raising of issues and concerns where is improvement is required.
- ✓ The Committee will hold partners to account for poor quality and for the delivery of responsive quality improvement. It will support risk based intelligent collaborative targeted interventions to improve services.
- ✓ The Committee will support in time the borough level development of a Quality Strategy.

5. **The Developing Locality Construct**



6. Recommendations

The System/Transition Board are asked to:

- Support the principals of an integrated System Quality, Safeguarding, Performance Assurance (and improvement) Committee
- Support the arrangements for creating the Committee
- Support staff to ensure the Committee can develop
- Agree to the Committee being stood up in the Autumn 2021

Catherine Jackson
Director of Nursing & Quality Improvement Bury CCG / OCO

Appendix 1

Local Authority Legislation

To discharge the Social Services functions of the Authority as defined in Section 1A of the Local Authority Social Services Act 1970 as amended from time to time other than those functions for which the Director of Children's Services is responsible under Section 18 of the Children Act 2004.

Plus functions in:

- National Assistance Act 1948
- Disabled Persons (Employment) Act 1958
- Mental Health Act 1959
- Health Services & Public Health Act 1968
- Chronically Sick and Disabled Persons Act 1970
- Supplementary Benefits Act 1976
- Mental Health Act 1983
- Health & Social Services & Social Security Adjudications Act 1983
- Public Health (Control of Disease) Act 1984
- Housing Act 1996
- Disabled Persons (Services, Consultation & Representation) Act 1986
- National Health Service & Community Care Act 1990
- Carers (Recognition & Services) Act 1995
- Community Care (Direct Payments) Act 1996
- Local Government Act 2000
- Health and Social Care Act 2001
- Nationality, Immigration and Asylum Act 2002
- Community Care (Delayed Discharges etc) Act 2003

• Health & Social Care (Community Health & Standards) Act 2003

• Carers (Equal Opportunities) Act 2004

• Mental Capacity Act 2005

• Health and Social Care Act 2012

• Mental Health (Amendment) Act 1982

• Equality Act 2010

• Care Act 2014

Local Current Quality & Safeguarding Functions including statutory functions

Patient safety as directed by the Serious Incident Framework

Children & Young People and SEND assurance

Learning Disabilities and Autism assurance

Infection Prevention and Control policy and assurance

Mental Health Homicides/Independent Investigations oversight

Continuing Health Care process and assurance

Patient Experience & Commitment to Carers assurance

Care Home assurance

Coronial processes oversight including Regulation 28 orders

Development of Patient Safety Specialist Roles and oversight requirements

Implementation of learning from LeDeR/Establishment of the LD Practitioner Forum

Supporting providers to develop & implement borough level Quality Improvement/Assurance systems

Implementation of Patient Safety Incident Response Framework linking to SI panel oversight

Continued oversight of Provider Mortality and Structured Judgement Reviews

Quality oversight of maternity services and standards including Ockenden standards

Harm reviews due to extended elective/cancer waits

Staff and patient engagement forums

Equal Statutory Partner of the BISP (1 of 3, Police, LA and CCG) in relation to strategic, borough wide safeguarding arrangements

Ensuring that the CCG meets the requirements of the NHS England Accountability Framework (2015), the Care Act 2014, Mental Capacity Act 2005 and Working Together to Safeguard Children 2018

Monitoring of Looked after Children (LAC) Key Performance Indicators

Safeguarding attendance at and contributions to Child Death Overview Panel (CDOP)

Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, Clinical Commissioning Groups and NHS England" (Dec 2020)

Ensure effective arrangements for information sharing within safeguarding, challenging and unblocking the health system.

Ensure that safeguarding is considered at all points of the commissioning cycle; objectively monitoring assurance of the safeguarding standards and support and professionally challenge as required

Work within local health economies to influence local thinking and practice particularly the learning from all local and national case reviews, assuring this is disseminated to front line staff

Objective scrutiny and to support organisations where they are investigating abuse and neglect and health is an element or where organisational neglect and abuse are known and suspected

Cooperation with MAPPA and as such attendance is mandatory and recorded and reported

Effective relationships across specialist and secure commissioning for the health economy of Bury

Programme of safeguarding training to GP practice colleagues, bespoke training for GP Safeguarding leads – requirement of intercollegiate document

Facilitating Safeguarding supervision and support to named nurse colleagues across the health economy – requirement of intercollegiate document

Small provider safeguarding assurance

Liberty Protection Safeguards (LPS) system under the Mental Capacity (Amendment) Act 2019 is intended to come into force on 1 April 2022. The CCG will become a responsible body under the Mental Capacity Amendment Act (2019).

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Receive
Item No	6.3	**Confidential / Freedom of Information Status**	No
Title	**Health and Care Neighbourhood Model – progress update**		
Presented By	**Will Blandamer, Executive Director of Commissioning**		
Author	**Will Blandamer, Executive Director of Commissioning** **Lindsey Darley, Director of Transformation and Delivery**		
Clinical Lead	**INT Clinical Leads**		
Council Lead	**Will Blandamer, Executive Director of Commissioning**		

Executive Summary

This paper presents the progress on development of the adult integrated health and care neighbourhood target operating model. This sits in the context of the Lets Do It strategy, and reflects two key themes

- how we organise ourselves to create the best opportunity for front line staff to know each, work with each other, see the residents they work with in the round rather than from only their own organisational view. It creates opportunities for staff to work differently with cohorts of particularly need and vulnerability
- the way we work with residents and communities – recognising the assets of residents and communities, and the opportunities to change the nature of the relationship between organisations and people.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Note the contents of the report, progress to date, and September timescale for presentation and approval of the model.

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?	Directly sits within the context of the Lets Do It strategy and its implementation.					
How do proposals align with Locality Plan?	Directly sits within the context of the Locality Plan and its implementation.					
How do proposals align with the Commissioning Strategy?	Directly sits within the context of the commissioning strategy and its commitment to investment in INTs.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	Not articulated in this document.					
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?	None as yet.					
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.		

Title: **Health and Care Neighbourhood Model – progress update**

Report of: **Will Blandamer, Executive Director of Commissioning**
Lindsey Darley, Director of Transformation and Delivery

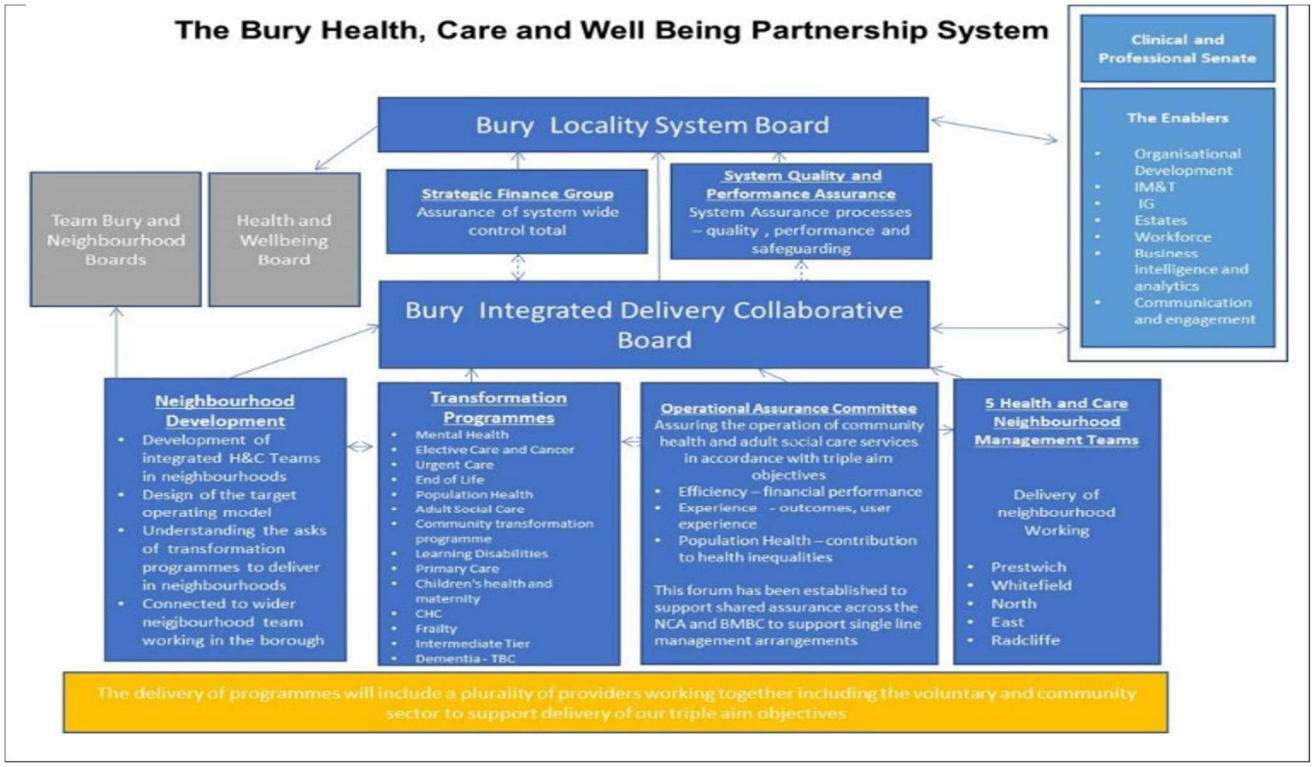
Report to: **Strategic Commissioning Board**

Date: **25th August 2021**

Introduction

This briefing paper sets out the current progress against describing a Target Operating Model (TOM) for health and care (H&C) neighbourhood delivery.

The GM ICS development provides a clear commitment to the continued work to develop models of integrated neighbourhood team working in health and care. Our new partnership architecture in Bury is designed to create the conditions to accelerate the model of neighbourhood working to be mainstream working. This will be recognised in the sub structure to the IDCB – where there is a sub group particularly focused on the development work required, and then also the reporting of the work of each of the neighbourhood teams as units of delivery.



Progress update.

To date a Neighbourhood Development group consisting of LCO Core Team, operational managers, Public Health, Social Care and Council colleagues have been meeting regularly to develop the TOM. Through this group connections are brought together with IDC colleagues, Public Service Reform/Early Help, and the Community Hubs.
Prior to commencing work on the Target Operating Model (TOM) it has been necessary to define the tasks required, and the process of developing the TOM as outlined in Figure 1. Progress against this structure is reviewed at every session.

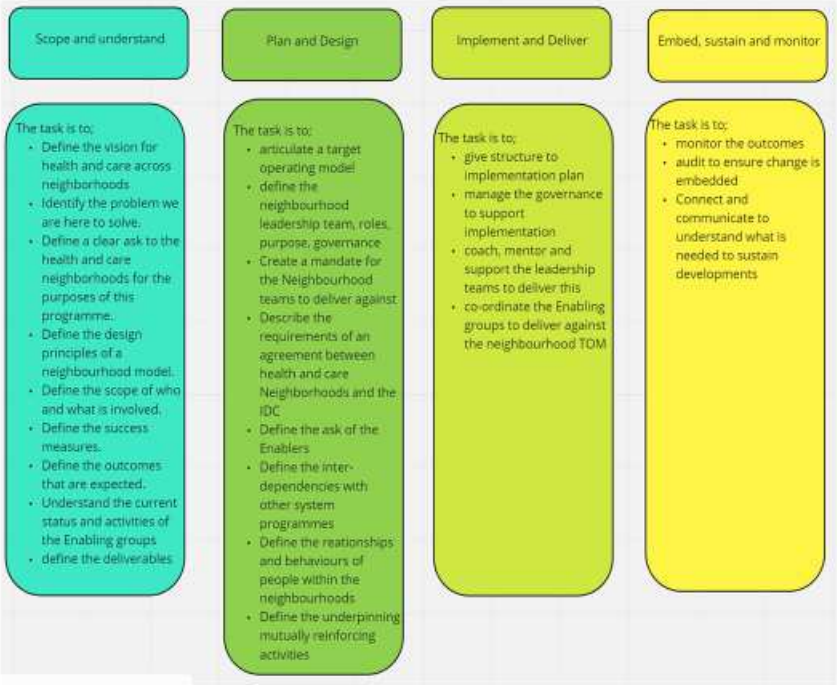


Figure 1. Development process.

To date the work has focused on the initial two stages of scoping and understanding, and planning and design.
In developing the TOM, the common components of a TOM have been described and utilised as a basis for development. The diagram below describes the key components of the TOM. Furthermore, we can describe the key aspects of each part of the TOM, with the exception of Process, which requires further work.

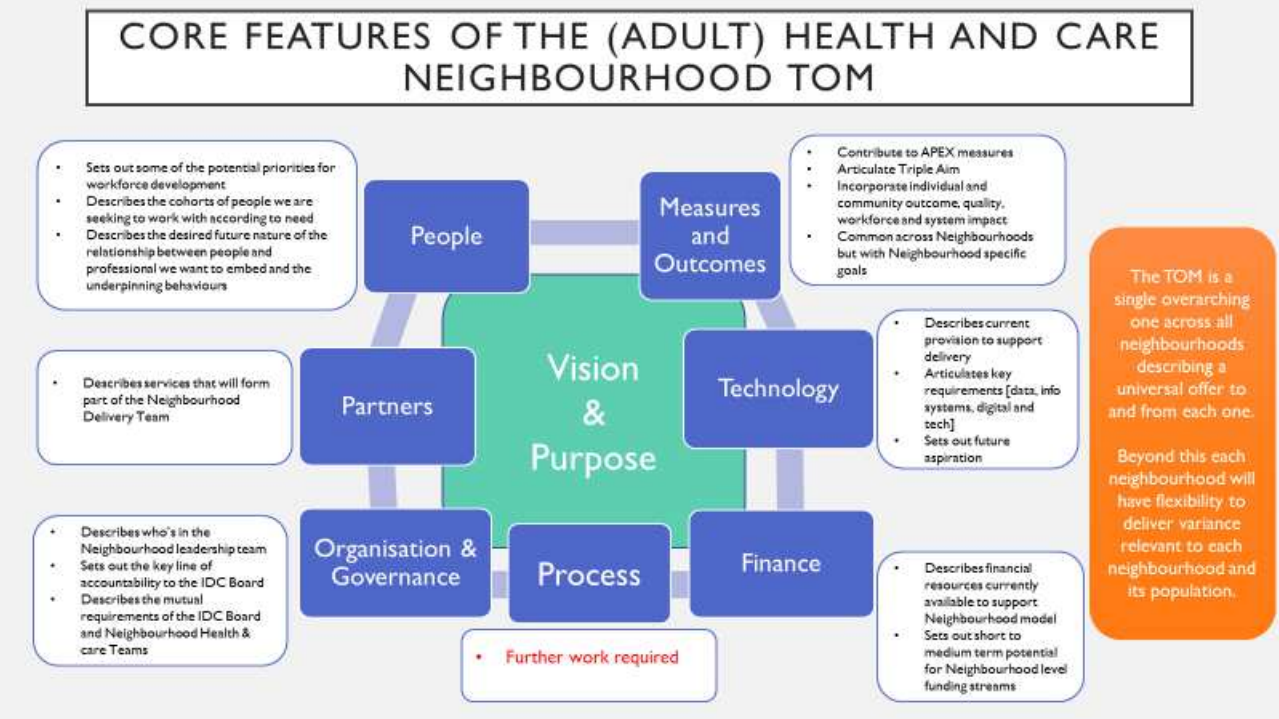


Figure 2. Current outline of the Health and Care (adults) Neighbourhood TOM.

Connection to the PSR Steering Group

The TOM has been co-produced with the leads responsible for other sections of the wider PSR model. This has been helpful in establishing some common approaches, on which other sections in Figure 3. can build, and in creating a common language across the system. The proposed common frameworks/approaches will provide consistency and enable a system wide approach which can then follow through the connections, outcomes, practice and financial impact. The common approaches that will be proposed to the PSR Steering Group in the first instance will be;

- Use of the iThrive model to describe the overarching framework that sits across the TOM.
- An outcomes framework that will support the Triple Aim and enable outcomes to be described that will then feed into the Apex reporting system
- A financial impact framework that describes common approaches to defining the impact of changes in practice and in the system.

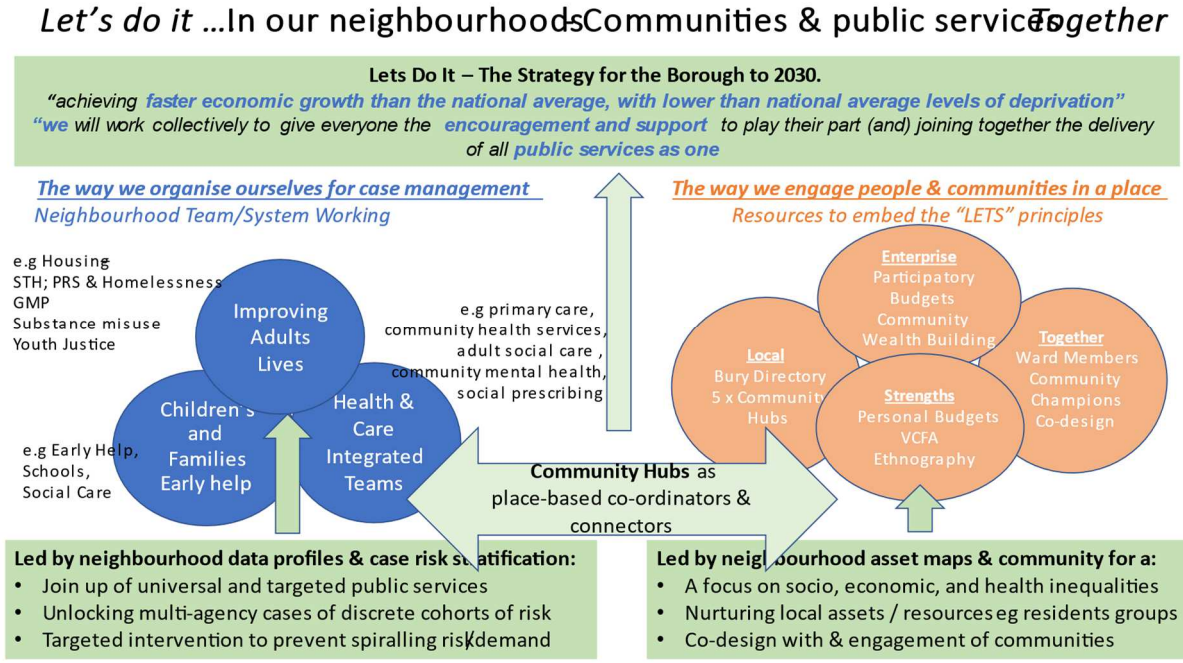
Testing and Making this real

There is an appetite to start testing out how some of this may work in practice. This is particularly relevant as the foundation of the H&C leadership teams are already in place and have been operational for some time, albeit in a limited fashion. The monthly neighbourhood team meetings are in place and well attended and it would not be a significantly huge step to expand this and include key additional people such as Public Health colleagues.
As such, a few key opportunities have been identified to test out the approaches we can already describe in the draft TOM, whilst also providing opportunity for learning, and understanding of the future possibilities for H&C. These are as follows;

- Funding and development of the PCN mental Health practitioners topped up to include 5, to be delivered on a neighbourhood basis.
- Application of the Public Health community grants scheme for allocation to each neighbourhood and an additional single pot for schemes covering more than one neighbourhood.

Next Steps

This paper has provided an update on the development of the Integrated Neighbourhood Teams in Health and Care. The operating model for the health and care INTS will be completed by September and further developed and refined through the IDCB and the Locality Board
The work to develop the INTS in health and care is nested in the wider public service reform ambition for the borough, as agreed at the Team Bury meetings. A PSR sub group of the Team Bury meeting has been established and is focused on the delivery of new models of team working, and a new way of working with patients and residents and communities. This approach is reflected in the following diagram.



The work is nested in the context of the Lets Do It strategy, and reflects two key themes

- how we organise ourselves to create the best opportunity for front line staff to know each, work with each other, see the residents they work with in the round rather than from only their own organisational view. It creates opportunities for staff to work differently with cohorts of particularly need and vulnerability
- the way we work with residents and communities – recognising the assets of residents and communities, and the opportunities to change the nature of the relationship between organisations and people.

The role of the INTS is clearly reflected in the element of the slide on the left, and creates opportunism for health and care staff to connect to other public services who significantly influence the health and well being of patients – in GMP, in housing, in schools etc, because

those partners are mostly recognising the same spatial level of the 5 neighbourhood teams. This work across the 3 elements of the Venn diagram on the left is progressing and the health and care INTs are working positively to make this a reality.

Recommendation

The Board is asked to;

1. Note the contents of the report, progress to date, and September timescale for presentation and approval of the model.

Agenda Item 7

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Approve
Item No	7	**Confidential / Freedom of Information Status**	No
Title	Proposal to manage funding requests to NHS Bury CCG for spot purchases of services		
Presented By	Howard Hughes		
Author	Maxine Lomax		
Clinical Lead	Maxine Lomax		
Council Lead	--		

Executive Summary

The purpose of the paper is to outline the current position within NHS Bury CCG for the management of requests for funding for services that are not currently commissioned.

NHS Bury CCG have utilized the services of the GM Effective Use of Resources team to manage the requests for Mental Health funding where the CCG does not commission a service. This is outside the remit of the GM EUR service and has been completed on a good will basis. The team complete this work on behalf of Bury and one other CCG. Additionally, the GM EUR team manage requests for Sensory Assessments for the CCG. NHS Bury are the only CCG they undertake this work for and is completed on a goodwill basis.

The paper outlines

1. The Current position
2. The potential position post 1st April 2022
3. A proposal to manage the issue until the 31st March 2022
4. Recommendations to the Strategic Commissioning Board

A previous version of the paper was considered at NHS Bury CCG Governing Body with the following decisions:

- Support the next steps as outlined for the presented paper to be taken to the Strategic Commissioning Board for approval.
- Support the Proposed Process (Appendix 1) to be set up in Bury to manage non-contracted IFRs.
- Support further work to be undertaken with work stream Leads and Clinical Leads to establish clear criteria for approving individual requests, based on NICE guidance, the current pathways of care in GM and the CCG agreed criteria for exceptionality.

The current paper has been slightly amended to support clarity following conversations with the Head of Commissioning Support at the Greater Manchester Joint Commissioning Team

Recommendations

It is recommended that the Strategic Commissioning Board:

- Acknowledge the current issues within the system relating to work undertaken on a good will basis by the GM Effective Use of Resources Team
- Approve for Proposed Process (Appendix 1) to be set up in Bury to manage funding request that fall outside the remit of the GM EUR team
- Request that the Executive Director of Strategic Commissioning identify a resource to act as the SPOC and establish a timeline for the pathway to commence
- Agree the that next steps for the identified SPOC closely with Work stream Leads and Clinical Leads to establish principles for approving individual requests, based on NICE guidance, the current pathways of care in GM, best use of resources and the CCG agreed criteria for exceptionality.

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

Implications						
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?	The proposal will ensure that there are no delays in decision making when requests are made for services outside the CCG commissioned services					
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	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
NHS Bury CCG Governing Body	28/07/2021	The proposal was supported, and the GB agreed for the paper to be presented at the Strategic Commissioning Board

Proposal to manage funding requests to NHS Bury CCG for spot purchases of services

1. Introduction

1.1. The purpose of the paper is to outline the current position within NHS Bury CCG for the management of requests for funding for services that are not currently commissioned

1.2. NHS Bury CCG have utilized the services of the GM Effective Use of Resources team to manage the requests for Mental Health funding where the CCG does not commission a service. This is outside the remit of the GM EUR service and has been completed on a good will basis. The team complete this work on behalf on Bury and one other CCG. Additionally, the GM EUR team manage requests for Sensory Assessments for the CCG.

1.3. The paper outlines

- The Current position
- The potential position post 1st April 2022
- A proposal to manage the issue until the 31st March 2022
- Recommendations to the Strategic Commissioning Board

2. Background

2.1. The NHS is under a statutory duty 'to promote comprehensive healthcare within the resources available'. It is not an absolute obligation to provide every treatment that a patient, or group of patients, may demand. The NHS is entitled to consider the resources available to it and the competing demands on those resources. The precise allocation of resources and the process for prioritising the allocation of those resources is a matter of judgement.

2.2. The GM Effective Use of Resources Operational policy (v5.0) aims to facilitate and support making these judgements at a named patient level by identifying individuals who should receive care on the NHS where their request is an exception to current commissioning arrangements. In April 2013 GM EUR service was established to support the delivery of this statutory duty.

2.3. The GM EUR team is part of the Greater Manchester Joint Commissioning Team (GM JCT) and since 1st April 2020 has been hosted by NHS Oldham Clinical Commissioning Group (CCG). The GM EUR service incorporates an administrative team alongside commissioned clinical and corporate support arrangements. The GM EUR service is commissioned by all 10 GM CCGs.

2.4. NHS Bury CCG have utilized the services of the GM EUR to team to manage the requests for Mental Health funding where the CCG does not commission a service.

This is outside the remit of the GM EUR service and has been completed on a good will basis. The team complete this work on behalf of Bury and one other CCG. Additionally, the GM EUR team manage requests for Sensory Assessments for the CCG. NHS Bury are the only CCG they undertake this work for and is completed on a goodwill basis.

3. Current and Future Position

3.1 As outlined above, the GM EUR team undertake additional work for NHS Bury CCG around Mental Health and sensory assessments. As Greater Manchester moves towards an Integrated Care System the model across GM for the review of requests for Individual Funding Requests due to Exceptionality will change. There are currently 10 panels, one for each CCG, and it is expected there will be only one panel post April 2022.

3.2 There are workshops, being led by the COO of NHS Bolton CCG which are looking at the transfer statutory function into the ICS, including Individual Funding Requests (IFR's)

3.3 Alongside the workshops, there is a review of the GM EUR service and it is likely that post the 1st April, that the team will be unable to support the management of cases that are outside their remit. Therefore, there will need to be a local model/solution to manage local requests

3.4 However, there remains the current pressure that NHS Bury CCG is being asked, by the GM EUR service, to manage its own Mental Health funding requests and other spot purchases such as sensory assessments.

4 Proposal

4.1 The proposed solution is a two step change. The initial change to commence as soon as is practicable and to continue until the end of March 2022 and the second step to be decided once the GM model for management of IFR is agreed.

4.2 It is recommended that the CCG adopt, until the end of March 2022, and potentially beyond, with any modifications required under the ICS, the model, the pathway as outlined in Appendix 1. This will enable the CCG to manage requests that fall outside the remit of the GM EUR team. The CCG would need to establish a single point of contact for referrals

4.3 Once a referral is received into the SPOC (Single Point of Contact) which is an administrative role, the information will be triaged as outlined on the flow chart and either directed to the GM EUR team or to follow the internal CCG pathway.

4.4 The SPOC process could align with the work of the team that manages Freedom of Information requests and PALS, as the work interfaces with patients and will require similar timelines and processes.

4.5 The existing IFR panel, until the end of March 2022 and as a local panel from the 1st April, would continue to review the most complex cases that cannot be resolved within the workstreams under a delegated financial responsibility

4.6 The CCG would need to establish clear criteria for approving individual requests, based on NICE guidance, the current pathways of care in GM and the CCG agreed criteria for exceptionality. Work with clinicians/commissioners and Finance to understand how and where high cost patients that are above the usual schemes of delegation should be reviewed and what checks need to be in place to ensure the most effective use of resource has been applied.

4.7 The SPOC would own the process, tracking, recording, communicating with the referrer and the panel as required, minuting the meeting and keeping logs of all cases.

4.8 The CCG would work closely with GPs in Primary Care to ensure guidelines are clear and patients' expectations are managed appropriately. The SPOC would ensure clear communication with GPs and Providers.

5 Recommendations

- Strategic Commissioning Board to acknowledge the current issues within the system relating to work undertaken on a good will basis by the GM Effective Use of Resources Team

- Strategic Commissioning Board to approve for Proposed Process (Appendix 1) to be set up in Bury to manage funding request that fall outside the remit of the GM EUR team

- Strategic Commissioning Board to request that the Executive Director of Strategic Commissioning identify a resource to act as the SPOC and establish a timeline for the pathway to commence as soon as possible

- Strategic Commissioning Board to agree the that next steps for the identified SPOC closely with Work stream Leads and Clinical Leads to establish principles for approving individual requests, based on NICE guidance, the current pathways of care in GM, best use of resources and the CCG agreed criteria for exceptionality.

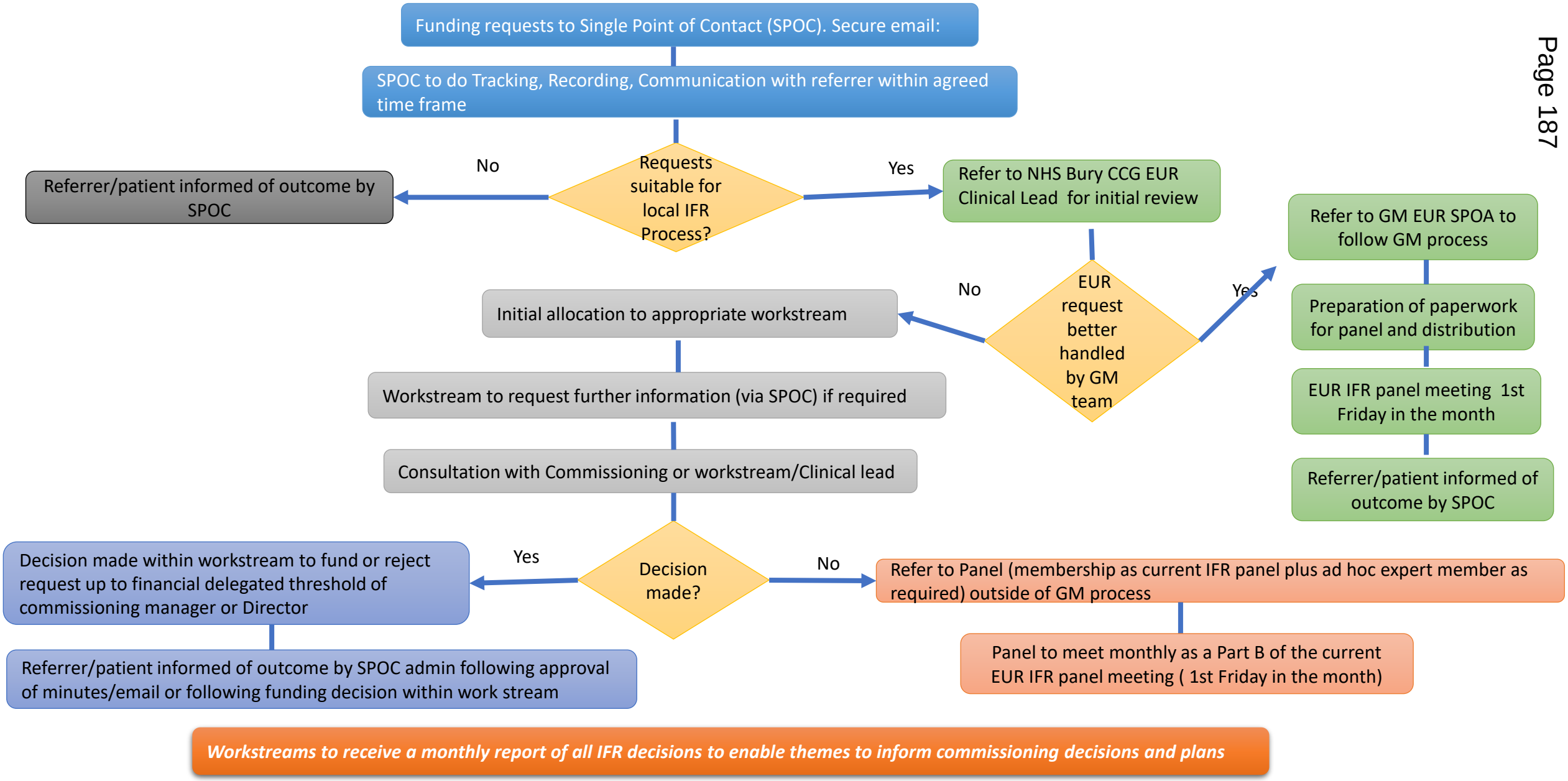
6 Actions Required

6.1 The Strategic Commissioning Board is requested to:

- Approve the recommendations as outlined above

Maxine Lomax
Clinical Lead, Effective Use of Resources
Maxine.lomax@nhs.net
August 2021

Individual Funding Request – Non-EUR process until the 31st March 2022



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Agenda Item 8

Classification	Item No.
Open	8

Meeting:	Strategic Commissioning Board
Meeting date:	6 September 2021
Title of report:	Review of Armed Forces Covenant
Report by:	Cabinet Member for Communities, Bury Council Chair, NHS Bury CCG
Decision Type:	Key Decision
Ward(s) to which report relates	None

Executive Summary:

The Armed Forces Covenant is a long-standing promise by the nation that those who serve or who have served in the armed forces, and their families, will be treated with fairness and respect within the communities, economy and society they serve and protect. In 2013, NHS England took up its full duties to ensure delivery of the commitments made by the Government under the Armed Forces Covenant, with specific responsibilities for Clinical Commissioning Groups (CCGs) including commissioning all secondary and community services required by armed forces' families where registered with NHS GPs, and services for veterans and reservists when not mobilised. Similarly, in 2017, Bury Council confirmed its support for the armed forces community by signing the Armed Forces Community Covenant, with bronze status later being awarded to the Council by the Ministry of Defence Employer Recognition Scheme.

Since this time, there has been significant work on a Greater Manchester covenant. Furthermore, forthcoming legislation (Armed Forces Bill, 2021), will have an impact on public sector delivery of the Armed Forces Covenant.

The legislation states that a public authority must, when exercising its public functions, have due regard to the unique obligations of, and sacrifices made by, the armed forces, and the principle that it is desirable to remove disadvantages arising for service personnel from membership, or former membership, of the Armed Forces. Due regard means that in making decisions, as well is in operational activity, a body subject to the duty must consciously consider the obligations previously stated. The duty to have due regard only applies to the exercise of functions in healthcare, education and housing, as these are perceived to be the key areas that disadvantage is most prevalent. The Bill will amend the Armed Forces Act of 2011 and is likely to come into law early next year. Bury is well advanced in planning for the new duty with the inclusion of the Armed Forces community as a protected characteristic within its Inclusion Strategy and approach to Equality Analysis (EAs). This report seeks to prepare Bury to continue to support those that are serving, have served, and their families, by way of a refreshed Armed Forces Covenant and associated Action Plan.

Recommendations

1. That the proposed Armed Forces Covenant is approved, to complement the Greater Manchester Armed Forces Covenant.

2. That Bury Council and NHS Bury Clinical Commissioning Group (CCG) refresh and re-sign the Armed Forces Covenant.

3. That delivery of the Armed Forces Covenant will be monitored by a working group comprising officer champions across the Council and Bury CCG, reporting to the Armed Forces Covenant Steering Group, with an annual report on progress being submitted to the Strategic Commissioning Board.

1. Background

1.1 The Armed Forces Covenant is a promise by the nation ensuring that those who serve or who have served in the armed forces and their families are treated with fairness and respect in the communities, economy and society they serve with their lives. The Covenant does not intend to replace current work by public service providers, charities and individuals, but rather formalise a commitment and build on existing sources of support. Further information and online support relating to the Covenant can be access here: https://www.armedforcescovenant.gov.uk/

1.2 The covenant introduced the concept of the wider "Armed Forces Community" of regular service personnel, reservists, veterans, their partners and children and builds upon the traditional remembrance obligation to focus on the wider sacrifices associated with military service in respect of restricted personal freedoms and choice, including access to commercial and public services and the challenge of transition to civilian life.

1.3 The underlying principle of the covenant is not to differentiate in terms of preferential treatment, (special consideration is reserved for the bereaved or seriously injured), but to ensure that the particular demands of military life are understood and that those returning to civilian life have equal access to services and experience no disadvantage as a result of their military service.

1.4 Since 2011 all local authorities have been invited to sign the Armed Forces Community Covenant and to make localised pledges which complement the national covenant at local leadership level, encouraging wider local public service and business organisations to support the armed forces community and to promote understanding and awareness among the public of issues affecting the armed forces community.

1.5 The Local Government Association (LGA) guidance[1] suggests adoption of the following infrastructure to support improved delivery of the covenant. An update on Bury's progress is also included.

Core infrastructure to deliver the Armed Forces Covenant	
Individuals	
LGA Guidance	**Bury Response**
• An elected member champion. • An officer point of contact within the Council.	The Cabinet Member for Communities is the Council's champion. The Chair of Bury CCG and Clinical Director are the CCG's champions. The Council's Research and Consultation Manager/Armed Forces Lead is the single point of contact.
Communication	
LGA Guidance	**Bury Response**
• A web page with key information and links for members of the Armed Forces Community. • A clear public statement of what members of the Armed Forces Community can expect from the Council. • A route through which concerns can be raised. • Training of frontline staff. • The production of an annual report highlighting key actions and plans.	Webpage content has been developed with veterans' groups and is in design stage. It includes information on employment and skills, housing and health and provides links to information. The Armed Forces Covenant and action plan sets out what members of the Armed Forces Community can expect from the Council and Bury CCG. Concerns can be raised via the Council's Research and Consultation Manager/Armed Forces Lead. Roll-out of the GM e-learning package is proposed for frontline staff. An annual report will be submitted to the Strategic Commissioning Board on progress towards delivering the Covenant Action Plan.

[1] LGA guidance

Collaboration	
LGA Guidance	**Bury Response**
• An outward facing forum that meets at least twice a year. It includes the following: military representatives; military charities; public sector representatives; council members (senior elected members on cabinet); and the officer champion. • A mechanism for collaboration with partners.	An Armed Forces Covenant Steering Group meets quarterly. This includes representatives from veterans' groups and partners.
Vision and Commitment	
LGA Guidance	**Bury Response**
• An action planning process that is proportionate to local needs and circumstances. • Policy reviews. • Enthusiasm and commitment.	Action planning will be with the members of the Armed Forces Covenant Steering Group. Policy reviews will take into account the Armed Forces Community and through the equality impact assessment process we will consider potential detrimental impact to the Armed Forces. Officer champions from across the Council and the CCG will take responsibility for delivery of their parts of the Covenant and action plan, working to the Armed Forces Covenant Steering Group. Once high level actions have been agreed by the Strategic Commissioning Board, the internal champions across the Council and CCG will agree a detailed delivery plan, with timescales, the progress of which will be reported to the Strategic Commissioning Board on an annual basis. Through Bury's Inclusion Strategy, the Armed Forces community is a protected characteristic within the approach to Equality Analysis.

2. THE ARMED FORCES COVENANT IN GREATER MANCHESTER

2.1 In 2014, the Greater Manchester Combined Authority (GMCA) became the first city region to sign the Armed Forces Covenant. One fifth of the armed forces are recruited from North West England; more than any other region in the UK. The commitment of the GMCA and local authorities in Greater Manchester to the Armed Forces Covenant was reaffirmed in June 2017, with a further re-signing in July 2021 in support of the Greater Manchester Mayor's commitment to improve support for people who have served in the armed forces.

2.2 Bury Council is a member of the GMCA Armed Forces Covenant Group that meets regularly and which has been instrumental in the development of the GM Armed Forces Covenant. By attending this group, Bury Council can learn from best practice and discuss ideas with each of the other Local Authorities.

3. OUR COMMITMENT TO THE ARMED FORCES COMMUNITY IN BURY

3.1 Governance and Delivery

3.1.1 The covenant requires each Local Authority to establish a Covenant Board to oversee local pledges and develop an appropriate action plan. Bury has an active and committed Armed Forces Covenant Steering Group, chaired by the Council's Cabinet Member for Communities, with representatives from the CCG, the armed forces community, voluntary sector, charitable organisations and public services meeting on a regular basis to discuss covenant matters.

3.1.2 Significant progress has been made with representatives from the Covenant Steering Group, in developing an action plan which will continue to improve the effectiveness of Bury's support for the armed forces community, to inform the refresh of the pledges in the Armed Forces Covenant, detailed in Appendix A. It is proposed that the Covenant Steering Group maintains oversight and ensures delivery of Bury's new covenant action plan set out in Appendix B.

3.1.3 It is further proposed to establish Armed Forces officer champions from across the Council and the CCG in the following areas, each taking responsibility for delivery of their parts of the Covenant and action plan, working through the Inclusion Group and the Armed Forces Covenant Steering Group:

Theme(s)	**Officer Lead(s)**
Housing and Homelessness	Head of Homelessness and Housing Options, Bury Council
Health and Wellbeing (to include Primary Care, Mental Health and wellbeing provision)	Head of Primary Care, NHS Bury CCG Assistant Director Operations, Bury Council Commissioning Programme Manager, NHS Bury CCG
Employment and Skills	Unit Manager - Economic Development
Human Resources	Head of HR, Bury Council

Community, Communications and Commemorations	Research and Consultation Manager/Armed Forces Lead

3.1.4 Following approval by the Strategic Commissioning Board of the Covenant, the Armed Forces officer champions will develop a detailed delivery plan, with timescales. The champions will be brought together quarterly by the Council's Director of People and Inclusion and will provide updates to the Armed Forces Covenant Steering Group on progress towards delivery of the Covenant action plan. The Strategic Commissioning Board will be formally updated annually.

3.2 Building on Bury's Neighbourhood Model

3.2.1. As part of our transformation work, significant progress has been made designing our neighbourhood approach and we are well advanced in establishing multi-disciplinary neighbourhood teams, covering the whole borough with activity comprised of:

- A **Community Hub** which will support people to take responsibility for their own health and wellbeing and seek support in the community in the first instance, including partnering with existing community services such as the Staying Well service and Community Education.
- The existing **health and care integrated teams** which, together with primary care services, focus on early intervention, prevention and the avoidance of unplanned care. The teams actively case manage the care for people with chronic, long term physical and mental health conditions, to help them remain in control of their care and live well at home.
- **Early help teams across wider public services,** to target our support to help vulnerable people to access opportunities and create new ones on their own, without creating long-term dependency on public assistance. The teams will provide joined-up support from social workers, schools, housing, youth services, employment teams, probation, police and other services.

3.2.2 It is therefore proposed that we commit to working through our developing neighbourhood / place-based approach by ensuring that those public facing teams listed above undertake the armed forces e-learning training, as a first step, so that they are well placed to support or signpost the armed forces community. We will also work, through our engagement with the armed forces community, to identify further opportunities to build awareness and understanding amongst these key staff groups. The Community Hubs will act as the front door for veterans, co-ordinating community engagement working with public services or with Bury Voluntary, Community and Faith Alliance (VCFA) partners.

3.2.3 Beyond the above, discussions will continue in relation to how we further strengthen the infrastructure to support veterans across the Borough based on the views of the veterans community and with reference to best practice models elsewhere in the country. This work will include the Borough's MPs and members of the Covenant Steering Group and is set in the context of the historic and strategic importance of the veterans community to Bury.

Community impact/links with Community Strategy

A priority in the Let's Do It Strategy is to strengthen the voices of individual communities; the refresh of the Armed Forces Covenant being aligned to that ensuring that the Council and CCG engage former armed forces personnel in local civilian life.

As part of the Inclusion Strategy, the armed forces community has been identified as a specific group, where the Council and CCG will consider if there are any unintended consequences from key policy changes which may affect the armed forces community.

Equality Impact and considerations:

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

> *A public authority must, in the exercise of its functions, have due regard to the need to -*
>
> (a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
>
> (b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
>
> (c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

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

Equality Analysis	*Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.*
The work will establish a co-ordinated approach to veterans' support across the Council and CCG. As part of the Inclusion Strategy, the armed forces community has been identified as a specific group, where the Council and CCG will consider if there are any unintended consequences from key policy changes which may affect the armed forces community. Equality Analysis has been undertaken.	

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

Assessment of Risk:

The following risks apply to the decision:

Risk / opportunity	Mitigation
Offering free access to facilities to veterans, given there is a broad definition of Armed Forces would be a cost to the Council. This also needs to be balanced against other characteristics within the Council's Inclusion Strategy.	Clear policy to be developed and costs to be kept under review.

Consultation:

Bury Armed Forces Covenant Steering Group.

Greater Manchester Combined Authority.

Legal Implications:

The covenant is a commitment by the Council and its partners that members of the armed forces will be treated equitably and are not disadvantaged when accessing services. The Armed Forces Bill 2021 – 22 was introduced to parliament on 26th January 2021 the Bill is progressing through the parliamentary approval stages and completed the Committee of the whole house on 23 June 2021, it is waiting for the final stages of the Bill to be scheduled parliamentary time.

Completed by the Council's Monitoring Officer.

Financial Implications:

The costs associated with adopting the armed forces covenant as it stands are in relation to loss of income due to offering free access to facilities such as leisure. Although this has been an offer in the Borough since 2017 further promotion of the covenant may increase uptake, the extent of which and any further financial impact of which cannot be quantified at this time. However, the covenant overall is more about having due regard to the organisations obligations to this cohort of residents and patients.

The Council is aware that other Boroughs have gone further than the existing parameters of this covenant and established specific services and hubs. As discussions continue within Bury to further strengthen our infrastructure to support veterans these will require costing and funds identifying on a case by case basis. Completed by the Council's Executive Director Finance.

Report Author and Contact Details:
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Executive Officer
Email: h.moore@bury.gov.uk

Background papers:

None.

Glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning
VCFA	Bury Voluntary Faith and Community Alliance
CCG	Clinical Commissioning Group
GMCA	Greater Manchester Combined Authority
GM	Greater Manchester
GPs	General Practitioners
LGA	Local Government Association
NHS	National Health Service

APPENDIX A: ARMED FORCES COVENANT

Bury Council and NHS Bury Clinical Commissioning Group

We, the undersigned, commit to honour the Armed Forces Covenant and support the Armed Forces Community. We recognise the value Serving Personnel, both Regular and Reservists, Veterans and military families contribute to our business and our country.

Signed on behalf of:

Bury Council and NHS Bury Clinical Commissioning Group

Signed: _____

Name: _____

Position: Cabinet Member for Communities, Bury Council and Accountable Officer, NHS Bury CCG

Date: September 2021

The Armed Forces Covenant

An Enduring Covenant Between

The People of the United Kingdom

Her Majesty's Government

– and –

All those who serve or have served in the Armed Forces of the Crown

And their Families

The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

Section 1: Principles Of The Armed Forces Covenant

1.1 We, Bury Council and NHS Bury Clinical Commissioning Group, will uphold the key principles of the Armed Forces Covenant, which are:

- *no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen*
- *in some circumstances special treatment may be appropriate especially for the injured or bereaved.*

Section 2: Demonstrating our Commitment

3.1 Bury Council and NHS Bury Clinical Commissioning Group recognises the value serving personnel, reservists, veterans and military families bring to Bury. We will seek to uphold the principles of the Armed Forces Covenant, through five key themes that can significantly and positively contribute to the delivery of the aims and objectives:

1. Employment and skills
2. Health and Wellbeing
3. Housing
4. Integration with Local Community
5. Recognise and Remember

We will:

- *continue to work in partnership other public and third sector organisations to create a coherent standard of provision for the Armed Forces community;*
- *enshrine the Armed Forces Bill 2021 in all appropriate policies and pathways, so that the duty of due regard to Service in the military is not only upheld, but a guiding principle in all we do;*
- *providing leadership, best practice and support to the transformation of the minimum guaranteed offer for the Armed Forces Community in Bury;*
- *promote the fact that we are Armed Forces-friendly organisations;*
- *aim to have all GP practices accredited by the Veterans Friendly Scheme;*
- *work with registered social housing providers, housing associations and voluntary organisations to provide support on housing matters and ensure that priority accommodation is given to members of the armed forces community and that veterans are not disadvantaged;*

- *work together to ensure priority treatment to armed forces personnel and veterans that have been injured or wounded in service;*
- *seek to support the employment of veterans young and old and working with the Career Transition Partnership and other employment service providers, in order to establish a tailored employment pathway for Service Leavers, linking in with business leaders in Bury;*
- *strive to support the employment of Service spouses and partners, both within the organisation and promoting their employment through business leaders in Bury;*
- *endeavouring to offer a degree of flexibility in granting leave for Service spouses and partners before, during and after a partner's deployment;*
- *seeking to support our employees who choose to be members of the Reserve forces, including by accommodating their training and deployment;*
- *offering support to our local cadet units, either in our local community or in local schools;*
- *actively participate and promote events that celebrate and remember the sacrifices of armed forces personnel, both past and present;*
- *offer free access to leisure provision to service members and ex-armed forces;*
- *aim to have Fairfield hospital accredited as 'Veterans Aware';*
- *promote the armed forces e-learning package for frontline staff so that the principles of the covenant can be applied at a local level.*

2.2 We will publicise these commitments through our literature and/or on our website, setting out how we will seek to honour them and inviting feedback from the Service community and residents of Bury on how we are doing.

APPENDIX B: ARMED FORCES COVENANT ACTION PLAN

Employment and Skills	**Publicity**	**Health and wellbeing**	**Housing**	**Recognise and remember**	**Integration with local community**	**Internal**
Play an active role in promoting the Ministry of Defence Employee Recognition Scheme, for example by encouraging Bury Business Leaders to sign up to the scheme.	Promote Veterans Gateway – and link to this on relevant Council and CCG webpages.	Ensure the Veterans Gateway is kept up to date with local information and promote this as an access point for obtaining support and advice.	Work with the housing associations and other agencies to provide and support on housing matters, ensuring that veterans are not disadvantaged.	Actively play a part in and promote participation in and support of events and functions to celebrate and remember the sacrifices of Armed Forces personnel, both past and present including Armed Forces week, Poppy Appeal, Remembrance Sunday, Reserves Day, Armistice Day, Gallipoli Day, VE day and VJ day.	Provide support to former Armed Forces in HMP Forest Bank and to respond to and co-ordinate any requests for assistance through Project Nova.	Offer a degree of flexibility in granting leave for service spouses and partners before, during and after a partner's deployment.
As part of the wider GM family, promote Bury as a veteran friendly Borough.	Publicise the covenant commitments through Council and CCG literature and/or on our websites, setting out how we will seek to honour the Armed Forces Covenant.	CCG to work with NHS services in Bury to ensure priority treatment to Armed Forces Personnel and Veterans that have been injured or wounded in service.	Encourage housing associations operating in Bury to include 'having served in the Armed Forces' as a community contribution in local lettings plans.	Celebrating the Freedom of the Borough of Bury with the Royal Regiment of Fusiliers.	Encourage collaborative community volunteering by signposting to charities and volunteering opportunities in Bury – working with Bury Voluntary Faith and Community Alliance (VCFA).	Support our employees in the Council and CCG who choose to be members of the Reserve Forces, including by accommodating their training and deployment where possible.
Lead by example - promote that Bury Council and NHS Bury CCG are Armed forces friendly organisations – examples include Reservist Policy, exploring the introduction of a guaranteed interview, offering veterans friendly interviews.	Improved signposting and support for customers who have a connection to the Armed Forces. We will look at ways in which we can ask the question: Have you or your spouse or partner served in the UK Armed Forces – highlighting that there may be additional support that can be accessed.	Look at how we can provide quicker/easier referral to mental health services.	Take action to support homelessness related to Armed Forces veterans – asking the question whether you or your spouse or partner served in the UK Armed Forces, making referrals to Royal British Legion / SSAFA to mitigate/prevent evictions (Section 21s).	Use of social media to promote case studies and raising the profile of the Armed Forces community.	Direct Armed Forces Community members to volunteering opportunities, additional support, services, sports clubs, charities and activities such as Breakfast Clubs and the Veterans Hub Café.	Seek to understand who within our organisation is a former or current member of the Armed Forces (including Reservists).

Employment and Skills	Publicity	Health and wellbeing	Housing	Recognise and remember	Integration with local community	Internal
Promote recruitment opportunities and jobs fairs to members of the Armed Forces.	Raise awareness by encouraging front line workers to be trained through the GM e-learning package	Aim to have all GP practices accredited by the 'Veterans Friendly' scheme and encourage GPs ask the question; have you or your spouse or partner served in the UK Armed Forces, making referrals to Royal British Legion / SSAFA to mitigate/prevent evictions (Section 21s).	Encourage tenancy officers to ask the question on whether you or your spouse or partner served in the UK Armed Forces – highlighting that there may be additional support that can be accessed.	Look at opportunities to have Armed Forces Flags around the town centre on the week leading to Armed Forces Day – linking with local businesses to seek support.	Identify and promote examples of good practice for community engagement and integration across Bury	Promote the GMCA E-learning package to understand and apply the principles of the Covenant at a local level and consider whether this becomes a mandatory requirement for frontline staff.
Support veterans on how they can relate military CVs to transferable civilian skills – promoting the service offered by the Career Transitions Partnership.	Refresh our Armed Forces Covenant webpage to better symbolise our commitment and to provide better signposting information, to also include the support within the community.	Promote access to training e.g. peer mentoring programme offered by the GM Armed Forces Hub and Suicide Prevention Training.	Provide a pathway for ex-service personnel in housing need by supporting them to move into a permanent home.	Thank-you reception hosted by the Mayor as part of flag raising ceremony for Armed Forces Day	Support the use of space in public buildings for use by veterans' groups.	Ensure a champion is nominated in each department and key service area including employment, skills, housing, civic services, communications and HR.
Promote organisations and charities that provide jobs, training opportunities to service leavers, reservists, veterans and their families e.g., Regular Forces Employment Association (RFEA) and the Career Transition Partnership.	Ensure we are represented and actively participate in the GM Armed Forces Leads Meeting.	Offer free leisure access provision to serving members and ex-Armed Forces (Operations Department lead)	Encourage town centre staff to ask the question and follow up - what is their service number and refer through to Housing Team.	Maintenance of war memorials	Veterans actively encouraged to be involved in Bury's Community Hubs. Role of Community Hubs offering a 'one stop shop' of advice, information and support to the community, with each hub manager being responsible for discharging relationships locally, complementing the local offer.	Ensure supporting Armed Forces is a specific requirement in the relevant Cabinet Member job description.
Bury Council will give priority to veterans for work experience opportunities.	Annual publication of covenant related achievements and progress made.	Aim to have Fairfield Hospital accredited as 'Veterans Aware'.	Give armed forces personnel and close family (spouse/partner, children) band 1 (highest need) on the housing register, provided they have a housing need in line with the Council's Allocations Policy.	Provide general support to commemorative events	Consider how Bury VCFA can support the commitments in the Covenant as an active partner in driving forward the action plan.	Increase awareness amongst staff, through team briefings and training about the covenant.
Promote access to the Department for Work and Pensions (DWP)	Promote community groups supporting Armed Forces e.g., Breakfast	Promote Broughton House multi-purpose Veterans Village for those who wish to maintain				Ensure the Council's Reservists Policy

Employment and Skills	Publicity	Health and wellbeing	Housing	Recognise and remember	Integration with local community	Internal
Armed Forces Champion for Bury	Clubs, Veterans Hub Café.	active, independent, living, with a strong focus on comradeship and mutual support				continually aligns to best practice in other areas.
Promote Operation Re-Org: Employment Skills for Military Veterans Across Greater Manchester led by Groundwork to refer veterans who may benefit from help and support from local business to broker job opportunities for veterans.	Review Bury's contribution on the GM website and Armed Forces Covenant portal to ensure it is up to date.	New patient checks process to include the identification of Armed Forces Veterans & Reservists and their families at registration.				Armed Forces community is a specific characteristic within the Council and CCG equality impact assessment process, having due regard to this group in making decisions on policy / service provision.
Advertise job vacancies on: Career Transition Partnership Forces Families Jobs RFEA: The Forces Employment Charity Poppy Factory Walking with the Wounded		Promote Leon House Rehabilitation Clinic in Prestwich, who offer care and support free of charge to veterans referred by their GPs, army charities and other related professionals if they are facing issues with mental health or addiction.				Offer the opportunity for work experience placements to veterans.
		Promote where to get help in relation to domestic abuse, including via the Veterans Gateway.				Offer a guaranteed interview to veterans who meet all the essential criteria.
		Encourage GP practices to update their websites with veterans information including entitlements				
		Encourage GP practices to complete training, specifically 3 modules on the http://www.e-lfh.org.uk , Care of Veterans/Care of Families and Care of Serving Personnel				
		Encourage GP practices to update their patient check forms to code Veterans				

Employment and Skills	Publicity	Health and wellbeing	Housing	Recognise and remember	Integration with local community	Internal
		Utilising GP waiting rooms to have key messages about veterans' support on specific awareness dates e.g. during Armed Forces Week.				
		Work closely with Northern Care Alliance and Manchester Foundation Trust who have both signed up to the Armed Forces Covenant.				
		Public Health to produce a Health Needs Assessment to include audit of quality of coding of GP records for veterans, building on this a project to increase coding of GP records. Also, to provide and education/training session for GPs around health needs of ex-military personnel, with input from ex-service members and a GP with an interest in military medicine.				
		Promote access to the Military Veterans' Service (MVS) who offer specialist psychological therapies for British armed forces veterans across Greater Manchester, offering a range of evidence-based treatments including Anxiety, depression, post-traumatic symptoms, alcohol and substance mis-use, adjustment difficulties and anger problems.				
		Promote access to TILS (Transition Intervention and Liaison Service) run by Pennine Care run by Pennine Care NHS Foundation Trust who provide specialist triage and mental health assessments and case management linking veterans into the most appropriate service as quickly as possible.				

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Agenda Item 9

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Approve
Item No	9	**Confidential / Freedom of Information Status**	No
Title	Adult Social Care - Care at Home Tender Contract Award		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Matthew Logan, Strategic Lead Integrated Commissioning - Provider Development Tracy Evans, Integrated Commissioning Officer		
Clinical Lead	-		
Council Lead	Cllr Simpson, Communities and Wellbeing		

Executive Summary

The current Care at Home service was re-tendered in 2017 for an initial period of 3 years with the option to extend for a further 2, with a contract start date of September 2017. There are currently ten providers on the framework who provide support to customers throughout the borough.

In line with best practice, it was agreed to review the Care at Home service in advance of its initial 3 year contract end to ensure that the contract is both effective and high performing for its final year and beyond. The outcome agreed was to re-tender the service.

The contract was advertised in accordance with Contract Procedure Rules on The Chest e-tendering system. Tender documents were made available to 163 providers with 52 tender submissions being returned by the closing time and date.

There are 10 providers who will be awarded Lot 1 – Neighborhood zones as detailed below and a further 15 providers who will be awarded Lot 2 – Backup framework.

Lots & Neighborhoods

The Contract is separated into two lots as follows:

Lot 1: Primary Framework Providers - to deliver the Care at Home service in the most cost-effective way, it has been agreed that the borough of Bury will be separated into five neighborhoods; these are based on the Integrated Neighborhood Teams, West Bury, Bury East, North Bury, Whitefield and Prestwich. Two providers will be allocated to each neighborhood as main provider on alternate weeks for the purposes of accepting new referrals and managing provision.

The successful providers for Lot 1 are as follows:

Neighborhood	Provider 1	Provider 2
West Bury	Health Care Resourcing Group	Care Connect
Bury East	Premier Care	1 Homecare
North Bury	Complete Care NW	Homecare Services
Whitefield	Mayday	I-Care GB Ltd
Prestwich	Surecare Bolton	Specialist Care Team

Lot 2: Providers who wish to remain at low volume (from 0 to 600 hours/week) will be accommodated on this framework. Lot 2 will be open to new market entrants twice per year (April and September) based upon identified need for provision.

The successful providers for Lot 2 are as follows:

Provider	Provider
Evolve Supporting Prospects	Angel Care
Newmark Care	Passion Home Care
I-Care Solutions	Pro Support
Myhomecare Manchester	Elmar Home Care
Right Care	Routes Healthcare
The Care Company Plus	Clarity Homecare
My Care My Home	Care 4 Us
Engage Care Services	

Next Steps

Strategic Commissioning Board are requested to approve the request to award the contract to those providers successful in the tender for the Bury Care at Home service.

Strategic Commissioning Board are also requested to approve an extension, of up to 2 months, to the current care at home contract to allow sufficient time for a smooth and successful transition from the current service to the new service. This is in line with the extensions allowed under the current care at home contract of which only 1 year has been used of the potential up to 2 years.

Once sign off has been received the first letters can be sent to providers with a 10-day standstill. Final award letters will be sent after 10 days.

Legal will be issuing contracts to providers once sign off is received and the 10-day standstill is complete.

Recommendations

It is recommended that the Strategic Commissioning Board approve the request to award the contract to those providers successful in the tender for the Bury Care at Home service for both Lots 1 and 2.

Strategic Commissioning Board are also requested to approve an extension of up to 2 months to the current care at home contract to allow sufficient time for a smooth and successful transition from the current service to the new. This is in line with the extensions allowed under

the current care at home contract of which only 1 year has been used of the potential up to 2 years.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The proposal re-tender the Care at Home service aligns to the Health and Wellbeing strategy and will allow for a greater focus on neighborhoods, prevention and flexibility for both providers and customers, ensuring they are supported to be as independent as possible while remaining well in their own home.					
How do proposals align with Locality Plan?	The proposals aligns to the Locality Plan including by ensuring support is provided on a neighborhood basis.					
How do proposals align with the Commissioning Strategy?	The proposals align to the commissioning strategy well as the new service will provide a value for money service that focuses on prevention and flexibility for both providers and customers, ensuring they are supported to be as independent as possible while remaining well in their own home.					
Are there any Public, Patient and Service	Yes	☒	No	☐	N/A	☐

Implications						
User Implications?						
How do the proposals help to reduce health inequalities?	The new Care at Home service will look to enhance the ability of people to live well at home longer. Carers will be supported to manage low level health tasks alongside social care needs to help reduce the health inequalities in the borough and ensuring the most vulnerable people in Bury have their needs met.					
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?						
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**
Community Commissioning Management Team (CCMT)	10/08/2021	Recommended

1. Background

The current Care at Home service was re-tendered in 2017 for an initial period of 3 years with the option to extend for a further 2, with a contract start date of September 2017. There are currently ten providers on the framework who provide support to customers throughout the borough.

In line with best practice, it was agreed to review the Care at Home service in advance of its initial 3 year contract end to ensure that the contract is both effective and high performing for its final year and beyond.

As part of the new contract Providers will work with customers to agree a more flexible, person centred approach based on the individuals needs and agreed hours over a four week period. This flexible plan is then assessed by CWB with the care plan / service order updated internally to reflect the agreed service delivery.

2. Tender Evaluation

The contract was advertised in accordance with Contract Procedure Rules on The Chest e-tendering system. The closing date for receipt of tenders was 12:00 noon on Friday 2nd July 2021.

Tender documents were made available to 163 providers with 52 tender submissions being returned by the closing time and date.

There were 25 providers who failed to meet the requirements so were not considered further and a following 2 providers who did meet the requirements of the specification but decided to withdraw from the process as they were not successful for their Lot 1 preference and did not want to be included in the Lot 2 framework.

There are 10 providers who will be awarded Lot 1 – Neighbourhood zones as detailed below and a further 15 providers who will be awarded Lot 2 – Backup framework.

Please see appendix 1 for full evaluation

3. Lots & Neighbourhoods

The Contract is separated into two lots as follows:

Lot 1: Primary Framework Providers - to deliver the Care at Home service in the most cost-effective way, it has been agreed that the borough of Bury will be separated into five neighbourhoods; these are based on the Integrated Neighbourhood Teams, West Bury, Bury East, North Bury, Whitefield and Prestwich. Two providers will be allocated to each neighbourhood as main provider on alternate weeks for the purposes of accepting new referrals and managing provision.

The successful providers for Lot 1 are as follows:

Neighbourhood	Provider 1	Provider 2
West Bury	Health are Resourcing Group	Care Connect
Bury East	Premier Care	1 Homecare
North Bury	Complete Care NW	Homecare Services
Whitefield	Mayday	I-Care GB Ltd
Prestwich	Surecare Bolton	Specialist Care Team

Lot 2: Providers who wish to remain at low volume (from 0 to 600 hours/week) will be

accommodated on this framework. Lot 2 will be open to new market entrants two time per year (April and September) based upon identified need for provision.

The successful providers for Lot 2 are as follows:

Provider	Provider
Evolve Supporting Prospects	Angel Care
Newmark Care	Passion Home Care
I-Care Solutions	Pro Support
Myhomecare Manchester	Elmar Home Care
Right Care	Routes Healthcare
The Care Company Plus	Clarity Homecare
My Care My Home	Care 4 Us
Engage Care Services	

4. Next Steps

Strategic Commissioning Board are requested to approve the request to award the contract to those providers successful in the tender for the Bury Care at Home service.

Strategic Commissioning Board are also requested to approve an up to 2 month extension to the current care at home contract to allow sufficient time for a smooth and successful transition from the current service to the new. This is in line with the extensions allowed under the current care at home contract of which only 1 year has been used of the potential up to 2 years.

Once sign off has been received the first letters can be sent to providers with a 10-day standstill. Final award letters will be sent after 10 days.

Legal will be issuing contracts to providers once sign off is received and the 10-day standstill is complete.

Appendix 1

2021.07.08 Care at Home Tender Evalua

Matthew Logan
Provider Relationship Lead
m.logan@bury.gov.uk

Summary

West Bury	Health are Resourcing Group	Care Connect
Bury East	Premier Care	1 Homecare
North Bury	Complete Care NW	Homecare Services
Whitefield	Mayday	I-Care
Prestwich	Surecare Bolton	Specialist Care Team

	Stage 1 Pass / Fail	Stage 2 Score	LOT 1 Preference	LOT 1 Back up	LOT 2		
PASS							
Health Care Resourcing Group	PASS	99.00%	West Bury	Prestwich			
Care Connect	PASS	91.00%	West Bury	Bury East			
Premier Care	PASS	90.00%	Bury East	Whitefield			
Complete Care NW	PASS	88.00%	North Bury	Prestwich			
Surecare Boton	PASS	87.00%	Prestwich	Whitefield		ECM Clarification	Confirmation received 02.08.21
Home Care Services	PASS	84.50%	North Bury	West Bury			
Willowbrook (Hyndburn)	PASS	81.50%	North Bury	North Bury		Withdrawn	
1 Homecare	PASS	80.50%	Bury East	West Bury			
Mayday Homecare	PASS	80.00%	Whitefield	Bury East			
Specialist Care Team	PASS	79.50%	Bury East	West Bury		ECM Clarification	Confirmation received 02.08.21
I-Care	PASS	79.00%	West Bury	Whitefield		ECM Clarification	
Evolve Support Prospects	PASS	78.50%	West Bury	Whitefield	Lot 2		
Connect Health	PASS	78.00%	North Bury	Prestwich	Lot 2	Withdrawn	
Newmark Care	PASS	75.50%	Bury East	West Bury	Lot 2		
I-Care Solutions	PASS	72.30%	Whitefield	Prestwich	Lot 2		
Myhomecare Manchester	PASS	68.50%	Whitefield	Prestwich	Lot 2		
Right Care	PASS	68.00%	North Bury	Bury East	Lot 2	ECM Clarification	
The Care Company Plus	PASS	66.90%	Prestwich	Prestwich	Lot 2		
My Care My Home	PASS	63.50%	North Bury	West Bury	Lot 2		
Engage Care Services	PASS	59.00%	Prestwich	Whitefield	Lot 2	ECM Clarification	Confirmation received 04.08.21 - GPS Only
Angel Care	PASS	59.00%	LOT 2 ONLY	LOT 2 ONLY	Lot 2	ECM Clarification	Confirmation received 04.08.21
Passion Home Care	PASS	53.50%	West Bury	Prestwich	Lot 2	ECM Clarification	Confirmation received 02.08.21
Pro Support	PASS	50.50%	Prestwich	Whitefield	Lot 2	ECM Clarification	Confirmation received 03.08.21
Elmar Home Care	PASS	75.00%	LOT 2 ONLY	LOT 2 ONLY	Lot 2	ECM Clarification	Confirmation received 03.08.21
Routes Healthcare	PASS	79.50%	LOT 2 ONLY	LOT 2 ONLY	Lot 2	ECM Clarification	Confirmation received 02.08.21
Clarity Homecare	PASS - LOT 2	71.00%	West Bury	Prestwich	Lot 2		
Care 4 Us	PASS - LOT 2	58.00%	Prestwich	Whitefield	Lot 2	ECM Clarification	Confirmation received 04.08.21
FAIL							
Kare Pro	FAIL	5.80%					
City Care Solutions	FAIL	0.00%					
Cornelius Healthcare	FAIL	0.00%					
Diamond Heart Healthcare	FAIL	0.00%					
Dignity in Life Bury	FAIL	0.00%					
Eagle Care Services	FAIL	0.00%					
Instant Care	FAIL	0.00%					
Kharbitas	FAIL	0.00%					
Monarch	FAIL	0.00%					
Moss Support Services	FAIL	0.00%					
PRM Care	FAIL	0.00%					
Rayman Healthcare	FAIL	0.00%					
Revelation Social Care	FAIL	0.00%					
Smartheart Professionals	FAIL	0.00%					
Socialcare Consortium	FAIL	0.00%					
Tamar Care	FAIL	0.00%					
Caring Connections	PASS	FAIL - scored 2 on more than 2 questions					
Cottage Homecare	PASS	FAIL - scored 2 on more than 2 questions					
Grace Live in Carers	PASS	FAIL - scored 2 on more than 2 questions					
JP4Life	PASS	FAIL - scored 2 on more than 2 questions					
Lionheart Domiciliary Care	PASS	FAIL - scored 2 on more than 2 questions					
Gable Healthcare	PASS	FAIL - CQC reating requires improvement					
Sigma Care	PASS - LOT 2	FAIL - scored 2 on more than 2 questions					
Alcedo Care	PASS - LOT 2	FAIL - CQC rating is poor					
P&R Healthcare Solutions	PASS - LOT 2	FAIL - scored 2 on more than 2 questions					

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NHS
Bury
Clinical Commissioning Group

Strategic Commissioning Board

Meeting Date	06 September 2021	**Action**	Approve
Item No.	10	**Confidential**	No
Title	Designated Beds – Shared Provision with Rochdale Council		
Presented By	Adrian Crook –Director Adult Social Care		
Author	Matthew Logan – Strategic Lead Integrated Commissioning		
Clinical Lead			

Executive Summary

The paper details the updated arrangement to maintain sufficient designated COVID beds in the Bury system and is an update to the papers presented by Adrian Crook in October 2020 and February 2021. These papers received approval for retrospective commissioning of additional capacity in the community to release hospital capacity.

Recommendations

Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning Board are asked to approve retrospectively the commissioning of designated units for COVID +ve patients at Millfield House in line with the request from the DHSC, with awareness of the financial risk resulting from the misaligned national funding guidance.

Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning Board are asked to continue to support the responsive rapid commissioning of additional capacity in forthcoming months should it be required. This will take the form of additional designated care home beds and home care, accepting a paper will be presented for retrospective approval and members of Bury Council and Bury Clinical Commissioning Group briefed beforehand.

Rochdale Council currently contract with Millfield Nursing Home (Qualia Care) to provide a discharge to assess service for patients who are Covid positive and require a residential placement for a period of time following their hospital stay. Situated at Bury Road, Heywood, Millfield Nursing Home, part of Qualia Care, has operated their Covid positive D2A facility since September 2020, offering a 9 bed independent nursing service exclusively for positive patients.

The current contract concluded on the 30th June and a new arrangement for this service is now required. Bury Local Authority is looking for approval to take a joint approach to commission the 9 beds and share the costs on a 50/50 basis.

Subject to approval the new contract will run from the 1st July to the 31st March 2022 and will cost £1,550 per bed, per night, £13,950 per week. With Bury funding half the cost will be £775 per bed / £6,975 per week. Note: Qualia Care are not willing to enter into an agreement for a shorter time

period, however, Bury will agree to joint contract until 30th September 2021 with extension to 31st March 2022 permitted subject to extension of funding arrangements.

The cost is based on agency staff covering most of the shifts and there is a clause built in to review the cost and the arrangements at the end of September with a view to reduce the costs subject to Millfield being able to contract with sufficient numbers of staff to fulfil the remaining 6 months of the contract.

Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning Board are asked to approve retrospectively the commissioning of the following in line with the request from the DHSC to maintain sufficient designated COVID beds, with awareness of the financial risk.

	Weekly cost
9 beds at Millfield Care Home – 50/50 split cost with Rochdale Council	£6,975
Total	**£6,975**

We will adopt a common sense approach when splitting the use of beds, with allocation being based on need. The designated setting must be a separate unit from the main residential site in order to comply with the necessary infection control guidelines. The Unit has 9 beds so there is no option available to negotiate a lower number of beds between the two local authorities.

Rochdale have utilised the designated beds already with 2 admissions in July and 3 in August with currently 2 residents still there.

Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning Board are also asked to approve retrospectively the GP Cover costs for the designated beds. 24/7 medical cover for 6 months. Providing clinical triage and GP visiting and provision of FP10 prescribing. Also the provision of issuing death certification if required. Quote from BARDOC is as follows:

	Weekly cost
GP Cover for Millfield	£2,918.45
Total	**£2,918.45**

Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning have previously given support to the responsive rapid commissioning of additional capacity where required and accepted that papers be presented for retrospective approval and members of Bury Council and Bury Clinical Commissioning Group briefed beforehand. This paper asks for this support to be maintained.

Links to CCG Strategic Objectives	
SO1 People and Place To enable the people of Bury to live in a place where they can co-create their own good health and well-being and to provide good quality care when it is needed to help people return to the best possible quality of life	☒
SO2 Inclusive Growth To increase the productivity of Bury's economy by enabling all Bury people to contribute to and benefit from growth by accessing good jobs with good career prospects and through commissioning for social value	☐

SO3 Budget To deliver a balanced budget	☐
SO4 Staff Wellbeing To increase the involvement and wellbeing of all staff in scope of the OCO.	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF *[Insert Risk Number and Detail Here]*	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
If you have ticked yes provide details here. Delete this text if you have ticked No or N/A						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
If you have ticked yes provide details here. Delete this text if you have ticked No or N/A						
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☒
< *If you have ticked yes,* Insert details of the people you have worked with or consulted during the process :						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
If you have ticked yes provide details here. *Delete this text if you have ticked No or N/A*						
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
If you have ticked yes provide details here. Additional expenditure as detailed below will be required from NHSE funding available to support the COVID-19 Hospital Discharge Guidance						
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☐	N/A	☒

If you have ticked yes provide details here. If you are unsure seek advice from Lisa Featherstone, Email - lisafeatherstone@nhs.net about the risk register.

Governance and Reporting		
Meeting	**Date**	**Outcome**
CCMT	20/07/2021	Agreed by CCMT
		If the report has not been discussed at any other meeting, these boxes can remain empty.

1. Background

1.1. On 12th October the Department of Health and Social Care (DHSC) issued all Clinical Commissioning Groups (CCG) and Local Authorities (LA) a letter mandating the delivery of designated schemes for people who are leaving hospital or are transferring to a care home who have tested positive. This was updated on 10 November and in further guidance issued on 17 May. The current requirement is to ensure 'sufficient' designated beds available to the local system.

1.2. A designated scheme must meet standards set out by the Care Quality Commission which include a completely separate unit or area, separate staffing teams and adherence to a range of infection prevention control standards.

1.3. At the beginning of the pandemic Bury showed foresight and delivered a number of settings able to support people with the virus. These were

- 27 beds at Spurr House
- 7 beds at Killelea Intermediate Care Home
- 11 beds at Gorsey Clough Nursing Home

1.4. All of these were set up to the standards now mandated by the DHSC and CQC and this approach proved successful in reducing the impact of the virus on our existing care homes and their residents.

1.5. As the number of people with the virus subsided these beds were turned into discharge to asses units to support the ongoing flow out of hospital.

Proposals

1.6. Gorsey Clough was the only remaining designated setting in Bury. It is a Nursing Dementia Care Home and the repurposing of 11 beds to COVID only has resulted in the decrease in nursing Dementia provision in the borough.

1.7. Despite the numbers with the virus needing this type of care the government has mandated that sufficient capacity is maintained and the hospital discharge fund is to b used to pay for them. This will ensure that the wider needs of patients in hospital and in the community can be met by community provision.

1.8. Following discussions with colleagues from Rochdale Council there is currently an over-provision of designated beds in Rochdale and a joint solution has been sought:

For the period from June to September 2021 it is recommended that the 11 beds at Gorsey Clough return to Nursing Dementia and Bury jointly purchase the 9 designated beds with Rochdale that are currently have available at Millfield Care Homes. This care home is on the border with Bury and so is ideally situated.

If additional COVID beds are needed in the future the Intermediate Care services will lead a review and rapid discharge programme to convert 1 corridor at Killelea back to a COVID unit.

1.9. This unit came into place on 30th June.

1.10. During May we have seen the numbers of people with the virus in our hospitals fall and today it is approximately 5 in Fairfield General.

2. Financial Requirements

2.1. The 4 weekly costs of these units are

	4 weekly cost
9 beds at Millfield Care Home – 50/50 split cost with Rochdale Council	£27,900
Total	**£27,900**

The GP Cover costs for the designated beds. Quote from BARDOC is as follows:

	4 Weekly cost
GP Cover for Millfield	£11,673.80
Total	**£11,673.80**

If these beds are required until the end of September **£76,725** will be required, while **£258,075** will be required up to end of March 2022 for just the beds.

2.2. All costs incurred in discharging patients from hospital under the updated hospital discharge guidance [1] in place during the pandemic is being reimbursed by £588m of hospital discharge funding made available by central government.

2.3. This guidance was issued on 21st September.

3. Sufficiency

3.1. The request from the DHSC asks we ensure we have sufficient designated COVID + ve capacity

3.2. This predication is difficult as it depends on the rate of spread of the virus, the age of the people it affects, the success of lock down measures and impact of the lifting of these measures

3.3. We will keep our capacity under review and if we need to commission further capacity we will present further papers to SCB, however due to our need to be rapid and responsive this may be retrospective

4. Timeliness

4.1.1 The requirement to deliver designated unit was originally reviewed by Bury's Silver command on 28th October and given the rapid nature of the need to commission these

[1] https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model

beds it has not been possible to present this request to Bury's Strategic Commissioning Board in advance of the need to commission the service. This paper asks for retrospective permission to commission this service.

4.1.2 Conversations are ongoing with Primary care services that currently support the unit to determine whether mutual support can be provided to Bury customers as well.

5 Recommendation

5.1.1 Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning Board are asked to approve retrospectively the commissioning of designated units for COVID +ve patients at Millfield House in line with the request from the DHSC, with awareness of the financial risk resulting from the misaligned national funding guidance.

5.1.2 Bury's Finance, Contracting and Procurement Committee and Strategic Commissioning Board are asked to continue to support the responsive rapid commissioning of additional capacity in forthcoming months should it be required. This will take the form of additional designated care home beds and home care, accepting a paper will be presented for retrospective approval and members of Bury Council and Bury Clinical Commissioning Group briefed beforehand.

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Agenda Item 11

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	06 September 2021	**Action**	Receive
Item No	11	**Confidential / Freedom of Information Status**	No
Title	Integrated Delivery Collaborative Programme Update for August 2021		
Presented By	Cllr E O'Brien, Co-chair of the SCB and Bury Council Leader / Dr C Fines, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author			
Clinical Lead	-		
Council Lead	-		

Executive Summary

The work of the IDC Board has been focusing on creating the structures and environment to enable the IDC to operate in shadow form through 21/22, and to be fully operational from April 22.

This highlight report will provide a monthly update to the Board with regard to:

- The structures being created
- The programme of development

Recommendations

It is recommended that the Strategic Commissioning Board consider the Integrated Delivery Collaborative Programme Update for August 2021.

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

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

Implications						
will be affected been consulted?						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒

Implications	
Additional details	

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

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Integrated Delivery Collaborative Programme Update: August

Kath Wynne-Jones

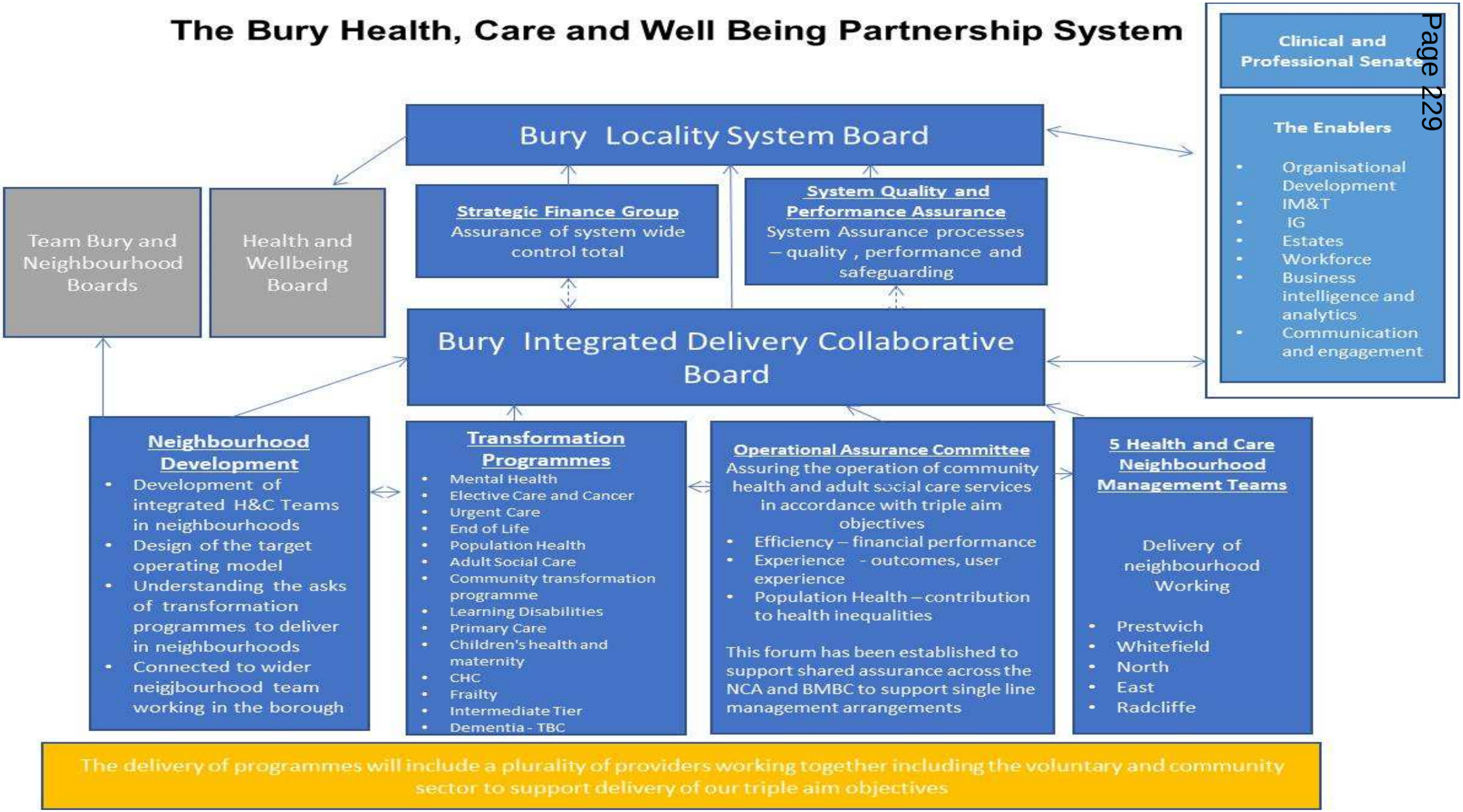
Context

The work of the IDC Board has been focusing on creating the structures and environment to enable the IDC to operate in shadow form through 21/22, and to be fully operational from April 22.

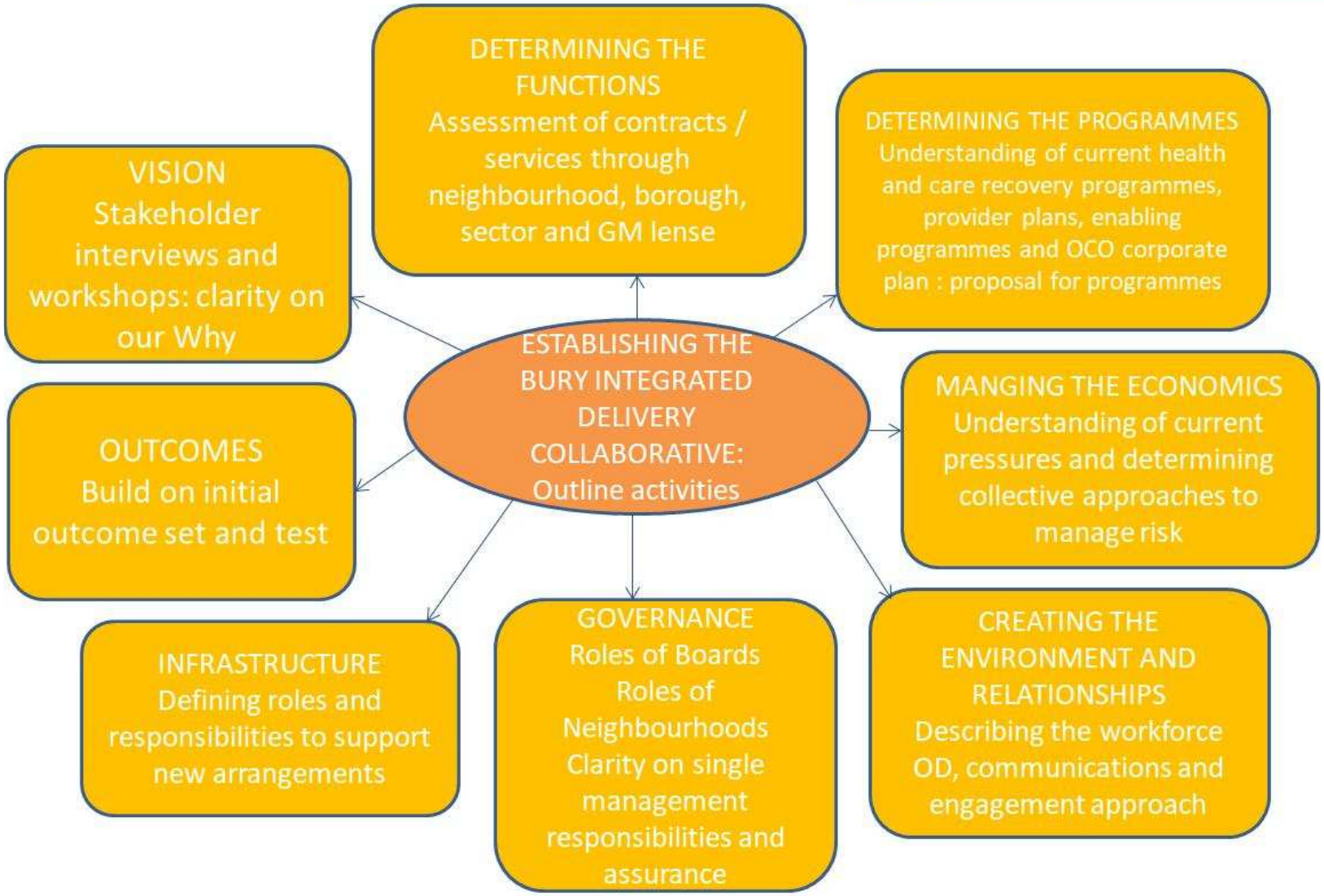
This highlight report will provide a monthly update to the Board with regard to:

- The structures being created
- The programme of development

The Bury Health, Care and Well Being Partnership System



Programme of Development



IDC structures

	Update	Risk	Responsible
Bury Integrated Delivery Collaborative Board	Meetings established from April 21 with a schedule of business and development until Autumn 21 . A forward plan is in place until Sept 21 with the plan from Oct- March currently being scoped TOR agreed Paper to Board in September outlining proposals for additional members from wider partners	Green	Chris O'Gorman / Kath Wynne-Jones
Neighbourhood Development Team (Health and Care Teams)	Target Operating Model (TOM) in development for September 21 with key features for Y1, Y2 and Y3 described : Development workshops held between May and August 21 Neighbourhood development team now established and transitioning from the TOM development group Development phase with Primary Care Oct 21 – March 22 aligned to quality in primary care contract where health and care neighbourhood teams will determine their local priorities for their neighbourhood Neighbourhood plans and agreements to be signed by March 22 to be operational from April 22	Green	Kiran Patel / Lindsey Darley
Transformation Programme Team	2nd meeting of TPT held . The July meeting through descriptions by the SRO's focused on: • Reflections on current scope and ambition • What's the problem you are trying to solve? Who's in your team (including enabler reps) and who is connecting to GM? Are you clear on alignment of all individual organisational strategies and approaches within the current programme scope? • Is there cross system ownership across commissioners and providers As a consequence of the discussions at the meeting a role description for SRO's and Clinical / Professional leads has been developed to outline expectations to ensure we have appropriate resources aligned. Key actions for August/September: Individual meetings with HH/LD and SRO's to understand: • Clarity on ambition • Programme resourcing - estimated WTE and any gaps. This will inform the conversations with the GM ICS with regard to resources required locally • Level of detail available with regard to milestones, financial and outcome assumptions The September TPT will focus on • The mandate to be agreed with IDC Board: finance , outcomes and measures • Milestone plans for the totality of the programme (including core business activities) • Outcome of programme conversations The outputs of this will be shared with the IDC Board in September	Amber: Some risks were flagged with regard to capacity available (SRO's and the broader teams) to support the ambition of this agenda . This risk will be further assessed following 1:1 conversations wih SRO's	Howard Hughes /Kath Wynne-Jones

IDC structures

	Update	Risk	Responsible
Operational Assurance Committee	4 weekly schedule agreed to assure finance, quality, performance and workforce of community health and adult social care services to be mobilised from the Autumn	Amber	Adrian Crook / Nina Parekh
5 Heath and Care Neighbourhood Management Teams	Closely connected to the development of the H&C neighbourhood TOM and arrangements through the Operational Assurance Committee Membership of Neighbourhood Management Teams currently being determined through the Neighbourhood Programme Team Operational assurance metrics for INT's currently being agreed through the Operational Assurance Forum Neighbourhood plans and agreements to be signed by March 22 so that 5 Heath and Care Neighbourhood Management Teams are clear of their responsibilities from April 22	Amber	Kath Wynne-Jones / Lindsey Darley / Kiran Patel
Strategic Finance Group (SFG)	The Strategic Finance Group for the Bury Health and Care System supports the locality to discharge its responsibility to manage the integrated budgets (pooled and aligned and in view) in a way that has NHS providers and the Council working transparently together to spend the Bury pound as effectively as possible. The Group will also support the IDCB in working with transformation programmes to manage effectively the delivery of anticipated reductions in demand and cost. Terms of Reference Agreed - established May 2021 Financial ask of IDC to support the system currently being agreed Risk management approach to the TF risks still to be agreed: At the moment these liabilities are sitting with the NCA and the Council, as contract variations have not yet been enacted. This could impact the future viability of the transformation schemes as the NCA cannot host unfunded posts and it may impact future funding allocations .	Amber	Sam Evans / Catherine Wilkinson
Clinical and Professional Senate	A proposition for the establishment of a clinical and professional senate for the borough has been developed. It describes two elements : a strengthened network of clinical and professional leadership in the borough, and at the heart of that network a clinical and professional senate steering group.	Green	Howard Hughes/ Kiran Patel /Will Blandamer
System Quality, Safeguarding and Performance Committee	This meeting will support both the Locality Board and the IDC in ensuring that quality and safety and performance operate as 'golden threads' from the Locality Board to neighbourhood working. In transition phase this meeting will grow out of the existing CCG quality and performance committee and the chair has supported the approach. Work continues to align quality reporting arrangements with providers. This will be established from Autumn 2021	Amber	Catherine Jackson

IDC Programme

Element	Update	Risk	Responsible
Vision	5 Board development sessions held focusing on: -Purpose -Principles -Values -Behaviours These will be finalised in the September development session	Green	Chris O'Gorman / Kath Wynne-Jones
Determining the Functions	List of contracts across the Borough currently being collated and connections into GM spatial footprints currently being identified	Amber	Lindsey Darley / Kath Wynne-Jones
Determining the Programmes	See update from Transformation Programme Team Currently determining support available from the council to support highlight reporting processes to IDC Board	Amber	Howard Hughes/ Kath Wynne-Jones
Managing the economics	Financial ask of IDC to support the system currently being agreed. See update on SFG	Amber	Sam Evans
Creating the environment and relationships	OD plan in development focusing on aspects of: -Board development -OCO/LCO / provider operational relationships : trying to secure external support from AQUA -Programme requirements We need to determine our approach with regard to comms and engagement to support the change: A strategic meeting with comms leads across the Borough is currently being arranged First strategic workforce group to be held in September	Amber	Kath Wynne-Jones / Will Blandamer
Governance	IDC Board TOR agreed MBA refresh paused until further clarity from GM	Green	Chris O'Gorman / Kath Wynne-Jones
Infrastructure	Programme teams identifying by the end of July current support –there will be gaps. 'Virtual' programme teams to be agreed by end of September	Amber	Kath Wynne-Jones
Outcomes	Discussions underway to ensure we are meeting national and GM requirements , delivering high quality services and are contributing to Bury 2030 strategy from a Health and Care perspective. The gap here is the resource required to support the strategic and technical development of this aspect of the programme. NCA have identified a day per week capacity from Paula Riding to support this agenda, with a working group being established, however this still needs greater capacity aligned across the Borough	Red	Kath Wynne-Jones / Will Blandamer

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NHS Bury Clinical Commissioning Group

Meeting:			
Meeting Date	06 September 2021	**Action**	Receive
Item No.	12	**Confidential**	No
Title	Bury Care Organisation Elective Care Improvement Programme - Orthopaedics		
Presented By	Ian Mello, Director of Commissioning, Bury CCG Penny Martin, Director of Operation, Bury Care Organisation, NCA		
Author	Catherine Tickle, Commissioning Programme Manager, Bury CCG		
Clinical Lead	Howard Hughes, Clinical Lead Elective Care, Bury CCG		

Executive Summary

This briefing paper provides a summary of an improvement programme NHS Bury CCG has commenced with the Bury Care Organisation (BCO) in Orthopaedics. The improvement programme of work aligns to the wider Elective Care Transformation Programme, co-developed and delivered with Northern Care Alliance (NCA), for which the Strategic Commissioning Board (SCB) received a comprehensive briefing in June 2021.

As at the end of June 2021, there were 22076 Bury patients waiting to commence treatment across all specialties and providers and of these, 2821 (13%) were in orthopaedics, making this the second highest waiting list for Bury patients with only gastroenterology being slightly higher. At 246 in June, orthopaedics also has one of the largest number of patients who have waited more than 52 weeks to commence their treatment though this marks a notable improvement from 383 in February. 82% of Bury's orthopaedic waiting list is held within the NCA whilst 6% are waiting at Wrightington, Wigan & Leigh (WWL) with the remainder split across several other providers and we will need to engage and work with these providers going forward. Further performance detail can be found within the main body of the report.

The programme of work with our BCO colleagues aims to support the recovery of the Orthopaedics speciality. It also has a distinct focus on inequalities and gaining a greater understanding of the needs of individual with orthopaedic conditions. It has brought together partners within Bury, including patients, to drive forward a programme of change interventions, where through a Bury system approach, changes to existing pathways and processes will be 'tested.' The programme aims to improve patients access and experience of 'care,' including self-care, and to support the recovery of this specialty.

It is intended that the learning from the 'tests of change' will be reported into the Elective Care Transformation Group with NCA, to inform the wider transformation work at a trust level. It will also support the scaling up of successful initiatives across the other localities within the NCA footprint, and across other specialities. Recognising the impacts of the pandemic on waiting times, supporting patients to 'Wait Well' is a key element of the work programme. The learning we experience as an integrated system team will be captured so that we can progress and develop our collective system wide understanding of the nature and impact of inequality for individuals; their families and how this shapes outcome affecting their daily lives.

Through their engagement at the Elective Care workshops, where several of the improvement areas were identified, Horizon PCN is supporting this programme of work. Using the practices within the PCN as a test bed it will enable the development of a 'blueprint' that can be rolled out across the other PCNs in Bury at pace. We are hopeful that other PCN colleagues will join us in this work in future.

The briefing provides a summary of the work to date with BCO and Bury partners and shares the programme action plan, which sets out an ambitious aim to have all the initial change ideas trialled by the 31st March 2022.
• To note the content of the briefing and work to date.

Links to CCG Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF	

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

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

Bury Care Organisation Elective Care Improvement Programme - Orthopaedics

1. Introduction

1.1 Following the report that came to the SCB in June 2021, updating the Board on the NCA and CCG Elective Care Transformation Programme, Bury CCG have developed a programme of improvement work in Orthopaedics with Bury Care Organisation (BCO).

1.2 The programme, supported by a range of system partners, is primarily focused on developing a greater understanding of the inequalities facing patients with orthopaedic conditions.

1.3 Gaining a greater level of understanding of what is driving these inequalities will help to identify changes that can be made to the current models of care to improve outcomes for patients and support recovery of this speciality.

1.4 Orthopaedics has been selected as a 'test bed' as the service is delivered in whole through the BCO, giving Bury Commissioners greater scope to work with the Operational Director and wider Orthopaedics Team to implement change at pace.

1.5 Orthopaedics is also a high-volume speciality that has been significantly impacted by the pandemic, resulting in large number of patients waiting for surgical interventions for extensive periods of time.

1.6 The CCG is engaged in the development of the GM 'Waiting Well' web base platform, which will have pathways to local 'Waiting Well' information. In Bury this will be via the Bury Directory and other sources to ensure equity of access.

1.7 A multiagency Task Group, including patient representation, has been established to co-produce the local 'Waiting Well' offer for Bury. Through the BCO Orthopaedic Improvement Programme, bespoke 'Waiting Well' information will be developed for orthopaedic patients as a 'test of change.' This will provide a blueprint to develop 'Waiting Well' information across other specialities.

1.8 The improvement work programme will also include the technical efficiencies work being undertaken by BCO in Orthopaedics to support recovery.

2. Purpose of the Paper

2.1 This paper is presented for information, to brief SCB members on the Orthopaedic improvement programme with BCO.

2.2 It is also intended to evoke a discussion to consider how the SCB can support the learning from this programme of work to scale successful initiatives at pace across other localities and specialities within the NCA and the wider Bury Integrated Health and Care System.

2.3 The transformation and improvement programmes of work is running in parallel to support the scaling up of any successful improvement initiatives across the other localities and specialities in the NCA footprint through larger scale transformation.

3. The Golden Thread

3.1 As with the overarching Elective Care Transformation Programme, co-production and reducing inequalities is the 'golden thread' running through the Orthopaedic improvement work. Understanding our local population deeply, their individual and collective needs, their experiences and understanding

of of services and their ideas for positive sustainable change, is paramount to the success of the programme.

3.2 The work is supported by Public Health at the Local Authority, through the Public Health Consultant and the Patient Experience Lead at the NCA. It also has links into the Greater Manchester (GM) Elective Health Inequalities Task and Finish Group.

3.3 Partners are working collaboratively to consider a different approach to waiting list management in orthopaedics to address inequalities. This work is being driven by local qualitative and quantitative data and modelling coming from GM through the GM inequalities group.

4. Alignment to the GM, NCA and CCG Elective Care Transformation Programme

4.1 The improvement programme of work with BCO will support the wider transformational programme with NCA to achieve the desired 'end state' as outlined below and shared in the June 2021 paper that came to the Board:

- Patients 'waiting well,' supported whilst on the waiting list to optimise their likely outcomes from surgery and any other form of treatment.
- Patients prioritised in accordance with clinical need, urgency, likely degree of benefit and consideration for the wider impact on an individual's socioeconomic factors that may drive further inequalities from waiting for treatment.
- A holistic approach taken to waiting list management to reduce inequality in access.
- Parity of esteem achieved across pathways to support improvement in both physical and mental health outcomes for patients.
- GPs and other stakeholder informed of expected waiting times for individual patients and the support available to patient whilst they wait.
- Integration across pathways to allow the patient to be seen by the right professional, at the right time in the most appropriate place, including within the neighbourhoods.
- All opportunities for non-surgical intervention explored, including those relating to social circumstances/social prescribing.
- Re-engineered pathways that deliver better patient outcomes that may not result in an elective or planned procedure.
- Enhanced pathways into non medicalised support to address socioeconomic factors, lifestyle, primary and secondary prevention and maximise Burys community assets.
- A tried and tested model of co-production that can be scaled to support transformation on a wider footprint and inform an overarching Bury Co-production Strategy.

4.2 All the above is within the current Greater Manchester Elective Care Recovery and Reform Board strategic direction, which in turn the Northern Care Alliance is a major partner in alongside other GM based providers.

5. Performance Context

5.1 In terms of elective care performance, the Bury position is outlined below.

5.2 For elective activity, the operational planning guidance for 2021-22 set a requirement for providers to reach 80% of the 2019-20 baseline by June and then to reach and sustain 85% across Quarter 2. This target is one of the key gateway measures associated with providers being able to access the Elective Recovery Fund (ERF). Across Quarter 1, elective activity for Bury patients was a little below the planned level though the national directive was for ERF monies to flow regardless. During July, NHS England announced that the target for Quarter 2 had increased to 95%. Data for Quarter 2 is currently

unknown though such an increase in target is likely to impact on providers being able to access the ERF monies. Outpatient activity in Quarter 1 is 34% above the planned level.

5.3 Performance against the Referral to Treatment (RTT) 18 weeks constitutional standard has been below target throughout the pandemic period and this position is reflected both regionally and nationally too. Performance of 63% against the 92% target is noted for Bury in Quarter 1 of 2021-22.

5.4 A month on month increase can currently be seen in the elective waiting list for Bury patients. The waiting list size stands at 22076 in June and marks a 17.1% (3223 pathways) increase when compared to March 2021. Across Quarter 1, the most significant increases have been in gastroenterology (+19.1%), Ear Nose and Throat (ENT) (+35.8%), ophthalmology (+24.1%), orthopaedics (+12.7%) and cardiology (+64.4%). There have been no significant decreases in waiting list size across Quarter 1.

5.5 For orthopaedics specifically, there were 2821 Bury patients waiting for treatment in June and this represents 13% of the total waiting list with only gastroenterology having a slightly larger list. 83% of Bury orthopaedic waiting list is at the NCA whilst 6% is at Wrightington, Wigan and Leigh (WWL) with the remainder spread across several other providers.

5.6 Despite the overall growth in the waiting list, the number of patients waiting longer than 52 weeks to commence treatment is reducing. There were 1316 such breaches in June, marking a 22.5% reduction (-381 pathways) when compared to March 2021. In particular, there has been a 33% (-121) reduction in such breaches for orthopaedics.

5.7 National data does now also include detail of waits exceeding 104 weeks. This figure has increased from six in April to 37 in June with the biggest numbers seen in general surgery, gynaecology, ENT, and urology.

5.8 Diagnostics performance for Bury remains significantly below standard across Quarter 1 though there has been some slight improvement. Both Bury CCG and Pennine Acute Hospitals Trust (PAHT) remain outliers when comparing performance with both the GM and England averages though the gap, particularly for the CCG, has narrowed a little. Performance at Bury's other main NHS providers, Manchester University FT (MFT) and Salford Royal FT (SRFT) is in line with the GM average.

6. NCA Elective Care Recovery Strategy

6.1 NCA is in the process of finalising a strategy for the recovery of elective care services, to include Orthopaedics, which is currently being taken through the Bury system governance for locality input.

6.2 The aim of the NCA recovery strategy is to deliver the NHS constitutional standards for patient access by 2025 ensuring patient safety, excellence, and improvement in all known inequalities.

6.3 This will be achieved through focus in the following 5 key areas: pathway re-design, safety & experience of patients waiting, clinical & operational leadership, automation & standardisation of processes and engagement of trust staff, partners & patients.

7. BCO Orthopaedical Improvement Programme Working Group

7.1 An integrated working group has been established led by the Director of Secondary Care Commissioning at Bury CCG and Director of Operations at BCO. The group is made up of colleagues from Public Health, BI, Primary Care, Clinicians, PCN, NCA and Community.

7.2 The group is currently meeting fortnightly to establish the programme infrastructure, including the links into existing work taking place in the locality and at GM; ensure processes are in place to support coproduction with patients; and to finalise the action plan.

7.3 Over the next few weeks this group will morph into a Steering Group to oversee implementation of the plan that will be delivered through several multiagency Task Groups.

7.4 As members of the Steering Group also sit on the Elective Care Transformation Programme Group with NCA, this will ensure alignment of the two programmes.

8. Orthopaedical Work Programme

8.1 The Driver Diagram in appendix 1 has been agreed with system partners. It sets out the overall aim of the improvement work to; *'Deliver effective system demand and waiting list management by March 2022.'*

8.2 The key drivers to support delivery of the project aim align with the priorities and expectations set out in the NHS Long Term Plan and GM Elective Care Priorities around referral optimisation, supporting patients waiting and managing capacity and demand.

8.3 The outputs of the Elective Care Matters series of workshops, co-delivered by CCG and NCA colleagues as part of the transformation programme, generated several 'ideas' for potential areas of work that could be considered 'quick wins.'

8.4 These ideas fall within 'business as usual,' with a focus on improvement, as opposed to larger scale transformation and lend themselves to tests of change in Orthopaedics. These have been included in the driver diagram.

8.5 Existing GM and nationally driven initiates, such as Waiting Well and Primary Care Networks, that can be accelerated in the locality through a focused 'test of change' in orthopaedics, have also been brought into this programme of work and are reflected in the driver diagram. It is intended that the benefits gained in orthopaedics can then be replicated in other specialities.

8.6 Also reflected in the driver diagram are existing initiates such A&G, PIFU, Care Navigation. Within the locality these have been implemented in part but are believed to have a greater potential. The test of change in Orthopaedics will provide the platform to develop a 'blueprint' and evidence base to support these key pathway components to be embedded across more specialities in NCA and at other points across the pathway, championed by local clinicians and patients.

9. Programme Action Plan

9.1 The change ideas within the driver diagram have been further developed through a series of multi-agency meetings and translated into an action plan that can be found in appendix 2.

9.2 Named leads have been identified to drive forward elements of the action plan and will be accountable to the Steering Group. Where required the Leads are developing Task Groups to ensure the right expertise is available to support delivery of the change idea.

9.3 A Data Analysis Task Group has been created to act as an overarching group, providing analysis to inform the development of the 'tests of change' and to monitor the impact of the initiatives.

9.4 The Task Group brings together CCG and NCA BI, Public Health, NCA Patient Experience, Primary Care and VCFA to get a system wide baseline for orthopaedics.

9.5 An integrated system wide Elective Care Performance Group will also be established in September to monitor the recovery position within Orthopaedics and model this to eventually cover other NCA specialities and other elective care provision. This group will be run with colleagues from our OCO

Performance Team, our locality system partners.

10. Governance

10.1 The improvement programme of work sits in the Elective Care Programme in the Secondary Care pillar of the OCO.

10.2 As a component of the Elective Transformation programme, the improvement programme will report into the Bury Integrated Delivery Collaborative Board and Bury CCG Governing Body.

11. Recommendations

SCB to:

- Note the content of the briefing and work to date.

Ian Mello
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Director of Operations, Bury Care Organisation, NCA
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Catherine Tickle
Commissioning Programme Manager, NHS Bury CCG
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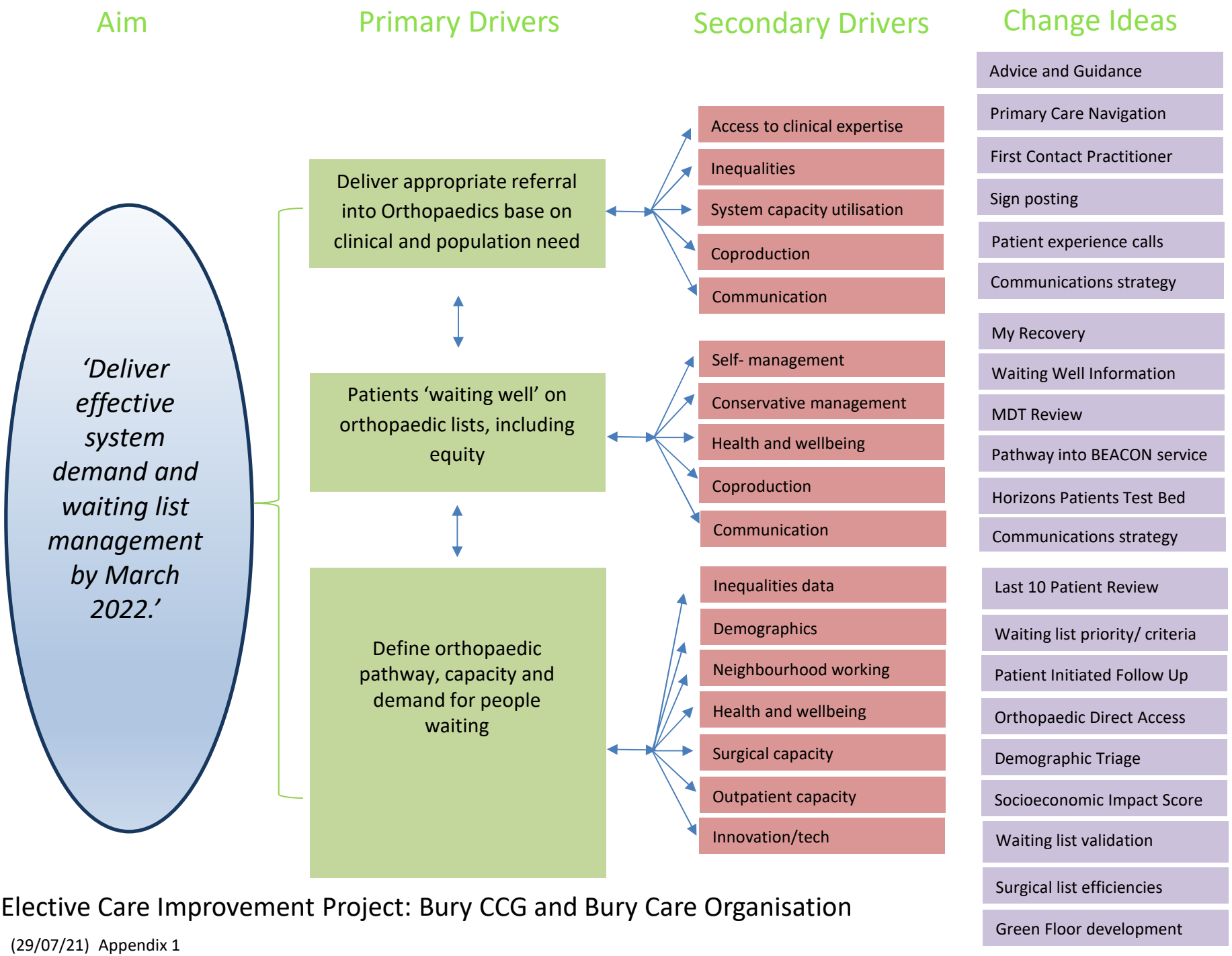

Elective Care Improvement Project: Bury CCG and Bury Care Organisation

(29/07/21) Appendix 1

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Appendix 2

Bury Care Organisation Improvement Project - Orthopaedics - Project Plan - DRAFT (27.07.21)

	Change Idea and Key Milestones	Task group Lead and Lead for Key Actions	Timescale	Update	Status
1. Data Analysis		**Lead : Angela Partington** **Milestone Owner:**	**(July 2021 - Aug 21)**		
1.1	Collate and review Orthopaedics triage data and admitted data	Katy Alcock	02.08.21		in progress
1.2	Identify areas for improvement	Katy Alcock	02.08.21		in progress
1.3	Identify quantitative metrics to monitor impact of 'test of change'	Angela Partington, Joe Keane	16.08.21		
1.4	Identify qualitative metrics to monitor impact of 'test of change' - including Last 10 Patient Review	Tracy Shaw, Mike Ryan	16.08.21		in progress
1.5	Develop and implement monitoring dashboard	Angela Partington, Joe Keane	01.10.21		
1.6	Agree frequency and mechanism of reporting	Angela Partington, Joe Keane	30.07.21		
2. Governance		**Lead: Cath Tickle** **Milestone Owner:**	**(July 2021 - Aug 21)**		
2.1	Meeting of key stakeholders for initial exploratory meeting	Cath Tickle	08.07.21		complete
2.2	Agree Driver Diagram for work programme	Cath Tickle	23.07.21		complete
2.3	Develop and agree action plan for implementation of schemes	Cath Tickle	30.07.21		in progress
2.4	Arrange schedule of meetings to deliver work programme	Cath Tickle	29.07.21		in progress
2.5	Identify chair and vice chair	Ian Mello	02.07.21		in progress
2.6	Agree project support	Ian Mello, Penny Martin	13.08.21		
2.7	Agree reporting framework	Cath Tickle	13.08.21		
2.8	Agree programme governance	Ian Mello, Penny Martin	13.08.21		
3. Patient Experience - Socioeconomic Impact Reviews		**Lead : Laurence Bond** **Milestone Owner:**	**(July 2021 - Aug 21)**		
3.1	Agree objectives for patient experience calls	Penny Martin	29.06.21		complete
3.2	Agree questions for patient experience calls	Tracy Shaw	09.07.21		complete
3.3	Align script for calls with Last 10 Patient Review process	Laurence Bond, Mike Ryan	13.07.21		complete
3.4	Pull dataset for calls	Joe Keane	09.07.21		complete
3.5	Obtain patient consent for data use	Tracy Shaw	24.07.21		in progress
3.6	Agree alignment to Last 10 pt Review	Cath Tickle	24.07.21		in progress
3.7	Develop and present summary report	Tracy Shaw	31.08.21		
4. Waiting Well		**Lead: Damian Aston** **Milestone Owner:**	**(July 21 - October 21)**		
4.1	Develop task and finish group/patient inclusion	Damian Aston	31.07.21		in progress
4.2	Scope current support services/capacity/Involvement	Damian Aston	20.08.21		
4.3	Review of current patients waiting and new patients	Katy Alcock	30.07.21		in progress
4.4	Design develop Bury GM Waiting Well page (support services/acute contacts to address patient concerns	Damian Aston	31.08.21		
4.5	Design/develop localised Waiting Well Platform /Bury Directory	Damian Aston	17.09.21		
4.6	Development a bespoke orthopaedic waiting well web page (specific needs)	Damian Aston	10.09.21		
4.7	Trial orthopaedic waiting well materials with patients waiting (Horizons PCN link)	Damian Aston	24.09.21		
4.8	Develop implementation plan - Web pages/comms etc	Damian Aston	07.09.21		
4.9	Launch Bury's Waiting Well Pack	Damian Aston	01.10.21		
4.91	Explore My Recovery App Opportunities	Aqueel	31.08.21		
5. System Navigation		**Lead: Damian Aston** **Milestone Owner:**	**(July 21 - Feb 22)**		
5.1	Review and share current role of primary care navigators	Lisa Lucas	02.08.21		
5.2	Develop signposting materials for orthopaedics patients	Damian Aston	20.08.21		
5.3	Develop navigation framework for Orthopaedics	Lisa Lucas	31.08.21		
5.4	Implement revised navigator framework	Victoria Moyle, Zoe Alderson	06.09.21		
5.5	Evaluate new navigator pathways	Lisa Lucas	04.02.22		
6. Pathway Re-Design		**Main Lead: Katy Alcock** **Milestone Owner:**	**(Aug 21 - March 22)**		
6.1	Review referral criteria and pathways for orthopaedics	Katy Alcock	20.08.21		in progress
6.2	Develop revised referral criteria and Pathways for orthopaedics	Katy Alcock	24.09.21		
6.3	Implement new referral criteria and pathways for orthopaedics pathway as 'test of change'	Katy Alcock	01.10.21		
6.4	Review referral criteria and role of FCP	Katy Alcock, Victoria Moyle	20.08.21		
6.5	Develop revised referral criteria and pathways for FCP	Katy Alcock, Victoria Moyle	24.09.21		
6.6	Implement new referral criteria and pathways into and from FCP as 'test of change'	Katy Alcock, Victoria Moyle	01.10.21		
6.7	Scope local services to support orthopaedics conditions	Damian Aston	20.08.21		
6.8	Review existing pathways into 3rd services	Damian Aston	03.09.21		
6.9	Implement revised referral criteria and pathways into 3rd sector, LA and community services as a 'test of change'	Damian Aston	01.10.21		
6.10	Evaluate new pathways	Katy Alcock	04.02.22		

6.11	Proposal for next steps	Laurence Bond, Cath Tickle	04.03.22		
7. Communications/Data		**Lead: Angela Partington**	**(July 21 - Oct 21)**		
		Milestone Owner:			
7.1	Collate and review waiting time data for orthopaedic waits	Angela Partington, Joe Keane	30.07.21		
7.2	Liaise with primary care to understand information required by general practice	Cath Tickle	20.08.21		
7.3	Agree data reporting fields for orthopaedics waiting times to GP	Angela Partington, Joe Keane	17.09.21		
7.4	Agree and cascade comms for GP re: waiting times for orthopaedics and programme of work	Caroline Dearden	30.07.21		
7.5	Agree reporting schedule for GP data and comms	Caroline Dearden	30.07.21		
7.6	Draft dashboard continuing orthopaedic waiting times data for via Tableau as a 'test of change'	Angela Partington, Joe Keane	01.10.21		
7.7	Trial database	Angela Partington, Joe Keane	01.10.21		
8. Referral Management		**Lead: Laurence Bond**	**(Aug 21 - March 22)**		
		Milestone Owner:			
8.1	Review Rockwood / Oxford or other appropriate functional assessment scores	Laurence Bond, Steven Senior	30.09.21		
8.2	Define demographic info required in referrals	Laurence Bond, Steven Senior	30.09.21		
8.3	Agree process to obtain demographic info in primary care as 'test of change'	Zoe Alderson	30.09.21		
8.4	Develop process for use of socioeconomic score in Orthopaedics	Victoria Moyle, Laurence Bond	30.09.21		
8.5	Develop local combined scoring algorithm for local assessment score and clinical prioritisation	Laurence Bond, Steven Senior	01.10.21		
8.6	Trial of assessment score in Horizon practices	Victoria Moyle, Laurence Bond	01.10.21		
8.7	Trial utilising combined score to prioritise waits and report findings	Laurence Bond, Steven Senior	01.10.21		
8.8	Develop proposal for next steps	Laurence Bond, Cath Tickle	04.03.22		
9. Last 10 Patient Review		**Lead: Mike Ryan**	**(June 21-Aug 22)**		
		Milestone Owner:			
9.1	undertake data protection impact assesment for the review	Mike Ryan	9-16th July	DPIA submitted 14/07/21	In progress
9.2	Identify pathway for analysis	Mike Ryan	Complete	Agreement that Arthritic Knee pathway would be focus	Complete
9.3	agree MDT membership	Mike Ryan	Complete	Reps identified from: GP, PH, INT, FCP, Acute - patient reps to be identi	In Progress
9.4	Agree review process	Mike Ryan	Complete		Complete
9.5	pull first set of 30 patients	Mike Ryan	Complete		Complete
9.6	call first set of 30 patients to to identify a core 10	Mike Ryan	Complete	Called by Susan Howard (PAT). 10 booked in for interview	Complete
9.7	anaylsis of individual pathway journey of the core 10 to identify variation	Mike Ryan	19-23rd July	To be done by Katie Alcock	To start
9.8	semi-structured interview with each of core 10 to gather experiential data	Mike Ryan	19-23rd July	To be done by Katie Alcock	To Start
9.9	data analysis to identify themes	Mike Ryan	23rd-30th July		To Start
9.10	MDT workshop to understand variation and identify areas for actior	Mike Ryan	WC 2nd August		To Start
9.11	MDT outputs shared with the wider programme	Mike Ryan	WC 16th August		To Start

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Approve
Item No	13	**Confidential / Freedom of Information Status**	No
Title	Bury Community Mental Health Services Investment Proposal, Adults and Children and Young People		
Presented By	Will Blandamer Executive Director of Strategic Commissioning		
Authors	Kez Hayat – Commissioning Programme Manager Jane Case – Childrens' Commissioning Programme Manager Nasima Begum – Commissioning Manager Sue Hargreaves – Assistant Chief Finance Officer Non Acute and Primary Care		
Clinical Leads	Dr. Daniel Cooke and Dr. Cathy Fines		
Council Lead	Andrea Simpson		

Executive Summary

This report initialises a step change in how we will move to redesign our mental health adults and children and young people pathways moving forward as we build back better from Covid. This paper relates to the service pressures and impact of Covid on Emotional Health and Wellbeing and Mental Health and our Bury population.

The report also highlights establishing a shared baseline of understanding of the current pressures and demands across the mental health system and also pulls together a range of propositions for Adults and Children and Young People's services, utilising investment from non-recurrent monies and future Mental Health Investment Standard funding to meet the growing demands.

This is done within the backdrop of the national and Greater Manchester funding streams and maximises investments to support innovation and system working to better support the delivery of the outcomes within Mental Health long term plan and the Bury 2030 strategy.

The adults briefing and associated recommendations outlines the current resource and capacity issues within the Bury Community Mental Health Team (CMHT) resulting from extra demand. To aid capacity and mitigate against the risks of not being able to meet the extra demand in the CMHT, an enhanced staffing proposal has been developed by NHS Bury Clinical Commissioning Group (CCG) and Pennine Care Foundation Trust (PCFT) that sees staffing enhanced and ensures demand can be met and delivers the ability to restructure the CMHT ensuring improved links with our neighbourhood system.

The children's briefing and associated recommendations seeks to address the step change needed to re balance the children's provision so that there is more of a wider community offer, to meet more need. Adopting the Thrive model and building capacity highlights the need for

more early intervention and prevention and the longer-term development of a strategy and investment plan.

These proposals are phased over 3 years to make use of the additional yearly investment required by the Mental Health Investment Standard national policy with ensures growth each year and is a significant contribution to Bury commitment to meeting the Mental Health Long Term Plan

Recommendations

It is recommended that the Strategic Commissioning Board:

Adults

- Approve part 1 of the 'Enhanced Staffing options proposal' which will allow the recruitment of 6 Mental Health Practitioner posts (NHS Band 6).
- Approve part 2 of the 'Enhanced Staffing options proposal' - further requirement of an additional 9 staff (NHS Band 6) to make the service safe. Recruitment is likely to take place in Quarter 4 2021/22 for an intention to employee 2 Mental Health Practitioners.
- Recognise the expansion of the service with the redesign of the CMHT service and development of the Community Mental Transformation.

Children and Young People

- Approve the actions and investment set out within this report for Children's and Young Peoples Mental Health investment
- Acknowledge the complexity and timeliness of the task at hand and endorse the use of any additional slippage in recruitments to be redirected to shore up the children's system within the ascribed financial costs

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

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

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

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

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

1. Adults Investment Proposal

2. Introduction

2.1. This briefing outlines the resource and capacity issues within the Bury Community Mental Health Team (CMHT) resulting from increased demand which risks impact on waiting lists, staff capacity/moral and overall quality of care being delivered to patients. To aid staffing capacity issues in the CMHT in partnership with the CCG, have developed an 'Enhanced Staffing proposal' for the SCB to consider

2.2. Part 1 of the Enhanced Staffing proposal highlights the need for the service to recruit 6 Mental Health Practitioner posts (NHS Band 6). Without these additional staff measures the capacity of the team would be stretched and the current waiting lists could rise. The current use of agency staff presents a significant risk to service delivery not just in the risk of turnover but also because the use of agency staff cannot be permanently funded by the Trust.

2.3. Part 2 of the Enhanced Staffing proposal also identifies recurrent funding for 9 additional staff (NHS Band 6 Mental Health Practitioners). This would be carried out in a phased approach and aligned to the redesign of the CMHT service and in the future with the Integrated Neighborhood Team (INT) function, Primary Care Network (PCN) development and Mental Health Community Transformation as part of the Bury Mental Health Living Well Model.

3. Background

3.1. Bury CMHT is an integrated health and social care workforce within PCFT to support patients aged between 16 to 64 years of age. It is currently provided under a block contract arrangement. The team provide a range of interventions including assessment, care planning, treatment, support and care for adults with severe and enduring mental health problems. The CMHT Social Workers are employed by Bury Council and are under a single line management structure of PCFT.

3.2. Bury CMHT cares for people in Bury and/or registered with a Bury GP (as per the GM cross border arrangements), who are suffering from severe and enduring mental illness, typically those with schizophrenia, severe affective disorder or a complex personality disorder, but this does not yet extend to the structured clinical case management programme for personality disorder. It provides a service for people with a substantial disability and/or vulnerability as a result of their illness, such as an inability to care for themselves independently, maintain relationships or sustain employment.

3.3. The CMHT is a multidisciplinary service that consists of Team manager, Community MH nurses, MH Social Workers (some qualified AMHPs). The CMHT can only accept referrals from the Access and Crisis service that have been assessed as requiring secondary care mental health services and meets the CMHT enhanced criteria for CPA coordination.

3.4. The CMHT service provides for people aged 16-64 years old. Once a service user has

been assessed as appropriate for the service they are allocated a Care Coordinator who can either be a mental Health Nurse or a Mental Health Social Worker. The Service operates Monday to Friday 9am to 5pm.

3.5. The NHS Long Term Plan sets out the ambition for the integration of primary and community care services for adults and older adults with severe mental illness (SMI). There is a requirement from the NHS long term plan and the recently announced Mental Health Transformation Programme for CMHT functions to work in collaboration with neighbourhood teams and primary care partners, where possible working across a neighbourhood footprint. Currently Bury CMHT is a single centralised specialist service that facilitates the borough however this proposal will facilitate further integration with our neighbourhood system.

3.6. Bury Local Authority have carried out a Service Review of CMHT from a Social Care perspective however, the scope has also taken account of the health and clinical provision. The review highlighted a number of clear themed areas for development with specific actions aligned to each theme. The service has been working over the last nine months to streamline systems, processes and functions and build collaborative relationships and pathways with VCFA partners in the locality. This has alleviated some of the historical pressures and a number of service users have had safe transitions into other supportive services.

3.7. Appendix 1 showcases the proposed new CMHT model that PCFT have been developing across the Trust footprint. The service model components effectively ensure that the two groups of service users (short term/long term group) benefit from assessment and formulation with input from a multi-disciplinary team (MDT).

3.8. The short term group will compromise of service users with conditions that require time-limited interventions, with discharge on completion or move to substantial intervention into the long term support. The long term service users will require ongoing treatment, care and monitoring for prolonged periods but managed within a recovery model to eventually discharge. This includes severe and enduring mental health disorders with an assertive outreach team for those who require intense one to one support or are difficult to engage. Care will be centred around an individual's needs and will be stepped up or down based on need and complexity, and on the intensity of input and expertise required at a specific time.

3.9. PCFT are confident that the Trusts proposed new CMHT model is consistent with the design principles outlined within the new national Mental Health Community Framework. Moreover, the GM Innovation Unit, which has been commissioned by GM Health and Social Care Partnership to support the Mental Health Community Transformation Programme, have reviewed the Trust's model in detail and agreed that it is entirely consistent with the new CMHT service approach. However, they also advise that the context in the new Mental Health Community Framework provides greater opportunity to consider new roles, increased integration and partnership approaches, and that the Trust need to review this with regards to the staffing models in particular, the role of VCFA partners to support with the non-clinical aspects of provision. These recommendations along with neighbourhood and place based principles will be followed as the Trust redesigns the Bury CMHT offer going forward. The recruitment of the 15 Mental Health Practitioners is required as well as to ease the immediate

pressures within the service but also to facilitate this continued development and transformation of the Bury CMHT.

3.10. Community care for adults and older adults with Serious Mental Illness (SMI) is one of the key priorities from the NHS Long Term Plan (LTP) because of historic timely access and quality gaps. Covid has only added to existing pressures with this group among those most adversely affected by the pandemic.

3.11. There are currently no national targets set against CMHT services however, NHS England is currently consulting on new Mental Health standards which have been piloted by Mental Health providers in collaboration with acute NHS Trusts and are backed by clinical and patient representatives. It is expected that these new standards will come into effect from April 2022. The following new standard relates to the CMHT service which given the current pressures would not be met:

3.12. "Adults and older adults presenting to community-based mental health services should start to receive help within four weeks from referral. This may involve the start of a therapeutic intervention or a social intervention, or agreement about a patient care plan"

4. Enhanced Staffing proposal

4.1. Bury CCG has worked with the CCG to develop an Enhanced Staffing proposal from which is requesting funding approval from the CCG for 15 additional Mental Health Practitioners (NHS Band 6) required to provide a safe CHMT service in a phased manner over the next 3 financial years

4.2. Following conversations with PCFT colleagues, it is clear that the immediate requirement is to allocate recurrent funding for the recruitment of 6 Mental Health Practitioner posts (NHS Band 6). The additional 9 staff required will need to be recruited in a phased approach. Both Commissioner and Provider have agreed to work together on mobilisation plans and progress recruitment along a phased approach.

4.3. It is acknowledged that there is a shortage of MH practitioners nationally and recruiting all 15 Mental Health Practitioners would be a challenge. PCFT have agreed to phase the recruitment over a 12 month period. This would mean recruiting 2 MH Practitioners per quarter – starting from Quarter 4 of 2021/2022.

4.4. The following table is the breakdown of funding required from October 2021 to March 2022 and recurrent pickup:

PCFT Community MH Service - Funding Request

		£000	£000	£000
Establishment	**Period**	**CYR**	**PYR 22/23**	**FYR**
6 wte Band 6 MH Practitioners	Oct 21 - Mar 22	125	250	250
2 wte Band 6 MH Practitioners	Jan 22 - Mar 22	20	80	80
7 wte Band 6 MH Practitioners phased - Q1	April 22 - Mar 23	-	80	80
7 wte Band 6 MH Practitioners phased - Q2			60	80
7 wte Band 6 MH Practitioners phased - Q3			40	80
7 wte Band 6 MH Practitioners phased - Q4			10	80
Non pay costs		14	20	20
Sub-Total (Pay & Non-pay)		**159**	**540**	**670**
Contribution to overheads/surplus at 14%		22	76	94
Total cost		**181**	**616**	**764**

Notes :

The above does not include any estates costs originally estimated £100k pa - to be discussed with PCFT. AFC uplift 21/22 not applied in above figs.

4.5.

MH funding request	CYR £000	FYR 22/23 £000	FYR £000
CMHT	181	616	764
CYP	247	464	464
Total request for funds	428	1,080	1,228

More detailed overview of the financial overview is available on request

4.6. The commitment form the Mental Health Investment Standard is as follows for the next 3 years

	Yr 22-22	Yr 22-23	Yr 23-24
Required from MHIS	-	1080	148

4.7. Please note the finance table does not yet include estates costs for the adults proposal which are yet to be calculated but will not exceed the funding available.

4.8. SCB should be aware of the continued funding pressures on Mental Health. It is expected that the CCG/ICS will still have to meet a Mental Health Investment standard for future years. Currently guidance is not available on how this will be calculated. However, if the calculation is similar to that for previous years i.e. spending more than the CCG's allocation growth, then it is likely that the overall target spend will be similar. This target spend will need to pick up inflationary costs

(pay and prices) and in addition the full year effect of schemes funded in 2021/22 namely the CMHT discussed here and the other priority scheme for the CCG namely Children and Young (CYP).

4.9. When the totality of the costs are taken into account, this will likely account for most of the CCG's MHIS target for 2022/23 leaving little resource to meet other known pressures such as EIP, Eating Disorder, Mental Health Liaison, CAMHS etc. These form part of the Mental Health commitment and priorities outlined in the NHS Long Term Plan as well as identified local service gaps. Further, it is not clear whether the CCG/ICS will need to make current year Service Development Fund (SDF) schemes recurrent in future years.

5. Associated Risks

SCB are asked to be aware of the potential risks associated with the CMHT service pressures:

- Significant patient risk – if staffing is not increased there is a significant risk of a number of patients being on the waiting list without an allocated Care Coordinator. There is a risk of patient conditions deteriorating and reaching crisis with a potential to have an impact on other services and the wider system.

- Staffing risk - staff well-being is a concern as CMHT managers may see staff requesting a reduction in working hours due to the pressure and demand of the work which may impact on staff moral and staff resilience**.**

- Service provision risk – there is a possible risk for the service to become non-operational if the current risks are not mitigated.

- Organisational reputation risk – there is a risk of adverse publicity and regulatory scrutiny if the service does not mitigate emerging pressures.

- Financial risk – Mental Health funding pressures exceed the expected MHIS target in 2022/23 and subsequent years.

6. Adult Recommendations

- It is recommended that SCB approve the recurrent amount of £181,000 required for the PCFT CMHT service to recruit 6 MH Practitioners from October 2021-March 2022 and to also recruit 2 additional practitioners with an expected start date in quarter 4 of 2021/22.

- It is recommended that SCB approve the incremental staffing increase to the total ask of 15 MH Practitioners required in the CMHT service at a part year cost of £616,000 in 2022/23 and full year recurrent costs of £764,000 from 2023/24 as part of the Mental Health Investment Standard.

1. Children's Investment Proposal

1.1. Introduction

1.2. This briefing outlines the resource and capacity issues within the local Bury Children's mental health system and the proposed series of interventions in the paper will start to address the system redesign in accordance with the Thrive framework.

1.3. We want the children and young people of Bury to have good positive mental health and we recognise that promoting and supporting positive emotional health and wellbeing is everyone's business. The aim is to move away from a system defined by services and organisations to one built around the needs and lived experience of children, young people, and their families, offering increased choice and control, intervening early, and building long term resilience. In achieving this we must work differently as a system and jointly own all our Bury children; to support this, we will develop a single shared vision for CYP in Bury to expect and receive the very best services and support, advice and guidance from Schools local health and care agencies including VCSE partners.

1.4. We also need to be building more capacity across other parts of the system to meet increased need and build a stronger system for children. The COVID 19 pandemic significantly impacted upon the delivery of acute services across the NHS.

1.5. 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. Added to this the exacerbation of pre-existing access and waiting time pressures has caused a considerable increase in the time children are waiting to receive non-urgent treatments.

1.6. Within this work we will always maintain a key focus on addressing health inequalities and inclusion at a neighbourhood level and becoming trauma informed in our approaches is needed as we progress.

2. Background

2.1. National context

2.2. The pandemic has had a devastating impact on many of the young people. The national charity YoungMinds have surveyed children & young people in early 2021. They reported feeling deeply anxious, resumed self-harming and are having panic attacks. They are losing motivation and hope for the future. Some young people will be dealing with multiple pressures, especially those who have been bereaved or experienced other trauma during this time. When asked what the main pressures were during the current lockdown, respondents mostly spoke of loneliness and isolation, concerns about school, college or university work and a breakdown in routine. Many young people also expressed fears about the future, and although some were optimistic about the vaccine roll out, others were concerned that easing restrictions too soon could lead to further restrictions in the future.

2.3. The YM survey of 2,438 young people aged 13-25, between 26th January and 12th February 2021 shows:75% of respondents agreed that they have found the current lockdown harder to cope with than the previous ones including 44% who said it said it was much harder. (14% said it was easier, 11% said it was the same)

2.4. 67% believed that the pandemic will have a long-term negative effect on their mental health. This includes young people who had been bereaved or undergone traumatic experiences during the pandemic, who were concerned about whether friendships would recover, or who were worried about the loss of education or their prospects of finding work. (19% neither agreed nor disagreed, 14% disagreed)

2.5. 79% of respondents agreed that their mental health would start to improve when most restrictions were lifted, but some expressed caution about restrictions being lifted too quickly and the prospect of future lockdowns.

2.6. GM policy and context The Northwest NHS Regional Office has produced a comprehensive analysis which describes how and why the region has been disproportionately affected by the COVID19.pandemic over the last 18 months.

2.7. Overall, GM has seen unprecedented growth in demand for mental health services during the COVID period, in key areas such as eating disorders, IAPT and inpatient care. Waiting lists have increased, with some individuals waiting more than 18 weeks in core community services and waits exceeding 1 or 2 years in highly specialist services such as ADHD assessment. The acuity of patients has also increased.

2.8. Higher rates of Mental Health Act detention and complex presentations have impacted on flow through the system and the ability to facilitate timely discharge. Pressures have been reported across the system, by both statutory providers and VCSE partners where increased demand, acuity and complexity, and long waiting times, are impacting on the wider system's ability to respond.

2.9. Within Greater Manchester Mental Health NHS Foundation Trust (GMMH) waits exist in a number of different pathways, and snapshot figures show over 1300 people waiting for ADHD and ASC assessments, 400 adults on community eating disorder waiting lists, and over 100 people awaiting admission to the substance misuse beds at the Chapman Barker Unit (CBU), among other areas.

2.10. With an investment of £20m revenue and £0.76m capital GM can support the increased levels of demand for mental health services through assessment and treatment pathways, facilitate earlier discharge and improve access times. In addition, targeted support for 7,000 existing long waiters will be provided. This investment will support additional capacity beyond that provided by Long Term Plan monies.

2.11. GM have seen unprecedented growth in demand for mental health services during the COVID period, in key areas such as eating disorders, IAPT and inpatient care. Waiting lists have increased, with some individuals waiting more than 18 weeks in core community services and waits exceeding 1 or 2 years in highly specialist services such as ADHD assessment.

2.12. The acuity of patients has also increased. Higher rates of Mental Health Act detention

and complex presentations have impacted on flow through the system and the ability to facilitate timely discharge. Pressures have been reported across the system, by both statutory providers and VCSE partners where increased demand, acuity and complexity, and long waiting times, are impacting on the wider system's ability to respond. Investment in additional capacity will improve access for target groups, reduce health inequalities, and improve both patient experience and outcomes. A similar picture can be seen in Pennine Care Foundation Trust (PCFT) with current waiting lists in CAMHS at 1000+ and particularly pressures in the ADHD/ASC pathways. There are also currently 2700 patients waiting for IAPT with key pressures accessing Step 3 pathways. Additionally, there are around 150 patients in the community pathway waiting for secondary care psychological therapy intervention. GM have requested funding to address these long waits. This report has been drafted with this investment in mind.

2.13. Whilst the GM proposals focus on waiting lists and specific groups and managing the demand the system is experiencing, it does not address stemming the flow of demand, which the proposals with this report address.

2.14. The impact of the pandemic in Bury has influenced children and young people's emotional wellbeing and mental health in Bury. It has brought to light system pressures that were perhaps previously being managed. However, Bury system pressures are increasingly evident with stress on emergency departments, schools, primary care, and the wider system.

2.15. This manifest in a range of ways, including, long waiting lists- Pennine Care NHS Foundation Trust enacted their business continuity plan in November 2020 and unfortunately there is still no mitigation or trajectory of recovery. This means that currently only risk management support is being provided. This a service to the highest risk young people who present in crisis.

2.16. Many children are in distress but don't have a diagnosable mental health condition. The service offer to these young people is within Early Break who are sub-contracted by PCFT but who also have waiting lists and reduced capacity to deliver more within the current funding envelope.

2.17. Schools report children acting out, with an increase in self-harming behaviours in young women and an increase in anger and aggression in young men. In one Bury high school alone, there had been 6 suicide attempts since schools returned in March 2021.

2.18. Schools are asking for increased support and guidance regarding CYP presentations with some schools not currently equipped to manage these issues confidently.

2.19. Upon review and gap analysis it appears there is a limited offer for children to access emotional wellbeing support before they fall into crisis. The recently commissioned Utilisation Management review highlighted the opportunities to meet need earlier by considering young peoples lived experiences in what drove them to crisis point.

2.20. We have seen a significant increase in the number of children and young people presenting at emergency departments in crisis. The personal circumstances that led

those young people to fall into crisis included: Increased anxiety, Loss of freedom, Self-isolating, or covid-19 symptoms, Parental anxiety, Family bereavement.

2.21. Key messages of what matter to Young people were:

2.22. Service provision; Face to Face Not being able to have face to face consultations had a detrimental impact on care for some young people. They felt not being able to assess someone's body language, surroundings, facial expressions, and other non-verbal communications created barriers.

2.23. A reliance on the Voluntary Sector provision which is a small component part of the HYM pathway for which demand outstrips capacity.

2.24. A lack of School based support.

2.25. The need for a community-based offer.

2.26. Children and young people within the Circle of Influence events told us that they wanted mental health provision within the school environment. They didn't want to wait for long periods on waiting lists with no contact.

2.27. School staff have detailed to us the lack of capacity and confidence in dealing with children and young people's emotional health and wellbeing needs. The professional help line pilot may support this but as, yet it has not gone live. Crisis pathways are not clear. Lastly, young people reported a lack of out of hours provision.

2.28. The impact of Covid-19 on young people has worsened with each wave. The UM review was initiated in 2021 and used data from the first wave in 2020 , we have since had wave 3 and nationally Young people report "Groundhog Day"; "No progress"; "no end in sight"; no "light at the end of the tunnel." (youngminds.org.uk, p8)

3. Service proposal

3.1. The proposal within this brief is to build capacity in what was typically Tier 2 (Getting Help Quadrant) provision to bolster and increase early low level provision , so that more children and young people have access to support mechanisms and trusted adults before their needs exacerbate into crisis resulting in the need for high level and high cost interventions. The proposals will secure increased provision in this quadrant to help mitigate Covid impact and provide early intervention and prevention. It builds and supports the THRIVE approach for CYP being developed as part of the Children and Young Peoples Mental Health Charter workstream. (A more detailed overview of the iThrive framework is within appendix 2.)

3.2. One of the additional wider system impacts of Covid has been recruitment and retention of staff, mental health providers are reporting a challenge with recruitment and retention of staff. However, CVS organisations can recruit and operationalise delivery of provision in a responsive and agile manner utilising a range of skill sets to meet need, developing a range of emotional support provision , rather than clinical based interventions.

3.3. It is proposed to work directly with one of our CVS organisations, to increase provision to intervene earlier and prevent poor mental health. Building on the long-standing partnership, it is proposed to inject investment in the wider system to support earlier interventions and to prevent CYP going into crisis.

3.4. Enabling the children's mental health system to rebalance, aiding mental health practitioners to focus on those children with diagnosable mental health issues and providing support across the wider system to those who do not.

3.5. It is pertinent to report that the overall offer from our colleagues in the CVS was more substantive and has been considerably amended to meet the current funding envelope. And as such there is a rolling priority of needs to be addressed should more funding become available.

3.6. There is still much more needed to be done across the children's mental health agenda, but this investment marks a step change in systems thinking and coming together as a single care system with equity of influence to deliver better systems and provision for Children in Bury. Should additional monies be identified there are a range of priority areas we would further build into the children's system. It is underpinned by an emerging strategy for children's and young people's mental health across Bury locality.

3.7. The following details proposals from a CVS organization in consultation with commissioners, in response to the current system pressures within the Children's Mental Health system. Supporting the delivery of a CYP Mental Health system more flexible, agile, and responsive.

3.8. The commissioning need is to develop and build capacity in traditional T2 provision as a significant gap is present. This is to prevent children and young people from falling into crisis and requiring higher acuity interventions further in the pathway.

3.9. The original proposal was designed to match the current level of need noted across the system but was more than the current funding envelope. Therefore, a review of what is currently essential provision has been applied. Below details a commissioner revised proposal, identifying what is needed within the system. However, those offers currently out of our financial scope can be prioritised as we progress into the next financial year. This paper offers a mix of additionality and innovations which help to address the current challenges we face in Bury, and which will lead us towards a robust sustainable children's iThrive model.

3.10. **Community support** in mental health provision. Supporting referrals, including pathways with: complex safeguarding, MASH, risk-taking behaviours, non-school mental health support and harm-reduction advice guidance and support via low-level interventions in school around mindfulness, self-care and wellbeing. Offering a group cycle- 6 weeks on anxiety management/ anger management/ self-injury/ peer-support.

3.11. **This investment will lead to the following outcomes**: Children and young people aged 14-25 would have access to community-based interventions to support lower level emotional and mental health needs. These needs would be met earlier, and those

needs would not exacerbate to reaching crisis point before they get access to support. This increasingly would support those young people who do not have a diagnosable mental health condition, but who are at high risk of developing one. It will provide children and young people with a seen presence of support in schools and communities. This investment would see the reach of the provision increase capacity by 240 YP. Added value, this would be supported by the already commissioned Getting Help line and social media presence of the provider, delivering wider messages on multiple platforms. **Cost £86,634 for 2 x EHWB workers**

3.12. The children and young people who presented in emergency departments or who have successfully completed suicide have predominantly come from this age group. It is recognised that more bolstering of the transition age group needs to be undertaken for those children who don't have a diagnosable mental health issue. The CVS organisation have previously secured external funding from a national charity to bridge this gap, however this funding is due to end in September 21, it is proposed that this be maintained and increased to meet demand.

3.13. Closing the Gap – This is a Grant funded transition pathway is due to end September 2021 – this has provided a F/T role for the last two years but a change in the funders priorities means this is to end. Enquiries and referrals are being directed to Access and Crisis and A&E at present putting additional pressure on the system. 10 referrals redirected into the system in the last week. Additional Investment -Transition EHWB workers- community -serving 16-25-year old's where there is unmet MH need and linked in with more acute pathways.

3.14. **This investment will lead to the following outcomes**: Working with and supporting those Young People who have undiagnosed mental health issues but who are at risk of falling into crisis will enable Bury to address those young people who present in emergency departments but do not meet CAMHS criteria. These young people are often known to multiple services and have complex needs. The provision will provide age appropriate support for 16-25 year olds who commonly do 'fall through the gap'. The project will provide holistic support for their emotional health and substance use and provides referrals/signposting for education, employment, housing, relationships, social prescribing, financial, sexual health. This provision will support and bridging the gap to deliver alternative support mechanisms and if needed support and transition into adult provision. Improving reach and provision to support more young people per year, delivering better outcomes and savings across the lifecourse. **Indicative costing: -£86,634k for x2 transition workers**

3.15. As Bury moves towards Place-Based working & community assets, it is pertinent to plan to engage and commission with the broader VCSE sector of community and grass roots organisations to further enhance the offer in our communities and neighbourhoods, linked in and supported by the detached and outreach offers across the borough.

3.16. **Bereavement and Loss Counselling**. Now, more than ever before children and young people are experiencing loss and grief on a measure not previously seen. Bury currently have one full time bereavement counsellor supporting approx. 70 young people per year. Additional counselling provision is essential now to prevent long term mental health issues across the life course. It is proposed to double this provision.

Dedicated 1:1 support with a specialist bereavement and loss counsellor delivered face to face or virtually. Currently 82 young people on waiting list/ waiting time of 1 year with expectation of increase in referral. Added capacity into current provision would see an additional : 1 FTE Bereavement and Loss counsellor-delivering an outcomes of - reducing waiting times, increasing reach and offer to community offering case-work and wider-family offer, developing resources and interventions to families and increase accessibility of psycho-education resources for wider community

3.17. **This investment will lead to the following outcomes**: an increase in the number of children and young people experiencing loss and bereavement able to access the right support. an additional 70 recipients of service over the year. **Additional budget request: £43,317 FTE counsellor**

3.18. **Protected cohort's LGBTQ**. Physical distancing, a practice that has been in place now for over a year, has particular consequences to The Proud Trust's primary beneficiaries through a "potential loss of the social connections that protect LGBTQ youth from suicidality" and, "negative consequences related to being confined to an environment that may be unsupportive or abusive" Those that accessed supportive places and services valued them as a safe place away from the homes or to connect with others that understood their lived experience, have been cut off from such assistance for a prolonged period.

3.19. In a study published in February 2021, the charity Just Like Us reports that, "over half of LGBT+ youth worry daily about their mental health during the pandemic and are twice as likely to feel lonely compared to their straight peers." In the research with almost 3,000 secondary aged pupils, they found that, 68 % of LGBT+ young people said their mental health had worsened during the pandemic, with a similar proportion (70 %) of trans youth saying their mental health had taken a turn for the worse. LGBT+ young people were twice as likely (52 %) as their non-LGBT+ peers (27 %) to have felt lonely and separated from the people they are closest to daily during the lockdown.

3.20. The Bury Emotional Health and Wellbeing Needs assessment highlighted in Bury, 10.4% of Children and Young People identify as LGBT according to the commissioned Bury School Survey, (SHEU, 2019). This is significantly higher than the ONS estimate for adults identifying as LGBT, which was 1.7% in 2015, (ONS, 2015). We currently have no bespoke provision for children who identify as LGBTQ, this proposal addresses this. LGBTQ+

3.21. A bespoke offer from a Partnership with the Proud Trust is vital for our CYP and a rationale for this has been previously shared and the evidence is highlighted above. Suggested quadrant: getting advice and signposting, getting help. Proud Trust offering: youth groups, training, trans-care navigator, outreach.

3.22. **This investment will lead to the following outcomes:** The delivery of Youth groups, training, trans-care navigator, outreach will support children and young people who identify as LGBTQ to feel more connected and experience less isolation and loneliness. Therefore, reducing the emotional distress and mental health pressures this cohort of young people can experience. Reduction in LGBTQ young people falling into crisis. Training into the wider system will support the wider Bury system in

becoming more inclusive and diverse. **Indicative costings: £33,000**

3.23. **The post diagnostic pathway** for families who have children with a diagnosis of ADHD and or Autism, is under increased pressures with families falling into crisis during lock down when the usual support mechanisms, such as respite were unable to be delivered. There has been a surge in demand for ASC ADHD assessment and support. Added capacity in current models of delivery, including is needed including developing a pre diagnosis would help prevent families falling into crisis, it would offer a needs led not diagnosis led approach to support offer: Pre and Post-diagnostic support ADHD/ASD/ Parent-Carer Seminars/ Referrals from School Nursing Team/ Pre-diagnostic parent support. To increase family support and response to safeguarding, risky behaviours and wider family dynamic,

3.24. **This investment will lead to the following outcomes**: Development of a pre diagnosis pathway to meet needs earlier and additional capacity to meet demand within the post diagnostic pathway. Families will be able to access support and advice and will be able to better support their children's needs. Increased family resilience, reduction in distressed behaviours. This would see a doubling of the parents currently supported and work being initialised to provide a pre diagnostic support offer. **Indicative costings: £50,000**.

3.25. **Physical Health and Wellbeing** Its recognised that to support children to develop resilience there are a number of evidence based support mechanisms that help, in particular a universal physical and emotional health offer, into all Bury schools. CVS organisations are working with partners in the sports and physical activity arena to develop assets-based offers to support thrive models- offering support for CYP, linking physical health and resilience.

3.26. **This investment will lead to the following outcomes**: children's will be supported to develop positive wellbeing routines and mechanisms that support resilience. There will be a universal offer that helps to mitigate the impact of Covid. Staff in schools will have increased understanding how they can support positive wellbeing and build resilience within the curriculum. Children and young people will be taught valuable life skills that will help provide some structure to help them maintain health and wellbeing as we build back from COVID-19. This funding would be nonrecurrent to provide proof of concept to schools to support the wider mental health agenda as part of the wider curriculum. This would also help engage schools as wider commissioners of service and help mitigate the impact of Covid on physical and mental health provision. **Indicative costings: £40,000 wider ways to wellbeing.**

3.27. This is in addition to the 3 members of staff previously agreed for within the current provision as part of the children's aspect of the Mental Health Investment Standard, these posts are currently covered with Bank staff.

3.28. The 2 x Mental Health Practitioners' and 1 Psychologist are expected to hold approximately 40 CYP cases each with the aim to reduce the waiting list. **This Investment will lead to the following outcomes:**

- Reduction in the waiting list and reduction in waiting times

- Improved clinical safety in the service
- Provide care coordination for complex patients
- Improved patient experience.

4. **Indicative costings £164.198**

4.1. There is a need to grow provision and offer for children and this proposal is linked into a wider strategy and five-year funding proposal needed to build a children's emotional health and wellbeing offer that meets need. Acknowledging that this is part of the ongoing work in the childrens workstream. This report seeks to alleviate current system pressures to enable this work to be carried on.

4.2. The following table is the breakdown of funding required from October 2021 to March 2022 and recurrent pickup:

CYP MH request	CYR £	FYR £	FYR £ Rec
Community-based CYPMH service	36,098	86,634	86,634
Closing the Gap - Transition	36,098	86,634	86,634
Bereavement and Loss Counselling	10,829	43,317	43,317
Proud Trust	33,000	33,000	33,000
Pre and post diagnostic Family Services	50,000	50,000	50,000
Wider ways to Wellbeing in schools	40,000	40,000	
CAMHs provision THRIVE (PCFT)	41,050	164,198	164,198
Total required	247,074	503,783	463,783

Note - overheads have been excluded from CAMHS costing

4.3. The request for part year funding is £247,074 as outlined in the above and assumes that where recruitment is required there maybe slippage. CVS organisations have recently been on a recruitment drive and will be able to be operational in October. Other recruitment may be staged and only be operational from January, this is built into the figures above.

4.4. Full year full cost is £503,787. With a recurrent funding request being £463,783 due to the one off nature of the wellbeing in schools workstream.

4.5. In addition, SCB should be aware of the continued funding pressures on mental health. It is expected that the CCG/ICS will still have to meet a Mental Health Investment standard for future years. Currently guidance is not available on how this will be calculated. However, if the calculation is similar to that for previous years i.e. spending more than the CCG's allocation growth, then it is likely that the overall target spend will be similar. This target spend will need to pick up inflationary costs (pay and prices) and in addition the full year effect of schemes funded in 2021/22 namely the CMHT discussed here and the other priority scheme for the CCG namely CYP (separate paper going to SCB September 2021). When these costs are taken into account, this will likely account for most of the CCG's MHIS target for 2022/23 leaving little resource to meet other known pressures such as EIP, AED, MH liaison

etc. Further it is not clear whether the CCG/ICS will need to make current year SDF schemes recurrent in future years."

5. Associated Risks

5.1. SCB are asked to be aware of the potential risks associated with the current service pressures:

- Significant system pressure – there is a significant system pressures number of patients on the waiting list without a diagnosis or support.
- Schools return, commissioners are concerned that as children return to school there will be another surge in distress and demand within the system.
- There is a risk of patient conditions deteriorating and reaching crisis with a potential to have an impact on other services and the wider system.
- Staffing risk - staff well-being is a concern as mental health services and managers are seeing staff requesting a reduction in working hours due to the pressure and demand of the work which is impacting on staff moral and staff resilience**.**
- Service provision risk –The children's mental health provision is already experiencing extreme pressures. The current provider is operating under a business continuity plan which manages risk.
- The associated ask within this report seek to redress the balance, building capacity across the system, supporting more children and preventing exacerbation of need. There is a possible risk for the system to become non-operational if the current pressures are not alleviated.
- Financial risk – Mental Health funding pressures exceed the expected MHIS target in 2022/23 and subsequent years.

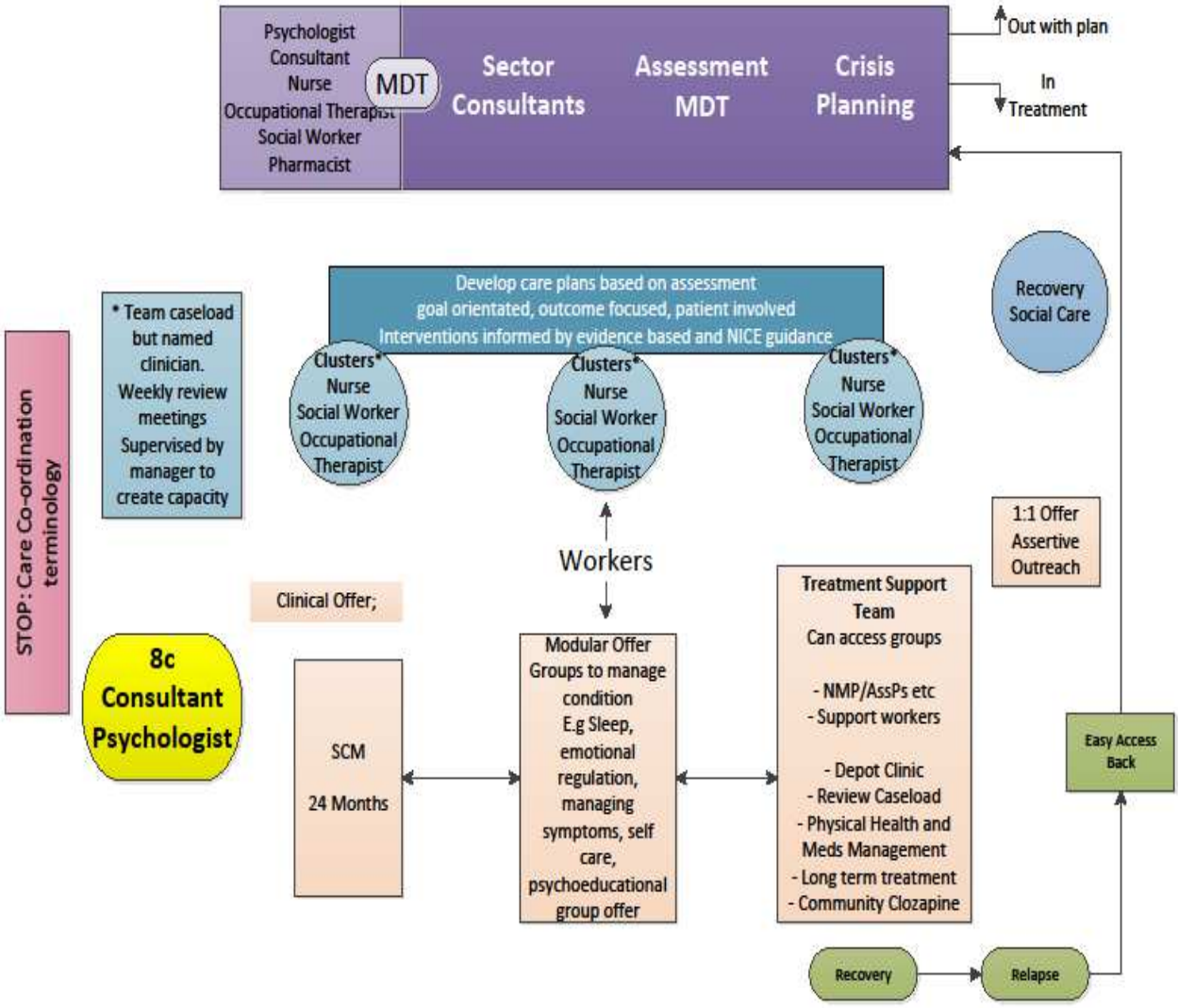
6. Children's Recommendations

- This report has been supported by finance, quality and safeguarding and clinical directors.

- It is recommended that SCB approve the investment in the children's system to commence the transformation and the recurrent amount of required for the investment in the transformation of the mental health system for children

- It is recommended that SCB recognise the opportunity of the invest to save approach in children's mental health brings across the life course and see this as the beginning of such action to deliver strategic outcome set out in Bury Strategies

Appendix 1 – PCFT CMHT Redesign Model

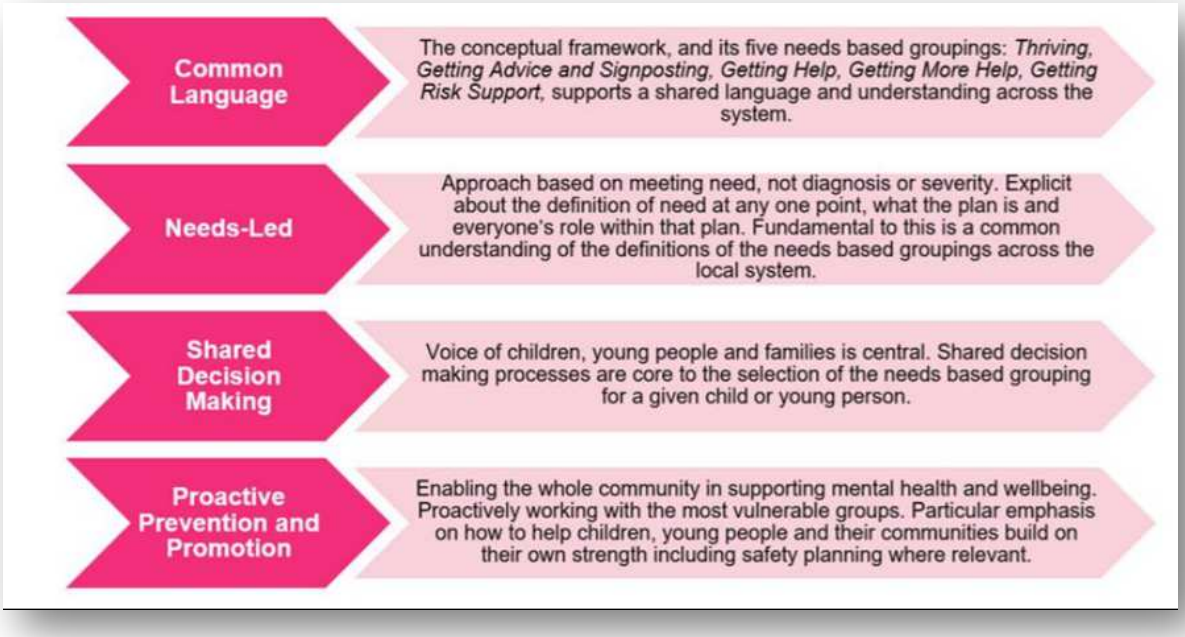


Appendix 2 – iThrive

iThrive

The THRIVE Framework: Replaces tier-based system with a whole system approach. It is based on the identified needs of children, young people (CYP) and their families. It advocates the effective use of data to inform delivery and meet needs and identifies groups of CYP and the range of support they may benefit from. Central to this it ensures CYP and their families are active decision makers.

The Key principles of the Thrive framework are -



What the THRIVE Framework will mean to young people?
No ‘wrong door’, meaning anyone they went to see for advice, whether they were a teacher, a GP or the school lunchtime assistant, would be able to provide support or to signpost a child. Whoever is offering them help would know the best ways to ask for their views about what was important to them and what they wanted to be different, so that there is genuine shared decision making about ways of helping. There will be a particular emphasis on looking at different things the young person, their family and friends could do to help including accessing community groups and resources, from drama, to sport, to volunteering Whoever is providing targeted specific help to address the mental health difficulties would support the young person to evaluate progress and to check that what was being tried was helping. There will be supportive but transparent conversations about what different treatments were likely to lead to, including the limitations of treatment and the possibilities of needing to put in place management of ongoing difficulties as relevant.
THRIVING Around 80% of children at any one time are experiencing the normal ups and downs of life but do not need individualised advice or support around their mental health issues. They are considered to be in the Thriving needs-based grouping. They may however benefit from prevention and promotion and communities implementing the THRIVE Framework should consider how best to support such initiatives at a system level.
Getting advice and guidance
Getting Advice and Signposting includes both those with mild or temporary difficulties AND those with fluctuating or ongoing severe difficulties, who are managing their own health and not wanting goals-based specialist input. Information is shared such that it empowers young people and families to find the best ways of supporting their mental health and wellbeing.
Getting Help comprises those who need specific interventions focused on agreed mental health outcomes. An intervention is any form of help related to a mental health need in which a paid-for professional takes responsibility for input directly with a specified individual or group. The professional may not necessarily be a trained mental health provider, but may be a range of people who can provide targeted, outcomes-focused help to address the specific mental health issue.
Getting More Help is not conceptually different from Getting Help. It is a separate needs based grouping only because need for extensive resource allocation for a small number of individuals may require particular attention and coordination from those providing services across the locality. It is for each community to determine the resource allocation threshold that defines Getting More Help from Getting Help.
The aim of specifying a category of Getting Risk Support is for all partners to be clear that what is being provided is managing risk ONLY. It is important to note that there are likely to be risk management aspects in all groupings. However, in the context of high concerns but lack of therapeutic progress for those in this group, risk management is the sole focus. Children or young people in this grouping may have some or many of the difficulties outlined in Getting Help or Getting More Help BUT, despite extensive input, they or their family are currently unable to make use of help, more help or advice AND they remain a risk to self or others.
The investment need across the children’s system needs to be invested in the Getting advice and guidance and getting help quadrants where there is a need to build support mechanisms for children to access.

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Agenda Item 16

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Consider
Item No	16	**Confidential / Freedom of Information Status**	No
Title	Strategic Commissioning Board Risk Register		
Presented By	Sam Evans, Executive Director of Finance		
Author	Lynne Byers, Interim Risk Manager		
Clinical Lead	-		
Council Lead	-		

Executive Summary

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

This report provides an update in respect of the five strategic risks which are captured on the CCG's Governing Body Assurance Framework (GBAF) which have been assigned to the Strategic Commissioning Board for oversight:

- Lack of effective engagement with communities (level 15);
- Creation of Integrated Care System (year-end 2021 level 12, July 2021 level 16);
- Urgent Care System - Re-design (level 12, at target level);
- Lack of effective working with key partners which influence the wider determinants of health (level 10, at target level); and
- Assuring decisions are influenced by all staff including clinicians (level 10, at target level).

The year- end reviews undertaken in April 2021 have been completed against all 5 risks and the Strategic Commissioning Board is advised that there was a reduction in the level of risk in respect to the Urgent Care Re-design risk.

Risks which have reached their target level will require ongoing management to ensure the risk does not escalate due to future uncertainties.

Further reviews in July 2021 have been completed against 4 of the 5 risks and the Strategic Commissioning Board is advised that there was an increase in the level of risk in respect of the Creation of GM ICS (Integrated Care System), all other risk levels remain unchanged.

Further ratification concluded that two risks are no longer classified as principle risks and will transfer across to the CCG's operational risk register in due course and managed in accordance with the CCG's Risk Management Strategy.

- Lack of effective engagement with communities (level 15)

• Lack of effective working with key partners which influence the wider determinants of health (level 10, at target level);
Recommendations
It is recommended that the Strategic Commissioning Board: • Receive the Strategic Commissioning Board Risk Registers; • Review the information presented; and • Provide a Strategic Commissioning Board opinion on the risks reported and any reflections for future development.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Yes
GB2022_PR_3.1 Lack of effective engagement with communities GB2022_PR_2.2 Creation of GM ICS (Integrated Care System) GB2022_PR_3.3 Urgent Care System - Re-design 2021/22 GB2022_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health GB2022_PR_2.3 Assuring decisions are influenced by all staff including clinicians	

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	☒

Implications						
How do proposals align with Health & Wellbeing Strategy?	The report reflects risks identified to delivery of the Health & well-Being Strategy					
How do proposals align with Locality Plan?	The report reflects risks identified to delivery of the Locality Plan					
How do proposals align with the Commissioning Strategy?	The report reflects risks identified to delivery of the Commissioning Strategy					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	Through the effective management of risk associated with delivery programmes identified to support wider commissioning and delivery agenda, improved outcomes will be delivered.					
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?	None					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
This is a report on risks associated with delivery of work programmes and does not required an EA.						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details						

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

Strategic Commissioning Board Risk Register Report

1. Introduction

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

1.2. The report presents the risk position and status as at **31 March 2021 and 12 July 2021.**

2. Background

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

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

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

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

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

3. Strategic Commissioning Board Risk Register

3.1 There are currently five risks included on the CCG's Strategic Commissioning Board Risk Register.

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

Risks with no reported change

3.3 During the year-end reporting period (April 2021) 5 risks remained unchanged, however during the assessments completed in July 2021, 1 risk has increased in score, with the remaining **4** being unchanged.

- **GB2022_PR_3.1 Lack of effective engagement with communities**

3.4 The year-end risk review resulted in no change to the level of risk and the risk remains at its current level of 15 and did not reach its target level of 10 by the end of March 2021.

3.5 Although good progress has been made there remains a level of uncertainly surrounding the new Integrated Care System (ICS) and although we are moving quickly in terms of the disestablishment of CCGs and new partnership arrangements, there is still a requirement to ensure there is effective engagement as part of the transformation programme.

3.6 The performance and outcomes framework remains in development to ensure health and well- being is built into regular reporting to the Health and Well-Being Board.

3.7 The Bury 2030 Strategy is now complete and evidences strong relationships from all sections of the community and has strengthened working relationships with the new Healthwatch Team.

3.8 A new action for 2021/22 has been identified which reflects the need to ensure the work on the Bury 2030 Strategy and the operating plan continues to include the particular contribution of the OCO throughout 2021/22.

3.9 This risk has been amended to reflect a new target date of March 2022 from March 2021and through further review, additional mitigating actions will be identified.

3.10 At the risk assessment exercise in July 2021, no further changes were reported, however it was agreed that the risk is no longer a principal risk to delivery of the strategic objectives and it would therefore be removed from the GBAF and will be included on the CCG's operational risk register in due course and managed in accordance with the CCG's Risk Management Strategy.

- **GB2022_PR_3.3 Urgent Care – Re-design 2021/22**

3.11 As previously reported this risk reached its target level of 12 in January 2021. The year-end and July 2021 risk reviews saw no further change to the level of risk. Minor updates have been made as set out below and the risk has been included on the 2021/22 GBAF:

- Revised title year from 2020/21 to 2021/22.
- Open actions transferred across with revised due dates.
- New actions considered.

3.12 All aspects of the urgent care phase 1 programme has been delivered. The next phase is to reconfirm next steps to enable progression to phase 2 implementation for urgent care transformation and doing so in the context of the lessons learnt through COVID and the new partnership arrangements through the System Board and the Integrated Delivery Collaborative.

- **GB2022_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health**

3.13 As previously reported, this risk reached its target level of 10 in November 2020 and

there were no further changes to report at either the year-end or July 2021 risk reviews. Whilst it is at target level, the risk and its open actions will transfer across to the 2021/22 GBAF for monitoring until all actions are completed.

3.14 The Health and Well-being Board membership has been refreshed there is a clearer shared understanding of what the neighbourhood team model with resemble within Health and Care and with wider public service.

3.15 Public engagement continues regarding continuous development and implementation of the Bury 2030 Strategy. A specific action, identified through the Strategic Commissioning Board and System Board, in relation to delivery of the transformation programme in health and care in the context of 'lets do it' has been agreed.

3.16 The continued development of the neighborhood team model in health and care with wider public services and communities has also been added as a new action and this was discussed at an inaugural meeting in April 2021.

3.17 In light of all the above, the risk will no longer be considered a principal risk to delivery of strategic objectives and has been transferred from the GBAF onto the CCG's operational risk register for management in accordance with the CCG's Risk Management Strategy.

- **GB2022_PR_2.3 Assuring decisions are influenced by all staff including clinicians**

3.18 As previously reported, this risk reached its target level of 10 in November 2020. The year-end review saw no change to the level of risk and although at target level, it was determined by the risk owner that this risk should transfer across to the 2021/22 GBAF and any further actions identified through subsequent reviews, as there is still uncertainty regarding clinical leadership in the context of the new Integrated Care System (ICS).

3.19 To mitigate against the potential loss of mandated and elected clinical leadership in the borough a clinical and professional senate has been developed which is currently in shadow form, with the expectation to be fully embedded by March 2022.

3.20 On-going joint work particularly around the integrated budget and cost saving plans for 2021/22 remain a priority with close oversight from the Strategic Commissioning Board.

3.21 This risk has not been reviewed as national guidance was awaited regarding the ICS transition arrangements. Additional information has been made available and will be reflected upon to inform the next risk review.

Risks that have reduced in score

3.22 During the reporting periods **0** risks have reduced in score.

Risks that have increased in score

3.23 During the year end reporting period 0 risks have increased in score, however during

the July reporting period **1** risk has increased in score.

- **GB2022_PR_2.2 Creation of GM ICS (Integrated Care System)**

3.24 The year-end risk assessment saw no change to the level of risk, however, in July 2021, the risk was re-assessed and saw an increase from a level 12 to a level 16 against a target level of 8 to be achieved by March 2022.

3.25 The likelihood of 3 (possible) has increased to 4 (likely) as although the white paper was circulated in February 2021 and has provided clarity on the shape of the GM ICS model and the cessation of the CCG further clarity on the GM ICS model was yet to be confirmed (at the time of the risk review).

3.26 All governance arrangements have been designed and are in the process of being implemented as the CCG enters in to the transition phase which will see the creation of the System Board in Autumn which will run in conjunction with the Governing Body and Strategic Commissioning Board to ensure statutory responsibilities continue to be discharged whilst preparing for the future.

3.27 Progress has been made in relation to a bespoke communication strategy to address this agenda and there is a comprehensive programme of briefings with Staff, Trade Unions, Health Scrutiny, Healthwatch, GPs and the VCFA as well as discussions in meetings in public of the Strategic Commissioning Board and Governing Body.

3.28 This risk has transferred to the 2021/22 GBAF.

Risks that have reached their target level

3.29 During the reporting periods **0** risks have reached their target score, however, as at March 2021 three risks remain at their target level.

- GB2022_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health
- GB2022_PR_2.3 Assuring decisions are influenced by all staff including clinicians
- GB2022_PR_3.3 Urgent Care – Re-design 2021/22

Risks recommended for closure

3.30 During the reporting periods **0** risks have been recommended for closure by the risk owner, however two will be transferred across to the CCG's operational risk register.

- GB2022_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health (level 10, at target level);
- GB2022_PR_3.1 Lack of effective engagement with communities (level 15)

New Risks

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

Risks that have not been reviewed in the reporting period

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

- Assuring decisions are influenced by all staff including clinicians

4 Risk Summary

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

	Mar	Mar %	Jul	Jul%
Total Risks on Report	**5**		**5**	
New Risks	0		0	
Risks reduced since last report	0	0.0%	0	0.0%
Risks increased since last report	0	0.0%	1	20.0%
Risk that have reached target level	3	60.0%	3	60.0%
Low Risks (1-3)	0	0.0%	0	0.0%
Medium Risks (4-6)	0	0.0%	0	0.0%
High Risks (8-12)	4	80.0%	3	60.0%
Significant Risks (15-25)	1	20.0%	2	40.0%
Risks reviewed in this period (March 2021 / July 2021)	5	100.0%	4	80.0%
Risks yet to be reviewed (March 2021 / July 2021)	0	0.0%	1	20.0%
Risks to be reviewed for next report (October 2021 due date)			5	100.0%

5 Recommendations

5.1 The Strategic Commissioning Board is asked to:

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

Lynne Byers
Interim Risk Manager
July 2021

Appendix A: Strategic Commissioning Board Risk Register: CCG Summary

Risk Management	Risk Id	Risk Description	Date Risk Identified	Original Risk Score	Risk Last Reviewed	Current Risk Score	Target Risk Score	Direction of Travel	Next Risk Review
GBAF **transfer to CCG**	GB2022_PR_3.1	Lack of effective engagement with communities	28-Nov-2016	20	**31-Mar-2021 12-Jul-2021**	15	10	➖	**Oct-2021**
GBAF	GB2022_PR_2.2	Creation of GM ICS (Integrated Care System)	04-Dec-2020	16	**31-Mar-2021 12-Jul-2021**	15	8	⬆	**Oct-2021**
GBAF	GB2022_PR_3.3	Urgent Care System - Re-design 2020/21	14-Aug-2019	20	**31-Mar-2021 12-Jul 2021**	12	12	➖	**Oct-2021**
GBAF **transfer to CCG**	GB2022_PR_2.1	Lack of effective working with key partners which influence the wider determinants of health	14-Aug-2019	20	**31-Mar-2021 12-Jul-2021**	10	10	➖	**Oct-2021**
GBAF	GB2022_PR_2.3	Assuring decisions are influenced by all staff including clinicians	29-Nov-2016	20	**31-Mar-2021**	10	10	➖	**TBC**

Appendix B: Strategic Commissioning Board: CCG Detailed Risk

Risk Code & Title	GB2022_PR_3.1 Lack of effective engagement with communities				
Risk Statement	3.1 - Because of a lack of effective engagement with communities there is a risk that the public will not access preventative services and make lifestyle changes which supports good health and quality of life	**Assigned To**	**Current Risk Status**	**Direction of Travel**	**Annual profile**
		Will Blandamer			
Current Issues					

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
28-Nov-2016	5	4	20	31-Mar-2021 / 12-Jul-2021	5	3	15	**Oct-2021**	5	2	10	31-Mar-2021

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Patient Cabinet reports to the Governing Body 2. Lay Member for PPI voting member on the Governing Body and Primary Care Commissioning Committee 3. Healthwatch attend PCCC 4. NHSE PPI indicator assessment (an external assessment of the CCG's website/annual reports etc.) 5. Annual 360 Stakeholder Survey 6. New Strategic Commissioning Board in place October 2019 7. Health and Well-being Board (role reformatted)	1. Close working with Public Health to co-ordinate joint working and messages 2. Communications and Engagement Strategy for CCG activity 3. Self-care has an increased focus in the refreshed locality plan 2017 4. Beginning to mobilise locality plan e.g. integrated neighbourhood teams. 5. Neighbourhood engagement models under development 6. Joint Comms & Engagement Team in place. 7. Inclusion of the objectives of the Locality Plan within the Bury 2030 Strategy **8. Strengthened working relationship with the new Health Watch Team**	**Gap(s) in controls**: 1. Engagement Strategy related to the locality plan not yet in place 2. Slow pace in respect of the implementation required to deliver the transformation programme **Gap(s) in assurances:** 1. Unable to monitor the strategy as currently being developed

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
3.1a To ensure the work on the Bury 2030 Strategy and the operating plan continues to reflect the particular contribution of the OCO throughout 2021/22	31-Mar-2022	Will Blandamer		**0%**		Assigned

Risk Code & Title	GB2022_PR_2.2 Creation of GM ICS (Integrated Care System)				
Risk Statement	2.2 - Because of the impending changes which will see the disestablishment of the CCG (2021/2022) in favour of an Integrated care System (ICS). There is a risk that current relationships and progress to deliver the local place-based agenda and outcomes is overshadowed. Resulting in adverse impact on delivery of outcomes at a locality /borough level	**Assigned To**	**Current Risk Status**	**Direction of Travel**	**Annual profile**
		Will Blandamer			
Current Issues	1. NHSE/I released 26/11/2020 consultation signalling creation of ICS (Integrated Care System) and disestablishment of CCG (subject to legislation) 2. Potential for work that has already progressed to address needs across the Bury locality to be derailed within a 'one way' GM approach 3. Potential for loss of locality memory and knowledge 4. Potential that Bury CCG is unable to influence what is retained at a place-based level to deliver best outcomes for the local population 5. Potential loss of mandated and elected clinical leadership in the Bury system				

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
04-Dec-2020	4	4	16	31-Mar-2021 / 12-Jul -2021	4	**4**	16	**Oct-2021**	4	2	8	31-Mar-2022

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Governing Body oversight 2. Strategic Commissioning Board oversight 3. Engagement in Greater Manchester Governance arrangements	1. Local governance structures reflect the proposal 2. Shadow operating of revised governance 3. Approved corporate plan which sets priorities for the borough 4. Bury 2030 strategy 5. Generic Communications and Engagement Strategy which supports the public message	**Gaps in controls:** 1. A clear public communication strategy specific to this agenda **2. Awaiting further clarity on the GM ICS model** **Gaps in current assurances:** 1. NHSE/I outcome of consultation paper and response submissions

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
2.2a Shadow governance arrangements to be designed	**30-Sep-2021**	Lisa Featherstone	**Governance has been designed and in the process of being implemented subject to key outstanding issues from the GM ICS including financial flow, workforce, and clinical leadership.** **Update: July 2021 3.27 All governance arrangements have been designed and are in the process of being implemented as the CCG enters in to the transition phase which will see the creation of the system Board in Autumn which will run in conjunction with the Governing Body and Strategic Commissioning Board to ensure statutory responsibilities continue to be discharged whilst preparing for the future.**	**100%**		Completed
2.2b Bespoke Communication Strategy to address this agenda	**30-Sep-2021**	Will Blandamer	**Progress has been made through briefing to staff, trade union, health scrutiny, health watch, GPs, and VSA as well as public bodies of the Strategic commissioning Board and Governing Body.**	**60%**		In Progress

Risk Code & Title	GB2022_PR_3.3 Urgent Care System - Re-design 2021/22				
Risk Statement	3.3 - Because of long standing pressures on urgent care there is a risk that If the urgent care system re-design (which also takes in to account an element of programme related to GM urgent care by appointment strategy) is not implemented in a timely manner, then the improvements across the wider economy will not materialise, impacting upon patient experience and CCG reputation	Assigned To	Current Risk Status	Direction of Travel	Annual profile
		Will Blandamer			
Current Issues					

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
14-Aug-2019	4	5	20	31-Mar-2021 / 12-Jul-2021	4	3	12	Oct-2021	4	3	12	31-Mar-2021

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Bury System Board 2. Governing Body oversight of performance reports 3. Detailed scrutiny by the Recovery and Transformation Board 4. Primary Care Commissioning Committee oversee the development of the Primary Care Networks and alignment with Neighbourhoods 5. Oversight by the Strategic Commissioning Board (SCB) 6. Clinical/Cabinet/Professional Congress	1. Review of the system wide urgent care facilities 2. Implementation of a suite of initiatives under Transformation Programme 5 (urgent care treatment centre, NWAS Green Car (approved), same day emergency/ambulatory care established) 3. Implementation of the redesign of intermediate care including the development of integrated neighbourhood teams, rapid response to minimise demand in the system 4. Engagement with GM Urgent and Emergency Care Board to explore system wide solutions to address urgent care demand and capacity 5. Working closely with HMR CCG to appropriately deflect A&E hospital attendances **6. Delivery of Phase 1 completed** **7. Reframing of urgent care phase 2 in the light of delivery of phase 1 and lessons learnt through COVID**	**Gap(s) in controls:** 1. Financial sustainability of the Urgent Care Treatment Centre to be determined as part of the urgent care review 2. Understanding the impact of covid **Gap(s) in assurances:**

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
3.3e **System Board and Integrated Delivery Collaborative** to ensure the development of Primary Care Networks is aligned with the Neighbourhood Teams	**31-Mar-2022**	Will Blandamer	**The neighbourhood development team are currently working through the urgent care model priorities in collaboration with the System Board and Integrated Delivery Collaborative**	**90%**		In Progress

Risk Code & Title	GB2022_PR_2.1 Lack of effective working with key partners which influence the wider determinants of health				
Risk Statement	2.1 Because of the significant impact that the Public Sector Services has on health, there is a risk that opportunities to reduce inequalities will be minimised if health does not influence and work in harmony with key partners	Assigned To	Current Risk Status	Direction of Travel	Annual profile
		Will Blandamer			
Current Issues					

Original Risk				Current Risk				Next Risk Review	Target Risk			
Date Risk Identified	Impact	Likelihood	Rating	Current Risk Review Date	Impact	Likelihood	Rating		Impact	Likelihood	Rating	Target Date
14-Aug-2019	5	4	20	31-Mar-2021 / 12-Jul -2021	5	2	10	Oct-2021	5	2	10	31-Mar-2021

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Health and Well-Being Board (reformatted) 2. Governing Body 3. Council Cabinet (key partner) 4. Joint Strategic Commissioning Board 5. Neighbourhood Development Group established	1. Bury 2030 Strategy under development, including supporting strategies and delivery plans (e.g. Housing, Industry, Environment) 2. Refresh of Locality Plan completed emphasising the importance of wider Public Sector Reform on improving health and reducing health in-equalities 3. The Northern Care Alliance (NCA) is the anchor organisation for commissioning social value (e.g. inclusion of social value goals in Provider contracts, support environmental sustainability etc) 4. Council and CCG Operating Plan under development - timeline December 2020	**Gap(s) in controls:** 1. Potential failure of a systematic process to oversee the implementation of a number of high level strategies which together could have a major impact in reducing health inequalities/improving health and well-being 2. Resources required to support the Bury 2030 Strategy is unclear **Gap(s) in assurances:** 1. None identified

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
2.1a Continue with on-going engagement as the Bury 2030 Strategy develops **and is implemented**	**31-Mar-2022**	Will Blandamer	**A management action has been determined through the Strategic Commissioning Board and System Board to deliver the transformation programme in health and care in the context of 'let's do it'**	**70%**		In Progress
2.1b Continue to build the neighbourhood team model in health and care and with wider public services and communities	**31-Mar-2022**	Will Blandamer	**Inaugural workshop scheduled April 2021**	**20%**		In Progress

Risk Code & Title	GB2022_PR_2.3 Assuring decisions are influenced by all staff including clinicians				
Risk Statement	2.3 - Because of the commitment to work as one commissioner there is a risk that the new governance structure fails to recognise the importance of staff and clinicians in shaping the One Commissioning Organisation (OCO) and its decision making	**Assigned To**	**Current Risk Status**	**Direction of Travel**	**Annual profile**
		Will Blandamer			
Current Issues					

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

Existing Assurance	Existing Controls	Gaps in Assurance / Gaps in Control
1. Reports to GB on progress and development 2. GB and Clinical Cabinet sessions - stakeholder engagement 3. Joint Executive Team meetings 4. Primary Care Working Together meetings 5. Monthly EMT meetings with Clinical Directors 6. Bury System Board 7. Strategic Commissioning Board 8. Executive Director in Post (July 2020) 9. System Wide Clinical Reference Group 10. Weekly Primary Care Webinar	1. Clinical Director and Executive Director involvement in all key decision making Committees/Groups / Boards 2. Regular meetings across Health and Social Care to shape the working arrangements for integrated commissioning 3. Staff engagement events ongoing 4. External capacity secured to support OCO transformation which has development of a comprehensive OD programme as a priority area which will ensure alignment across CCG and Council offer. 5. OCO Senior Team restructure now complete 6. Additional Clinical Director (CCG) appointed	**Gap(s) in controls:** 1. Clarity regarding support available to staff during the period of restructure 2. Sub Senior structure still under review **Gap(s) in assurances:** 1. Different decision making cultures 2. Clarification of the committee substructure and role of clinicians in future sub-committees being explored 3. System wide Clinical Reference Group yet to be strengthened

Action	Due Date	Assigned To	'Action' progress update (latest)	% Progress	Status	
2.3a Development of a clinical and professional senate	31-Mar-2022	Will Blandamer	**Currently in shadow form. Inaugural meeting of the Senate expected May 2021.**	**50%**		In Progress

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	06 September 2021	**Action**	Information
Item No	17	**Confidential / Freedom of Information Status**	No
Title	Bury System / Transition Board Meeting		
Presented By	-		
Author	-		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The paper includes the minutes of the Bury System / Transition Board Meetings held on 20 May 2021 and 17 June 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the Minutes of the Bury System / Transition Board Meeting held on 20 May 2021 and 17 June 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 System / Transition Board	20 May 2021	Minutes being submitted for ratification
Bury System / Transition Board	17 June 2021	Minutes being submitted for ratification

BURY HEALTH, CARE AND WELL BEING PARTNERSHIP

Title	**Minutes of the Bury System/Transition Board** **20 May 2021**
Author	Jill Stott, LCO Governance Manager
Version	2.0
Target Audience	Members of the Bury System/Transition Board
Date Created	
Date of Issue	
To be Agreed	17 June 2021
Document Status (Draft/Final)	Final

Document History:

Date	Version	Author	Notes
24.05.21	1.0	Jill Stott	Draft Minutes submitted to W.Blandamer for checking
25.05.21	2.0		With amendments by W Blandamer
17.06.21	2.0		Approved by Bury System/Transition Board
Approved:			
Signature:			.....

Bury System/Transition Board

MINUTES OF MEETING
20 May 2021, 10.30 – 12.45 pm Via Teams **Chair –** Cllr Eamonn O'Brien

Members Present:

Cllr Eamonn O'Brien, Leader of the Council (EO'B)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council
Dr Jeff Schryer, Chair Bury CCG
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council
Ms Lesley Jones
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Ms Pat Crawford, Interim CFO, Bury CCG (PC)
Mr Chris O'Gorman, Independent Chair, IDC Board (CO'G)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation (TR)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Ms Mui Wan, Associate Director of Finance, Bury LCO (MW)
Ms Sam Evans, Executive Director of Finance, NHS Bury CCG and Bury Council (SE)
Ms Lisa Kitto, Interim Director of Financial Transformation, Bury Council (LK)

Others in attendance:

Ms Jill Stott, LCO Governance Manager (JMS) - minutes
Ms Helen Smith, Strategic Performance and Intelligence Manager, Bury Council (HS)
Ms Angie Partington, Head of Business Intelligence, Bury CCG (AP)

Apologies

Apologies for absence were received from:

Ms Julie Gonda, Director of Community Commissioning, Bury CCG/Bury Council
Ms Sheila Durr, Executive Director Children and Young People, Bury Council
Ms Catherine Wilkinson, Director of Finance, Bury Care Organisation
Dr Cathy Fines, Clinical Director, NHS Bury CCG
Dr Daniel Cooke, Clinical Director, NHS Bury CCG
Mr Keith Walker, Executive Director of Operations, PCFT
Dr Kiran Patel, Medical Director, Bury LCO
Ms Lynne Ridsdale, Deputy Chief Executive, Bury Council

MEETING NARRATIVE & OUTCOMES

1.	**Welcome and Apologies**
	EO'B welcomed those present to the Bury System/Transition Board and apologies were noted as outlined above.

2.	**Declarations of Interest**
	Members were asked to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Bury System/Transition Board. None were declared.
3.	**Minutes of Last Meeting (15 April 2021)**
	The minutes of the previous meeting were agreed as a correct record.
4.	**Review of Action Log**
	The Action Log was noted, and updates were recorded within the log accordingly.
	TRANSITION PROGRAMME
5.	**GM ICS Transition**
5(i)	**Update** An update paper, along with appendices of the Farrar report and programme plan, had previously been shared with the group. GL highlighted the main points from these, giving the background to the current position. GL said that he found the White Paper helpful in its suggestion of a move away from a competition model and the commissioner/provider split. He noted its emphasis on integration and of decisions being made at a local level, where "place" means neighbourhood level. Accepting that the White Paper allows more power and resource to a GM level he noted the need for appropriate delegation routes to be agreed to locality level. GL noted some of the main challenges which had come out of a series of workshops: • Agreement on the spatial level for planning and delivering services • Money flows • Accountabilities and governance He also noted the difficulties in moving away from our current models and their legacy, concerns regarding GM's role and tensions between some acute providers. He said that good leadership is needed to override these issues, moving to a focus on people and place and addressing inequalities. GL highlighted Mike Farrar's view that the system needs to be bold in its ambition, even within challenging times; to learn from the Covid work; to continue to make transformational change happen; to align priorities across the system. Mike Farrar's report highlighted that the White Paper gives the opportunity to bring providers into the heart of partnership working. GL went on to list the 3 main programmes of work: 1. Reducing deprivation 2. Primary Care's role in pro-active intervention at place level (linking with wider public sector services) 3. Joining up of community services and adult social care to enable the flow of care into the community GL continued to describe further areas of focus:

- NCA work on which services are provided at what level
- How to link the PCNs into the wider neighbourhood work
- The introduction of a system board for each locality including political and provider members
- A focus in Bury for clinical leadership to be part of the system board
- Consideration on a place-based leader
- Bury's role in playing its full part in the GM ICS
- A desire for 1 board, rather than 2, at GM level
- Staff deployment, with details on which staff would be kept at a locality level
- Acute sector's direct access to national resources in this year and next to address the planned care backlog
- Integrated community services' role in supporting the backlog
- Pooled budgets to remain in place for the next 1-2 years
- Creative use of pooled budgets in influencing the direction of all public services

Responding to the role of PCNs in neighbourhoods KWJ referred to a GM LCO chief officers' meeting, where the link between neighbourhoods and population health was confirmed. The role of PCNs in supporting Primary Care had also been highlighted. KWJ said there was a need to demonstrate the value of the neighbourhood work in supporting core Primary Care services and population health.

GL recognised the huge step forward made around the Integrated Delivery Collaborative (IDC) work. He emphasised that this shouldn't be a hierarchical structure and that the IDC Board should be a part of the Bury system and not reporting into Bury System Board.

EO'B highlighted the role of place-based leadership and the need for devolved powers in our own right.

5 (ii)

Workforce Update

WB had shared a GM briefing update paper outlining the outputs of the GM-wide Workforce Transition Group, along with 5 further documents covering the following areas:

- Staff engagement
- Employment stability principles
- Approach to equality
- FAQs
- GM ICS update discussion

WB confirmed that CCG staff have been in receipt of this information and that regular update meetings involving CCG and OCO staff are taking place.

He explained that there is a presumption that all CCG staff will be employed by the GM ICS, but that most will be deployed back to localities; this will allow the integration work at a local level to continue. He said that work on the employment conditions of staff was underway.

WB said that concerns around the clinical leaders' role in a future model have been escalated to GM.

Responding to the previous 2 updates AS made the following points:

- Is Bury losing staff due to the current instability in the system?

- Funding to support clinical leadership is required
- Benchmarking on the number of and finances for the joint CCG/council roles is needed
- Agrees that 1 board at GM is the preferred option, but has intelligence to suggest otherwise
- Need to make representations regarding the historical shortfall and underfunding in Bury
- Clarity needed on whether the weighting for deprivation will not work in Bury's favour

WB confirmed that staff are not being lost but the situation continues to be monitored. He said there was clarity on the secondments in place, particularly at CCG senior level and that the GM framework is being followed in addressing this issue.

GL commented that people now want to come and work in Bury due to the successful work taking place on integration. He said that joint roles in BI/Comms/Finance/Performance will be protected for the next 2 – 3 years.

Referring to the issue of 2 boards, rather than 1 GL noted that although the White Paper suggests a separate NHS board is required to provide financial accountability the issue could be overcome; this could be done by following Bury's model of having one committee (currently the SCB) which agrees decisions which are then ratified by separate governance routes. He reported that Mike Farrar is leading work around this topic.

EO'B said that pooled budgets encourage joint decision making, as happens in Bury.

5(iii) **Financial Flows**

SE gave a verbal update on current funding information. She thought that this current transition is more challenging than the move from PCTs to CCGs, but that there were positive opportunities as part of the changes.

She explained that the 3 areas for funding from national monies via the GM ICS are:

1. ICS infrastructure
2. Direct payments to providers
3. Direct payments to localities

SE said that the decision making behind this system was the crux of the matter and that it was important to hold on to transformation and innovation across the system.

SE noted that although the GM system overall was in deficit GM NHS broke even at the end of the last financial year and that current plans are for the breakeven position to be repeated this year.

SE said that with regard to the CCG's underfund the plan is to roll forward last year's funding. She said there was opportunity to challenge funding decisions, but that knowledge around the locality's specific needs are required to support this process.

SE reported on the intentions of the Bury Strategic Finance Group which include:

- Transparency between partners
- Avoidance of cross shunting
- Removal of inefficiencies in the system

	SE said that decision making needs to be kept within the locality, that funding approaches have been affected by Covid, with the acute sector requiring more funding early on. She highlighted the need for a collaborative and integrated approach. LJ asked about monies that come into the system via other routes than the GM ICS, e.g additional funding for prevention work. SE said that the System Board allows us to see all funding coming into the system, even if from a number of sources.
6.	**Bury Partnership Transition**
6(i)	**Bury ICS Update** WB provided an update on the progress on transition to the new partnership model previously agreed by the system board. An update paper had been shared with Board in advance of the meeting. WB explained that a number of committees in the system would review the Update on Partnership Arrangements document, which aims to outline what Bury is trying to achieve and Bury's current position. For the purposes of the meeting WB focused on the last part of the document which gave a summary of transition arrangements and their status. These included: • System Board terms of reference to be refined, with an aim to start the shadow board in September (recognising that full authority has not yet been received and that current decision-making arrangements remain in place) • Confirmation that the Integrated Delivery Collaborative Board (IDCB) is not subservient to System Board • Work on the Clinical and Professional Senate and the importance of its leadership role • Health and Wellbeing – a focus on population health and thanks to AS and TR for their leadership in this area • Patient voice – work underway with the new Healthwatch leadership team • CCG closedown – including statutory obligations • NCA-wide footprint – programme plan to be delivered • Shift of recovery work to IDC arrangements – thanks to HH for his support this work • Public Health transition
6(ii)	**Refreshed Locality Plan – Draft** A revised draft of the plan had been shared in advance of the meeting. WB explained that its purpose is to explain what is trying to be achieved in Bury; to act as our strategic framework. He noted the influence of the Let's Do IT strategy and the Covid work in this iteration. WB said the document would act as touchstone for the Health and Care Strategy in Bury. He explained that the Strategic Finance Group would own the financial aspects of the document. WB welcomed any comments back on the revised plan. JS said that a refresh of the plan was a great idea and that there is benefit in spreading our principles across the system. He emphasised the need for the document to speak to all parts of the system. WB agreed that the messages within the document should be simple and clear and the aim is for as wide a dissemination as possible. **Action: Discussion on the Locality Plan to be an agenda item at the next meeting (ref A/05/01)**

6(iii)

Establishing System Board
WB noted the transition arrangements required whilst retaining the safety of current governance and accountability processes. He highlighted the requirement, at some point, for the SCB to recognise the powers of the new System Board.

The meeting agreed to move to the transitional version of the new system board in the autumn, notwithstanding ensuring the formality of governance through CCG board and SCB and cabinet is maintained as required.

6(iv)

Update from the Integrated Delivery Collaborative
KWJ had shared her update paper in advance of the meeting; this described the progress with and development plan for the IDC. Areas highlighted were:

- The IDC's role in enacting the System Board's strategy and ensuring that System Board is assured on its aims
- Flow of business into different forums, with a commitment not to delay decision making
- More detail needed on the delegation parameters into the IDC and to neighbourhoods
- Inaugural meeting of the IDCB held, along with 2 development sessions
- Future development sessions to focus on purpose, the MBA, neighbourhood agreement, connection to the Clinical and Professional senate
- Programme work on successes and future plans to be scheduled
- Outcomes work, ensuring that all programmes contribute to these
- Enablers work on their role in supporting delivery
- New groups to be set up, led by LD/HH and Kiran Patel
- Workforce update to follow at a future meeting, with this being led by LD; key activities recognised at GM level
- Management of financial pressures

With reference to the above WB recognised the value of conversations already taking place across the system. He said the next stage would be to specify what the new transformation programmes are and then to invite enablers to make their contribution to achieving the ambition.

WB thanked CJ for her work on quality assurance in the system.

TR confirmed that CJ has joined some of the NCA's quality and safety committees.

CJ said that work in this area was being done at a place level and suggested that TR joins a meeting with her, KWJ and LD.

CJ confirmed that descriptions for quality and safety standards in the new system will soon be available. She suggested that a future update on this comes to a future meeting.

Action: Information on quality and safety standards to come to a future Board as part of the regular updates (ref A/05/02)

GL noted the original intention was that the integration of community services would reduce demand on the acute sector but noted that this won't happen over the next 2 years due to the backlog in the system.

He said there needed to be:

1. Clarity on how integrated services will help planned care
2. Recognition that public services as a whole need to be part of the integration of community services, which will lead to a financial benefit for the system, e.g. high-cost placements

6(v)	GL suggested cohort analysis on financial flows for areas such as housing/schools/the criminal justice system. KWJ alerted the group to MW's new role in the community services division in the NCA; she cited this as a good signal of trust and collaboration across the system. SE recognised the challenge over the next couple of years in measuring what transformation is delivering, e.g. the effect on elective rates. She said it was important to have access to additional monies for the backlog and not to use our own resources to address this work.
6(vi)	**Terms of Reference for IDB** The latest draft of the ToR for the IDB had been shared previously. CO'G explained that the LCO's mutually binding agreement has been rolled over until the end of June; this will be revised and the ToR become a schedule within it. CO'G welcomed any comments on the document, noting that those already made have been included in this version. He said that IDB will be asked to approve the ToR before ratification by this Board. **Update from the Neighbourhood Team development programme** A paper had been shared in advance of the meeting and KWJ noted that this will be a fuller agenda item at the June meeting; a suite of documents to support this session was described in the paper. KWJ explained that to date the focus of the INTs has been on the active case management (ACM) referrals. Her paper also described the impact of the social prescribing work. She explained that the next focus will be on phase 2, population health needs, led by LD and Kiran Patel. Information highlighted from the paper included: • Proposed operational model • Each neighbourhood to have its own plan by the end of September • Cordis Bright have contacted LD regarding the successful work described in their evaluation, with a request that this is shared with the London borough of Hackney. GL praised the remarkable progress that has been made within the neighbourhood work. He suggested that a variety of methods should be used to engage with local people, e.g. engaging with those living with long-term conditions and seeking opinions from those with lived experience. LD said that it was critical to engage with local people; she cited the work of the INT and clinical group, which has focused on how to obtain the patient voice. She gave examples of some of the engagement work happening in the neighbourhood groups and urged members to visit the neighbourhood group meetings if possible: • Prestwich – engaging with "what matters to you"? • Whitefield – plans around walking and tailoring this to different parts of the population • North – focusing on dementia and engaging with dementia group representatives LD described the engagement work within neighbourhoods as emergent, innovative and embedded. WB said there were 2 aspects to the neighbourhood work: building and developing the teams and working on the lived experience outputs and their influence on the model.

	KWJ referred to the success of the strengths-based training, which 880 staff have taken advantage of. She said that there has been recognition by health staff in particular of the benefits this offers. She noted the ethnographic training which is also in train.
7.	**Bury Partnership Transition – Clinical and Professional senate** **Bury Proposal – update** HH informed the group of the work currently in progress in this area; he explained that WB has offered to capture current thinking in a paper which will be shared over the next few days. He described the dual track process being employed and reported that workshops are planned for July and September. HH explained that the plan is for an interim senate to meet in the near future. He welcomed any feedback on the plans. EO'B noted that the clinical and professional senate would be an integral part of the new system. **The meeting agreed to move to an initial meeting of key stakeholders in July to help co-design the transitional clinical senate to be operational by the end of the calendar year**.
8.	**Public Health System Reforms** LJ had shared a paper with the Board alerting them to the national and local changes in the PH system. Highlights included: • Introduction of a cross-government ministerial board on prevention • Learning from the Covid experience – success in being locally-led and nationally supported • Health inequality work embedded in Bury, putting us in a good position for future modelling • GM DsPH are developing a framework Responding to TR's question on whether LJ sees the reforms as a positive move she expressed concern at the possibility of fragmentation at national level; however, she said that the local team will work in a pragmatic way to ensure a locally-led system, drawing on available expertise. EO'B offered the system's support to LJ and colleagues.
	SYSTEM BOARD
9.	**Bury Local Care Approach: Final Evaluation**
	The Cordis Bright final evaluation report had been previously shared with Board. Due to a shortage of time WB suggested that the item be deferred. He noted, however, that the Bury system has already moved beyond the recommendations of the report.
10.	**Update on the Systems outcome framework**
	HS and AP joined the meeting for this item. HS presented on the Bury Performance Framework Hierarchy, which outlined the monitoring of outcomes of the 7 key CCG/council indicators. HS noted that currently the provider elements of the system are not incorporated into the work and that discussions with KWJ and her team would need to take place to rectify this. HS said that the system would provide both formal reports and self-serve dashboards. AP then gave a brief demonstration of the reporting system; via a cog system this aims to show the status of the whole system on one page. The functionality is available to then drill down into individual areas in much greater details.

	AP emphasised that this is a bespoke system which can be tailored depending on what information is required. The demonstration was well received; EO'B said he was impressed by its adaptability. KWJ said there was a need to tie in the outcomes conversations with the IDC and System Board into this work so that there is alignment across the system. She said the June workshop focusing on outcomes will be a critical session, where we confirm as a system what we are trying to achieve. SE said that there was good information coming from the Tableau system, but that consideration needs to be given to which parts of it we use, to whom we provide the information and the best way of using risk stratification. She suggested that we don't lose sight of the work underway at North Manchester. HS explained that there is a mapping exercise underway, aimed at identifying which reports are needed and where. MW reported on her work with the BI team around the urgent care work stream; this had shown that all self-referrals at Fairfield had come from one neighbourhood and this allowed more focused work on the causes of this. She said that different neighbourhoods may require bespoke information to use in the best way for them. EO'B suggested that a focus on how to use performance data could be a focus for a future System Board meeting.
11.	**Closing Matters**
	Change to schedule of this meeting As GP colleagues (Dr Patel, Dr Fines, Dr Cooke) are unable to attend meetings on a Thursday due to their clinical work HH asked if the schedule could be re-arranged. EO'B said that options to amend or rotate the days for this meeting would be looked at, hopefully in time for the next Board. **Action: schedule for this meeting to be reviewed (ref A/05/03)**

Next Meeting	**Date: 17 June 2021, 10.30-12.30pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

BURY HEALTH, CARE AND WELL BEING PARTNERSHIP

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25.06.21	2.0		With amendment by W Blandamer
19.08.21			Approved by Bury System/Transition Board (no meeting in July)
Approved:			**19.08.21**
Signature:			.....

Bury System/Transition Board

MINUTES OF MEETING
17 June 2021, 10.30 – 12:45 Via Teams **Chair –** Cllr Eamonn O'Brien

Members Present:

Cllr Eamonn O'Brien, Leader of the Council (EO'B)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council (AS)
Ms Lesley Jones, Director of Public Health, Bury Council (LJ)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Mr Chris O'Gorman, Independent Chair, IDC Board (CO'G)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation (TR)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Ms Mui Wan, Associate Director of Finance, Bury LCO (MW)
Ms Sam Evans, Executive Director of Finance, NHS Bury CCG and Bury Council (SE)
Mr Ian Mello, Director of Secondary Care Commissioning, Bury CCG (IM)
Ms Catherine Wilkinson, Director of Finance, Bury Care Organisation (CW)

Others in attendance:

Ms Jill Stott, LCO Governance Manager (JMS) - minutes
Ms Vicky Clark, Assistant Director Public Service Reform, Bury Council (VC)
Ms Cath Tickle, Commissioning Programme Manager, Bury CCG (CT)

Apologies

Apologies for absence were received from:

Dr Jeff Schryer, Chair Bury CCG
Ms Sheila Durr, Executive Director Children and Young People, Bury Council
Dr Cathy Fines, Clinical Director, NHS Bury CCG
Dr Daniel Cooke, Clinical Director, NHS Bury CCG
Mr Keith Walker, Executive Director of Operations, PCFT
Dr Kiran Patel, Medical Director, Bury LCO
Ms Lynne Ridsdale, Deputy Chief Executive, Bury Council
Ms Sian Wimbury, Network Director of Operations: Mental Health, PCFT

MEETING NARRATIVE & OUTCOMES

1.	**Welcome and Apologies**
	EO'B welcomed those present to the Bury System/Transition Board and apologies were noted as outlined above.
2.	**Declarations of Interest**

	Members were asked to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Bury System/Transition Board. None were declared.
3.	**Minutes of Last Meeting (20 May 2021)**
	The minutes of the previous meeting were agreed as a correct record.
4.	**Review of Action Log**
	The Action Log was noted, and updates were recorded within the log accordingly.
	TRANSITION PROGRAMME
5.	**GM ICS Transition**
5(i)	**Update** GL referred to the ICS design framework document which had been released by NHSE/I on 16 June; he explained the context of the document and some of the background intentions around collaborative working, taking positives from the response to Covid and working at pace. He also outlined some of the challenges within the system, including increased waiting times, pressures on Primary Care, health inequalities and pressures on staff. He noted the ongoing commitment to joined up services and getting the maximum value for money across the system. **Action: link to the ICS Design Framework document to be share with Board (ref A/06/01)** From the document GL highlighted the proposed governance arrangements, which include a separate GM Partnership Board and an NHS Board. He explained that the Partnership Board will lead on strategy and will consist of members from the 10 GM localities. It will be led by NHS and local government leaders and will be charged with developing a health and care plan, including Children's and adult social care. The NHS board will be responsible for a health plan only and will be responsible for the allocation of resources to providers and place. This structure will allow commissioning at a place level. GL said that these new proposals did not preclude ICS monies joining with council funding, though further detail on the required parameters for pooled budgets is yet to be confirmed. **GM Programme of Work** GL reported on the position statement submitted to GM from all 10 localities and listed a core set of proposals from them: • All 10 localities to have their own local system board • Clinical/political/provider leadership to be part of the new boards • Integrated delivery collaboratives (IDCs) to be part of each locality system • Neighbourhoods to be at the core of the work • Pooled budgets to be retained • All localities to have a place-based lead (taking delegation from the GM ICS) • Relationship around accountabilities and local plans to be agreed

Action: An options paper on the place-based lead for Bury to come to a future meeting (ref A/06/02)

GL explained that discussions are still taking place on funding flows into localities, but that there is still the option for section 75 agreements at a locality level.

EO'B noted that there is still the option to keep close relationship between the new NHS board and councils and that the collaborative approach can continue in this new structure.

Responding to CO'G's question on the membership of the new boards GL said that the board would be constituted once the appointment of the chair, chief executive and chief finance officer have taken place. He said that discussions continue around the relationship between the partnership board and the NHS board.

5 (ii) **GM Founding Finance Principles**

SE had shared a paper on proposed finance principles in advance of the meeting. She explained that although this had already gone through a number of key committees this is still an iterative document. She highlighted that the decision-making process is key to this area and that funds should follow function.

She highlighted that:

- The intention is to reduce the number of transactions
- There will be 1 NHS ledger and that the ICS will need to produce 1 set of accounts
- How to get flows into localities is to be confirmed
- There is flexibility around section 75 arrangements
- The intention is not to lose what we already have in GM, but to build on this work

SE agreed to bring regular updates to this Board.

Responding to AS's question around retaining the financial status quo in order to avoid de-stabilisation in the system, SE agreed that it was likely that monies would flow as currently for the next year of so.

SE said the challenge would be to manage funding within a cost envelope and to be able to move funds across localities without a detrimental effect on any one locality. She said that decision making and the focus on addressing health inequalities are at the forefront of this work.

GL agreed with these sentiments, recognising the need to deal with pent up demand and to balance budgets. He said that this would not stop the development of work in communities and that a long-term financial strategy will be needed to ensure funds are directed where needed.

GL noted that it takes time for cashable reductions in demand to be realised as part of any transformation programme.

Responding to EO'B's query on the opportunity to test an element of our principles in practice, SE gave an explanation around the elective recovery fund and how these national additional monies could be used as a system. She confirmed that a paper on these proposals is due to go to the Strategic Finance Group.

	CW supplemented this explanation with an update on how Bury (Fairfield Hospital) is supporting NCA system priorities in its use of theatres. KWJ added that as part of the community services work INTs are looking at managing demand by looking at alternatives to surgery, e.g. MSK work, rehab programmes EO'B noted that it was important to have this type of conversation now so that opportunities are flagged early for future work across the system.
6.	**Bury Partnership Transition**
6(i)	**Bury ICS Update** WB had shared a slide deck in advance of the meeting giving the latest updates from a GM and Bury perspective. As GL had updated on the main GM developments WB concentrated on the local picture. He outlined progress on the committees within the new Bury architecture and explained that a wider framework for place-based work is being developed. WB explained that the governance around the new Locality System Board will be determined by the GM ICS model, but that it will replace the current SCB, CCG governing body and system board. He noted the change in membership and its future function and role, as a strategic forum and a place-based budget holder. WB noted the IDC Board's role in overseeing the operational elements within the system. He reported on an SCB development session scheduled for 5 July, designed to look at the transition of SCB functions into the new architecture. WB described progress around the Clinical and Professional Senate, referring to a vibrant network of colleagues who will inform decision making. Other areas highlighted were: • Further guidance received on employment commitments, with an expectation that CCG staff will move into the GM ICS, but be deployed back into localities • Clinical leadership roles to be included in the above • Paper due to go to SCB on patient engagement and Healthwatch's support to the patient engagement agenda and lived experience informing work on a systematic basis • CCG closedown, including a celebration of its achievements WB highlighted the work on operational assurance within the "pillars" slide. TR noted the need to avoid duplication, but to do this work as a system, whilst still fulfilling statutory commitments. TR reported that he had been part of some positive discussions on this topic. Referring to an issue that had arisen at Digital Board LD alerted the Board to the issue of system versus organisational decision making for some of the enabler programmes. WB noted that enablers are at different stages of maturity and TR suggested drafting an agreed set of principles in order to overcome some of these issues. LD agreed that this would be a good way forward.
6(ii)	**Refreshed Locality Plan – final version** The final version of the plan had been shared with Board; this now includes a section submitted by the Strategic Finance Group. WB suggested that the plan acts as a touchstone for the system and informs our way of working and our development of partnership working. **The Bury Locality Plan was approved by the Board**.

6(iii)	**Bury Locality Board – draft terms of reference** WB highlighted the political, non-executive and senior clinical leadership which will make up this new committee. He noted the need to avoid de-stabilising governance structures this year by running a transition governance system alongside the current one in the short-term. He explained that the outputs of the SCB development session will inform the terms of reference and that a draft version of these will come to next Board. **Action: Locality System Board ToR to come to the next meeting for review (ref A/06/03)**
6(iv)	**Update from the Integrated Delivery Collaborative** KWJ had shared her update paper with Board in advance of the meeting. She noted some of the main highlights from it: • The IDC's work on its purpose, values and principles and the need to connect the enablers into this piece • The IDC's role in being able to achieve what individual organisations can't do singly • Work on the broader place-based offer and a target operating model, working in conjunction with Vicky Clark and Lynne Ridsdale • "show and tell" sessions planned for the transformation and enabler programmes • Stocktake on recovery plans, including a review of economic requirements • Work on the critical success factors for the IDC • 2 x outcomes workshops scheduled, looking at population health, effectiveness, economics • New committees to be convened in July allowing for the necessary relationships and an environment for productive conversations to take place **Outcomes Framework** KWJ explained that this is in development at present and will comprise 2 parts: 1. Operational assurance on community services, including adult social care 2. Total system assurance, including the quality and safety of services EO'B highlighted the IDC's role as being at the heart of the system and WB paid tribute to the leadership of CO'G and KWJ and their embracing of the move from LCO to IDC.
6(v)	**Clinical and Professional Senate -update** HH updated the group on the latest developments of this group, explaining that an interim committee is due to start in September, with a final group in place by Jan/Feb 2022. He noted the networks that are being developed as part of this piece of work. HH reported on a workshop planned for 26 July, where the intention is to: • Re-affirm roles, networks and supporting networks • Agree the senate's membership • Agree a process for mandating roles HH listed those invited to the workshop and asked for amendments/additional names to be emailed to him.
6(vi)	**Quality Assurance** CJ gave a verbal update on the background to this piece of work, explaining that a report on system assurance is due to go to Integrated Delivery Board on 23 June. She said that there

	was now an opportunity to do things differently, noting that statutory functions might not necessarily continue to sit in localities. CJ highlighted the role of the VCFA and Healthwatch in supporting the perspective of the patient experience in this work. She said that conversations on this topic are taking place between partner organisations and that a paper will come to the next meeting of this Board. **Action: System quality assurance paper to come to this Board on 15 July (A/06/04)** GL highlighted the work around children's safeguarding arrangements, where a community of practice approach is being utilised. He said work will be taking place over the next few months to ensure formal accountabilities are in place before the cessation of CCGs. He suggested that the work is fed into this Board. WB said there was work to be done on a range of statutory functions and where these would fit in the new architecture. Summing up, EO'B noted that there is a clear vision and direction of travel in Bury; he thanked everyone for their hard work and commitment in progressing this.
	SYSTEM BOARD
7.	**Bury Local Care Approach: Final Evaluation**
	The Cordis Bright final evaluation report had been previously shared with Board. WB gave the background to this work and its context within the evaluation of GM around the effect of the transformation fund and transformation programmes. WB noted the key theme in the document (in the context of the pandemic) was the quality of partnership working, especially that within neighbourhoods. He said it was important to capture any learning and that the document was here for receipt and acknowledgement. KWJ said that the strategic issues highlighted in the document are being picked up as part of the IDC development programme. She said the report had acted as a validation tool and would be used to inform the next stage of strategic development. TR reported that on the regular system calls with Raj Jain Bury is highlighted in a positive way, specifically for its responsive approach. Via the Chat facility AS noted the work the NCA has done on health inequalities and waiting lists is exemplary. Via the Chat facility LD reported that Cordis have now asked us to share our practices and development in INT's with systems in other parts of the country, referring to the Bury model as "one of the furthest developed in GM".
8.	**Elective Care Work - update**
	IM and CT jointly presented on the Elective Care transformation work, setting this in the context of the impact of Covid, increased waiting lists and increased health inequalities. Areas highlighted were: • Programme objectives • Series of workshops held on scoping, building back better and Let's Do It • Roadmap for June – August • Governance and the establishment of the Bury Advisory Group, acting as a critical friend • Key role of the joint communications group for collective messaging • Last 10 patients review, supported by NHSE/I and the integrated neighbourhood teams

- Focus on the patient experience and what outcomes an individual would want
- Alternatives to a medicalised approach, including pathways to social prescribing
- Working towards a model of co-production which can be scaled up

Responding to KWJ's question around short-term solutions within the acute sector IM confirmed that quick wins around MSK opportunities are being investigated.

Responding to GL's questions IM confirmed that:

1. Data is available for our different communities, including information on waiting lists, wards and ethnicity
2. Conversations are underway with Sajid Hashmi so that a strategic approach to the residents' lived experience is included in this work
3. Alternatives to non-medical admission are being investigated via an MDT approach; PCNs are working on this area

TR asked about the body of evidence on behaviour change and the use of coaches. CT explained that the team were working closely with Public Health colleagues on the prevention agenda. TR said he would share the link to the King's Fund podcast on this topic.

Action: TR to share a King's Fund podcast around behaviour change (A/06/05)

LD said there was a need for joined up conversations around system finances, noting the reliance on neighbourhoods in this proposed model. She noted the challenge around ethnographics and behaviour change and the need to expand this work.

LD suggested that a joint system and financial discussion is required in order to agree priorities as a system. She suggested further detail on this may be available following the scheduled "show and tell" sessions.

WB placed this work as sitting alongside the NCA's work on technical efficiency.

9. High Level Target Operating Model for Health and Care Neighbourhoods

A diagram on the intentions behind the place-based co-ordination of the wider neighbourhood model work had previously been shared with the group. VC joined the meeting to highlight some of the aspects of this work, including:

- Joining of public services in one place
- Consistency of language
- Collective community action including ward members and community champions
- Differing levels of intervention as and where required
- Creation of a person-centred, strengths-based framework
- Multi-agency approach
- Building on community resources
- Cohort analysis

Target Operating Model for Health and Care Neighbourhoods
LD's update paper on this topic had previously been shared with Board. Main points included:

- Components of the TOM
- Expansion of the INTs
- Testing out with wider staff groups
- Development of the neighbourhood task and finish group into a formal committee in July
- Further work being developed on an outcomes framework and KPIs across neighbourhoods
- Testing around the MH PCN roles and Public Health community grants and decision making

	LD confirmed that a more detailed paper would be available at the next meeting. **Action: Paper on the TOM for health and care neighbourhoods to come to the next meeting (A/06/06)** SE noted the opportunities and challenge of roles in the PCNs and wider and the need to attract more people into this area. GL noted the key aspect of case co-ordination, saying that if there are challenges around participation these need to be reported to this Board. LD noted that the use of the Primary Care contract in neighbourhoods will be an important aspect of this work. She confirmed that a benefits realisation proposal is due to be reviewed by the Strategic Finance Group, before being socialised more widely through the system.
10.	**Closing Matters**
	None discussed.

Next Meeting	**Date: 15 July 2021, 10.30-12.30pm, via Teams**
Enquiries	e-mail: jill.stott@nhs.net Tel: 07770 896 521

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