AGENDA FOR HEALTH SCRUTINY

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To: All Members of Health Scrutiny

Councillors : J Grimshaw, S Haroon, M Hayes, T Holt (Chair), K Hussain, C Tegolo, S Walmsley, C Birchmore, R Brown, J Lewis and T Pilkington

Dear Member/Colleague

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Tuesday, 18 January 2022
Place:	Council Chamber, Town Hall, Bury, BL9 0SW
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 MINUTES OF THE LAST MEETING *(Pages 3 - 12)*

The minutes from the meeting held on 16th November 2021 are attached for approval.

4 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

5 UROLOGY RECONFIGURATION *(Pages 13 - 30)*

Report from Catherine Tickle, Commissioning Programme Manager attached.

6 HEALTH SCRUTINY TASK AND FINISH GROUP - PLANNING AND LICENSING

Councillor Holt to provide an update from the Health Scrutiny Task and Finish Group - Planning and Licensing of takeaway's.

7 BURY INTEGRATED CARE PARTNERSHIP AND LOCALITY PLAN *(Pages 31 - 72)*

Will Blandamer, Executive Director of Strategic Commissioning to present at the meeting. Reports attached.

8 COVID-19 UPDATE

Will Blandamer, Executive Director of Strategic Commissioning to provide a verbal update at the meeting.

9 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

Agenda Item 3

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 16 November 2021

Present: Councillor T Holt (in the Chair)
Councillors J Grimshaw, M Hayes, K Hussain, C Tegolo, S Walmsley, C Birchmore, R Brown, J Lewis and T Pilkington

Also in attendance: Will Blandamer, Executive Director of Strategic Commissioning
Adrian Crook, Director of Adult Social Service and Community Commissioning
Jane Case, Programme Manager, Children's CCG
Jon Hobday, Consultant for Public Health
Chloe Ashworth, Senior Scrutiny Officer

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: Councillor S Haroon

HSC.1 APOLOGIES FOR ABSENCE

Apologies for absence are listed above.

HSC.2 DECLARATIONS OF INTEREST

Councillor Pilkington declared an interest due to being employed by Manchester Foundation Trust.

HSC.3 MINUTES OF THE LAST MEETING

The minutes of the meeting held on 16th September 2021 were agreed as an accurate record.

Matters arising: Councillor Walmsley requested that a meeting with the Chair of Licensing, Planning and Health Scrutiny takes place prior to the next meeting to look if there are any positive steps we could take to tackle the obesity crisis.

Councillor Holt requested that Licensing on Gambling Establishments be brought to a future meeting.

HSC.4 PUBLIC QUESTION TIME

There were no public questions

HSC.5 MEMBERS QUESTION TIME

There were no members questions.

HSC.6 MENTAL HEALTH UPDATE

Adrian Crook, Director of Adult Social Service and Community Commissioning and Jane Case, Programme Manager, Children's CCG provided an overview of the report.

It was reported that the impact of the pandemic has influenced Adult and Children and Young people's (CYP) emotional wellbeing and mental health nationally, regionally, and locally. This has brought to light system pressures that were previously being managed. This briefing is to update on the developments over the last 10 months regarding mental health provision for Adults and CYP in Bury and the proposed series of interventions that will start to address the system redesign in accordance with the Bury Mental Health Thrive framework.

Some of the developments that have taken place over the last ten months are as follows:

Children's and Young Peoples Mental Health

- The establishment of a digital offer for children and young people's wellbeing (Kooth) providing online counselling provision and support
- The standing up of emotional health and wellbeing practitioners in 9 of the 13 High schools delivering in Bury. Offering 1-1 support and guidance
- Launched the Bury early attachment service
- Utilised the creative care kits from GM
- Established a waiting list initiative to support the early years neurodevelopmental pathway
- Linking into the wider Youth participation BEE Heard Children's and Young Peoples Voice At the Circle of Influence * session Children and Young People told us that:
- They wanted more provision
- They didn't want long waiting lists
- They wanted more visible support, preferably in school

Adult Mental Health

- Development of the **"Thriving In Bury"** Mental Health brand and a dedicated Mental Health and Wellbeing directory of services on the Bury Local Authority directory website along with a communications plan.
- Launch of the Bury **"Getting Help Line"** via a local VCFE provider (Early Break) which has supported over 500 people with their Mental Wellbeing and provided person centred resource packs and established pathways into universal primary, community and secondary care services.
- Development of a Mental Health education programme.
- Mobilisation of the **"Urgent Emergency Care by Appointment Service"** to support the wider urgent care pathway and is operational 7 days per week from 8am – 9pm. Based at Fairfield General Hospital and excepting direct referrals from GP's.
- Launch of the "**Bury Peer Led Crisis Service"** in April 2021, delivered by a local VCFE provider (BIG) and is operational Monday, Thursday and Friday 6pm-11pm. The service has made a real difference to the lives of those experiencing Mental Health Crisis and is projected to support over 200 people by the end of March 2022.

- A review of the **Community Mental Health Team** led to a number of changes to improve operations and links with wider pathways.
- The Launch of a number of Mental Health and Wellbeing digital services in partnership with Greater Manchester Health & Social Care Partnership (GMHSCP) to support vulnerable groups such as BAME, LGB. The Silver Cloud digital therapy is now offered with support from Healthy Minds therapists in Bury.
- Local VCFE partner "The Creative Living Centre" made **1424** welfare calls during lockdown.
- Launch of the Pennine Care Foundation Trust (PCFT) 24/7 Crisis Helpline to support known and unknown service users who are experiencing a crisis. Pathways have been established with emergency services via the GM Clinical & Assessment Service (CAS).

Councillor Birchmore asked if there is a pattern in people who are at risk of suicide and if the Council are working with local voluntary organisations.

In response Jon Hobday, Consultant for Public Health advised that Rebecca Jackson who runs the big Fandango in Bury is part of the Suicide Prevention Group. Statistically Bury has not seen a significant rise, but what we have seen is an increase in factors that are seen as contributors such as self-harm and mental health. We work with many local voluntary organisations and training offers. We also work with BIG who run a peer support crisis group and the Creative Lining Centre.

Councillor Walmsley raised a query regarding two recent inquests that are happening and the mental health support they did not receive. She asked for reassurance if we are getting our mental health offer right yet as there are many examples of restricted or no opportunity for access.
Adrian Crook, Director of Adult Social Service and Community Commissioning, advised it is locally and nationally accepted that mental health services have suffered due to underfunding. Money is being re-invested incrementally and therefore change will take time.

Councillor Pilkington advised looking for mental health support proves difficult for many residents as triage is carried out over the phone. He asked if it is going to be possible to have face to face support for those who need it.

Adrian Crook, Director of Adult Social Service and Community Commissioning advised the majority of triage is done over the phone but there are also face to face options if the telephone appointment is not suitable.

Councillor Pilkington questioned that service providers tend to shy away from supporting individuals who identify with ASD or ADHD due to neurodiversity, what is being done to assist this.

Jane Case Programme Manager, Children's CCG advised we have a strong parents forum who hold Bury Council accountable and using lived experience to shape support.

Councillor Grimshaw advised that many residents have concerns around accessing a GP.

In response it was advised around 60% of appointments are now face to face but an update report on GP access can be brought back to a future meeting. The new way of accessing a GP is viewed by many as good but unfortunately it is proving difficult for others.

Councillor Lewis questioned if walk in centres will be opened soon as they are often the first point of call for people in a crisis. Councillor Holt further questioned what the journey is for a person in crisis.

Adrian Crook, Director of Adult Social Service and Community Commissioning advised that wherever they present there will be an element of triage and then pointed into the right direction. If a need is lower, for example needing healthy minds and healthy young minds the wait is longer.

Councillor Brown asked what sickness levels are like due to the pandemic.

Adrian Crook Director of Adult Social Service and Community Commissioning advised that the GP model has been changed to limit people in a GP practice.

Councillor Walmsley questioned when the GP app will be up and running.

Will Blandamer advised we will get an update on the app for GP's including requesting a prescription on this app.

It was agreed:

1. An update report on GP access can be brought back to a future meeting.
2. An update on the app for GP's to be brough to a future meeting
3. Adrian Crook and Jane Case be thanked for their report.

HSC.7 SUBSTANCE MISUSE UPDATE

Jon Hobday, Consultant in Public Health did a presentation and provided an overview of the report. It was reported that substance misuse is a major public health issue and can increase health inequalities.

Councillor Birchmore had questions regarding the bed for every night project. Jon Hobday advised he will feed this information back to the homeless team.

Councillor Pilkington questioned what happens to monitor retail on nitrogen oxide canisters who they sell too and if this acts as a gateway to further drug misuse.

Jon Hobday advised he is not aware of any evidence but will look into this in more detail. Early Break work on the education side of drug misuse to understand why they use it. The availability issue is often due to it being available online but locally we can pick this up with health colleagues.

Councillor Hayes questioned if information has since come out from the spending review. Jon Hobday advised that Bury has an extra £290,000

It was agreed:

1. Jon Hobday advised he is not aware of any evidence that nitrogen oxide leads to further drug misuse but will investigate this in more detail.
2. Jon Hobday to pick up what can be done further to monitor the sale of nitrogen oxide locally and will pick this up with health colleagues.

HSC.8 SPURR HOUSE CLOSURE UPDATE

Adrian Crook, Director of Adult Social Service and Community Commissioning provided an update on the closure of Spurr House. It was reported that following a period of public and staff consultation, on 21st July 2021, Council Cabinet supported the recommendation to close Spurr House as part of a wider saving and transformation programme with the Council's Local Authority Trading Company; Persona Care and Support Ltd. Savings achieved by this action will support delivery of the savings required by the Council.

Councillor Grimshaw voiced her concerns on the closure of Spurr house, the process of informing people and where the residents are now.

Adrian Crook Director of Adult Social Service and Community Commissioning advised the decision was taken by the Cabinet. The facility was only for short stays and the unit was regularly half full for several years therefore it drew the conclusion we are no longer able to fund it.

The Service was commissioned by the Council and was no fault of Persona that it was not full, this is a factor of insufficient demand for residential care and the demand of nursing care not provided by Persona is increasing.

Councillor Lewis advised that the first hearing of the closure of Spurr House was by the employees of Spurr House. As we now have a large facility laying empty what is next for the building.

Adrian Crook Director of Adult Social Service and Community Commissioning advised that the building is handed back to the Council and the business growth and infrastructure department is looking at this going forward. Until the department decide the plan of action for the building it will lay dormant as to staff the building was an expense we could no longer afford.

The committee recognise the pressures the Council is under as its not savings it is cuts as it is costing so much to run and is not full.

The Chair recognised the passion of Councillor Grimshaw and Councillor Lewis and thanked them for their views.

Will Blandamer Executive Director of Strategic Commissioning advised that all the appropriate processes were followed, the move was managed well and in a dignified way and staff have been re-deployed.
Councillor Tegolo reflected on an article from a care assistant at Spurr House who stated there is a short advantage in closing but will not be financially effective in the long term. She asked what is our long-term plan for doing this.

Adrian Crook Director of Adult Social Service and Community Commissioning reported that in next few months we will have a position statement and strategy paper of which an element will include housing options. They are looking at the demography of bury and setting future ambitions. The first cut of the data says residential care will continue to drop but complex care (could not be delivered in Spurr house) will increase.

Cllr Tegolo questioned that people there for short term care gave great comments but longer term longer stays were complaining. It was asked if respite care will continue.

Adrian Crook Director of Adult Social Service and Community Commissioning reported that the detail of respite is in alternative reports looked at both services and as both were half full, they decided the consolidate into Elms Hurst. If we do need respite, there are still residential space in 30 plus care homes in Bury.

Councillor Brown questioned if there is a condition on the building that it has to be used for the purposes it has been so far.

Adrian Crook Director of Adult Social Service and Community Commissioning advised there is a covenant on the land which is being considered by the Business and Infrastructure Department.

Councillor Birchmore questioned about the crisis in the social care sector currently and what the provision if this happens is?

It was reported that business continuity plans are done for all care homes in Bury. However, the current pressure is with staff more then business viability.

It was agreed:

1. To thank Adrian Crook Director of Adult Social Service and Community Commissioning for his update.

HSC.9 BURY ELECTIVE CARE UPDATE AND WAITING WELL INITIATIVE

Will Blandamer, Executive Director of Strategic Commissioning provided an overview of Bury Elective Care and the Waiting Well Initiative.

It was reported that the pandemic has provided limited supply of capacity in terms of availability of accommodation and also on infection prevention services in place. The update highlighted the current position for Bury patients waiting for Elective Care appointments/procedures. It provides a high-level overview of the on-going work being undertaken through the Elective Care Transformation and Improvement Programme, delivered by Bury CCG in partnership with Northern Care Alliance (NCA), to recover from the changed environment that has resulted from the impact of the COVID 19 pandemic.

The paper includes information on the completion of a locality review of the Bury Orthopaedic pathway, which has a focus on addressing inequalities for patients waiting, and redesigning care pathway to reduce the burden on secondary care

through integrated working across primary, acute, community and 3rd sector services.

The implementation of the Greater Manchester Waiting Well initiative within Bury is a key element of the Orthopaedic work and the wider recovery of Elective Care waiting lists.

Will Blandamer, Executive Director of Strategic Commissioning opened to questions.

Councillor Hayes questioned if there is any evidence that these prolonged waiting lists are having adverse effects on physical and mental health of patients.

Will Blandamer, Executive Director of Strategic Commissioning advised he will look and provide evidence if he can find it. Waiting so long can be detrimental to health especially mental health. To support patients to have control of their period of wait is where the Waiting Well initiative to help.

Will Blandamer, Executive Director of Strategic Commissioning advised Waiting Well means supporting people to be active, stop smoking, eat well, support their own conditions. Patients want to be in control of their care and circumstances of their lives. The Bury Directory has more detailed information and resources on the Waiting Well initiative.

Cllr Tegolo questioned the issues to recruit staff and why are we not addressing staffing issues in conjunction with this report findings.

Will Blandamer, Executive Director of Strategic Commissioning advised the consequences of this can be felt across all services and there are increasing gaps in the workforce. We want to increase the option to make bury a great place to work as there are many opportunities to connect to so many parts of the health system and a workforce group is looking into delivering this.

It was agreed.

1. To note the report.

HSC.10 COVID-19 UPDATE

Will Blandamer, Executive Director of Strategic Commissioning provided a verbal update on COVID-19 and the vaccine programme on behalf of Lesley Jones.

Community incidents rates in Bury are just below the English average at 328 per 100,000 which equates to around 600 cases of COVID-19 in bury in the week up until last week. The rate is falling after a rapid increase but the rate of decrease has begun to slow.

The COVID-19 prevalence is not related to deprivation and COVID-19 positive patients requiring hospital treatment is decreasing. We still have three or four patients dyeing per week as a result of COVID-19.

In terms of the vaccination programme, we outperform the Greater Manchester average in terms of all cohorts of the vaccination programme. We are close to 80% of over 12 year olds receiving the vaccination are the third best in Greater Manchester for the 12-15 year old cohort and our booster uptake of those eligible is the third best in Greater Manchester. We have given out around 44,000 boosters, our booster offer is aligned with our flu vaccines and we are already over the total number of residents that had the flu vaccine last year.

There are some challenges around vaccination programme such as the compulsory vaccines in hospitals and home care providers and younger children and considering dropping the age for the booster.

Will Blandamer, Executive Director of Strategic Commissioning wished to place on record his thanks to colleagues on the vaccine rollout.

Will Blandamer, Executive Director of Strategic Commissioning opened to questions.

Councillor Pilkington questioned the transmission and location of it. He asked if there is any statistical data if it is being transmitted more in Hospitals than outside.

Will Blandamer, Executive Director of Strategic Commissioning advised he will check this data and provide an update by email.

Secondly Councillor Pilkington asked a question regarding the vaccination of school children despite giving verbal consent.

Will Blandamer, Executive Director of Strategic Commissioning advised he will provide feedback after speaking to the school's team.

Councillor Birchmore stated there are no clinics currently in Radcliffe to deliver booster injections and asked if there are plans to do this.

Will Blandamer, Executive Director of Strategic Commissioning to check and provide an update by email.

It was agreed:

1. Data about nosocomial infection rates at Fairfield General Hospital to be provided
2. Confirmation if the Gillick competence test is being applied to the school vaccination programme.
3. To update if we are we offering any further vaccination sites in Radcliffe.
4. To thank Will Blandamer for the update.

HSC.11 URGENT BUSINESS

Councillor Holt offered the Committee the option to attend a pre-meeting prior to Health Scrutiny. Chloe Ashworth, Senior Scrutiny Officer will provide an invite for this at the next meeting.

It was discussed how seeing statistics and figures helps with update reports especially on Mental Health.

COUNCILLOR T HOLT
Chair

(Note: The meeting started at 7.00 pm and ended at 9.10 pm)

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Agenda Item 5

Meeting: Strategic Commissioning Board			
Meeting Date	Click here to enter a date.	**Action**	Approve
Item No		**Confidential / Freedom of Information Status**	No
Title	Urology Services – Bury System 'End to End' Pathway Review		
Presented By	Ian Mello, Director of Secondary Care Commissioning, NHS Bury CCG		
Author	Mike Ryan, Head of Planning and Delivery, NCA. Catherine Tickle, Commissioning Programme Manager, NHS Bury CCG		
Clinical Lead	Howard Hughes, Clinical Director, Bury CCG Simon Minkoff, Urology Clinical Lead, Bury CCG Laurence Clarke, Consultant Urologist, NCA		
Council Lead			

Executive Summary

A report on the reconfiguration of Secondary Care Urology Services, being led by the Northern Care Alliance (NCA), was presented to the Board in May 2021 (appendix 1). The paper was received by the Board and members requested further information on the 'end to end' clinical pathway and opportunities for delivery of care in primary care and community-based services.

This paper provides Board members with an update on the collaborative work being undertaken by the CCG with NCA, as a means of assurance to the Board that the concerns raised at the previous meeting are being addressed.

A programme of work has commenced with Secondary Care Clinicians, Primary Care Clinicians, Community Services, and other stakeholders. Through a Development Group approach, Bury system partners are reviewing the 'out of hospital' elements of the Urology pathway, alongside the new Secondary Care Urology Model.

Taking an integrated system approach to developing the pathway will ensure that the right care is provided at the right time, in the right place for Bury patients and the secondary care and primary/community parts of the pathway align.

The paper provides the Board with an overview of the work undertaken to date, identifies opportunities for Rapid Action and work being undertaken to review pathways through the Urology Development Group and outlines the proposed governance arrangements through which this programme of work will be held to account.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the update on the work undertaken to date.

- note that a further update on the work of the Development Group and pathway review/redesign will be provided to the Board in April 2022.
- endorse the NCA pan-locality delivery model for the secondary care aspect of the Urology pathway, into which the pre-secondary care locality pathway will align.

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?	Focus on prevention, place-based delivery of care and improved outcomes for patients.					
How do proposals align with Locality Plan?	Focus on system integration, prevention, place-based delivery of care, system efficiencies and improved outcomes for patients.					
How do proposals align with the Commissioning Strategy?	To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐

Implications						
How do the proposals help to reduce health inequalities?	EIA to be completed and managed by the Development Group					
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:						
EIA to be completed and managed by the Urology Development Group						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

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

Urology Services – Bury System 'End to End' Pathway Review

1. Introduction

1.1 Following the paper that went to the Board in May 2021 (appendix 1), seeking endorsement of the pan-locality Urology model of care, as part of the Northern Care Alliance (NCA) Urology reconfiguration, work has commenced locally to address the concerns raised by Board members.

1.2 The GM Model of Care (MoC) for Benign Urology was developed through the Improving Specialist Care (ISC) programme. The hub and spoke configuration for the delivery or Benign Urology services was endorsed by the Greater Manchester (GM) Joint Commissioning Board (JCB), though implementation at a GM level were delayed due to COVID-19.

1.3 The Key features of the new secondary care model are:

- A single comprehensive Benign Urology Service delivered within the NCA.
- 'Hub and Spoke' delivery model –
    - Oldham and Salford as inpatient hubs and Rochdale and Bury as spokes.
    - Virtual corridors running from Bury to Salford and Rochdale to Oldham.
    - Single workforce within two integrated functional teams – NCA West & NCA East.
- A disaggregation of the activity from North Manchester, which will align to MFT, and the activity for Bury, Oldham, Salford and HMR which will align to the NCA.

1.4 Clinical Leads from the NCA and Bury CCG are working in partnership, along with other Bury stakeholders, to review the Urology pathway 'end to end' with a particular emphasis on integrating the provision of Urology care between primary, community, and secondary care.

1.5 A Bury system wide Urology Pathway Development Group, chaired by the Head of Planning and Delivery at NCA, has been established to deliver the pathway review and subsequent re-design of elements of the pathway, to ensure that the right care is provided at the right time, in the right place for Bury patients.

2. Purpose of the Paper

2.1 This paper is intended to assure Board members, that whilst the secondary care model is changing, the opportunity to review Bury's primary care and community elements of the pathway is being progressed alongside and aligned with the secondary care reconfiguration.

3. Background - Urology Secondary Care Reconfiguration

3.1 The NCA new model of care previously presented to Board members will allow for a single NCA wide Urology team, under a single leadership, with standardised processes

and governance. Sub speciality teams will remain in place delivering MDTs across the NCA localities.

3.2 In-patient High Acuity Complex Hubs will operate at Salford Royal Hospital and Royal Oldham Hospital, both part of the Northern Care Foundation NHS Trust. The Salford 'Hub' will service the people of Bury, with Fairfield acting as a 'spoke' in the new architecture, to support high volume low acuity patients, based on a proven model at Rochdale Infirmary.

3.3 The remodelling of Urology Care at NCA, through the hub and spoke model, provides an opportunity for NCA Clinicians to work in partnership with Primary Care and Community services in Bury, to enhanced the offer into the locality and ensure greater alignment of the pathway from primary/community into secondary care.

3.4 The planned development of Urology Investigation Units (UIU) will allow for the delivery of ambulatory pathways delivered 'closer to home.' Through the Bury Urology Development Group, it is intended that Bury stakeholders, including patient representatives, will work with NCA to define the scope of the locality based UIU and explore opportunities where appropriate for delivery of care at a neighbourhood level within the Bury locality.

4. Initial Primary Care Engagement

4.1 The Consultant Urological Surgeon from NCA and the CCG Clinical Lead for Urology delivered an update to Bury Primary Care Colleagues on the reconfiguration of Urology Services at NCA and the single service model in October 2021. This took place through the Bury GP webinar chaired by the CCG Clinical Chair.

4.2 Primary Care colleagues were given the opportunity to ask questions, discuss the new model of care and explore what it means for Primary Care and Bury patients with the Urology Consultant who sits on the NCA Urology Delivery Board.

4.3 The session outcome, despite a limited number of questions from GPs, was a clear commitment made by NCA and CCG Clinical Leads to work in partnership with Primary Care and Community Services to explore the model of care required to redesign an integrated pathway.

4.4 Primary Care colleagues were invited to volunteer to be part of the Urology Development Group, where this pathway work is being undertaken.

4.5 Through the GP webinar, discussions between the Secondary Care Clinical Lead and CCG Clinical Lead, and learning from other interrelated programmes of work e.g. Phlebotomy review and NES Pathology Group, the following were identified as key areas of focus:

- Review of the Prostate Pathway and management of PSA in Primary Care
- Review of follow up pathways in primary care and secondary care
- Utilisation of lower tier services and third sector services
- Use of non - medical workforce in the Bury pathway

- To scope the requirements for a Urology Investigation Unit (UIU) to support in the identification of suitable site in the community from which to host a service
- Development of UIUs
- Access to PSA lab results for Bury GPs and other necessary pathology
- Access to Phlebotomy and Diagnostics within the pathway
- Role of Community Based Services e.g., Incontinence and District Nursing
- Exploring Bury estates for potential out of hospital delivery
- Implementing Advice &Guidance (A&G) into the pathway and Patient Initiated Follow Up (PIFU).
- Review of interrelated pathways e.g., Urology and Gynaecology and links to Gynaecology and Physiotherapy (see 5.2 below)
- Links to GM and Bury Cancer pathways (see 5.2 below)

4.6 In addition to the areas above, it was suggested at the webinar that the pathway re-design work could facilitate work to look at boundary-spanning, primary-secondary care interface roles and the possibility of identifying funding sources for a pilot of a Physician Associate for the Urology pathway work as a 'test of change.'

4.7 Through the Development Group these conversations will be extended to engage with PCN Directors and GP Federations.

5. Development Group – Overview

5.1 Terms of Reference (ToR) for the group were tabled at the first meeting and have been signed off by system partners. The first meeting provided an opportunity to review the proposed membership of the group.

5.2 Urological Oncology and gynaecology were identified as interdependencies and it was acknowledged that links will need to be made with staff from these specialities through the Development Group, as and when required. An action to seek patient input into the pathway review from the Bury Patient Involvement and Participation Group (PIP) was agreed and is being progressed.

5.3 The aims, objectives and key principles agreed by the group in the ToR reflect the request from the Board to consider the opportunity for 'place based' primary and community care. They also support the vision and ambitions set out in the Bury 'Let's Do it Strategy,' to improve the wellbeing and health outcomes of the Bury population. The pathway review will be based on codesign and accountability for shared decision making, with a focus on wellbeing, prevention and early intervention and neighbourhood working.

5.4 The Development Group meetings act as platform for stakeholders to integrate and develop relationships, define the local need and desired outcomes for Bury patients, explore opportunities, and agree transformation/re-design opportunities.

5.5 The Development Group will also oversee the implementation of a programme plan to include monitoring and evaluation.

5.6 The Urology programme of work will act as another 'test of change,' along with Orthopaedics, in the Bury system to support learning that can be scaled up across other specialties in the NCA to aid elective recovery.

6. Progress to Date

6.1 At the first meeting the Bury Community Team provided an update on the current community pathway, with clinicians from Continence and Stoma supporting this discussion. The following areas were identified as areas of opportunity from the initial discussion:

- Review of the Trial Without Catheter Pathway (TWOC) due to increasing demand
- Integration across secondary care and community services
- Review of the diagnostic pathway
- Review of community data to include patients presenting acutely with retention, post-operative referrals and referrals from A&E and cost.

6.2 An update on the secondary care pathway transformation was shared by NCA partners to ensure all group members were aware of the changes taking place. The following areas of opportunity were identified from the initial discussion:

- Realignment of ambulatory pathways
- Establishing specialist nursing workforce with presence in the Bury locality – interface roles between primary and secondary care
- Reviewing future bed capacity requirements
- Maintenance of 'Hot' Urology Lists – maximise theatre capacity
- Review of secondary care data and costs
- Learning from current Prostate Pathway in Salford
- Learning from the advanced triage pilot commenced with Salford and learning from the planned pilot of A&G in Salford
- information sharing - access to shared care records and opportunities from the NCA new Electronic Patient Referral (EPR) System

6.3 The following areas of opportunity were identified at the second meeting of the group, from a presentation of the current primary care pathway led by the CCG Clinical Lead:

- Currently Primary Care pathways are based on clinician's individual knowledge, experience, and review of published guidelines.
- Patient experience may be variable with potential inequalities arising.
- This is an opportunity to develop a more integrated and consistent service partnered between primary care, community care, and secondary care.
- New pathway will require softer boundaries, increased co-operation, less duplication of investigation, and meaningful use of Advice & Guidance and Patient Initiated Follow-Up.
- Improved referrals will identify where illness impacts on occupation or social care enabling social prescribing and signposting to lifestyle services.

7. Rapid Action Opportunities

7.1 The following 'quick wins' have been agreed by the group as the outcome of the first two meetings. Named leads have been identified to progress these at pace alongside more medium/longer term work on the wider pathway reviews:

- Review of the Prostate pathway and agreeing the optimal pathway
- Review of the TWOC pathway and agreeing the optimal pathway
- Trail of advanced triage in Bury based on the Salford pilot results.

8. Transformation Work Programme

8.1 A high level system workplan has been developed and agreed by the group as an iterative document. The plan includes the 'quick win's' and the key elements of the pathway (primary care and community) for review and redesign. Key within the action plan is alignment of new pathway with the new secondary care model of care.

8.2 The 'quick wins' and pathway reviews will be progressed in parallel. The Group Chair is meeting with named leads for each area of the plan to agree the key deliverables and milestones for the work programmes, after which the plan will be updated.

8.3 Analysis of the Urology data and finances across the pathways is being undertaken. An existing Performance and Data Group supporting the Orthopaedic Improvement work, as part of the wider Elective Care Programme, will provide the forum to bring pathway 'experts' together with BI, finance, patient representative and Public Health to agree the scope of the analysis required.

8.4 Building upon the existing group will allow the methodology developed for the analysis of inequalities in access to Orthopaedic services to be replicated for Urology, to ensure the pathways have a lens on equity and inclusion.

8.5 Named leads to attend the Planning and Data group have been agreed and an initial meeting is being arranged to scope the work. The data analysis will feed back into the Development Group.

8.6 Any impact of the secondary care reconfiguration on Bury patients and their families, such as access to care at Salford Royal, will be explored as part of the work of the Development Group. Through the pathway re-designs opportunities for 'place based' care will be a key priority.

8.7 Links will also be made with the VCFA to support the pathway work to consider support for patients and families where access to care is required outside of the Bury locality.

8.8 An Equality Impact Assessment (EIA) will be completed by the Development Group and any risks highlighted fed into the pathway redesign work to identify opportunities to mitigate the risk of inequity in access to care.

8.9 Another key principle of the re-design will be efficiencies and improved flow of patients. During the Development Group discussions, it has been acknowledged that the pathway can't be linear, and a key part of the transformation will be getting the interface between community, primary care and secondary care correct, through a blurring of organisation boundaries and ensuring the right care is provided at the right time by the right professional. It is hoped that the new pathways will allow for a more streamlined and efficient journey for patients that supports flow through the whole system.

9. Governance

9.1 The Development Group will sit within the newly proposed Bury Elective Care and Cancer governance architecture, subject to its sign off, reporting into the Elective Care and Cancer Recovery and Reform Board, due to commence in December 2021. In the short term whilst the new governance structures are being implemented the Development Group will report into the Bury Elective Care Recovery and Reform Group.

9.2 Embedding the pathway work within the Elective Care and Cancer architecture will afford it links to interrelated programmes of work e.g., diagnostics, elective improvement work, While You Wait, A&G and PIFU and the NCA led Being Well Programme that supports delivery of the NCA Recovery Strategy, which includes Elective Care.

9.3 By embedding the Urology pathway work within a robust Bury system governance framework, with clear lines of accountability, it is hoped that Board members will feel sufficiently assured that the Bury Urology pathways are being looked at in its entirety, 'end to end, 'and allow Board members the confidence to endorse the secondary care pan locality model, whilst the associated Bury pathway work is completed as a transformation programme within the Elective Care and Cancer governance.

10. Bury System Commitment

10.1 In line with the changing health and social care landscape and the transition to Integrated Care Systems (ICS), NCA and Bury CCG are committed to undertaking at pace the review and redesign of the Urology pathway as outlined in this paper.

10.2 The integrated system Development Group model, supported by NCA and Bury CCG Senior Leaders, will remove traditional divisions between hospitals and GPs, between physical and mental health, and between NHS and council led service.

10.3 Through a place based partnership approach that ensures 'systemness,' NCA and Bury CCG will deliver to the Locality Board a Urology pathway that is patient-focused and maximises the opportunities for high-quality care across the many parts of the system to maximise value for Bury residents.

11. Risks

11.1 The Board is asked to note that the Secondary Care Urology reconfiguration, overseen by the NCA Urology Board, which has senior CCG representation, is a NCA pan-locality approach. Therefore, any delays to the endorsement of the model by a locality will in turn impact upon the phased implementation across the localities, as outlined in the previous paper brough to the Board (appendix 1).

11.2 The assurances provided in this paper, with regards to the work being carried out on the pathway review and opportunities to provide care 'closer to home, 'is intended to mitigate the risk of delays to the secondary care implementation.

11.3 There is a risk that the new primary and community pathways are still in development and alignment with the new secondary care model may require unknown investment. This risk will be mitigated through the Development Group ensuring it is fully cited on the secondary care developments as they progress, and primary care and community are fully engaged with the pathway redesigns. Progress will be reported to the new Elective Care and Caner Board and risks escalated as required.

11.4 The reconfiguration of secondary care services and provision of inpatient care at SRFT for Bury patients may present a risk in terms of widening the inequalities gap. Completing an EIA, a focus on placed based care and strong links with the VFCA to support the 'end to end' pathway development will help to mitigate this risk.

11.5 Issues with the current flow of patients across the system and bed blockages in the secondary care services presents a risk to the optimal functioning of the new pathways. The close working relationships that the pathway will bring between secondary care surgical consultants and primary and secondary care clinicians, will mean that patients are only progressed for surgery where it is considered essential and where appropriate all other means of treatment have been exhausted. This will help to reduce demand in secondary care.

12. Recommendations

12.1 The Board is asked to:

- receive the update on the work undertaken to date.
- note that a further update on the work of the Development Group and pathway review/redesign will be provided to the Board in April 2022.
- endorse the NCA pan-locality delivery model for the secondary care aspect of the Urology pathway, into which the pre-secondary care locality pathway will align

Ian Mello
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Bury OCO
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November 2021

NHS
Bury
Clinical Commissioning Group

Meeting:			
Meeting Date	26 May 2020	**Action**	Receive
Item No.		**Confidential**	No
Title	Urology Services Across Bury, Oldham, Rochdale, and Salford		
Presented By	Ian Mello, Director of Commissioning		
Author	Mike Ryan, Head of Planning and Delivery, NCA North East Sector Commissioners		
Clinical Lead	Howard Hughes, Clinical Director		

Executive Summary

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

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

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

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

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

Recommendations

- Endorse the key design features of the pan-locality delivery model, which are fully consistent with the Greater Manchester Model of Care (MoC).
- Support a phased approach to mobilisation overseen by the Programme Board.

Links to CCG Strategic Objectives

SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐

Links to CCG Strategic Objectives	
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:						
Requirements re: consultation/engagement and impact assessments being considered by the Programme Board.						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

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

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Urology Services Across Bury, Oldham, Rochdale and Salford

1.0 Executive Summary

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

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

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

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

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

2.0 Background

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

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

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

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

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

3.0 The Proposed Pan-Locality Delivery Model

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

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

3.3 Key features of the pan-locality model are:

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

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

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

4.0 Summary of Drivers for Change

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

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

5.0 Impact and Benefits

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

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

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

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

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

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

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

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

6.0 Recommendations

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

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Bury Integrated Care Partnership

Operating Model from 1/4/22.

Version: Draft Version 1.3
Status: For Initial Consideration of the Locality Board 6/12/22
Owner: Will Blandamer
Date: 2/12/21
Target Date: 22/12/22 - GM Shadow Joint Planning and Delivery Committee.

Purpose of Document

In advance of the establishment of the GM ICS from 1/4/22, the Bury Health and Care System has moved to establish the new partnership arrangements in transition form. This document consolidates the progress to date and describes as far as possible how the system will operate in practice.

It is recognised that the arrangements may continue to develop and refine up until 1/4/22 in the light of national guidance and the GM wide operating model. We will also use the transition period December 2021 to March 2022 to test the arrangements described here with a series of scenarios – understanding how the system would work to address particular issues. This document will be updated as required.

It is also recognised that the arrangements may change and develop after 1/4/22 and again this document will be updated as required.

A strategy and operating model for health and care in the borough sits in the context of the ambitions of the Let's Do It 2030 Strategy for the Borough – securing sustainable economic growth and reducing the inequalities in life chances for many borough residents.

Presentation

We are presenting this operating model in a way that meets three objectives.

- to provide confidence and assurance to key stakeholders, including the GM ICB and Bury Council – that we can effectively discharge the obligations of the locality board in relation to delegated authority.

- To describe to all partners in Bury the way the system will work in as clear and simple way as possible.

- To provide as much clarity as possible to staff affected by the changes, notably CCG staff.

Contents

Operating Model of the Bury Integrated Care Partnership System

A. Background and Context

1) From the 1/4/22 – subject to legislation – the NHS is being reconfigured to work as part of Integrated Care Systems. The practical impact of this for Bury is the abolition of the CCG with its functions adopted by a single Integrated Care Board for Greater Manchester, and the creation of a number of other GM wide partnerships.

2) This is a high-level operating model for the **Bury Integrated Care Partnership** to be effective from 1/4/22. The term "Bury Integrated Care Partnership" describes the joint work of all partners in the health and care system to deliver the Bury Locality Plan – our strategy for health, care and wellbeing. The locality plan can be seen here.

3) The Locality Plan for Health and Care in Bury sits as one part of the Strategy for the Borough – Let's Do it 2030 - seeking to improve life outcomes for all residents in the borough. Let's Do It can be seen here

4) This document is an operating model for the way in which partners work together as a Bury Integrated Care Partnership, and refers to the partnership meeting arrangements, and the roles capacity and governance and running costs required to support the system.

5) The Bury Integrated Care Partnership is part of the wider Greater Manchester Integrated Care System, and we work closely with colleagues across Greater Manchester – including the GM Integrated Care Board, the GM Provider Federation Board, and the GM Primary Care Board – to both contribute to and benefit from the conurbation wide perspective.

6) In developing this locality operating model, we assume.
   - All CCG staff will TUPE to the GM ICS, and the bulk of staff will be redeployed in Bury. The expectation is that the number of posts that will not be locally redeployed back to Bury will be small.

   - We recognise that some CCG staff will be deployed at a GM level either directly in the GM ICB or via the GM provider Federation Board and other GM NHS partnerships. The posts in scope are yet to be determined.

   - We also recognise that most staff will continue to be deployed locally but the connections to GM wide working may be strengthened – connecting expertise across all parts of GM and the GM core.

   - We are further developing our integrated working arrangements in Bury e.g in terms of the work we have done in the last year to blend the expertise across what was the One Commissioning Organisation, and the Local Care Organisation, and in the way we have integrated business support functions between council and NHS – for example in finance, comms, business intelligence, IM&T.

B. Locality Plan for Health and Care and the context of 'Let's Do It'.

7) Regardless of organisational change, the partners in Bury have recently adopted a refreshed Locality Plan. The Bury Locality plan describes our strategic ambition for the health and care system in Bury. It remains our 'north star' – to retain a focus on the outcomes we seek to achieve for residents of Bury during a period of transition. The Bury Locality Plan can be accessed at… In summary the agreed objectives are as follows

1) We will seek to **influence the factors that improve population health** and wellbeing 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 work through **5 neighbourhood teams** to create opportunities for front line staff to know each and work effectively together
8) We will secure **timely access to hospital services where required**
9) We will work to **reduce dependence of people on institutional care** – hospitals and care homes.
10) We will work to ensure **high quality responsive services** where people describe a good experience of their treatment

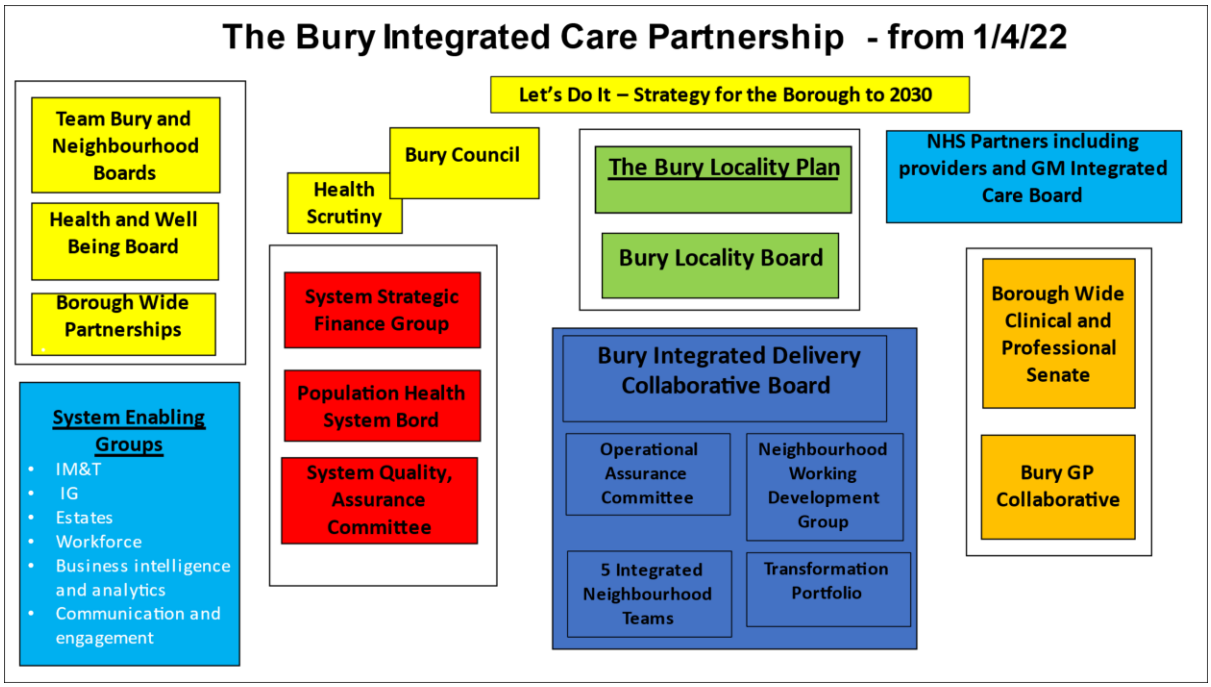
8) Let's Do It – The Bury Borough Strategy for 2030

The Let's Do It strategy is committed to securing access for all residents to sustainable economic growth, and to address the entrenched inequalities in the borough the limited life chances and outcomes for some residents and communities.

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.

C. Partnership System

9) Partners in Bury have from October 2022 established in transitional form the partnership arrangements we will have fully operational from 1/4/22. The diagram below describes this.



10) The component parts of our partnership model are as follows

6.1 Locality Board

- The partnership leadership of the Bury Integrated Care Partnership is through the Locality Board, made up of senior representatives from all relevant statutory organisations and other key partners. It will bring together political, clinical, managerial and professional leaders to help shape the strategy, prioritise and focus on integrated health and care for the Place. The Locality Board will include the Council, Primary Care Leadership, Northern Care Alliance, Pennine Care NHS FT, Manchester Foundation Trust, GP Federation on behalf of PCNs, the Greater Manchester ICB, the Bury VCFA, and Healthwatch. The Locality Board sets the shared strategy for the partnership and ensures triple aim outcome are improving, including overseeing the implementation of the planned budget for health and care in the borough (some of which may be formally pooled), ensuring services are high quality efficient and effective, and ensuring population health outcomes for our Borough are improving. The Board will set the direction for the way services are delivered as described in the Locality Plan. The terms of reference for the Locality Board can be **seen at...**

- To discharge its functions effectively the Locality Board should operate as formally a joint committee of the statutory partners – that is a joint committee of the boards of the NHS organisations who are party to it, including the GM Integrated Care Board, and as a committee with delegated authority from the Council. Operating as a formal joint committee will not only support delegated decision making in relation to any financial pooled budget, but will allow more nimble decisions of policy, strategy, and operational decisions. For the Locality Board to operate as a Joint Committee, each board of the

members will need to agree the necessary scheme of delegation from its own board to the Bury Locality Board.

- The Locality Board will have an accountability to all of its partners. In particular the Locality Board will together own the delivery of the MOU between the GMICB and the Bury Integrated Care Partnership for the delivery of GMICB priorities and commitments.

6.2 Integrated Delivery Collaborative, and Board

- The 'engine room' of the Bury Health, Care and Well Being system is the Integrated Delivery Collaborative'. This is the vehicle through which we are building relationships, structures and solutions between all the partners to drive improvement in the way we are working to improve triple aim outcomes for our Borough, and to deliver services and interventions in innovative ways. The IDC includes all partners to the Locality Board and several other key providers – e.g Persona (the Council owned social care delivery organisation), the Voluntary and Community Faith Sector Alliance and Bardoc. The Integrated Delivery Collaborative supports collaborative working at borough, neighbourhood and individual community level.

- We have undertaken significant organisational development work to determine the purpose, principles and values of the IDC. We have defined the purpose of Bury integrated delivery collaborative to be enabling health and care organisations and the voluntary sector in the borough to achieve more together than each individual organisation could do alone to provide more effective integrated services, to achieve better outcomes and experience for people, to improve cost control in health and care services and to have a greater impact on improving population health, reducing health inequalities and increasing inclusivity. Our scope includes all health and social care services for people of all ages. We recognise that for some services their optimum footprint may be greater than the borough of Bury. However, it is still essential these services are considered part of, and integrate with, the Bury system for the benefit of our local population.

- The vision of Bury IDC is

  - ✓ To create the right environment, right relationships and best conditions to deliver effective integrated care, closer to home

  - ✓ To work with all system partners to deliver the health and care system's ambitions for transformation so as better to achieve the triple aim (better care, better health, better value), address health inequalities and be inclusive.

  - ✓ To develop the platform to deliver effective integrated health and care at neighbourhood level in line with the locality plan and across the entire system.

  - **The principles of the IDC are as follows:**

  People

  - ✓ We will seek to develop and promote self-care and wellbeing
  - ✓ We will put neighbourhoods at the heart of our work with an emphasis on quality and safety.

- ✓ We will emphasise assets and strengths at every level: individual, family and community, encouraging and enabling people to take responsibility for their own health and wellbeing.
- ✓ We will seek out, value and learn from the lived experience of local people
- ✓ We value and will provide skilled leadership to our services and system which is representative of all aspects of our diverse community

Relationships

- ✓ We will prioritise develop and strengthen our relationships including by doing hard things together, such as working through conflict
- ✓ We will value creativity and innovation, including but not limited to digital innovation, which improves the personal, social and economic well-being of people in our borough
- ✓ We will always promote inclusivity, social justice and fairness and we will seek to add social value in everything we do
- ✓ We will be accountable in our actions to each other, to the wider system, and to the people of Bury
- ✓ We recognise, and seek always to learn more about, each other's pressures, environments, and statutory duties
- ✓ We will aim to align our work to our individual organisational priorities

Decision-making and resources

- ✓ We are committed to working within a jointly developed structure, with a shared purpose, and operating principles
- ✓ We will look to the IDC board as an authoritative body when, for example, there is challenge or ambiguity in our work
- ✓ We will seek to make the best use of our collective assets, to make best use of the public resources invested in the borough
- ✓ We will promote and advocate for the health and well-being of Bury people, and for the resources and access to services that people need, in our work with the Greater Manchester integrated care system

- Key tasks for the Integrated Delivery Collaborative include:
  a. To create the conditions for the delivery of high-quality integrated health and care services in each of 5 neighbourhood teams,
  b. To co-ordinate the delivery of the system wide transformation programmes – including for example urgent care, mental health, elective care, adult care transformation, learning disabilities
  c. to create the frameworks and partnership arrangements to deliver the expectations of the Locality Board as described.
  d. To assure the delivery of directly managed services

- To provide a focal point for all that we have established an Integrated Delivery Collaborative Board (IDCB), with senior representatives from all partners. The IDCB is independently chaired by Chris O'Gorman.

- The IDCB is alliance of partners and is bound together by a 'Mutually Binding Agreement' – a copy of which can be seen at ..

- There will be an MOU that describes the relationship between the Locality Board and the IDCB. The MOU describes particularly the adoption of the triple aim methodology – effectiveness, efficiency, and population health gain. A draft MOU between locality board and IDCB can be seen at:

- The national ICS guidance identifies three models that NHS providers have typically used to form collaboratives under existing legislation. The models are not mutually exclusive; they can be combined or work in parallel, and one may evolve into another. The models are described below:

Model Type	Description
1. Provider leadership board model	Chief executives or other directors from participating organisations come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners[1]. This model can make use of committees in common, where committees of each organisation meet at the same time in the same place and can take aligned decisions.
2. Lead provider model	A single NHS trust or foundation trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required. Alongside the contract between the commissioner and NHS lead provider, the NHS lead provider enters into a partnership agreement with other collaborative members who contribute to the shared delivery of services.
3. Shared leadership model	Members share a defined leadership structure in which the same person or people lead each of the providers involved, with at least a joint chief executive. This model can be achieved by NHS trust or foundation trust boards appointing the same person or people to leadership posts. In the case of NHS trusts, this model can also be achieved by the board of one trust delegating certain responsibilities, consistent with the remit of the provider collaborative, to a committee which is made up of members of another trust's leadership team. Under either of the above approaches each provider's board remains separately accountable for the decisions it takes (even if aligned). Nevertheless, alignment of decision-making can be supported by using shared governance (such as committees in common).

- In Bury our preferred model is Option 1 - In effect this would be described as a non-lead provider collaboration organised through a formal agreement and committee in common.

- The scope of services within the view of the Integrated Delivery Collaborative to transform and redesign to deliver improvements to improve triple aim outcomes for our population include:

  - all and any services required for the 'next step care' after a GP consultation; and
  - all care that can be provided in community settings, unless by exception – supported by specialists' opinion. Integration opportunities would therefore cover as a minimum:
  - the majority of support and services that are presently delivered in outpatients;
  - a significant array of diagnostics;
  - a range of ambulatory and same day emergency care (SDEC) pathways;
  - day case work;
  - the full range of community health services;
  - the full range of adults and children's care services; and
  - an extensive range of services provided from the voluntary sector.
  - The detail of the relative role of GM and Locality working is contained within the GM target operating model spatial planning levels of working and the detail can be seen

here. However, we expect to see the Locality Board and the IDCB as mechanism by which the inter-relationship between services, and the development of pathways – whether planned or delivered at a GM or local level – can be reconciled for the benefit of Bury residents.

6.3 Neighbourhood Working

- The default setting for integrated community health and care services in Bury is though joined up delivery across 5 integrated neighbourhood teams. These are:
    - Ramsbottom and Tottington
    - Bury
    - Radcliffe
    - Whitefield
    - Prestwich

- We have an operating model and development plan for integrated neighbourhood working in health and care and this can be seen at..

- The model of integrated neighbourhood team working in health and care operates at the same spatial levels as our community hubs - a focal point for community leadership and co-ordination in each of 4 places. In 2021 the community hubs have created opporuntiis for public services and volutary and community partners to come together with a shared understanding of each others role, the assets in those communities, and the residents and communities at risk of vulnerbaility.

- Increasingly wider public services are also working on the same spatial level - this includes GMP, Housing Providers, GMFRS, wide Council Services - with the understanding that prevention and early intervention across a range of public service can sustainabley improve outcomes. From a health and care perspective this work explicitiy recognises that the organisation of service delivery of health and care is actually a minority contributor to the health and well being of residents. More important is, for example, the quality of housing, the availability of quality work, the extent to which residents are connected to their communities, and whether a life is led free from harm and fear. This work is co-ordinated by the Bury Public Service Reform Board. A picture of the alignmenet of health and care INTS and the wider PSRR approach can be seen at....

- Primary care is at the heart of our model of integrated care. We have 4 Primary Care Networks working across the 5 neighbourhoods. The Primary Care Networks are supported in their development by the Bury GP Federation and work continues to explore how best to support the maturity and system leadership of the primary care networks, and the role of the GP Federation in doing so. The primary care team of the CCG/future ICB will work closely with the capacity of the GP Federation to support practices and PCNs.

6.4 Triple Aim Assurance

- The triple aim approach is well understood in health and care systems. It is a framework that describes an approach to optimising system performance through the simultaneous pursuit of three dimensions: improving the quality of healthcare, improving the he alth of the population, and achieving value and financial sustainability. Accordingly, the Bury Integrated Care Partnership will have a System Groups with dedicated leadership and capacity

reflective of whole system working, for each of the triple aim objective. These groups will be:

- **System Wide Quality and Assurance Group.**
  The role is to co-ordinate quality assurance arrangements on behalf of the system – connecting to uni-organisaitonal assurance processes. The Terms of Reference for the group can be seen at.

- **Strategic Finance Group**
  It will ensure oversight of the integrated fund in Bury – made up of pooled, aligned, in view funding, and also the delivery of financial risk and gainshare from system wide initiatives. It will also be a role of the FG to ensure that we can invest over the medium term into early intervention and prevention and move funding across agency boundaries at neighbourhood level. The terms of refence for the SFG is at

- **Population Health System Board**
  This strand is led by the statutory DPH Lesley Jones and supported by the capacity of the Bury Council Public Health team. The Health and Well Being Board operates as a standing commission on health inequalities, working with 'Team Bury', and a specific and operational population health board comprised of operational leadership from health and care and wider partners. The terms of reference for the HWBB and the population health board are at.

6.5 Clinical and Professional Leadership

- Bury has established a clinical and professional senate with the intention of ensuring clinical and wider professional (e.g social worker) leadership is significantly influencing, leading, guiding, and challenging the work of the wider partnership arrangements. It is also intended to create opportunities for strengthened clinical and professional leadership across different sectors and interfaces e.g primary care/secondary care, mental/physical health, health/care.

- A clinical senate board operates through mandated leadership and will coordinate the work of the wider clinical and professional senate. The terms of reference for the clinical and professional senate are at..

- In addition to the work of the GP Federation Bury will also seek to establish a GP Collaborative. This is a joint initiative between GP practices in Bury, the 4 Primary Care Networks, the GP Federation, and the Local Medical Committee. It is intended to support the voice of GP leadership particularly in the partnership arrangements, recognising the potential risk of the loss of the CCG as a GP membership organisation and as a key statutory authority in the borough. A draft terms of reference is at

6.6 Enabling Groups

- Bury Council and Bury CCG have in the last few years established a number of joint and integrated teams – a shared comms and engagement function, a shared Business Intelligence Unit, and joined up working in IM&T development. These functions will continue to build relationships with key partners to create and further mature system wide approaches where required.

- The Bury Health and Care System already has some existing system wide working groups – connected expertise from across council, NHS and other partners and these will be further developed.

- The Bury Integrated Care Partnership Groups are therefore the following:
    - Bury ICP Strategic Workforce Group
    - Bury ICP Strategic Estates Group
    - Bury ICP Business Intelligence Group
    - Bury ICP Comms and Engagement Group
    - Bury ICP IM&T Group

D. Leadership System

11) Having described the role and function of the partnership arrangements to deliver our Bury Integrated Care Partnership, we need to consider the leadership architecture we need to manage and operate the system.

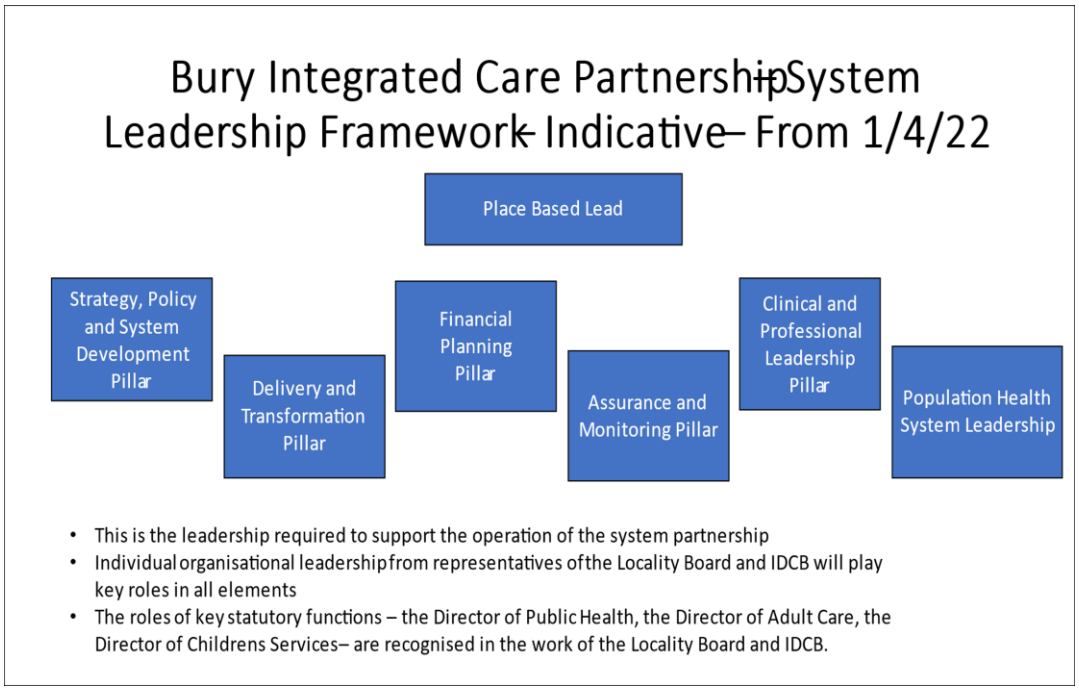
12) This is not about 'management structures' – because the system is complex with very many different organisations working together and with their own management arrangements. This is about the leadership arrangements of the partnership system.

13) The leadership architecture described below is indicative and is subject to wider consultation with all staff affected. Its is intended to represent a further step forward in the way all partners have worked together in the last 18 months – worrying less about who they work for, and rather focusing on the bringing the talents of all to the priorities of the system.

14) In particular the draft system leadership architecture draws heavily on the roles of current CCG staff who will transfer into the employment of the GM ICB, and of teams working across the Council and CCG as part of what is currently described as the one commissioning organisation, and of capacity and leadership of what is currently described at the Local Care Organisation. However, this is not about 'recreating' a CCG. It is about bringing the capacity and expertise of CCG staff, LCO staff, Council staff and colleagues from across provider organisations to support the whole partnership system be as effective as possible.

15) The following describes the pillars of work required to support the system partnership described.

16) We envisage there are 6 teams/pillars supporting the work of the place-based lead and the wider Bury Integrated Care Partnership.



17) The responsibilities of each pillar are described below.

Pillars	Functions
Strategy Planning and System Development	• Strategy Development • Business Planning • Business Intelligence • Organisational development • Policy & Partnerships • Ensuring enabling functions support system delivery • Benchmarking
Delivery and Transformation	• Creating the conditions for system change enabling partners to work together to deliver improvements in triple aim outcomes for our population • Managing the Business of the Bury Integrated Delivery Board • System Reform – interventions to improve performance through system and process redesign. • System Redesign – continuing pathway redesign development • Creating conditions for neighbourhood team working • Determining the requirements of enabling functions from a health and care perspective • Workforce strategy
Financial Planning	• Financial Management – Financial Planning, Operational and Strategic Decision/Investment Support, Financial Monitoring • Financial Reporting, Financial Control & Governance
Assurance and Monitoring	• Patient Experience • Provider Quality Management • Escalation and Resolution • Clinical Quality Assurance • Compliance Monitoring • System Safeguarding (connected to Bury Integrated Care Partnership)
Clinical and Professional Leadership	• Convening Clinical and Professional Senate • Clinical Development and Networks • Connections to clinical networks on sub regional and GM footprint • PCN Development • Medicines Management – ongoing medicines management and prescribing support
Population Health System Pillar	• Ensuring a focus on health inequalities in all we do • Reporting to Health and Well Being Board operating as a standing commission on health inequalities.

18) The following are key considerations of leadership of each of the elements described above. It will be noted that the proposal remains subject to consultation.

The Place Based Lead.

- Each of the 10 Districts in GM will also identify a 'place-based lead'. The role of the place-based lead is to ensure the effective operation of the Bury Integrated Care Partnership with an accountability to both the GM ICB and the Council for the effective operation of the partnership.

- In Bury the partners have agreed that the place-based lead should be vested in the role of the individual currently the Accountable Officer of the CCG and the Chief Executive of the Council. We would expect that from 1/4/22 this person would have

a formal role/accountability to the GM ICB as well as a continuation of the role of the Chief Executive of the Council.

Strategy Planning and System Development Pillar Lead

- It is expected that this role is filled by the current Bury CCG/Bury Council Executive Director for Health and Care, and further that this role continues to be a joint appointment between the Council and the GM ICB. It is further expected that the staff currently formally reporting to the Executive Director will continue to report for reasons of managerial accountability but will of course work across all pillars.

Transformation and Delivery Pillar Lead

- It is expected this pillar lead role is filled by the current Chief Operating Officer of the LCO.

The financial planning pillar lead

- It is considered that the financial planning pillar lead is assumed to be the individual currently operating as the Section 151 Officer of the Council and the Director of Finance of the CCG. It is further expected that the post will continue to be operated as a joint appointment between the Council and GMICB. It is further expected that the current CCG finance team will report to the Joint Director of Finance as leaders of the Financial Planning Pillar

Assurance and Quality Pillar

- It is expected that this role is filled by the current Bury CCG Director of Nursing and Quality and that the staff in the current QA team and the Safeguarding and CHC staff will report to the lead of the Assurance and Quality Pillar.

Clinical and Professional Lead

- It is expected that the clinical and professional lead for the system leadership arrangements will be determined by the work of the Clinical and Professional Senate Board, and will in transition and beyond will be the current Chair of the Bury CCG.

Population Health Pillar

- It is expected that the population health pillar is led by the Director of Public Health and supported by the Council Public Health team.

19) There are three key statutory functions in the borough accountable to the Council that connect to all parts of the partnership arrangements described.
    a. The Director of Adult Services – this role is currently combined with the role of Director of Community Commissioning. There are no changes planned to the management scope of this role from 1/4/22. As now the role will work closely with all pillars described.
    b. The Director of Children's Services. Childrens services in health and care are in scope of the arrangements described above, and the Bury Children's Strategic Partnership will work to ensure the connection between the NHS service and the wider Children's partnership arrangements in the borough.
    c. The Director of Public Health will, as previously described, managing a team influencing across the borough from a population health system perspective, and particularly the work of the Health and Well Being Board

20) This structure also recognises where there are already integrated functions existing between the Council and the CCG, that we wish to build on and further develop. For Example

    a. The System Strategy pillar may have responsibility for Business Intelligence, the leadership would be provided from the existing CIO who leads the integrated NHS/Council BI function providing expertise and oversight to the team. The key task is ensuring the alignment of business and performance reporting to the system partnership arrangements, and ensuring performance and outcomes inform delivery and transformation priorities. There will be "a dotted line" to the Strategic Planning and System Development Pillar.

    b. The integrated Council/CCG Comms team will continue with the current management arrangements provided by the Council but will describe a "dotted line" to the Strategic Planning and System Development pillar.

21) That we recognise we are seeking to operate as a whole system – and that in addition to the formality of attendance at the locality board and the IDCB, there is a need for a relatively informal **system leadership group,** to be chaired by the Strategic Planning and System Development pillar lead. This brings in to the 'system management' sphere key senior operational leaders from a range of partners to work alongside the Pillar leadership described and the enabling group leads.

22) There is further work to be done to map the wider system governance of Oldham, GM and the Northeast Sector to avoid duplication. This has been partly described by work commissioned by the Northern Care Alliance and the 4 localities it serves – Bury, Oldham, Salford, and Rochdale – from Carnall Farrar and this is available at… A named "Alliance lead" has been appointed working across all 5 organisations.

E) Running Costs

23) Partners in the Bury Health and Care System are committed to the capacity required to operate the Bury Integrated Care Partnership in way that secures the achievement of the objectives of the Locality Plan for residents of the borough.

24) Partners in Bury also recognise the national commitment that the implementation of the Integrated Care System arrangements is not in itself intended to be a cost saving measure, nor is intended to denude 'places' like Bury of the capacity to drive the scale of transformation required to deliver a clinically and financially sustainable system

25) Nevertheless, it is recognised that the Greater Manchester Integrated Care System is under significant financial pressure.

26) Our default setting is that the Bury Integrated Care Partnership needs the bulk of running costs and in scope programme management costs currently attributable to the Bury CCG. This is particularly true given the significant given that Bury is furthest from its target CCG funding than everywhere else in Greater Manchester, equivalent to £xm.

27) Bury CCG has one of the smallest headcounts of capacity, and the capacity is as below.

Overall CCG staffing structure

Staff group	Total headcount
Admin and Business Support	9
Business Development	2
Business Informatics	7
CEO and Board	5
Chair and Non – Execs	6
Clinical Leads	6
Clinical Support	8
Safeguarding	9

Staff group	Total headcount
Commissioning	9
Communication and PR	3
Continuing Health care	13
Primary Care IT	5
Finance	15
Primary Care– Enhances services	6
Primary Care – Admin Projects	8
Meds Optimisation	9

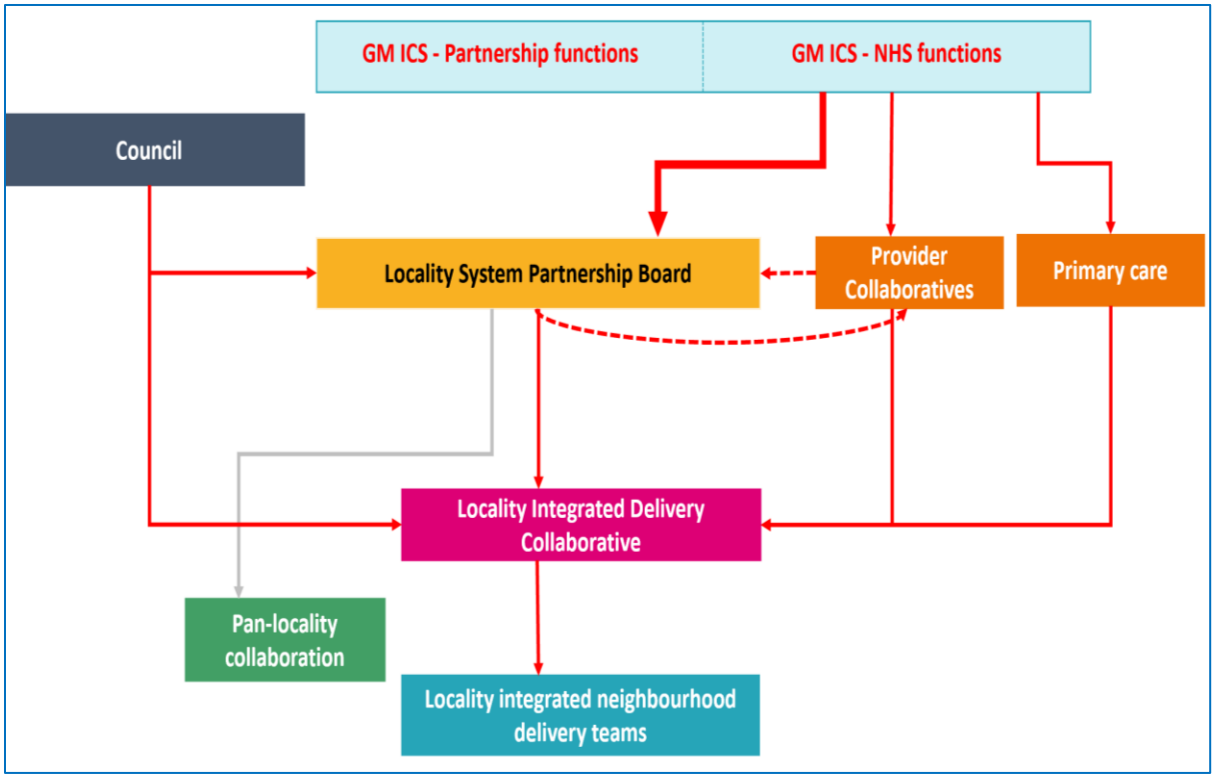
28) Further work is being done to develop the running costs proposition associated with this operating model.

F) Funding and Financial Flow

29) We have done an initial assessment of the financial flows within the new GM ICS in tandem with the work going on across GM. Our assessment of options is as follows:

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

30) Our view is that significant NHS funding should be delegated from the GM ICB to the Locality System Partnership Board. But we also recognise significant funding flows from the GM ICB to directly to GM wide collaboratives, and in some circumstances to primary care. Again, regardless of funding flow we would expect the Locality Board to have the total health and care system funding for the borough in view, and a proportion of that may be pooled.

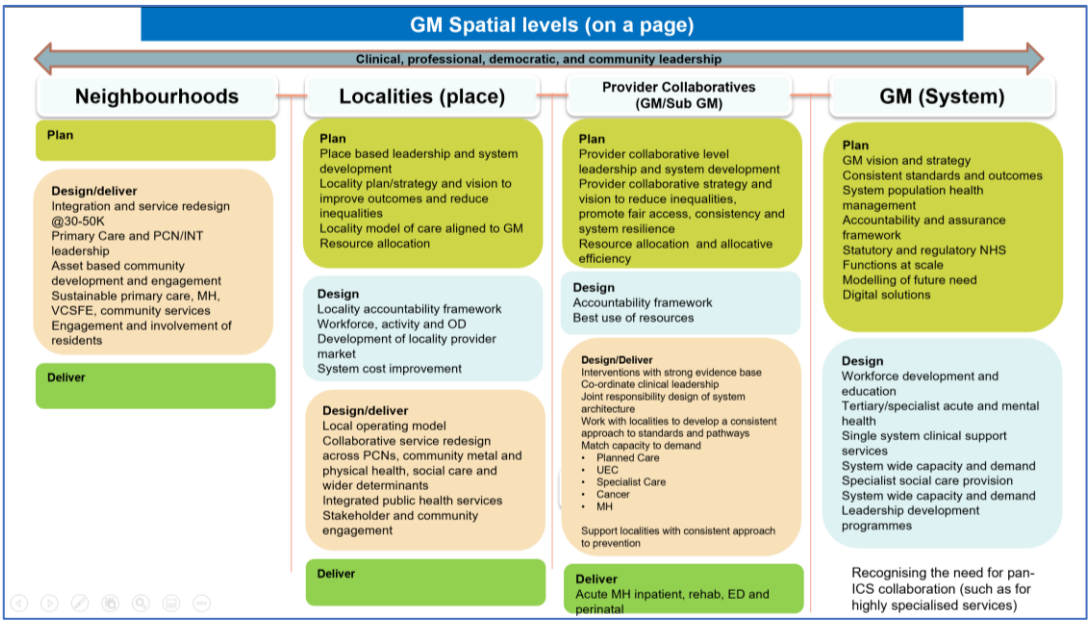

GM ICS - Partnership functions
GM ICS - NHS functions
Council
Locality System Partnership Board
Provider Collaboratives
Primary care
Locality Integrated Delivery Collaborative
Pan-locality collaboration
Locality integrated neighbourhood delivery teams

G) Greater Manchester Integrated Care System

NB – this section is consistently described in the Oldham and also Rochdale Locality Plan – reflecting our ambition to share learning and develop a consistent approach to working within the GM ICS arrangements.

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

32) Equally there has been considerable work done on the spatial level at which service planning and delivery should be organised and undertaken.



33) In some specialities and conditions, such as mental health, these spatial levels have been taken to a more detailed and granular level with a clear explanation as to how services and programmes could address the challenge GM faces.

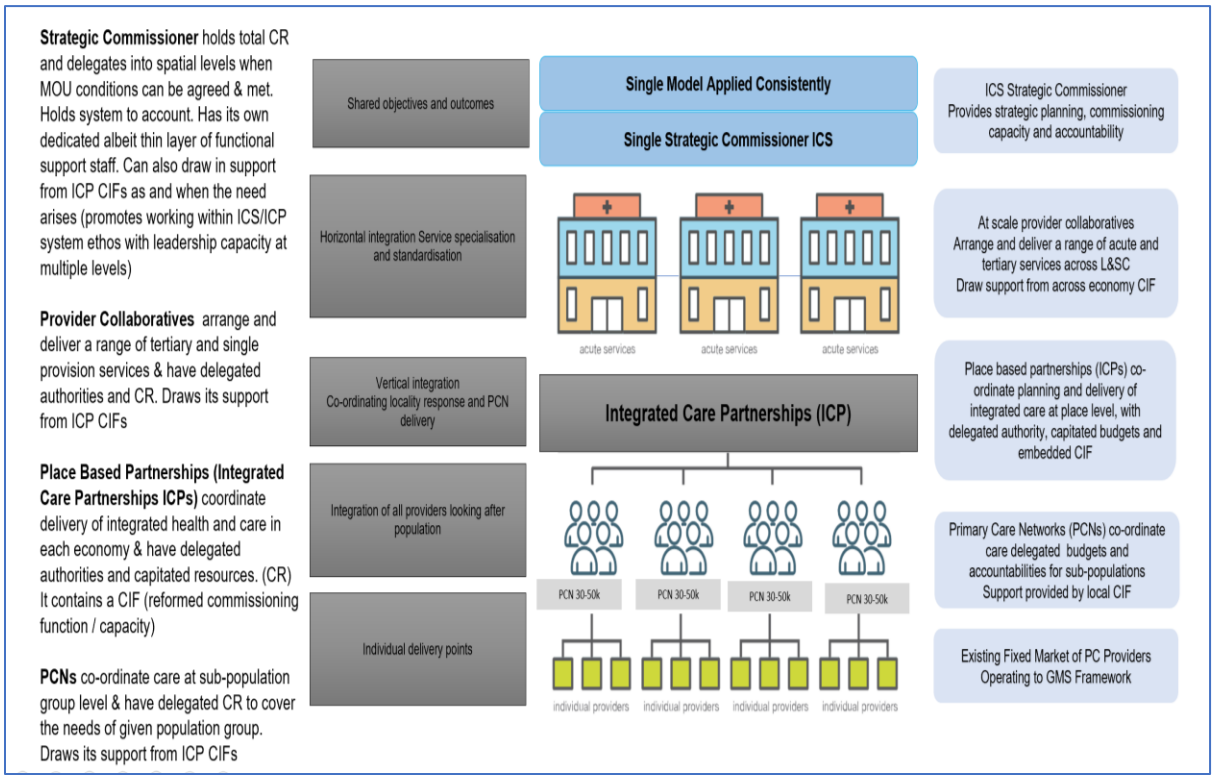
34) Provider Collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care as defined in the spatial model. The governance arrangements must enable the constituent organisations to hold/manage a shared budget and to address the associated shared risks and 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.

35) 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.

36) 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

37) 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 (e.g 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.).

38) The following diagram provides an overview of what this would likely look like.



39) The longer-term aim would be for other reform areas locally to be brought more closely into the Locality Board space, to help with the issues around the wider determinants of health and other local reforms

H. Values and Behaviours of the Bury Integrated Care Partnership

40) The effective operation of the Bury Integrated Care Partnership is a matter for all partners to positively commit and engage in accordance with an agreed set of values and principles. These have been developed through the IDCB and will be adopted across the whole Health and Care System. In summary, all partners to the partnership arrangements commit to the following 7 Values and Behaviours

Collaboration

Working cooperatively to achieve a common purpose, sharing responsibility and accountability.

- I take responsibility for developing and maintaining good relationships with all partners
- I take accountability for delivering on our collective purpose, vision and staying aligned to our principles, values and behaviours
- I will share organisational perspectives/challenges etc but remain focussed on putting the people of Bury first
- I will act with empathy to understand and appreciate the challenges and pressures that my colleagues are facing I keep others informed in a timely manner
- I will bring back the perspective of the IDC into my own organisation
- I will actively encourage participation/create the conditions that enable others to participate
- I will be proactive in participating
- I will role model the behaviours outside Board meetings as a system leader

Courage

Pushing past our comfort zone to take risks, challenge each other, have the hard conversations, and take the difficult decisions.

- I will contribute to difficult conversations/meetings and decisions
- I will choose courage over comfort by facing the difficult conversations/decisions
- I will stay aligned to our values when facing tough decisions
- I will take a risk even when the outcome isn't certain
- I surface concerns when I anticipate/experience conflict with a positive intent to seek resolution
- I will embrace challenge, fears, and feelings

Creativity

Trying new things together that we know will add value/improve outcomes.

- I look for the opportunities to try new things together
- I create a culture where people are given permission and psychological safety to fail and feel supported to learn from their experiences, free from blame.
- I am pragmatic in my approach to excellence
- I provide challenge or question the status quo/traditional way of doing things in a positive manner and am open to new ideas
- I will provide the space for new ideas, thinking, learning, discussion

Integrity

Consistently to do what we say we are going to do in accordance with our purpose, principles, values and behaviours.

- I act with honesty and truthfulness
- I keep my word
- I consistently practice and model the values rather than just professing them
- I will be honest about potential conflicts of intentions
- I act with the best of intentions

- I will act in the interest for the greater good

Inclusion

We will be inclusive in everything we do and address any potential barriers to this.

- I seek out and actively listen and involve others' views to develop ideas and solutions
- I will create a culture where everyone can feel safe, seen, heard, understood, and are respected
- I will create the conditions where everyone feels like they belong.
- I look for the strengths/talents in everyone and am inclusive in my daily practice
- I value and encourage diverse thinking and experiences and will be open in learning and understanding including what this means
- I will call out a lack of inclusion and discrimination where I see, hear, experience, or become aware of this
- I take decisions that will address the inequalities that exist within our population
- I will ensure we listen and coproduce with those who are seldom heard and most likely to experience discrimination and inequality.
- I actively seek to understand and remove barriers to inclusion
- I act with empathy, compassion, kindness to everyone

Making a difference

By doing together what no one partner can achieve on their own.

- I will look for the opportunities to work together that collectively add value
- I recognise what works already and build on that
- I will share information in an open transparent way in support of our collective goals
- I will share strengths/assets in the pursuit of our ambition, and I recognise that I may need to give something up for the benefit of the system.
- I will endeavour to bring my organisational colleagues along the journey with us to enable system working
- I will enable system working and remove organisational barriers/challenges to this
- I will adopt the methodology of co-production with partners, our staff and our communities
- I will strive for improvement

Trust

To be vulnerable with one another by being willing to admit our mistakes, share our struggles, or ask for help/support from others

- I am open and honest with my communication about what is going on in my organisation including when I don't know
- I communicate where there are any conflicting/competing priorities
- I consistently do what I say I am going to do
- I will not take action that could damage trust
- I will use curiosity to explore confusions
- I act with empathy and compassion to understand and appreciate everyone's individual pressures/challenges
- I am open and honest about any mistakes and own my mistakes
- I ask for support and clarify needs
- I will give and receive feedback in situations where it is felt trust has been damaged to restore trust
- I will not have conversations without the involvement/knowledge of our partners about actions that affect us
- I put my trust in my colleagues' abilities, knowledge and expertise

Refreshed Bury Locality Plan

The Bury Strategy for

Health, Care, and Well Being

Draft Version 6

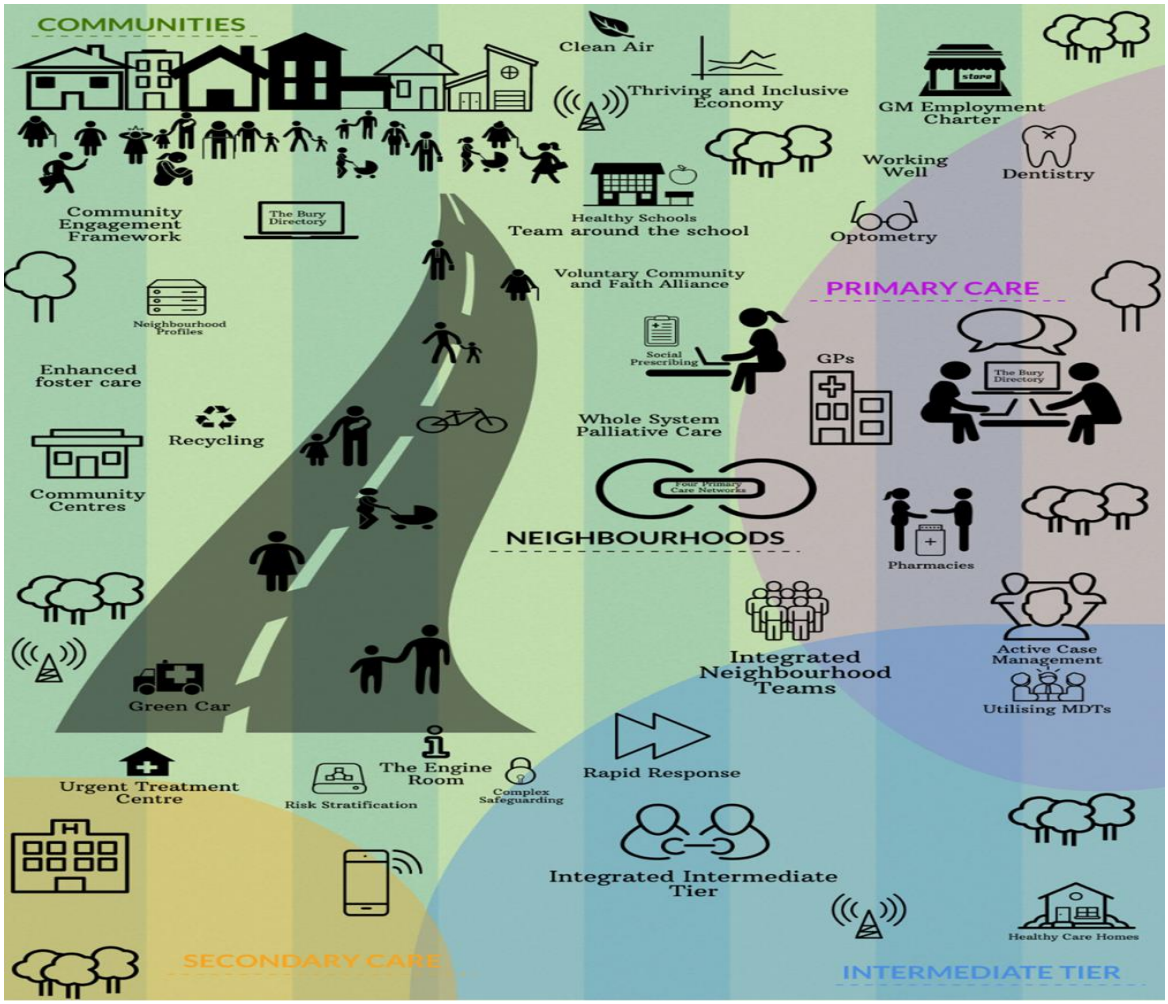
Endorsed at System Board 20/8/21

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.

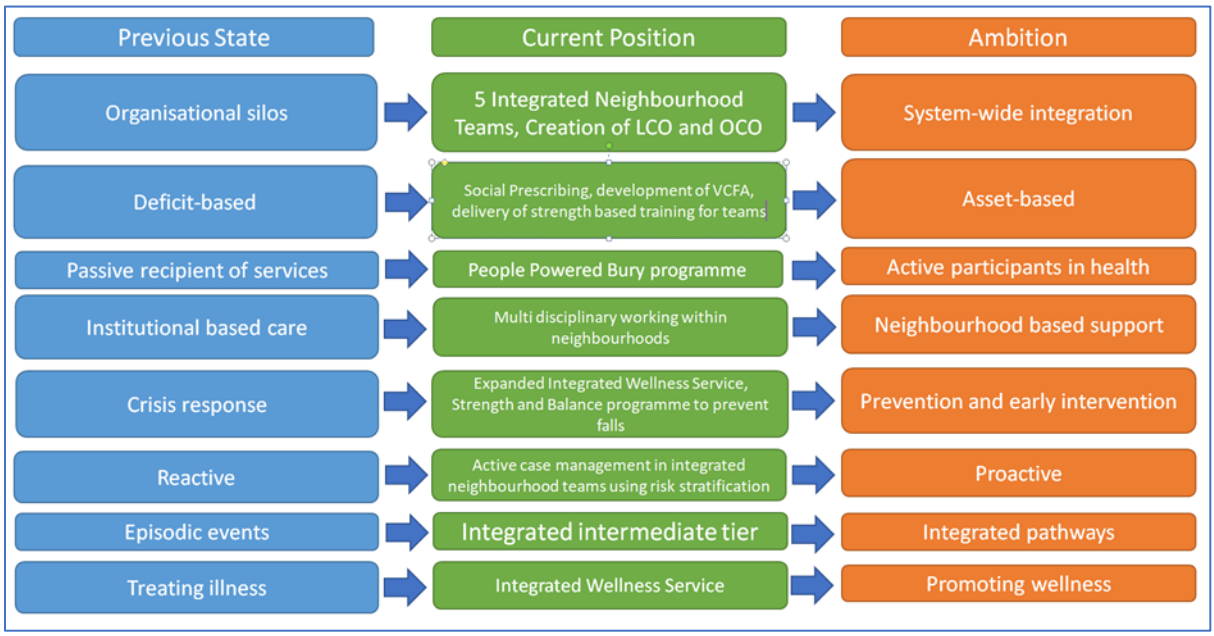
    c. The NHS White Paper of March 2021 has signalled a shift in the focus of the system – from competition to collaboration in the NHS, to a focus on 'place', to a blurring of the commissioning/provision distinction. It signals the end of CCGs from 31/3/22 to be replaced by a GM Integrated Care System 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...

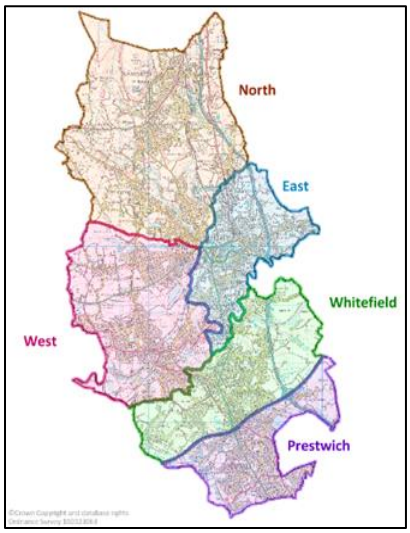
24. We have several excellent examples of co-design and co-production of transformed services that reflect these "I statements" with residents, carers and patients, for example in the SEND transformation programme, and in our work with residents with learning disabilities. However, we recognise that much can be done in the way we involve and engage people in the way se rvices 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.

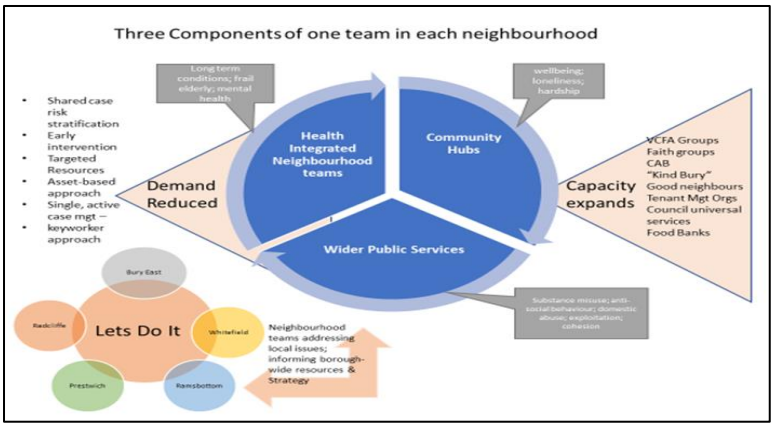
27. Integrated Neighbourhood teams (INTs) were created, providing unified management or a coordinating focus across community health services, adult social care and more recently community mental health services, and connected to communities. INTs have focused initially on delivering Active Case Management – 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.

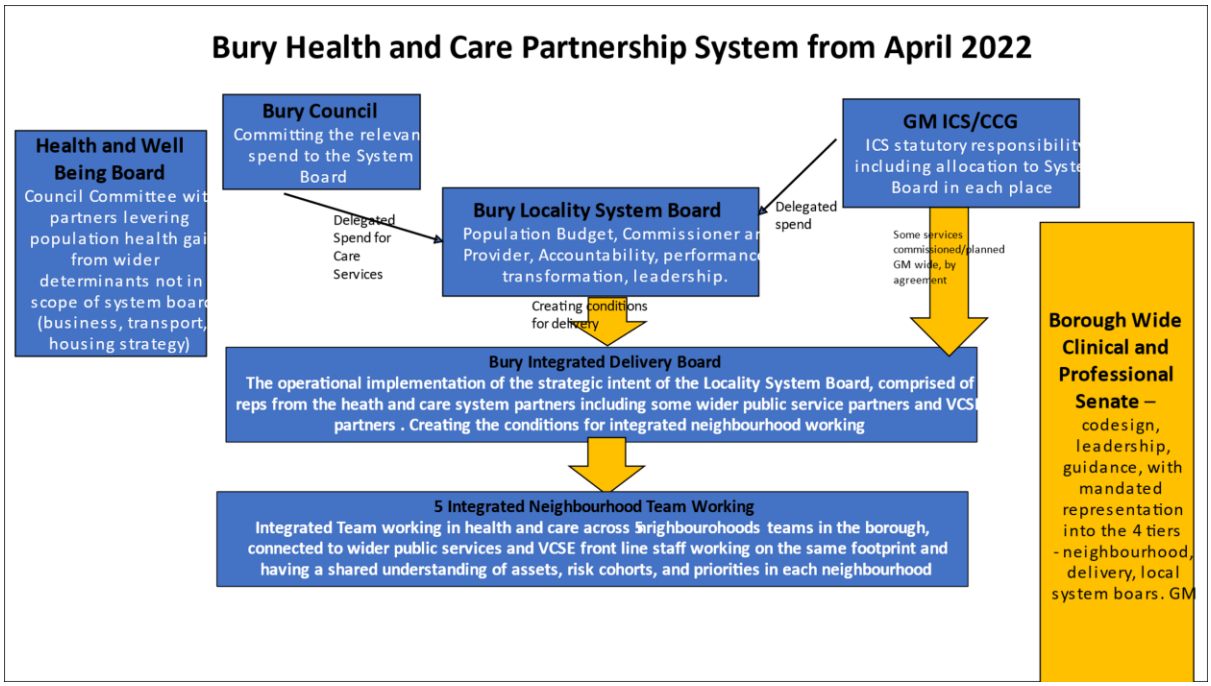
30. Neighbourhood team working in health and care is one part of a wider ambition in "Lets Do It" to build integrated teams of public services, working with communities differently. The other two parts – the work of community hubs, and the work to organise wider public services like GMP. DWP, housing 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.

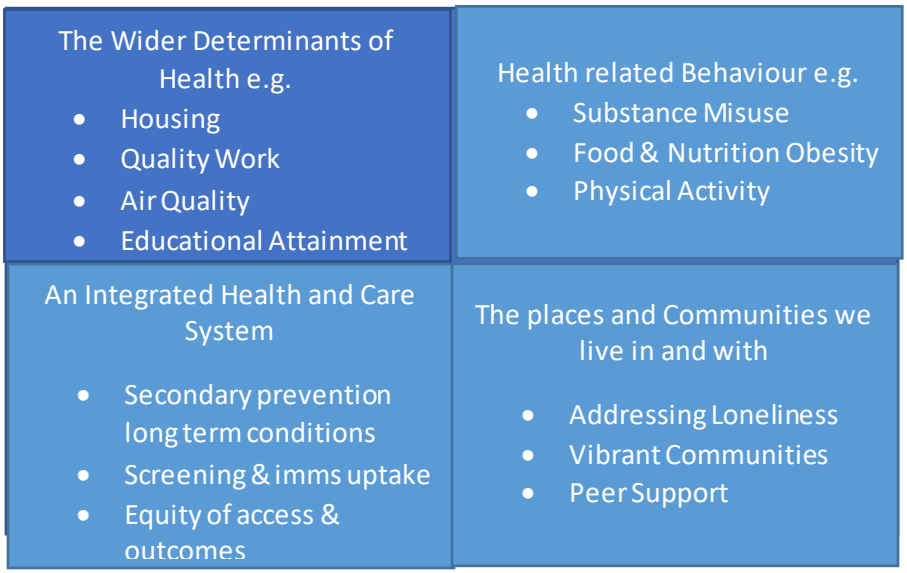
37. The programmes above are intended to transform the way key services work. There are, in addition, very many important programmes of work that reflect a business as usual – our work on safeguarding arrangements with partners and in the context of the Bury Integrated Safeguarding Partnership, or work 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.

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