AGENDA FOR

LOCALITY BOARD

Contact:
Please visit https://gmintegratedcare.org.uk/meetings-and-events for all information and papers
Website: www.bury.gov.uk

To: All Members of Locality Board

Councillors : E O'Brien (Chair), L Smith and T Tariq

Dear Member/Colleague

Locality Board

You are invited to attend a meeting of the Locality Board which will be held as follows:-

Date:	Monday, 2 September 2024
Place:	Microsoft Teams
Time:	4.00 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.

AGENDA

1 **FULL MEETING AGENDA PACK** *(Pages 3 - 272)*

Agenda Item 1

BURY INTEGRATED CARE PARTNERSHIP

Agenda

Locality Board – Meeting in Public (via Microsoft Teams)

Date: 2nd September 2024

Time: 4.00 pm – 6.00 pm

Venue: Via Microsoft Teams

Chair: Dr Cathy Fines

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.	4.00 – 4.05	5 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.			Declarations of Interest	Paper	Information	Chair
3.			Minutes of previous meeting held on 8th July 2024	Paper	Approval	Chair
4.			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.	4.05 – 4.15	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Locality Board Priorities/Deep Dive - Childrens Services						
6.	4.15 – 4.25	10 mins	NHS contribution to the Childrens improvement board plan and the SEND plan.	Presentation	Discussion	Will Blandamer
7.	4.25 – 4.35	10 mins	Overview of Health Service Provision for Looked after Children	Paper	Discussion	Catherine Jackson
8.	4.35 – 4.45	10 mins	Family safeguarding model	Presentation	Approval / Discussion	Linda Evans
9.	4.45 – 4.50	5 mins	Minutes of the SEND Improvement Board	Paper	Information	Will Blandamer
Integrated Delivery Collaborative Update						
10.	4.50 – 4.55	5 mins	Integrated Delivery Collaborative Update	Paper	Discussion	Kath Wynne-Jones

11.	4.55 – 5.05	10 mins	Manchester Foundation Trust Strategy/ North Manchester Hospital development	Paper	Discussion	Sophie Hargreaves
12.	5.05 – 5.15	10 mins	Workwell Partnership Vanguard	Paper	Approval	Jon Hobday
13.	5.15 – 5.25	10 mins	Bury's Palliative & End of Life Care Service Model Development	Paper	Approval/ Discussion	Will Blandamer
14.	5.25 – 5.35	10 mins	Mental Health Commissioning Proposals	Paper	Approval	Will Blandamer
'Quadruple Aims' Updates						
15.1 15.2	5.35 – 5.45	10 mins	Strategic Finance Group Update Section 75 Agreement	Paper Paper	Discussion Discussion	Simon O'Hare
16.	_____	Take as read	Primary Care Commissioning Committee update	Paper	Information	Adrian Crook
17.	_____	Take as read	System Assurance Committee update	Paper	Information	Catherine Jackson
18.	5.45 – 5.50	5 mins	Performance Report	Paper	Information	Will Blandamer
19.	_____	Take as read	Clinical and Professional Senate update	Paper	Information	Kiran Patel
20.	5.50 – 5.55	5 mins	Population Health & Wellbeing Update	Verbal	Information	Jon Hobday
Closing Items						
21.	5.55 – 6.00	5 mins	Any Other Business		Verbal	
22.	_____	_____	**Date and time of next meeting in public - Monday, 7th October 2024, 4.00 - 6.00pm at Bury Town Hall**		_____	

Meeting: Locality Board			
Meeting Date	2nd September 2024	**Action**	Consider
Item No.	2	**Confidential**	No
Title	Declarations of Interest		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary

NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).

NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.

The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.

Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.

In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.

The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.

There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

Recommendations

It is recommended that the Locality Board:-

- Receive the latest Declarations of interest Register;
- Consider whether there are any interests that may impact on the business to be transacted at the meeting on 2nd September 2024 and
- Provide any further updates to existing Declarations of Interest within the Register.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						

Implications						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

Committees and Sub-Committees

Locality Board

Declaration of interest as per policy:
- Declare in meetings where relevant
- Not to be sent papers where conflicted
- Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting)
- Remaining present at the meeting but withdrawing from the discussion and voting capacity
- Remaining present at the meeting and participating in the discussion but not involved in any voting capacity
- Being asked to leave the meeting

Name			Current Position	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments		
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To			
Voting Members (Pooled Budget & Aligned & Non-Pooled Budget)														
Cllr	Eamonn	O'Brien	Leader of Bury Council & Joint Chair of the Locality Board	Bury Council - Councillor Young Christian Workers - Training & Development Labour Party Prestwich Arts College Bury Corporate Parenting Board No Barriers Foundation CAFOD Salford Prestwich Methodist Youth Unite the Union	X X	 X X X X X X X		Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct	Councillor Development Team Member Governor Member Trustee Member Trustee Member			As per policy - see details above		
Cllr	Tariq	Tamoor	Executive Member of the Council Adult Care and Health	Bury Council - Councillor Health Watch Oldham Pretty Little Thing Action Together CIC The Derby High School St Lukes Primary School Unite the Union Labour Party	X X X	 X X X	 X	Direct Direct Indirect Direct Direct Direct Direct Direct	Councillor Manager Spouse Employed Governor Member Community Member Member	May 2010 August 2020 Present April 2018 May 2012 June 2007	Present	As per policy - see details above	######	Y
Cllr	Smith	Lucy	Locality Board Member	Bury Council Business in the Community The Christie NHS Foundation Trust Labour Party Community in the Union Socialist Health Association Catholics for Labour GMB Union	X X	 	 	Direct Direct Indirect Direct Direct Direct Direct Direct	Councillor Related to spouse Member Member Member Member Member	July 2023 July 2023	Sept 2023 Present	As per policy - see details above (Y,Y,Y,Y,Y)		
Dr	Fines	Cathy	Associate Medical Director and Named GP	GP Federation Tower Family Health Care Horizon Clinical Network Greater Manchester Foundation Trust	X X X	 	 	Direct Direct Direct Indirect	Practice is a member Partner in a member practice in Bury Locality Practice is a member Husband is employed	2013 2017 2019	Present	Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)		
	Jackson	Catherine	Executive Nurse	NCA				Indirect	Partner is the Director of Patient Safety & Professional Standards at the NCA.	25/10/2021	Present	As per policy - see details above		
	Ridsdale	Lynne	Chief Executive for Bury Council	Bury Council		X		Direct	Chief Executive	Mar-23	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	O'Hare	Simon	Associate Director of Finance – Bury Interim Associate Director of Finance – HMR	Simkat Shore Holdings LTD	X			Direct	Director	2	Present	As per policy - see details above. (Y,Y,Y,Y,Y)	######	Y
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest		Present		######	y
	Heppolette	Warren	Chief Officer for Strategy & Innovation	Greater Sport FC United			X X	Direct Direct	Trustee Director	2018 2021	Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		
Voting Members (Aligned & Non-Pooled Budget)														
Dr	Howarth	Vicki	Member of the Locality Board	Unilabs Ltd - Private Histopathology Service Tameside and Glossop Integrated Care NHS Foundation Trust	X X	 	 	Direct Direct	Providing services as Consultant Histopathologist to the Alexandra Hospital, Cheadle. Bank Consultant Histopathologist performing Coronial Post-Mortems for Manchester South Coroner	2011 2015	Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest		Present			
	Allan	Lorna	Chief Digital and Information Officer Digital Services, NCA	Trustee at St Leonard's Hospice in York			x	Direct	Trustee	Dec-23	Present			
	Stott	Jill	Declaration of Interest form awaited											
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice Bury GP Federation - Enhanced Primary Care Services Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments Tower Family Health Care - Primary Care General Practice	X X X 	 	 	Direct Direct Direct Indirect Indirect	GP Partner Medical Director Medical Director Spouse is a Shareholder Spouse is a Director	July 2018 April 2018 1994 2012 July 2018	Present Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest		Present			
	Hargreaves	Sophie	Member of the Locality Board	Manchester & Trafford LCO				Indirect	Spouse works as Transformation Manager	Sep-18	Present	As per policy - see details above (Y,N,N,N,N)		
	Tomlinson	Helen	Member of the Locality Board	H Tomlinson is Chief Officer in organisation which may seek to do business with health or social care organisations Bury One Commissioning Organisation	X			 Indirect	H Tomlinson is Chief Officer in organisation which may seek to do business with health or social care organisations Close family member is an employee at Bury One Commissioning Organisation	01/11/2021 Nov 2021	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	Blandamer	Will	Deputy Place Based Lead & Executive Director Health and Adult Care	Ashton on Mersey Football Club Trafford Manchester Football Association Ashton on Mersey Rugby Club Trafford Manchester Foundation Trust (Trafford) & Francis House Hospice (Manchester) University Hospital of Wales Leeds University			X X X	Direct Direct Direct Indirect Indirect Indirect	Chairman Board Champion for Safeguarding Director Spouse is a Community Nurse & Qualified Nurse Daughter is a Junior Doctor Daughter is a medical student	2018 2018 2023 2024 2024 2019	Present Present Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	Richards	Jeanette	Executive Director of Children and Young People, Bury Council	None Declared					Nil Interest		Present			
	Hobday	Jon	Director of Public Health	None Declared					Nil Interest		present	As per policy - see details above		
	Crook	Adrian	Director of Adult Social Care and Community Services Member of the Locality Board	Bolton Hospice			X		Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
Non-Voting Members														
	Wynne-Jones	Wynne	Member of the Locality Board	KWJ Coaching and Consulting Roots and Branches CIC The University of Manchester - Elizabeth Garrett Anderson programme	X X X	 	 	Direct Direct Direct	Owner Director Tutor	July 2021 Nov 2023 Oct 2022	Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	Passman	Ruth	Chair of Bury Healthwatch	None Declared					Nil Interest			As per policy - see details above		
	Wilkinson	Catherine	Member of the Locality Board	Bury Provider Age UK Lancs	X		 X	Direct	Director of Finance Trustee and Treasurer	November 2020 May 2018	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
Invited Members														
Cllr	Bernstein	Russell	Cllr Bury Council, Conservative Leader	Bury Council Philips High School Bury and Whitefield Jewish Primary Conservative Party	X	 X	 X X	Direct Direct Direct Direct	Councillor Councillor	May 2021 September 2019 September 2019 July 2019	Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		
Cllr	Smith	Mike	Attendee of the Locality Board as Leader of Radcliffe First	Angles and Arches Anodising Colour Radcliffe First Radcliffe Litter Pickers Growing Older Together	X	 X X X		Direct Indirect Direct Direct Direct	Director Spouse is a lab technician Leader Member Member	16/1/2009 2017 2019 2019 2019	Present Present Present Present Present	As per policy - see details above (Y,Y,Y,Y,Y)		

Meeting: **Locality Board**			
Meeting Date	03 September 2024	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 1st July 2024 and action log		
Presented By	Cllr Eamonn O'Brien/Dr Cathy Fines, Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead			

Executive Summary

The minutes of the Locality Board meeting held on 1st July 2024 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decision and actions agreed.

Recommendations

It is recommended that the Locality Board:-

- Approve the minutes of the previous meeting held as an accurate record;
- Provide an update on the action listed in the log.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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

Implications						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

Draft Minutes

Date: Locality Board, 8th July 2024

Time: 4.00pm

Venue: Teams

Title	**Minutes of the Locality Board**
Author	Chloe Ashworth
Version	0.1
Target Audience	Locality Board
Date Created	9th July 2024
Date of Issue	July 2024
To be Agreed	02nd September 2024
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:

Date	Version	Author	Notes
09th July 2024	0.1	Chloe Ashworth	Draft Minutes produced
Approved:			
Signature:			..... **Add name of Committee/Chair**

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public 09th July 2024 4.00 pm until 6.00 pm **Chair – Councillor E O'Brien**

ATTENDANCE

Voting Members
Dr Cathy Fines, Senior Clinical Leader in the Borough Cllr Eamonn O'Brien, Leader of Bury Council **(Chair)** Cllr Lucy Smith, Executive Member of the Council for Children and Young People Cllr Tamoor Tariq, Executive Member of the Council for Health and Wellbeing Ms Lynne Ridsdale, Place Based Lead Mr Neil Kissock, Section 151 Officer Ms Catherine Jackson, Executive Nurse Ms Joanna Fawcus, Director of Operations, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Jill Stott, Director of Nursing Bury Care Org (NCA) Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care Mr Jon Hobday, Director of Public Health Ms Jeanette Richards, Executive Director of Children & Young People Mr Adrian Crook, Director of Adult Social Services and Community Commissioning Dr Vicky Howarth, Medical Director, NCA Mr Simon O'Hare, Associate Director of Finance Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Ms Helen Tomlinson, Chief Officer
Non-Voting Members
Ms Kath Wynne-Jones. Ms Ruth Passman Ms Catherine Wilkinson, Director of Finance, NCA
Invited Members
Cllr Russell Bernstein, Conservative Opposition Party Mr Ian Trafford, Head of Programmes, IDCB Ms Chloe Ashworth, Democratic Services, Bury Council Fin McCaul,
Observers
Ms Ceri Kay, Legal Services, Bury Council

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from, Dr Kiran Patel, Medical Director, IDCB, Ms Sophie Hargreaves, Councillor Mike Smith, Ms Lorna Allan and Ms Ruth Passman.
1.3	The meeting was declared quorate and commenced.

2	Declarations Of Interest
2.1	NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).
2.2	NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
2.8	**Declarations of interest from today's meeting held on 08th July 2024** No declarations to note.

ID	Type	The Locality Board	Owner
D/06/01	Decision	Received the declaration of interest register.	

3	Minutes Of the Last Meeting and Action Log		
3.1	The minutes from the Locality Board meeting held on 03rd June 2024 were considered as a true and accurate reflection of the meeting.		
ID	**Type**	**The Locality Board**	**Owner**
D/06/02	Decision	Accepted the minutes and actions from the previous meeting as a true and accurate reflection of the meeting.	
D/06/06	Decision	Ratified the following recommendations from June's meeting: a) The commissioning of a provider of adult ADHD and ASD assessments and follow up treatment (for ADHD) and support. b) That Bury commissions this jointly with Oldham and HMR	

4	Public Questions
4.1	There were no public questions.

5	Place Based Lead Update
5.1	Ms Ridsdale introduced her item which provided an update on the key issues of the Ofsted/CQC inspection of SEND arrangements. It was reported that: - • Members were informed that the Council has been issued with an Improvement Notice following the SEND inspection which was issued via the Leader and published after the election. • Overview and Scrutiny is taking place with Ms Deborah Glassbrook' as Chair of the SEND Improvement and Assurances Board to co-produce the improvement plan. To support the delivery of the plan, Workstream Leads would each co-produce detailed operational plans. These operational plans would provide key assurance activity, including performance data and quality assurance findings that will be monitored by the SEND Improvement Assurance Board (SIAB) and would provide the tracking mechanism for the progress of actions and impact. Each Priority Action (and Area for Improvement) had a nominated lead officer, who would be a senior officer within their organisation. They would provide monthly highlight reports to the SIAB and ensure monthly reviews of the risk register. • The Department for Education has highlighted that the improvement work required is to be delivered over a two-year programme. Whilst improvement is still within the early stages and services are facing more demands, more capacity is expected, and mainstream inclusion is the expected approach to continue. • Further to the update to the June Locality Board, the ICB is undertaking a series of assurance visits to each locality – focused primarily on the delegated ICB functions to ICB locality teams, but also reviewing the effectiveness of the orchestration and operation of the wider health and care partnership in each locality and with a particular focus on key NHS GM priorities around urgent care, mental health and primary care. Formal feedback has not yet been received but broadly the visit was positive. • In relation to performance Ms Ridsdale provided assurance to the Locality Board that local assurance meetings are taking place to monitor improvement progress and the first meeting of this group took place on the 20th June 2024. • The ICB is required to produce a 5-year sustainability plan - demonstrating a road to a financially sustainable future for the GM health and Care system. In accordance with the ICP Strategy this plan balances the need for cost effective, efficient and quality service delivery with the requirement to change the key determinants of health and care service demand through improved population health. The sustainability plan is in development and brings together a range of key programmes of work into a unified framework, including the Carnel Farrar analysis and proposition on population health gain, the work of Health Innovation Manchester, and the potential work of the GM Health and Care review. Work has continued on the Greater Manchester ICP Sustainability Plan and the Greater Manchester ICB Improvement Plan covering Leadership, Performance and Quality.

The June Locality board received an update on the 'undertakings' arrangements for NHS GM. As part of these arrangements the ICB is required to deliver an improvement plan for the year 24/25. The plan and governance arrangements are being finalised and will be considered by the July NHS GM Board.

- While reported prevalence of COVID remains relatively low and there are relatively few patients in hospital with COVID, it remains really important that eligible cohorts continue to receive their vaccinations, including Housebound patients, those with Learning Disabilities, immunosuppressed patients and those with Serious Mental Illness. It was reported that the spring vaccination campaign in Bury was very successful and Bury was the second best locality in GM in terms of uptake.

- A programme of work is in place by the Health of LAC & Care Leavers Steering Group (last meeting 19th June) chaired by NHS GM (Bury) the Designated Nurse for Looked after Children & Care Leavers – Sophie Babb under the auspices of the Council Corporate Parenting Board to continue to strengthen the quality of initial health reviews, the availability and timeliness of services, and the provision of health summaries to young people. This will be circulated to all locality board members in due course. The Locality Board will note Mark Riddell will be visiting Bury on August 6th and 7th to review corporate parenting arrangements including access to health services. Mark Riddell is the National Implementation Adviser for Care Leavers at the Department for Education.

- The locality board receives an update on the work across the whole system in supporting urgent and emergency care in the borough, up to and including the focus on 4 hour waits and Days Kept Away From Home. Members were reminded of the NHS England letter of 26th June focusing on patient safety and quality and specifically Maintaining focus and oversight on quality of care and experience in pressurised services

The following comments/observations were made by Locality Board members: -

- Mr Blandamer reported Pennine Care and the NCA have done some great joint working on SEND waiting times, Support and ADHD referrals.
- Dr Cathy Fines questioned the Neuro-Developmental Pathways and was informed work is being completed with Jane Case who has a dual role with the Council and the NHS.
- An update on progress against the SEND Improvement Plan should be brought back to the Locality Board ahead of the six months review due in November 2024.

ID	Type	The Locality Board	Owner
D/06/04	Decision	Received the update.	
A/06/01	Action	To bring an update on the SEND Improvement Plan ahead of the review in November 2024	Mrs Kennett

6.1	Urgent Care Performance
6.1	Mr Blandamer submitted a presentation in relation to an update on performance and plans against the metrics in the Bury UEC Locality Performance Improvement Plan, and Ms Joanna Fawcus provided an overview.
6.2	It was reported that: -

- This report measures the 4-hour performance for Bury registered patients attending any A&E department anywhere in the country. The data for the whole system performance report states May performance as 65.3% however the later cut now shows this as 64.9%.
- Bury is currently showing as above the GM average of 63.7% and is ranked 4th in GM (although HMR is not a like for like comparison).
- This report also measures the 4-hour performance at Fairfield General Hospital for all A&E attendances. Data shows Fairfield General Hospital performance of 64.39% for May which is below plan (66% for May). This figure is also down slightly from the 65.75% performance attained in April.

6.3	The following comments/observations were made by Locality Board members: - • Winter preparations are now taking place • Attendance at Accident and Emergency has decreased from April 24 to May 24.

ID	Type	The Locality Board	Owner
D/06/05	Decision	The Locality Board are asked to note and provide any comments in relation to the update.	All

7.0	Integrated Delivery Collaborative Update
7.1	Ms Kath Wynne-Jones submitted a report which set out an update to the Board on progress with the work of the IDC, and progress with the delivery of programmes across the Borough. In the absence of Ms Wynne-Jones, Mr Will Blandamer provided an overview of the report.
7.2	The paper outlined key developments over the past month including: • Establishing programmes of work for the major conditions board, community and elective, and the neighbourhood delivery programme. • Aligning capacity to support the delivery of agreed priorities. There is a workshop planned for the 25th June to consider how to improve management support arrangements across the Borough to deliver set priorities • Following up the initial VCSE and IDC workshop in April to consider opportunities for the development of greater partnership working to support workforce challenges. A further workshop is planned for July • Aligning work across partners to support the Bury Care Organisation Discharge and Flow Collaborative. Specific workshops have been held focusing on care homes, primary care, urgent and crisis response and community pathways. High intensity users and mental health pathways have been identified as a specific challenge. Specific workshops will be held for these 2 areas • Realignment of the neighbourhood programme to support delivery of the agreed priorities at the workshop in May • Continuation of discussions at GPLC to ensure greater cohesiveness between neighbourhood and GPLC priorities. • Preparation for North neighbourhood Primary Care and Community Pharmacy engagement on the 25th June. • Discussions with HINM regarding support for the Borough regarding digital opportunities of GMCRS. • Opportunities scoped regarding potential pathway improvement for respiratory. • Risk management training workshops processes agreed for July / August to support the new risk reporting processes

ID	Type	The Locality Board	Owner
D/06/06	Decision	The Board noted the progress of the strategic developments, and progress of the programmes	All

8	Public Service Reform and Neighbourhood Development
8.1	In the absence of Ms Wynne-Jones, Mr Will Blandamer provided an overview of the report in relation to Public Service Reform and Neighbourhood development. It was reported that: - • Over the past year Neighbourhood working has matured with examples of the LETs principles being reflected in practice through the operation of PSLTs and the Neighbourhood health and care model. • There is a lot to be proud of relating to neighbourhood working, which needs to be celebrated • There are agreed priorities which will start to contribute to the long term population health improvement • There are a number of significant development conversations to have over Q2 to accelerate our ambitions for neighbourhood working, and to ensure we connect strongly to the PSR agenda

	• There are some risks facing the neighbourhood programme the key ones being alignment being neighbourhoods and PCN's and available capacity to support the programme. The following comments/observations were made by Locality Board members: - • Mr Ian Trafford advised that a full evaluation of each neighbourhood has been conducted and can be shared with the Locality Board. • It was unanimously agreed that all partners resources should be involved in the delivery of neighbourhood development and should be brough back as a future item on how this looks in practice for all partners

ID	Type	The Locality Board	Owner
D/06/07	Decision	• Note the contents of the paper. • The Locality Board to acknowledge and promote the wider assets we have within the community and how they contribute to positive outcomes. • The Board to provide feedback on how best to build and share information on assets with partners to ensure they are effectively utilised for maximum impact on residents health and wellbeing. • Mr Ian Trafford to provide the piece of work which evaluated each neighbourhood to the Locality Board • Item to be brough back at a future date	All Mr Trafford

9	GM Health and Care Services Review
9.1 9.2	Mr Warren Heppolette was in attendance to provide a briefing paper that gave an overview to the introduction of Greater Manchester (GM) Health and Care Service Review, which will be informed by data and be clinically led. It was reported that: - • The paper set out the approach that will be undertaken in relation to the Health and Care Service Review and the services in scope for 2024/25 and provides an indication of some of the services being considered for future years which are yet to be finalised. • The board is asked to consider the approach set out in the Health and Care Service Review – Our Approach document and provide comments and feedback in order to inform the development of a final document which will be adopted to deliver the aims and objectives of the Health and Care Service review and the service in scope for the current and future financial years.

ID	Type	The Locality Board	Owner
D/06/08	Decision	The Locality Board is asked to note the update provided.	All

10	FLP Work Plan/Steering Group
10.1 10.2	Ms Joanna Fawcus presented an update to the Locality Board in relation to the Four Localities Partnership and Single Elective Workplan. It was reported that: - • The Four Localities Partnership has become established as a mechanism to support collaborative working between the NCA and Salford, Bury, Oldham and Rochdale localities. • It was established in 2022 in recognition of the fact that, whilst partners share the commitment to a GM operating model which is anchored in Place, there are common finance, quality and health outcomes challenges across our localities which benefit from collaborative working across the footprint. • The partnership has been successful in the development of specific FLP wide change programmes (for example the Discharge Integration Frontrunner programme) and in improving the co-ordination of our work within the GM system. • Partners have expressed a desire to go further where we have clear shared priorities, in establishing shared governance and leadership arrangements for these programmes of work. There is also a desire to embed clinical leadership more directly within our FLP governance arrangements, and to establish a mechanism to collectively address performance issues.

	• An updated FLP Operating Model has been developed and endorsed by the FLP Steering Group to satisfy these requirements

ID	Type	The Locality Board	Owner
D/06/09	Decision	he Locality Board noted the update.	All

11	Strategic Finance Group Update
11.1	Mr Simon O'Hare submitted
11.2	It was highlighted that: -
11.3	The financial position of all partners continues to be very challenged in 2024/25. NHS Greater Manchester (GM) remains in undertakings with NHS England, and this brings additional scrutiny and rigour around finance, performance and quality. In the latest financial planning submission to NHS England in early June, NHS GM had a deficit plan of £175m, which has improved from the previous submission. To enable this overall system position all organisations and functions within NHS GM have Cost Improvement Plans (CIP) of 5%, including the Northern Care Alliance (NCA), Pennine Care Foundation Trust (PCFT), Manchester Foundation Trust (MFT) and the Bury Locality. The delivery of these targets and overall financial positions is being rigorously monitored at a local, regional and national level. As in 2023/24, the Locality Board has delegated responsibility for the budgets delegated to the locality from NHS GM. The total value of these opening budgets, after the removal of the 5% CIP target is £99.9m. An update on locality operating costs budgets will be brought to the next meeting. The local schemes for 2024/25 brought to the last Locality Board are subject to potential revision and a further update will be brought to the next Locality Board with revised values.

ID	Type	The Locality Board	Owner
D/06/10	Decision	• Note the contents of this report • Note the likely change to BCF discharge and UEC capacity schemes monies approved at the last meeting and expect an update at the next meeting. • Approve the delegated Locality Healthcare budgets and await an update on operating and admin costs budgets at the next locality board.	

12	Primary Care Commissioning Update
12.1	Mr Adrian Crook presented the Primary Care Commissioning update which was provided as a highlight report from the meeting held on the 28th May 2024.
12.2	The Locality Board were provided with updates in relation to: • GM Primary Care Blueprint Delivery Plan Year 1 approach and agreed actions to be taken. • Q4 Contracting overview of performance against Primary Care Contracts across Bury at the end of 2023/2024 and resumption for 2024/25. • Primary Care Quality Visits (PCQV) for 2024/25. • Quality Outcomes Framework • Capacity Access Improvement plans- achievement of the Primary Care Networks (PCNs) Capacity and Access Payment (CAP) Plan and the timescales, locally and at Greater Manchester (GM) level. • Review of additional support programmes including schemes and recommendations for winter 2024/25. • The latest CQC position of practices in the borough and comprehensive and assessment- based inspections differentiation. • Primary Care Programme • Primary Care Risk Register

ID	Type	The Locality Board	Owner
D/06/11	Decision	• note the highlight report from the last Primary Care Commissioning Committee.	

13	Pharmacy First update

13.1 13.2	Mr Fin McCaul, Portfolio Clinical Lead presented the Pharmacy First update which provided information and next steps in relation to supporting Pharmacy First in Bury, including NHS Pharmacy Contraception and NHS Hypertension Case-Finding services in Bury It was reported that: - The paper references work being developed to strengthen communication and relationships between General Practice and Community Pharmacy colleagues. The work is being addressed in line with the GM "Primary Care Demand – Supporting General Practice and Community Pharmacy" document, as per the recommendations: • Managing patient expectations • Strengthening communication between General Practice and Community Pharmacy • Reducing the number of short notice routine repeat prescription requests.

ID	Type	The Locality Board	Owner
D/06/12	Decision	• Noted the update provided.	

14	Performance Report
14.1	Mr Blandamer presented the latest Performance Report to the Locality Board and the second time to Board had received this update in this format. Members were guided through the current performance presentation. The following comments/observations were made by Locality Board members: - • This was an easy read report, and members preferred this style • Members requested that the narrative and explanations on why issues may be occurring would be beneficial. It was agreed that a revised Performance Report in light of the error contained within the original report relating to non -elective admissions be circulated following the meeting.

ID	Type	The Locality Board	Owner
D/06/13	Decision	Received the update.	

14	Performance Report
14.2	Mr Hobday presented a brief overview of the Bury Population Health Improvement Report which included the health and wellbeing outcomes framework. Members were informed that the following areas are performing positively: • % Youth Not in Education, Employment or Training, 16–17-year olds (NEET) • % people (16-64 years) in employment • Economic inactivity • Homelessness (households with dependent children) Areas where the need for improvement has been identified are: • Number of children living in relative low-income families (under 16s) • Children in relative low income (under16s) • Children in care Members discussed the complexity of the issues identified and discussed some of the targeted intervention that has taken place and made a difference.

ID	Type	The Locality Board	Owner
D/06/13	Decision	Received the update.	

15	Any Other Business
	There were no items raised.

ID	Type	The Locality Board	Owner
D/06/15	Decision	Noted the information and the meeting in public was closed at 17.53pm.	

Locality Board

Action Log – June 2024

Status Rating: • **In Progress** **Completed** • **Not Yet Due** **Overdue**

Date	Reference	Action	Lead	Status	Due Date	Update
8th April 2024	A/04/01	The Locality Plan/operational planning priorities submitted to the March Locality Board to be revisited in the context of the draft Operational Plan. Mr Blandamer reported that there was an update on priorities included within the Integrated Delivery Report on today's agenda and there was a need to refresh the wider Locality Plan for the borough as part of this work. Mr Blandamer would speak to Ms Wynne-Jones in this regard.	Mr Blandamer	In progress	July 2024	
3rd June 2024	A/06/01	Amendment required to the IVF section of the report ahead of publication of papers following the election	Mrs Kennett	In progress	July 2024	
3rd June 2024	A/06/02	Agreed to check how views had been gathered as part of the Dermatology Transformation programme work.	Dr Fines	In progress	July 2024	
3rd June 2024	A/06/03	A more substantial update on A&E 4 hour waits to be brought back to a future Locality Board meeting. There was also a need to clarify whether performance related to Bury patients or was site specific.	Mr Blandamer	In progress	July 2024	

Status Rating: • **In Progress** **Completed** • **Not Yet Due** **Overdue**

Date	Reference	Action	Lead	Status	Due Date	Update
3rd June 2024	A/06/04	The latest Population Health Framework to be circulated after the meeting so that the Board is sighted on totality of data working to.	Mr Hobday		June 2024	Circulated to members on Email.

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Place Based Lead Update - Key Issues in Bury		
Presented By	Lynne Ridsdale, Place Based Lead		
Clinical Lead	Dr Cathy Fines, Associate Medical Director, GM Integrated Care Board		

Executive Summary
To provide an update on key issues of the Bury Integrated Care Partnership
Recommendations
The Locality Board is asked to note the update.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

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:						

Implications						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

BURY INTEGRATED CARE PARTNERSHIP

1. Community Tensions

Locality Board colleagues will recall well the recent civil disorder experienced in many parts of the country following quickly from the tragic deaths of children in Southport. Locality Board colleagues will think of the very many members of the public frightened and harmed as a result of these incidents. I am sure locality board colleagues will also recognise outstanding public service from many public servants including health and care staff, and the role of the voluntary, community and faith sector in showing the best of us.

Thankfully we in Bury were not subject to the same level of disorder as some other parts of the country. I am profoundly grateful for the qualitive of collaboration in the borough between GMP, the County, voluntary and faith sector colleagues and others, despite widespread misinformation circulating on social media. Thanks particularly to a number of GP practices in the immediate vicinity of the Town Hall for engaging calmly and positively in sensible precautionary steps.

While the immediate challenge was averted, we should nevertheless recognise the very real harm and distress to well being caused particularly to colleagues from black and minority ethnic populations. I am aware partners such as Pennine Care and NCA and others have taken a number of steps to address risk and harm and I am sure we would all agree there is more work or us all to do in this space.

2. Fit for the future

Colleagues may be aware that from 5th August NHS GM launched an NHS Fit for the Future engagement programme. The programme invites the people of Greater Manchester to contribute to the vision for the NHS in GM the future that recognises a proud history, understands the significant challenges, and an ambition to Support people to live happy healthy lives, balance our finances and deliver great services.

More information on the campaign is available at https://gmintegratedcare.org.uk/fit-for-the-future/ and campaign materials are available at https://gmintegratedcare.org.uk/campaign_resource/campaigns/an-nhs-fit-for-the-future/
and members of the locality boards are invited to spread the word via your own channels and networks to let people know how they can get involved and share their views.

At a GM level there are two events for stakeholders and members of the public to have their say.

- Thursday 12th September 2024, 1.30pm to 4pm, Seminar room 1, Kings House, Kings Church, Sidney St, Manchester M1 7HB.
- Wednesday 25th September 2024, 6pm to 7.30pm, online using Microsoft Teams.

In Bury the locality board previously discussed the opportunity of the campaign and concluded that we really wanted to build out of existing communication arrangements rather than build a new one and we asked Bury Healthwatch and VCFA to work with GM colleagues. This work is continuing, and we will bring an update paper to the October locality board.

3. Car Parking at Fairfield General

Many colleagues have previously expressed concerns about car parking provision at FGH, including NCA, Pennine Care and Cllr representatives of local residents. We are pleased to confirm a planning application has been received by the council for consideration of the planning authority for the provision of a temporary car

park with 97 spaces on the formerly occupied by nurses' accommodation buildings which were demolished in late 2023.

4. Super MADE (Multi Agency Discharge Event)

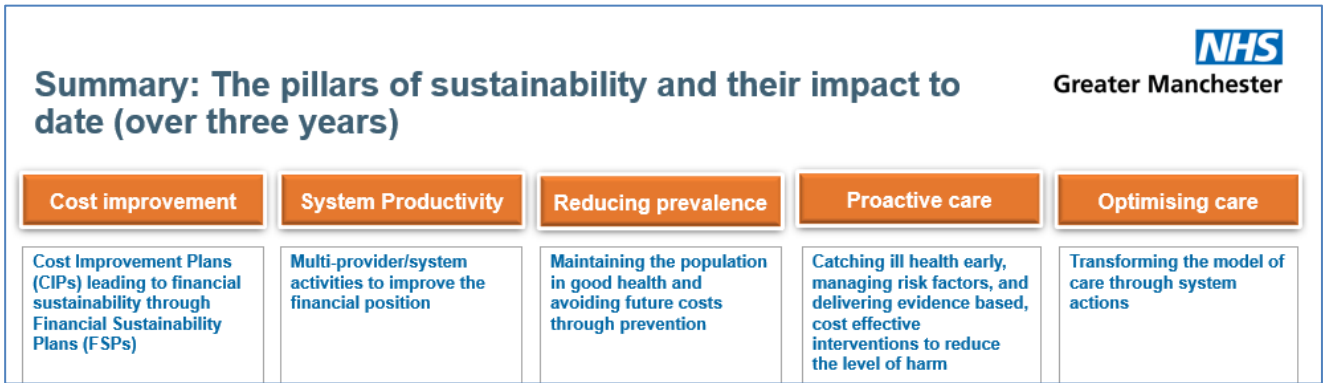
A MaDE event brings together local health and care system partners to support improved patient flow across the system, to recognise and unblock delays; and to challenge, improve, and simplify complex discharge processes. A GM Super MaDE will take place over seven days from Friday 6th September 2024 to Thursday 12th September 2024.

Clinical and operational staff from across the system are all involved. This includes representation from social care and links to the voluntary, community and social enterprise sector. Primary care, community care, mental health and acute organisations are all involved.

The contribution of Bury Colleagues is being co-ordinated through the twice weekly bronze meeting and an update will be provided to a future locality board in the context of an update on the operation of the urgent care system.

5. NHS ICP Sustainability plan

The last locality board meeting received a briefing on the work to establish the three-year ICP sustainability plan. This work is nearing completion and NHS leadership are invited to an event on 11th September to reflect on the plan and commit all possible endeavour to its achievement.
The sustainability is framed by 5 key pillars of work as below:



In the plan there is a strong recognition of the contribution of individual organisations in relation to for example cost improvement requirements. But there are also key system wide responsibilities in relation to, for example, reducing prevalence and optimising care.

The sustainability plan will act in part as an invitation to each of the 10 locality boards to make the fullest contribution to a fundamental reformed health and care system predicated on reducing prevalence, promotion of health and independence, and more integrated delivery of proactive care. We will look to consider the implications of the sustainability plan in terms of our own refresh of a vision for the Bury Health and Care system at the next meeting of the Locality Board.

6. GP Industrial Action

Since the last Locality Board, it will be recognised that the GP community nationally voted overwhelmingly for Industrial Action. The precise form of action to be taken is an individual GP practice decision but guidance on the potential actions have been circulated by the BMA and LMCs. GP practices are not obliged to report to NHS GM (Bury) on the nature of the action being proposed. The primary care improvement team is nevertheless working closely with practices and reporting issues through the current Bronze command arrangements. We will this week establish an additional Bury system meeting as proposed action becomes clearer.

In Bury we have recognised that some aspects of the work GP colleagues may wish to avoid during action are in fact elements of the 'reducing bureaucracy' chapter of the GP implementation plan previously considered by the Locality Board. It remains true that GP colleagues are frequently facing obstacles to supporting patient accessing appropriate services, or being asked to undertake tasks that should be done elsewhere in the system. We need to make more rapid progress as a whole system in supporting GPs in reducing unnecessary workload and bureaucracy and we will revisit this chapter with all partners.

7. Falls admissions from care homes.

Last week Bury received welcome recognition for the work being done to reduce the number of ambulance admissions from care homes into hospital. The digital health initiative was piloted across 37 care homes in Bury using a deterioration management and multifactorial falls prevention app.
The SafeSteps collaboration between Bury Integrated Delivery Collaborative (IDC), Primary Care, Local Authority, SafeSteps, and Health Innovation Manchester, sought to to improve early intervention and proactive health management.

The project achieved encouraging early results in terms of preventing falls in care homes and reducing the logistical and financial pressure on the local ambulance service. According to North West Ambulance Service data, falls in the Bury care homes fell from 83 in Jan-Mar 2023 to 51 in the same quarter in 2024 - a reduction of 38%, resulting in a reduction of 35 to 15 ambulances treating patients at care homes (57%), and a further 12% reduction in patients being conveyed to hospital. The rest of Greater Manchester saw a 10% overall rise in falls in Q1 2024.

My thanks to all colleagues involved in the work and particularly to Clare Hunter in the Integrated Delivery team for leading the work.

8. Medical examiner Introduction

The 9th of September sees the implementation nationally of the role of the medical examiner The Medical Examiner Service is a team that review all non-coronial deaths within the acute and community setting. It works on an independent basis and the team reports direct to NHS England. With the enacting of the updated Health and Social Care Act, the service is a legal requirement that all deaths that are not directly referred to a coroner are reviewed by the Medical Examiner Service before a Medical Certificate of Cause of Death can be issued.

In Bury the implementation of the service, hosted by NCA, has been tested with a number of practices, and the subject of GP webinar. Further information packs have been circulated to all teams.
A particular focus for many parts of the country has been to ensure as far as possible that there are no

delays to the religious requirement of some communities for the burial to take place within 24 hours. We are working with GPs, the medical examiner service (staffed at weekends and bank holidays) to ensure this is observed.

9. Inspirational Event for Care Experienced Children and Young people – 23rd October

In Bury we currently have a population of 338 young people (0-18 years old) and 180 care leavers (18–25-year-old) that we as an authority and our partner agencies have corporate parenting responsibility for.

We recently developed an inspirational event for Care experienced young people in partnership with our big development partner Muse Developments. As part of this day, we took several young people to meet the developers, architects, property managers, partners and assistant directors. The purpose of this event was to introduce a number of cares experienced young people into the world of property development. They got to listen to how these people got into their roles. The different avenues they took and some of the work they did before they got to where they are now. They also showed them what they did in their job role. i.e. architectural planning, drawing and 3d modelling. They took the opportunity to Consult with the young people about their upcoming developments in Bury. As a result of this event, we have successfully secured an apprenticeship offer for a care leaver.

Following this event the young people were very enthused and some of our other groups of care experienced young people expressed that they would like to understand what other opportunities they could access in the NHS/Pennine care.

We are wanting to replicate a similar day for our care experienced young people in October half term week on the 23rd of October.

We would like young people to have hands on experience of different job roles in the NHS and wider such as Mental Health, Nursing, Admin, senior leaders, Paramedics, Dr's and many more. With some hands-on practical things that the young people can engage with.

An update on the proposed event was provided to the Integrated Delivery Board on 28th August and Locality Board colleagues are asked to support staff to attend and share their experience.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
30/8/24

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	6	**Confidential**	No
Title	NHS contribution to the Childrens Improvement Board Plan and the SEND plan.		
Presented By	Will Blandamer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)		
Author	Will Blandamer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)		
Clinical Lead	___		

Executive Summary
The attached paper relates to NHS Partners (and Public Health) contribution to the Children's Service Improvement board plan and the SEND improvement plan.
Recommendations
The Locality Board is asked to discuss and provide comments in relation to the presentation.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

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

NHS Partners (and Public Health) Contribution to the Children's Services Improvement Plan and the SEND Improvement Plan:

Progress report: 11/7/24

Reported Most recently to: Childrens Improvement Board July 2024

Purpose of Document

- NHS Partners (and Public Health) have a key contribution to make the delivery of the Council Childrens Services Improvement Board and the Bury Partnership SEND Improvement Board
- Each of those Boards has its own improvement plan to be implemented and tracked
- A number of elements of NHS contribution talk to both plans and there is a risk of confusion and duplication.
- This document seeks to articulate the NHS partners contribution to the achievement of both plans and ultimately to ensure better outcomes for children and families in the borough.
- In addition to the specific contributions in this overview, there are a number of generic contributions to be made – for example health partners wider contribution to the graduated approach, and to transition planning.
- In addition to updates to the Childrens Improvement Board and the SEND Partnership Board, this paper will also be provided to the Locality Board and to the Childrens Strategic Partnership Board
- The document holder is Will Blandamer – Dep Place Lead for NHS GM in Bury.

	Task	Lead Officer	CYP Improvement Board Priority	SEND Improvement Board Priority	Locality Board Specific Priority	Childrens Strat Partnership Board Priority
1	Improving Health Visiting Capacity	W Blandamer	Yes	Yes	Yes	Yes
2	Strengthening Early Years/1st 1001 days partnership working	J Hobday	Yes	Yes	Yes	Yes
3	Strengthening Health input into MASH	C Jackson	Yes	No	No	Yes
4	Strengthening NHS Contribution to Partnership Governance	W Blandamer	Yes	Yes	No	No
5	Improving NHS Services for Looked After Children	S Babb	Yes	No	No	No
6	Improving NHS Services for Care Leavers including Health Summaries	S Babb	Yes	No	No	No
7	Improving Outcomes for Pregnant Care Leavers	S Babb	Yes	No	No	No
8	Reducing Waiting Times for services for SEND (not mental health)	J Case	Yes	Yes	Yes	No
9	Improving Access to Specialist Mental Health Support /CAMHS Action Planning	P Thompson J Whittingham	Yes	Yes	Yes	Yes
10	Supporting Children and Families (While you wait)	J Case	Yes	Yes	No	No
11	Supporting the Emotional Health and Well Being of CYP	J Case	Yes	Yes	No	Yes
12	Ensuring Timely NHS input to EHCP Completion	J McMaster	No	Yes	No	Yes
13	Commissioning of an Adult (post 18) ADHD service	I Trafford	No	Yes	Yes	No
14	Improving Health Attendance at Childrens Review	P Hayes-Bower	Yes	No	No	No
15	Securing Care Leaver Employment Opportunities	W Blandamer	Yes	No	No	No
16	Supporting Your Nuero Diverse Child – Neuro profiling and Resources	J Case	No	Yes	No	No
17	Ensuring NHS Partner Understanding of Neglect	V Woodall	Yes	No	No	No
18	Ensuring NHS Partner Contribution to Addressing Domestic Abuse	V Woodall	Yes	No	No	Yes
19	Securing NHS Partner Contribution to Complex Safeguarding (in addition to staffing in MASH)	V Woodall	Yes	No	No	No
20	Delivering a Joint Strategic Needs Assessment for Children	J Hobday	Yes	Yes	Yes	Yes

RAGB : Green

Date Updated: 5/7/24

Task 1:	Improving Health Visiting Capacity
Lead Officer/s:	Jon Hobday
Date of Latest Update:	**Locality Board updated March 2024 in place based lead update.**
Reported to:	**Locality Board and Childrens Improvement Board**

Key Objectives

1. Secure investment into HV capacity in the borough to strengthen and sustain the service
2. Ensure HV contribution to the transformation of early years arrangements in the borough predicated on a model of neighbourhood working.

1) February 2024 Cabinet confirmed £300k additional funding from Council
2) Implementation plan in place to recruit additional team members June 2024
3) First additional capacity appointments due Autumn 2024
4) This council investment conditional on steps towards an integrated neighbourhood model as described in the 1001 days programme, and connected to family hub development.
5) Feedback from Health Visitors is that the registration process (Story So Far) can be a deterrent to registering these families, as this is a duplication in recording. Discussions with the local authority to explore whether there are opportunities to simplify the process have commenced.
6) Data issues still ongoing – inability to provide key data sets to understand outcomes
7) Progress report on recruitment reported to CSPB July 2024

RAGB : Amber

Date Updated: 5/7/24

Task 2:	**Strengthening Early Years/ First 1001 days Partnership Working**
Lead Officer/s:	Jon Hobday
Date of Latest Update:	January 2024
Reported to:	**Childrens Strategic Partnership Board**

Key Objectives

1. Describe and implement a model of neighbourhood based working for 1001 days of a child's life
2. Ensure the establishment of a family hub model is progressed and connected.

Update:

1) Start Well sub group of CSPB has been reestablished chaired jointly by DPH and lead childrens officer – first meeting took place 03/06/24, ToR, Governance, membership and priorities have been discussed and agreed
2) East Bury family hub now open and fully operational
3) The parenting strategy has been reviewed and updated and comms lead has developed the document for public launch
4) Work is underway to clarify the vision and roll out of the family hub model across Bury, this has involved a number of multi-agency meetings to work through data, intelligence and review of potential availability of venues
5) Continued work is underway to promote the uptake of the EY funding entitlements
6) Development of a new multi-agency antenatal offer underway

RAGB : Blue - complete

Date Updated: 10/6/24

Task 3:	Strengthening Health Participation in the MASH
Lead Officer/s:	Catherine Jackson
Date of Latest Update:	May 2024
Reported to:	

Key Objectives

1. To ensure NHS partners are full participants in the operation of the MASH

Update:

1. Business Case previously confirmed requirement for additional capacity in the MASH
2. Three mental health practitioners have been appointed to operate a rotating duty arrangement within the front door
3. Due to internal restructuring across the NCA Safeguarding team there is increased resilience in the Bury MASH with an increase to 1.4 WTE Band 7 Specialist Nurses from November 2023 which increases staff and expertise locally. Additional cover for leave available from the central safeguarding team to support the Band 7 post
4. Review undertaken (February 2024) of NHS capacity in MASHs in GM – Bury is comparable.
5. Review of overall MASH operation presented to January 2024 Childrens improvement board report indicated no significant risks related to health input
6. Capacity required to be held under review in the context of the wider development and maturity of the Bury MASH
7. MASH health screening template completed and uploaded to systm1 and shared with GP and MASH social worker to ensure appropriate information sharing.
8. All new staff joining the NCA corporate safeguarding service will have an updated contract to support a rotational approach to covering MASH health role.

RAGB : Green

Date Updated: 9/5/24

Task 4:	Strengthening NHS Contribution to Multi Agency Governance
Lead Officer/s:	Will Blandamer
Date of Latest Update:	
Reported to:	

Key Objectives

1. Full participation in Childrens Improvement Board, Borough SEND Improvement Board, Corporate Parenting Board, Safeguarding Partnership
2. Joint Chairmanship of Childrens Strategic Partnership Board
3. Availability of NHS performance dashboard

Update:

1. Senior Representation available in all partnership boards.
2. Full NHS representation confirmed April 2024 in SEND Improvement Board include ICB, NW Advisor, Associate Medical Director, Deputy place lead for NHS, Associate Director o Nursing and Quality, NHS GM Exec Nurse representation, and Senior Officers from NCA and Pennine Care.
3. Joint Chairmanship of the Childrens Strategic Partnership Board.
4. Full NHS GM (Bury) participation in Childrens Safeguarding Board arrangements. Associate Director for Nursing, Quality and Safeguarding handed over chairing the L&D sub-group of the Bury Safeguarding Children Partnership to Deputy Designated Nurse for Children.
5. Scrutiny, Performance & Assurance sub-group of the BSCP have requested Section 11 audit returns. Progress to be review.
6. Bury health data dashboard now available from ICB – to be presented to July SEND Improvement board
7. New starters training dates now planned, January, May & September. New website launched, see link for all up to date information Bury Safeguarding Partnership - Bury Safeguarding Partnership

RAGB : Amber

Date Updated: 11/7/24

Task 5:	**Improving NHS Services for Looked After Children**
Lead Officer/s:	Sophie Babb – NHS GM (Bury)
Date of Latest Update:	**May 2024**
Reported to:	**Council Corporate Parenting Board**

Key Objectives

1) Annual Health Assessment Compliance
2) Dental Access
3) LAC in the CAMHS system
4) Emotional Health and Well Being Support
5) Specialist Nurse

Update:

1) Annual Health check compliance current reported as 98% for 23/24
2) Update on accessing Dental Health checks to be confirmed.
3) Access to dental services - local mitigation is in place with 2 child friendly dental practices and local referral pathway for all children in care which enables access to the dental service if they are unable to register themselves. GM Care Leaver Board and GMCA are raising the issue nationally and a national scheme has been implemented in April 2024 to improve dental access for all adults, which will support Care Leavers who are not currently registered with a dentist.
4) Bury CAMHS have put protocols in place to ensure that our care experienced young people wait no longer than 4 weeks for initial assessment (although this does not able for neuro and further work is required
5) Further work required on confirming the number of LAC in the CAMHS system.
6) GM ICB Bury locality are supporting the development of commissioning intentions to develop intensive support teams for experienced children and young people. The NHS Programme Manager is the lead officer of the Corporate Parenting Board 'Emotional Wellbeing' task and finish group led by Cllr Tariq.
7) Working to increase the uptake of care leavers accessing health support via the Specialist Nurse. The Specialist Nurse service works closely with the PA team and now offers monthly drop ins at 6KP.
8) Co-design session held Feb 2024 with care leavers to redesign the Care Leaver Health Summaries and accompanying process. This was finalised and shared with partners in March 2024.
8) At a GM level, plans are progressing to develop an intensive support offer for looked after children and care leavers within Hospital Trust footprints as part of the ICB commitment to developing a core mental health offer across GM. The 3 Trusts are progressing with footprint design workshops and we should see posts out for recruitment in quarter 4
9) **Stressed Out Brian (Trauma informed training) secured and being delivered to social care teams and health professionals.**

RAGB : Green

Date Updated: 16/5/24

Task 6 :	Improving NHS Services for Care Leavers including Health Summaries (see separate section on pregnancy)
Lead Officer/s:	Sophie Babb – NHS GM (Bury)
Date of Latest Update:	April
Reported to:	Corporate Parenting Board

Key Objectives:

To ensure all care leavers should have access to a summary of their health history at the point of leaving care. NHS GM data indicates that these are provided either during their last health assessment (if within 6 months of their 18th birthday) or separately if their final health assessment is due before. They contain details of key health history, how to access local services and have the Specialist Nurses contact details should they be required.

1. When young people spoke to inspectors during the November monitoring visit, they reported that they did not know what a Health Summary was.
2. **Workshop Feb 2024 to co-design new model of health summary recognisable to the young people**
3. PAs are informed via email when a young person has had a health summary completed, enabling the PA to update the young person's social care record (on LCS) is updated to indicate that the young person was given their health history and had opportunity to discuss this with a health professional (not that the health history itself should be shared on the LCS record).
4. A full paper is available including the co-design work completed if required.

RAGB : Green

Date Updated: 16/5/24

Task 7:	Improving Services for Pregnant Care Leavers
Lead Officer/s:	Sophie Babb
Date of Latest Update:	
Reported to:	

Key Objective

To ensure pregnancy care leavers are supported ante and postnally to have the best possible outcomes.

1. Locally maternity services screen all families and offer enhanced maternity care if vulnerabilities are noted. Care Leaver status is a vulnerability that would trigger this screening.
2. Care Leaver status is flagged in GP records (with young person's consent) which enables the GP to consider all vulnerability factors in the pre and post natal period. Fathers who are Care Leavers would also be flagged in their GP records.
3. As with local maternity services, Care Leaver status is a vulnerability that would trigger Health Visitors to screen for Universal Plus support where additional visits can be arranged as required to meet the individual family needs and referral to the Enhanced Health Visiting Service if required.

RAGB : Red

Date Updated: 9/5/24

Task 8:	Reducing Waiting Times for Services for SEND (not mental health)
Lead Officer/s:	Jane Case – NHS GM (Bury)
Date of Latest Update:	**March 2024**
Reported to:	**Locality Board**

Key Objectives

1) Speech and Language Therapy
2) Community Paediatrics
3) Paediatric Physiotherapy
4) Paediatric OT

Update:

Full comprehensive overview provided to locality board and scrutiny committee

1. **SALT – GM wide access and equity review delivered – further understanding of next steps . A targeted approach for SLCN has been rolled out in schools.** MDT CDC – 1 Week / Schools – 87 Weeks / Community – 66 Weeks
2. **Community Paediatrics reduced capacity in the team means that the reduction in waiting times that was seen in January has halted and waiting times are increasing** Reduced waiting times longest wait not booked from **79 weeks Jan 2023 to 39 weeks Jan 2024**
3. **Paed Physio;** waiting time 12 (April 24) weeks monthly review undertaken (clinical prioritisation no P1 or P2)
4. **Paed. OT;** 28 weeks waiting (April 24) due to long term vacancy, full recruitment now in place, monthly review undertaken (clinical prioritisation no P1 or P2)

RAGB : Red

Date Updated: 16/5/24

Task 9:	Supporting Access to Specialist Mental Health Support
Lead Officer/s:	Jane Case – NHS GM
Date of Latest Update:	
Reported to: All Age MH board and CSPB	

Key Objectives

1. Waiting Times for Paediatric Pathway and CAMHS Services
2. Waiting times for Neuro Services
3. Roll out of Mental Health in Schools Programme
4. Eating Disorders

Update:

1. An additional £1.4m investment has been secured to build on the core CAMHS and increase capacity to 18, as well as widen the therapeutic offer. Work to date has seen the mitigating action from CAMHS reduce core waiting times from 6 months to 9 weeks.
2. There are still significant pressures within the Neuro pathways however there is planned activity to try and mitigate this.
3. We have 2 Mental Health Support Teams dedicated to supporting CYP mental health in schools and colleges, reaching 30% of all schools. Full role out is expected in September.
4. GMCA Funding was agreed for 500 licences for L1 & L2 Trauma informed Training which is being rolled out. Over 300 Bury staff have accessed the courses so far.
5. PCFT CAMHS community eating disorders service provides care and support to children and young people with an eating disorder. We also offer advice and support to families, carers, and those who work with, or support, a child or young person”

RAGB : Red

Date Updated: /5/24

Task 10:	Supporting Children and Families 'While you wait'
Lead Officer/s:	Jane Case – NHS GM
Date of Latest Update:	
Reported to: All Age MH board / CSPB / SEND Partnership Board	

Key Objectives

1. While you wait materials
2. Review of all services documentation
3. Respond to Ofsted action

Update

1. We are progressing with a range of 'Helping you whilst you wait' materials . There are a range of Padlets with QR codes for mental health resources Neurodiversity / SALT / Epilepsy / ADHD post 16 .
2. Following recent SEND inspection all NHS providers asked to review all patient comms/letters to ensure up to date support resources.
3. Established a working group to progress development of materials
4. Further development of Padlets within NCA services; Community Paediatrics , CCNT, physio, OT
5. Ensure consistent use of the 'Essential Parenting' app; evidence increase in use within services
6. Requested support of ICB Mental Health System Board for priority focus on while you wait GM wide.(9/5/24)

RAGB : Amber

Date Updated: 9/5/24

Task 11:	Supporting the Emotional Health and Well Being of Children and Young People
Lead Officer/s:	Jane Case – NHS GM
Date of Latest Update:	
Reported to: All Age Mental Health Board , CSPB	

Key Objectives

1. Children and Young People in Bury have access to emotional health and wellbeing resources and services
2. Develop and implement Thrive offer at locality and school level
3. Develop an Early Support Hub

Update:

1. myHappymind roll out in primary schools complete. myHappymind Teens is set to roll out in May 2024 Called myMindcoach in response to Circles event.
2. Emotional wellbeing hub developments are progressing with co-production sessions being held and pathways being pulled together .
3. Worked with Spectrum Gaming to help us better understand how we can support mental health of young people with autism. There will be an additional offer in the Hub to support autism and anxiety on top of the group-based interventions and case work being undertaken.
4. The CYP Mental health campaign has being refreshed and additional materials being sent to schools for promotion.
5. GMCA Funding was agreed for 500 licences for L1 & L2 Trauma informed Training which is being rolled out.
6. Roll out of padlets for assured advice. Further work to be done on assessment of use.
7. Update to CSPB July 2024

RAGB : Amber

Date Updated: 04/07/24

Task 12:	Ensuring Timely NHS input to EHCP Completion
Lead Officer/s:	Jo McMaster
Date of Latest Update: 4th July 2024	
Reported to: Will Blandamer	

Key Objectives

1. Health advices to be completed within 6 week statutory timescales.
2. Advices to include SMART outcomes inline with SEND Code of Practice.

1. Multiagency SEND presentation delivered to health visitors / occupational therapists / physio and additional sessions on quality and pathways advice with Community paediatricians and OT. Next steps quality outcome individual service training support with EHC advice.
2. Health audits tool reviewed and currently trialling new format directly through services with scrutiny, oversight and support from DCO.
3. Monthly audits of EHCP as multiagency approach and action plans to support key issues identified to be supported through new strategic lead for SEND.

RAGB : AMBER

Date Updated: 10/5/24

Task 13:	Ensure there is a clear pathway for ASD assessment and support and ADHD assessment and treatment into adulthood
Lead Officer/s:	Ian Trafford
Date of Latest Update:	**April 2024**
Reported to:	**Locality Board**

Key Objectives

- To ensure timely access to neuro developmental assessments for young adults with the highest levels of need.
- To ensure there is a clear transitions pathway for children and young people on medication for ADHD into adult services.

Update:

NES commissioners are in the process of re-contracting with Optimise Healthcare for three years. As part of this revised contract a pathway will be established to enable young people being prescribed medication for ADHD under the supervision of CAMHS and Community Paediatrics to be transitioned to Optimise. A meeting has been scheduled for 29th May with PCFT and Optimise to define the transition arrangements.

GMICP have undertaken a pre consultation exercise and will be moving to full consultation on the redesign of adult ADHD services. A GM Adult ADHD Steering Group is being established with representation from Bury – first meeting planned for 14ht May.

A paper setting out commissioning proposals for a neuro developmental assessment service for adults is in development and will be presented to the NES Locality Boards in May / June. Bury Locality Board – 3rd June.

RAGB : Amber

Date Updated: 28/5/24

Task 14:	NHS Partners Attendance at Childrens Review Meetings
Lead Officer/s:	Catherine Jackson, Petra Hayes Bower
Date of Latest Update:	
Reported to:	

Key Objectives

1. Attendance at Core Groups is now tracked and escalation processes in place. No escalation regarding non-attendance received.
2. Northern Care Alliance Trust raised that they have not received minutes for conferences/core groups for 15 of the 20 children. To check if this has been resolved. Audit of 110 records underway to review, 40 completed (as of 28.5.24) results to be shared when completed.

RAGB : Amber

Date Updated: 18/7/24

Task 15	Securing Care Leaver Employment Opportunities
Lead Officer/s:	Will Blandamer
Date of Latest Update:	**18/7/24**
Reported to:	

Key Objectives

1. As part of the Care Leaver Offer meeting, an offer for Care Leaver apprenticeships in GP surgeries (Tower Practices) was developed with processes and training implemented to support apprenticeships in the GP practices. This work stalled following the departure of several officers involved (from both Health and the Council) and a refresh is therefore needed. This will be raised at the next Health LAC meeting to develop a co-ordinated plan to address this gap.
2. Proposed date of 25th October to convene a workshop for care leavers to speak to reps from across the health and care system to get an understanding of roles. For discussion in integrated delivery board – Mike Nichols working with Kat Sowden.

RAGB : Amber

Date Updated: 15/5/24

Task 16:	Supporting Your Neuro Diverse Child – profiling and resources
Lead Officer/s:	Jane Case
Date of Latest Update:	
Reported to:	**SEND Partnership Board , CSPB**

Key Objectives

1. Transformation of needs led Neuro developmental offer
2. Link into ICB transformation work to address waiting times

1. Autism Education Trust Training is secured and delivered via the SENCO network
2. Autism in Schools programme running for a second Year running in 3 Schools
3. Partnerships for inclusion of neurodiversity in schools (PINS) programme proposal successful and will be run in 4 schools
4. Currently coproducing a GM peer to peer offer for Autistic young people going live in July 2024 with Spectrum Gaming (Developed and to be run from Bury locality for GM)
5. Supporting your Neuro diverse child - Mental Health QR code and campaign materials
6. Funding secured from ICB to start development of an Autism transformation programme (ND Profiling Autism Hub)

RAGB : Green

Date Updated: 15/5/24

Task 17:	NHS Partners Role in Understanding Neglect
Lead Officer/s:	Petra Hayes Bower
Date of Latest Update:	
Reported to:	

Key Objectives

1. Ensuring NHS partners play the full part in the implementation of the borough neglect strategy

1. Full day training on Neglect, linking in with the Continuum of Need document formally launched the strategy. All details on the BSP Safeguarding website.
2. Prevention, Early Recognition and Accurate assessment is at the heart of our strategy, it will require action by all partner agencies - statutory and non-statutory - and collective commitment and leadership to address child neglect and drive the system, culture and process changes required to reduce the prevalence of child neglect in the borough.
3. NCA Lead nurse engaged and delivering multiagency training with partners.
4. NCA have identified X3 practitioner to complete the ‘training the trainer’ training, to cascade internally to NCA workforce. Awaiting the training dates
5. Training role out plan to be developed, once completed audit of implementation to be completed.

RAGB : Amber

Date Updated: 15/5/24

Task 18:	NHS Partners Contribution to Addressing Domestic Abuse
Lead Officer/s:	Vanessa Woodall
Date of Latest Update:	
Reported to:	

Key Objectives

1. Ensuring NHS partners are fully engaged in the strategic development of locality based domestic abuse initiatives and that operationally, this is evident a point of delivery

1. SafeNet are commissioned by Bury (NHS and the LA) to support Primary Care with domestic abuse. There is one WTE dedicated PCSW. Their role is to support the patient and assist the practice with completion of referrals, risk assessments and safety planning

2. The PCSW is responsible for the delivery of domestic abuse training across the GP practices of Bury. The PCSW is also responsible for taking information from Primary Care to MARAC and reporting back on the outcome from MARAC to Primary Care. Processes have been developed to ensure information governance and data protection is safely managed. Until the commissioning of this service, primary care information was not available at MARAC, which was a significant risk. The service was launched in May 2023 – data to follow

3. MARC is attended and prioritised by provider and ICB safeguarding teams; information is collated, analysed and shared to the multi agency meeting to inform risk assessment and safety planning

RAGB : Green

Date Updated: 28/5/24

Task 19:	NHS Contribution to Complex Safeguarding (in addition to staffing in MASH)
Lead Officer/s:	Petra Hayes Bower
Date of Latest Update:	
Reported to:	

Key Objectives

1. Ensure all staff are aware and understand the complex safeguarding strategy

1. A CST Nurse is co-located in the Police station and can signpost to other health services as needed. A robust health assessment is completed by the CST nurse and shared within CST record. Ofsted's feedback in the August monitoring visit indicated that there is good information sharing from partners.
2. The BSCP L&D sub-group held a CST conference in January 2024; good attendance from Health
3. NCA has introduced the complex safeguarding strategy to the most recent care organisation steering group and it is to be on the next agenda for further discussion. The plans are to consider how, as an organisation, we embed and evidence the strategy within both community and acute settings. Training will be required with the acute setting in relation to recognition and response to indicators of complex safeguarding.
4. Conversational learning is provided to staff within A&E by CST nurse to raise awareness in A&E of indicators of complex safeguarding. Dip sample of referrals in to MASH made by A&E completed monthly by Named Nurse. Analyses to be shared.

RAGB : Blue

Date Updated: 9/5/24

Task 20:	Providing a Joint Strategic needs Analysis
Lead Officer/s:	Jon Hobday
Date of Latest Update:	
Reported to:	

Key Objectives

1. To ensure we have an accurate understanding of the needs of children and young people who have SEND in Bury.
2. To ensure we have a data led approach to addressing the health and care needs of children and young people with SEND in Bury.

1. An updated SEND JSNA was produced in September 2023 which clearly outlines the health and care needs of our SEND population.
2. The document is being used at a strategic level to help shape and plan local services and provision.
3. The SEND JSNA will be reviewed regularly to ensure it captures any significant changes in local data.

Meeting: Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	7	**Confidential**	No
Title	Overview of Health Service Provision for Looked after Children		
Presented By	Catherine Jackson (Associate Director for Nursing, Quality and Safeguarding, Bury Locality)		
Author	Sophie Babb (Designated Nurse Looked after Children & Care Leavers, Bury Locality)		
Clinical Lead	Catherine Jackson (Associate Director for Nursing, Quality and Safeguarding, Bury Locality)		

Executive Summary
This paper will set out the current health service provision for Looked after Children, both looked after by the Bury locality living in and out of Bury and those placed into Bury from other Local Authorities.
Recommendations
The Locality Board is required to receive the report.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

Overview of Health Service Provision for Looked after Children

1. Introduction

1.1. This paper will set out the current health service provision for Looked after Children, both looked after by the Bury locality living in and out of Bury and those placed into Bury from other Local Authorities

2. Background

2.1. Children who enter care, or are care experienced, often encounter physical and emotional health difficulties due to their early life experience. This, alongside, where they live, access to health services and how they are treated – especially in the early part of their life, can amplify the risk of experiencing health inequalities. Care experienced children have consistently been found to have higher rates of mental health difficulties, with them four times more likely to have a mental health difficulty than their peers.

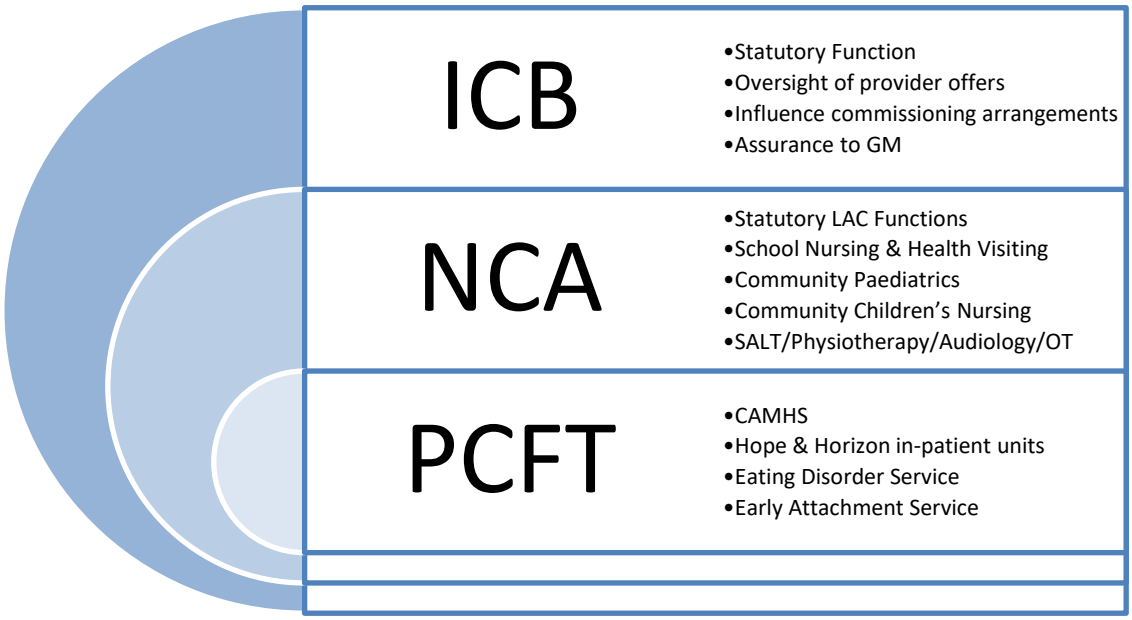
2.2. The effect of poor physical and mental health and the experience of health inequalities impacts people throughout people's lives and is strongly linked to their ability to achieve and attain within education, their employment opportunities and overall quality of life.

2.3. As a result of the above, Statutory Guidance *Promoting the Health and Well-being of Looked after Children* (2015), states that all children who enter care should receive an Initial Health Assessment (IHA) within 20 working day of becoming cared for. Thereafter, all children should receive 6 monthly Review Health Assessments (RHAs) until their 5th birthday and then annual health assessments after this until they reach their 18th birthday or are discharged from the care of the Local Authority.

2.4. The purpose of Statutory Health Assessments is to enable timely identification of health needs and establish the appropriate actions needed to address them.

3. Overview of Health Service Provision for Looked after Children

3.1 Within Bury there are a range of governance, health services and third sector organisations that support the health needs of Looked after Children, with the main being set out below:



3.2 The ICB, via the Designated Nurse for Looked after Children and Care Leaver role, is required to provide assurance and have oversight of compliance against statutory functions including quality and timeliness; influence commissioning arrangements within GM and locality to support the needs of children in care and provide support for complex cases in which requires bespoke packages of care.

3.3 The Northern Care Alliance (NCA) provide the delivery of the statutory functions as set out in section 2.3.

The Safeguarding team who facilitates this consists of:

1 WTE – Named Nurse Child Protection & Looked after Children (of which 0.2 WTE is protected for LAC))
1 WTE – Specialist Nurse Looked after Children & Care Leavers
0.6 WTE – Administration Support (post currently vacant on hold pending NCA workforce consultation)

3.4 All IHA and RHA requests are facilitated by the NCA Safeguarding team, who manage these, either from Bury Local Authority or other outside authorities. The team are responsible for ensuring the completion of IHAs and RHAs for any Looked after Child living in Bury/attending school in Bury and for facilitating the completion of health assessments for Bury children living outside of the locality by requesting these are completed via the relevant team. They are also required to ensure appropriate quality of health assessments, via regular quality assurance and training of staff and supervision.

3.5 NCA also provide Community Paediatric Services at Fairfield General Hospital, in addition to Children's Community Nursing, Physiotherapy, Speech and Language Therapy, Children's OT and audiology services.

3.6 Pennine Care Foundation Trust provide both community and inpatient mental health services within Bury. CAMHS offer community mental health support in Bury for children up to 16 years old. Referral acceptance in based on having two of the three criteria within the locality – Address, School, GP. This provides a consistent approach for Bury LAC placed out of the area, within other areas that PCFT provide CAMHS input.

3.7 CAMHS input includes therapeutic support for anxiety, depression, PTSD, and psychosis as well as assessment and support of ADHD and ASD. Further support is also available for 16 & 17-year-olds with emotional dysregulation.

3.8 Looked after Children and Care Leavers status is flagged on health records and PCFT ensure an assessment is completed as a priority within 4-6 weeks or earlier if there are concerns. Assessment to treatment is prioritised for this cohort and interventions commenced promptly.

3.9 Mental health services have been identified as a priority by Bury's looked after children and care leaver young people and Bury has a wide range of access and signposting to mental wellness advice and support available on the Local Offer through the 'Padlets' [1]and 'Kooth'[2] online support. There is other support available on the Local Offer[3].

3.10 PCFT also provide inpatient services, located at Fairfield General Hospital. The Hope and Horizon units provide Tier 4 inpatient mental health services for 13–18-year-olds.

3.11 The local eating disorder and early attachment services are also both provided by PCFT.

3.12 Further inpatient mental health support is offered within Bury via Greater Manchester Mental Health Trust

[1] https://padlet.com/ThriveinBury/YoungPeople
[2] Kooth Online Support
[3] Care Leavers Offer in Bury - Bury Council

(GMMH) as the Prestwich Hospital site and Cygnet Hospital near the centre of Bury. Both are centrally commissioned on a needs basis via the Greater Manchester Assessment and in reach Centre (GMAIC).

3.13 A range of third sector organisations also supplement support available to our children in care in Bury. These include Early Break, who offer a range of services around drug, alcohol, and mental health, Kooth, offering online emotional health support, Barnardo's, who offer practical support to young people with special educational needs or disability and BEAT – eating disorder service, amongst others.

3.14 Dental services open to looked after CYP, and until recently there was not always an offer for new Care Leavers, although there were two practices that supported this cohort. Dental provision in GM has recently improved and now our young people are able to access a dentist. Information on how to access a dentist is provided to PAs and is available on the NHS website.[4]

4 Unwarranted Variation

4.1 The variability of health service commissioning can disrupt the interface between health assessments identifying needs and services available to support and manage them, leaving young people with unmet needs, or with the requirement for bespoke commissioning arrangements. Whilst steps have been taken to reduce this within GM and provide an equitable service offer for our children in care, this remains an issue for those placed further afield. In most cases, commissioning arrangements can be agreed for an additional cost to ensure this is available for the young person.

4.2 Unanimously, services should recognise "Looked after Children" status as vulnerability and take this into account when allocating children onto waiting lists if they move from one geographical locality to another. Clinical need is always paramount in the allocation of health services, but a child should never be disadvantaged due to moving placements. Within GM arrangements are in place but there is an opportunity to work with wider ICBs to develop arrangements for hand over of care so that our young people are not delayed in receiving the help they need.

4.3 To support the above further, the priorities of the Health of Looked after Children & Care Leavers Steering Group have been set and include:

[4] Find a dentist - NHS (www.nhs.uk)

5 External Scrutiny

5.1 Bury has been fortunate to receive external scrutiny which has supported the borough to focus on improvement. Mark Riddell MBE, National Implementation Adviser for Care Leavers visited the borough in May 2023 and identified areas where the ICB should focus to ensure Care Leavers had the very best offer of support. The follow up visit took place in August 2024. The informal feedback to the whole partnership was very positive with Mark saying, 'absolutely brilliant' and a 'totally different level of ambition and a massive shift' from his visit 2 years ago.

5.2 From the NHS perspective he spoke really positively about the partnership commitment, the evident progress, the establishment of the hub.

5.3 There were some generic points highlighted, including good progress but still more to do on the voice of the young people themselves, including feedback on services. All of the key services need to be able to describe a forward plan of improvement to provide young people with confidence in the system. The opportunity of the hub as a real focal point for a range of service delivery and as a safe space but there is a need to review NCA LAC nurse capacity which would support the great progress on health summaries and drop-in sessions at the hub.

6 Recommendations

6.1 Supports the priorities set out in 4.3 by the LAC and Care Leaver Steering Group.

7 Actions Required

7.1 The Locality Board is required to receive the report.

Sophie Babb
Designated Nurse Looked after Children & Care Leavers

Catherine Jackson
Associate Director of Nursing, Quality & Safeguarding

August 2024

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	9	**Confidential**	No
Title	Minutes of the SEND Improvement Board Meeting		
Presented By	Will Blandamer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)		
Author			
Clinical Lead			

Executive Summary
The attached minutes are from the SEND Improvement and Assurance Board Meeting which was held on 16 July 2024 and are attached for Locality Board members information.
Recommendations
The Locality Board is asked to note the minutes.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒

Implications						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

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

Bury Council
Department of Children & Young People

Minutes

SEND Improvement & Assurance Board Meeting
16th July 2024

	ATTENDANCE	**ROLE**
	Deborah Glassbrook	Independent Chair
	Jane Bernhardt	Chair, Parent Carer Forum, Bury2gether
	Martin McAndrew	Rolling Representative, Bury2gether
	Dr Cathy Fines	Associate Medical Director, NHS GM
	Catherine Jackson	Associate Director of Nursing, Quality & Safeguarding (Bury), NHS GM
	Jane Case	Programme Manager, NHS GM
	Janet Wray	NHSE Adviser
	Kevin Burns	DfE SEND Adviser
	Finlay Olivier	SEND Case Lead – Vulnerable Children's Unit, DfE
	Cllr Lucy Smith	Lead Member for Children & Young People
	Cllr Tamoor Tariq	Lead Member for Health
	Will Blandamer	Executive Director of Health & Adult Care, Deputy Placed Based Lead for Bury
	Kate Waterhouse	Executive Director of Strategy & Transformation
	Jeanette Richards	Executive Director for Children, Young People & Education
	Stephen Holden	Director of Education & Skills
	Sonja Butterworth	Senior School Assurance
	Jen Mills	Family Resource Manager
	Wendy Young	Head of Service, SEND & Inclusion
	Gemma Walker	Childrens Improvement Delivery Officer
	Collette Radcliffe	Early Years Service Manager
	Nick Bell	Secondary Inclusion Lead
	Kathryn Mort	Headteacher, East Ward Primary School

	ADDITIONAL ATTENDEES	
	Lynne Ridsdale	Chief Executive Bury Council Place Based Lead for Health and Care NHS GM ICB (Bury)
	APOLOGIES	
	Gill Gibson	Deputy Chief Nurse, NHS GM
	Louise Rule	Assistant Director of Children's Services, NHS GM
	Linda Evans	Director of Children's Social Care & Early Help
	Jon Hobday	Director of Public Health
	Scout Stirling	SEND Youth Ambassador
	Adrian Crook	Director for Adult Social Care
	Alex Fair	Academy Principal
	Gemma Parkes	Virtual Headteacher

1	**INTRODUCTIONS & MINUTES**	
	The Chair welcomed everyone to the first official SEND Improvement and Assurance Board meeting with the June meeting being a set-up meeting. Introductions were made and apologies given. The Chair reiterated the expectations that everyone in attendance read all the agenda papers prior to the meeting. The minutes from June SIAB were accepted as a correct record.	
2.	**ACTIONS & DECISION LOG**	
	The action log was reviewed and updated. The Chair reiterated the need for everyone to read the SEND Code of Practice in order to fully understand what the Code of Practice and the Children Family Act 2014 is expecting of us. There is a fundamental expectation that if you are a Board member that agreed actions are undertaken. In terms of the JSNA review there is an expectation that the Board understands the demographics and challenges that Bury is specifically facing. The Terms of Reference Appendices were completed and agreed in principle. There is one outstanding element to finalise in terms of ICB Strategic Lead attendance. The amended Principles of the Board membership have been re-circulated. The Youth Voice Network meeting dates were shared in the agenda pack.	

	It is important that all leads comment on workforce implications and what is happening in terms of communication as part of their highlight reports. This will make sure that the two of the three Areas of Improvement are being addressed. The first stock-take of the Board to be completed in November. **Action** – to establish a meeting to discuss the first stock-take meeting. Consideration to be given to not holding a Board meeting in December and instead hold a meeting to undertake the first stock-take. A question was raised around the whole Board being regularly kept up to date on the progress being undertaken with the highlight reports. The Chair advised that the highlight reports need to provide the Board assurance and evidence of what has progressed and what the impact is. The full Priority Impact Plan will be RAG rated so that Board members will understand the impact and progress being made. The Board need to be assured by the information that they are reading and if not, what action/evidence Board members are needing.	
3	**VOICE OF THE YOUNG CHILD/YOUNG PERSON**	
	It is really important that we hear what children are saying and that the SIAB remain focused on children's experiences. It is essential that we achieve sustainable positive outcomes for the children and young people of Bury. Highlights from the presentation were: The Youth Cabinet has had the opportunity to discuss how they would like to feed into this Board in the future. They advised that they would like to be invited to the Board and have representation as an equal partner. They asked if they could present at the start of each meeting. Consideration would need to be given around the future timing of meetings as it would not be possible to come out of school to attend. The Youth Cabinet stated they would like to see something visual rather than just reports, for example a video of the board summarising what had been discuss at the Board. The Youth Cabinet said that they would like to have reciprocal arrangements so that Board members could attend Youth Council. Five 5 young people said they would like to come along to the next Board meeting. The dates of the Youth Voice Network are on: 12 November 2024 4 March 2025 24 June 2025 They did have some questions of the Board: • How many young people would you like to attend the meetings?	SIAB 16.7.24.pptx

	• What would you like to feed back to the groups from today? • Based on what young people have said, how will you be feeding back to them moving forward? <u>Discussion</u> • The Board members agreed the importance of inviting young people to come along and speak to the Board directly and express themselves. • Is it appropriate for them to stay for 3 hours and do we have a specific section for them? • Reports currently include some technical language and can be quite complex therefore we need to create space for sharing reports and opportunity to engage with the young people and feedback on the progress of the Board. • Are we engaging children outside of the education system? It was confirmed that the children and young people in the group are those who have been reached out to. However, more work is being done to increase the number of children and young people reached. • The Board needs to understand who they are representing and the range of groups. • Could the Board produce an executive summary of the highlight reports to be written directly for young people? **Action** – Gemma and Scout to consider how we present the information for young people moving forward. • The ethnicity mix needs to be considered. • The SIAB minutes are being made available on the Local Offer and podcasts to be developed so that children and young people can access the information as well as parents, families and other stakeholders. However, all names will be redacted. The minutes are to go on the Local Offer this week, possibly with the photograph of the Board from the June SIAB along with the Ofsted/CQC Inspection report and the Priority Impact Plan. • We need to decide which Board members are going to attend which of the Youth Voice Network meetings. **Action –** SIAB Board Members to check availability to attend Youth Voice Network meetings and let Scout know by September SIAB.	
4	**GOVERNANCE**	
	<u>Terms of Reference</u> The Terms of Reference is to be reviewed on a six-monthly basis but is currently still in draft format. Will informed the meeting that Mandy Philbin, Executive Nurse at the ICB and her deputy, who are named in the Terms of Reference, is keen to talk to the Chair and other Chairs around Greater Manchester about representation. **Action** – the Chair to meet with Mandy Philbin and other Chairs of SEND Boards before August Board. In principle Board members approved the Terms of Reference.	

	It was highlighted that there is an action due for June that states 'ensure clear governance including escalation routes and various impact measures'. A question was raised whether the education system was feeding back information to schools. It was confirmed that feedback i to every provided to every school and that they can escalate information back to this SIAB. The Board needs to receive information from sub-groups and schools. The Leads of each Priority Impact areas will be talking to all key stakeholders when writing their reports to bring forward evidence. and that is where the evidence regarding what is happening across Bury will be obtained. <u>Principles of the SEND Improvement and Assurance Board Membership</u> It has come about in the past that there needs to be clarity around what Board members are expected to do. As part of the SEND Improvement Board toolkit, this document was developed. Everyone agreed to sign up to the document and document to be updated with 'final copy' at the bottom and to be reviewed in six months' time.	
5	**PRIORITY IMPACT PLAN (PIP)**	
	The Chair informed the SIAB that the Priority Impact Plan is about sustainable impact and not just actions. It was very impressive that it was signed off at first time out. This is a tool to use as a Board to ensure we are moving at pace; timeframes need to be adhered to. Currently, Bury is 10 years late in delivering on some of this work which was outlined in the Children and Families Act 2014 and the subsequent Code of Practice. The Board's responsibility is to use the Priority Impact Plan as tool to check, as a partnership. The SIAB will use it to cross reference against the highlight reports to assess progress and impact. The Priority Impact Plan is now signed off and cannot be changed without agreement with DfE and NHSE Advisors. <u>Discussion</u> Who owns the RAG rating? The Chair enquired if the PIP should be presented every other month in terms of the RAG rating. The Chair advised that the Project Manager will oversee the collating of this and the Board will need to agree the rating criteria. There is an action outstanding to identify project management support and how the role will be resourced. Funding has been identified and the Council are out to market on the PMO role. It was suggested that there should be a dashboard presented at every Board meeting as it is important to use the dashboard to evidence the delivery of what has been committed to. The SIAB also need to make sure that co-production work is moving forward. Bury2gether will identify from the highlight	

	reports where this is not happening. There is a need to be mindful that teams and organisations are no longer about working in silo, it's about partnership working. The work is about impact and not process. Cllr Tariq informed SAIB that the Health Scrutiny and Childrens Scrutiny are keen to receive feedback from the SIAB. The Chair advised that she is happy to attend and present to Boards. The Kent paper which was shared with Jeanette is to be shared with Will.	
6	**REVIEW OF THE 6 PRIORITY ACTIONS INCLUDING AREAS OF IMPROVEMENT**	
	The Chair confirmed that the August Board meeting will still take place, despite it being the holiday season, and that she is expecting as much attendance at possible. At the August Board we will carry out deeper dives with data, with analysis and looking at impact measures for each of the three Priority Impact Areas that will be presented. <u>Priority Impact 1</u> The action is about ensuring that the SEND strategy continues to be implemented to improve the lived experience of children and young people with SEND. There are essentially five elements to this: • To create a SEND strategy on a page by October 2024 • To work with Buy2gether colleagues to co-produce a model for parental feedback around families' experiences with a mechanism to be clarified by December 2024 • Confirm the Governance by June but recognising that we undertake reviews after three and six months • To review the QA framework by August 2024 • To make progress on the effective communication of the strategy by November 2024 <u>Updates</u> 1. Strategy – the update is the opportunity to progress engagement and working with the strategy and communication with a plan on a page to be developed by October. 2. Parental feedback – we need to clarify how this is done systematically to allow a good framework of co-operation and no later than by December 2024. 3. Governance is substantially complete. We have clarified the Governance within the council, and we are connected to all elements of ICB governance. 4. QA Framework – consideration around strengthening our audit processes and quality assurance processes. 5. Communication of the strategy – there is a gap due to the limited support capacity.	

On 19 August the Chair and Executive Director of Strategy & Transformation are co-ordinating a Task and Finish group to take a look at communication and to undertake a mapping exercise of what is already is in place and what needs to be done whilst we get some capacity in place.

Update from Wendy Young

- Bury has a Quality Assurance Framework which is being reviewed.
- Quality assurance tools have been developed and have been trialed with a series of multi-agency audits.
- Uncertain of how we are gathering data in terms of our Quality Assurance Framework and our implementation of that.
- Establish from the multi-agency audits what do we know so far in terms of the quality of our EHCPs and where our strengths and where are our opportunities for development.
- DCO has undertaken some work with the ICB.
- Need to re-establish our multi-agency audits especially from the Autumn term.
- Work has taken place with our Envision 360 colleagues in establishing a digital quality assurance tool.
- Looking at Health and Education Care plans within the EHC team in terms of the quality and knowledge of experience.

There is a bigger piece of work around setting the vision and articulating the strategy and the young people have begun to express what this should look like and there is work to do to co-produce a strategy with our parents/carers forum. The next steps are to move to a position where we can articulate what we are seeking to achieve with inclusion woven through it.

Everyone needs to understand our key priorities and how we are going to get there.

There is the potential for some duplication with Project Safety Valve (PSV) and we need to ensure we have some alignment to those priorities and how we are achieving what is needed.

Parental feedback would make more of a difference and we need to hear and evidence the voice of the parents to ensure that our parents feel they are being listened to and heard.

Action - Scout to link in with Bury2Gether around demographic breakdown of parents involved.

Correction to highlight report - The highlight report states that it is a neuro-diversity survey, and it is a neuro-pathway survey.

Priority Impact 2

The action is in relation to Early Identification.

- The Graduated toolkit is online and is crossing over to PSV.
- The school section is complete and online.
- The writing of other sections is complete but not digitally online, but this will happen over summer and Stephen is linking in with IT to ensure it is fit for purpose and live.
- The CPD programme for schools is now fully delivered and has comprised of 56 online sessions.
- We are now looking at how do we get out in the community and deliver on our side of the Graduated Approach using our Outreach team which is still being built. We now need to amalgamate with what we have in-house.

Discussion

- Where are we in terms of Midwifery, Health Visiting, Early Years? Early identification is fundamental, and the Board needs to hear if Midwives, Health Visitor understand about identification, what training have they had, what are their expectations and what are they expecting. We also need to check whether we are talking only about the education elements or all additional needs.
- Some services are not able to be accessed without an EHCP which is causing waits and delays to meet a child's needs.
- It would be interesting to understand which teams/services say that that children and young people require an EHCP in order to receive a service.
- SENCOs have had some training around identification with 54 schools attending. The feedback questionnaire only talks about 8 responses which does not give enough assurance on the validity of impact. Stephen to follow-up on satisfaction and impact.

ACTION – SIAB Members to consider how to assess the approach and language being used by professionals/teams in relation to expectations of needing an EHCP to access services.

Priority Impact 3

The action is about Leaders across the partnership needing to improve the quality and availability of support for children, young people and their families while they wait for specialist assessments.

There are two broad action points under this item:

1. Timely access to services – there are a massive number of services involved and we will be clearer in future reports in itemising progress against all the individual items. Jane and Will have been meeting with providers of services and are assured that there is a determined effort with partners

to make good progress especially around waiting times for Speech and Language Therapy. There has also been additional training and development around Health Visiting.

2. Lots of examples of engagement especially with Jewish community). There is more to do with Bury2Gether around co-production.

The Chair expressed the need for data to be seen within each of the highlight reports.

Action – Consider forming a working group to discuss feedback, policy/comms, consultation and co-production and to define our terms and set some expectations. Stephen to feed this back to the Delivery Group in August for the first time.

Priority Impact 4
This is relation to children and young people being prepared for adulthood.

- There is more to do around preparation and more opportunity to explore around health and social care involvement.
- There needs to be more robust informative information around access to pathways that children and young people will follow if they move through to adulthood.
- Multi-agency audits have evidenced a lack of preparation for adulthood.

Discussion

- The work needs to be done by everyone across the partnership. Preparation for Adulthood is expected to start around age 14 (year 9) and we need to make sure that schools understand what that is about and help families think about what and how they are doing things and think about it more widely.
- The Transition Framework is to be published by NHS England. It's around clinical pathways and will have a focus on preparation for adulthood but for SEND it will need some work.
- Ofsted and CQC is publishing a thematic document on Preparation for Adulthood which is due to be published around September.
- The Council for Disabled Children's website has good information about Preparation for Adulthood.
- Co-production in section 3 does not talk about consulting with young people and needs to in the future.

How is the Board going to manage risks that are identified? The Chair advised that we are waiting for a project manager to be employed and to develop the risk register. SIAB requires regular updates on mitigating risks from each of the Leads.

All information will be used as part of the ongoing assessment when there is a stock-take at month 6 and month 12.

Priority Impact 5
This action is about Transitions.

- Secondary schools have a named Transitions Lead.
- As a team they recognise that they have not got transitions right in primary and secondary schools, so the work had already begun and there has been positive responses to this.
- A Task and Finish group has been established with representations from Adult Care. The next steps will be around how we involve parents in this.
- Standard operating procedures have been agreed.
- A risk has been added in the report which is more of an awareness at this time and does not need addressing yet.

Discussion
- When writing reports, we need to ensure we are using the Priority Impact Plan with the required timeframes.
- On a point of clarification, it is Ofsted **and** CQC that undertake these inspections.
- An EOTAS policy is currently being developed - Education Other Than At School. The first Parents' Forum was held last week where they discussed how we best get the young people's voice heard in this piece of work. Suggestions were offered from parents as to how we may be able to do this.

Priority Impact 6
This action is about Education, Health and Care Needs Assessment and EHC plan, including monitoring and review (statutory service).

- Looking at the quality and timeliness of Education and Care plans.
- Quality is about improving communication.
- Need to establish the functionality of our systems in terms of how they are supporting us to administer the statutory functions within the teams.
- It's not just about increasing our staff numbers; we want to ensure that they are appropriately trained and supported to conduct their statutory duties in a timely manner.
- Addressing communication issues.
- Risk around timelines to build capacity up of case officers in the team. We want to attract the most appropriate candidates and attract experienced SEND professionals.
- Carrying out baseline salary and comparisons.
- We need to have a single version of the truth around how our Local Area is performing in relation to the statutory duties that we hold.

	Discussion • We need to have a session in August around what is an EHCP. • A scorecard/dashboard based around what our statutory duties are, rather than what we historically measure, would be welcomed. • We need to focus on what areas we need to fix. • Are we sighted enough on what has gone wrong as there a high level of parental dissatisfaction in relation to EHCP needs. • There are evident barriers within the team preventing us delivering the change. • Identifying some quick wins but currently gathering more information around this. • There are variances in the team around knowledge, skills and statutory compliance. • Looking at the structure in terms of escalation of cases. • Need proper diagnostic around what is not happening now. • Need to ensure that we look at the welfare of our staff in terms of abusive parents etc. • We need to bring to the Board reviews and new plans as there is the worry around case officer workload. • There needs to be clarity around expectation of who is doing what. • The partnership needs to fully understand the child's full journey. **Action –** Chair and Wendy Young to plan a session about EHCPs in August.	
7	**COMMUNICATION**	
	Kate Waterhouse provided an update on Comms. • Currently undertaking some scoping on this piece of work. • We need to be clear on the definition because we have got culture meets communication meet workforce development which means that not everything is a part of the communications plan. • We need to understand the channels through which we are going to operate which, internally is divided into two pieces of work: 1. Internally, within our own organisations about our own staff understanding why this is of strategic importance and understanding what our organisational priorities are. 2. Internal workforce messaging for those who are directly delivering this. Externally, the channels that we need to look at is working with our children and young people and parents and parent groups and then partners and wider partners as in Team	

	Bury. Comms needs to go out to wider public to recognise what is being discussed in the media, that there needs to be some messaging about what Bury, and its partners, are doing about this. • A programme of work is to be developed through a Task and Finish group to get as much to mapped as possible as to what is in the system already. • We are currently recruiting to Send Engagement Officer which we failed to recruit recently • We will require a senior Comms person to help pull all this work together. <u>Discussion</u> A Communications mapping workshop is being held on 19th August at 10.30am – anyone wanting to attend let the Chair or Kate know. **Action -** ask all workstreams to provide input for the workshop on the 19th August about what the Board is looking for them to deliver.	
8	**WORKFORCE**	
	Will Blandamer provided an update on workforce. • Lots of workforce implications and some evidence reflected in all of the highlight reports. • Identify dedicated capacity around workforce that would help. • Asked for examples of best practice and Janet has provided some initial good practice. If anyone else has any evidence of good practice, please share with Will. **Action -** Leads to report on communications requirement and workforce in all future highlight reports. SIAB members need to ask if you are assured that we are on the right track from the evidence being presented in the highlight reports. Today was a benchmark around where we are currently, but now we need to move into deeper dives around three priority areas in August and a further three in September and then again in October and November before the first Stock-take.	
9	**FORWARD PLAN**	
	For the August meeting it was agreed that Priority Actions 1, 2 and 3 be discussed in more detail then in September, Priority Actions 4, 5 and 6 be discussed in detail. If feels that there is an energy and traction in all six priority areas. We need to move to quite quickly into the impact and what that will look like. We also need to ensure that we are	

	capturing information and data in order to see the differences that are being made.	
10	**ANY OTHER BUSINESS**	
	Draft Improvement Notice The Board is to hold back from publishing the Improvement Notice until it has been finalised.	
11	**DATE OF NEXT MEETING**	
	20th August at 10.00am – 1.00pm. 25th September at 10am – 1.00pm 14th October at 11am – 2.00pm 27th November at 10am – 1.00pm	

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	10	**Confidential**	No
Title	Integrated Delivery Collaborative Update		
Presented By	Kath Wynne-Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Kiran Patel		

Executive Summary

This paper is intended to provide an update to the Board of progress with the work of the IDC and progress with the delivery of programmes across the Borough.

Recommendations

The Locality Board are asked to note the progress of the strategic developments and progress of the programmes.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐

Implications						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
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:						
Once achieved, the ambition of the IDC will have a positive impact on the quadruple aim domains of population health ,experience, workforce and economics						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

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

Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Board progress which has been made with the key programmes of work within the IDC

2. Key strategic developments

Key developments over the past month include:

- Continuation of discussions at GP Leadership Collaborative (GPLC) to ensure greater cohesiveness between neighnourhood and GPLC priorities. This is a major risk at present given some of the decisions which individual PCN's are making that reduces services available within our neighbourhood offer. A dedicated workshop will be held on the 18th September to consider this issue.
- Commenced the stocktake of Cardiovascular Disease priorities across the patch to enable us to benchmark ourselves against GM asks ahead of our locality session with GM on the 4th September . We need the support from PCN's to identify current offers available not just in CVD but across all disease areas to ensure we are not creating psilo working.
- Commenced the benchmarking exercise of community services at service line level in line with GM requirements. We undertook an exercise to review all our community services 2 years ago, which this exercise will build upon, recognising there are some pressures on funding within some community services. Service specifications have not been formally refreshed for a period of time due to the approach we were taking to redescribe our services in a co-produced way. The GM approach may mean that we need to refresh all our service specifications.
- Submission of respiratory proposal to GM to be considered as part of a national pilot to expand our respiratory hub and community service provision further. If this bid isn't successful we will continue work to deepen integration across respiratory services anyway.
- Follow up session with the North neighbourhood Primary Care and Community Pharmacy teams planned for the 9th September. Some small improvements have been made since the event at the end of June, including the sharing of bypass numbers.
- Discussions with Health Innovation Manchester regarding support for the Borough regarding digital opportunities of the GM Care Record. Through the End of Life (EOL) Programme Board we have agreed to focus our attention on electronic palliative care coordinating systems, given the high % of bed days attributed to EOL patients.
- Workshop being planned for October to assess ourself across GM Dementia United standards.
- Commenced stocktake of cancer priorities across the Borough to ensure alignment with NCA and GM asks.
- Consideration of and preparation for GP industrial action.
- Agreed a way forward with regard to Stataement of Intent processes preparing for implementation of new guidance from the 9th September. Dr Patel and Dr Chauhan will agree a joint communication to be shared with General Practice ahead of this date.
- Positive recognition of the work undertaken as part of the Safer Steps programme.
- Commenced the development of proposals to enable closer working across the RBMS and the community services single point of access.
- Risk management training held throughout July and August for programme

managers to support the new risk reporting processes . A complete review of all programme risks will be undertaken with programme leads on the 23rd September.

- Workshop held on the 25th June to consider how we improve our management support arrangements across the Borough to deliver our priorities. This will be taken forwards through the IDC SMT.

3. August IDC Programme Highlights:

Elective Care, Cancer and Community Health*:*
Bury Integrated Community and Elective Pathway System Board monthly meetings will commence on September 10th 2024.

Mental Health:

- Recent commissioning work has focussed on the review of all service contracts and development of commissioning recommendations with a deadline of end of August 2024.
- There has been positive progress in the recruitment of new clinical posts to support the planned expansion of core CAMHs.
- The provider contracts for the VCSE led element of the Ling Well model have been signed and recruitment to the peer support and key work posts have commenced.
- A plan for the relocation of most elements of PCFT community MH services into KP3 has been agreed.
- There has been a really positive stakeholder workshop with commissioners, PCFT and other stakeholders to develop a locality action plan to reduce the number of bed days on inpatient wards lost as a result of delayed discharge. While numbers of patients on the wards who are clinically ready for discharge has dropped in recent weeks we remain above target for total bed days lost.

Neighbourhoods:

- The final version of the LCS contract has been agreed along with the targets and indicators for the Neighbourhood elements relating to frailty and COPD.
- A revised version of the ACM SOP has been approved strengthening arrangements in relation to adult safeguarding.
- The new Neighbourhood Lead for Prestwich, Clare Rayson, commenced in post in July.

Urgent and Emergency Care:

- Work underway to assess ourselves against GM UEC standards
- Approach agreed to ensure we are compliant with asks relating to Integrated Care Coordination (supporting admission avoidance)

Palliative and EoLC:

- A new programme SRO and joint Board chair has been identified - Sarah Ingleby, Director of Quality and Safety, NCA Diagnostics and Pharmacy.
- The new multi-disciplinary Palliative & EoLC Clinical and Professional Delivery Group has commenced and will lead on a number of programme workstreams.
- Progress continues to be made in developing the application and business case for the MacMillian Social Investment Fund.

LD & Autism:

- “Together Towards Independence” programme: 40 staff trained in Progression © approach (strengths-based) April-June
- LD & A Service Development Plan 24-25 completed.

- LD & Autism commissioning intentions published on website.
- Preparation for ASC CQC visit continues (e.g. deep dive report – coproduction).

Primary Care:
- GP Collective Action – letter from Rochdale and Bury Local Medical Committee – Appendix A:-

Workforce:
- Workforce Enabler Update Report to be presented at the IDC Board August 2024

4. Performance

- A&E 4 hour wait performance – July was 65.7%, an increase on the previous month's performance of 65.5%. July 24 performance is 65.7% which is lower than July 23 which was 71.0%.
- A&E attendances - There were 6898 A&E attendances from Bury registered patients in July 24, lower than July 23 (6913). Bury had 32.6 attendances per 1000 population - the 6th lowest attendance rate for localities within GM.
- No Readon/no citeria to reside (NCTR) - percentage for Bury in July 24 wass 18.9% which is a decrease on June 24 which was 19.0% Bury had higher than the GM percentage of 15.5% - the 8th highest percentage of the GM localities
- Specific Acute non-elecive spells - There were 1815 specific acute non-elective spells from Bury registered patients in July 24, higher than July 23 (1659)
- LD Health checks 14+ - The percentage of patients aged 14+ having received an LD health check in June 24 was 13.3%, which is an increase on June 23 which was 7.9%. [NB the trend is for the majority of health checks to be completed in Qs2 & 3]
- Access to Children and Young People MH Services There were 3620 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in June 24, higher than June 23 (3195).
- Dementia: Diagnosis Rate (age 65+) - The percentage of patients aged 65+ having received a dementia diagnosis as of July 24 was 76.2%, which is lower than July 23 at 76.7%. Bury currently has a higher diagnosis rate than GM which had a rate of 74.4% and Bury had the 3rd highest dementia diagnosis rate of the GM localities.
- MH – Inappropriate Out of Area Placements - There were 635 inappropriate OAP bed days for Bury registered patients in March 24, higher than March 23 (370) but significantly lower than the pealk of 1,120 in Dec 2023.
- Length of stay adults: Mental Health Patients - The proportion of discharges with a long LOS in June 24 was 57.1%, an increase on June 23 at 27.3%. Bury currently had a higher proportion with a long LOS than GM at 49.0% and Bury had the 7th highest proportion of the GM localities.

- MH Patients with no criteria to reside / clinically ready for discharge - The percentage of mental health patients with NCTR as of July 24 was 17.6%, an increase from June 24 at 17.2%.
  The latest data indicates that for June Bury had 302 bed days delayed with patients clinically ready for discharge c30% above the target of 204

- Access to community MH services - There were 1530 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in June 24, less than May 24 (1545) but the exact same figure as June 23 (1530). Bury currently has 9.2 contacts per 1000 population and has the 5th lowest rate per 1000 for localities within GM.

- Talking Therapies Access Rate – There were 310 accesses to Talking Therapies for Bury registered patients in June 24, Lower than May 24 (330) and lower than June 23 (345) Bury currently had 1.5 accesses per 1000 population - the 4th lowest rate per 1000 for localities within GM.

- 2 hour UCR referrals - The percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in June 24 was 95.9% - an increase on June 23 at 62.5%. Bury had the highest performance in GM.

- GP Appointments within 14 days - The percentage of GP appointments taking place within 14 days of booking in June 24 for the Bury population was 83.9%, which is a slight increase on June 23 which was 83.7%. Bury had the same percentage as GM which is 83.9%.

- Diagnostics Waiting 6 weeks + - June 24 performance of 16.4% of patients waiting more than six weeks, this is a decrease on the June 23 figures (26.0%).

- RTT Incomplete 65+ weeks - June 24 data shows an increase in 65+ Week Waits from May 24 (28 pathways). There was a large decrease in pathways in June 24 with 218 Pathways, Compared to June 23 685 pathways (- 467 Pathways).

- 28 day wait from referral to faster diagnosis (all patientss) - The percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in June 24 for the Bury population was 75.9% - an increase on June 23 which was 67.0%. Bury is currently meeting the target of >75%.

5. Recommendations

The Board are asked to note the progress and risks outlined within this paper.

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
kath.wynnejones@nca.nhs.uk
August 2024

Appendix A

Dr R Bedair
Medical Director
Northern Care Alliance
Salford

Friday 9th August 2024

Dear Dr R Bedair

A national ballot undertaken by the British Medical Association (BMA) amongst GPs resulted in over 98% supporting national collective action. This is in response to the forced national GP contract imposed by NHS England. As a result of this course of action the BMA proposed a number of possible options GPs across the country could take.

Having locally reviewed current services, GP practices across Rochdale and Bury will withdraw from supporting non-contractual services that support requests from the hospitals as well as community services. These services include:

- Requests for phlebotomy after discharge from hospital
- Requests for sick notes post hospital discharge and from OPD
- Requests from one specialty to refer to another for the same original referral, hospital should refer internally between departments
- Expectation for GPs to refer on standard proforma templates
- GPs to undertake non-contractual diagnostics including phlebotomy, spirometry and ECGs
- Shared care arrangements where non-contractual
- GP to undertaken pre-op or post-op checks
- Request from community nurses to arrange diagnostics, these should be directed to NCA as they are employed by the trust
- Requests from A&E, UCC, OPD or post discharge to chase test results

This is not an exhaustive list; GPs will add to the list as clinical scenarios arise.

Standard template has been shared by the LMC across both boroughs which will be attached to any hospital letters requesting a course of action that is non-contractual that is refused and returned to the sender. I would be grateful if you could share this with consultants and clinical leads across the 4 hospital sites.

Yours sincerely

Dr M Jiva MBE
GMC; 4107396
CEO Rochdale and Bury LMC

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	11	**Confidential**	No
Title	MFT Strategy and North Manchester Hospital Development		
Presented By	Sophie Hargreaves		
Author	Sophie Hargreaves		
Clinical Lead	n/a		

Executive Summary
MFT have recently published a 5-year strategy, detailing the aims and objectives of the organisation. The strategy document is attached. In addition a verbal update will be given regarding the redevelopment of North Manchester General Hospital.
Recommendations
To note the strategy document and verbal update.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒

Implications						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

MFT Strategy and Verbal Update on North Manchester General Hospital Redevelopment

1. Introduction

1.1. The aim of this paper is to ensure that Bury ICP is informed about the developments that have and are taking place at MFT and North Manchester General Hospital.

1.2. This paper contains a copy of the MFT Strategy: Where Excellence Meets Compassion for review and discussion, and will be supported by a verbal update on North Manchester General Hospital redevelopment.

2. Background

2.1. MFT published their 5-year strategy in May 2024. The strategy was developed with input from a number of focus groups, which included representatives from the GM Health Economy. The strategy details the 5 aims, 11 objectives and approximately 80 specific actions that the trust has prioritised for delivery over the lifetime of the strategy.

2.2. In addition to the strategy, MFT is involved in the New Hospitals Programme for the redevelopment of North Manchester General Hospital. A verbal update will accompany

3 Associated Risks

3.1 Not Applicable

4 Recommendations

4.1 To note the contents of the MFT Strategy and the verbal update on North Manchester General Hospital redevelopment.

5 Actions Required

5.1 The Locality Board is required to:

- consider information provided in the strategy and verbal update

Sophie Hargreaves
Director of Strategy
sophie.hargreaves2@mft.nhs.uk
August 2024

NHS
Manchester University
NHS Foundation Trust

Manchester University NHS Foundation Trust *Strategy 2024-29*

Contents

Foreword

Working together to improve the health and quality of life of our diverse communities.

Manchester University NHS Foundation Trust was created in October 2017 with a mission to improve the health and quality of life of the communities we serve. Whilst our mission is still the same, a lot has changed in the last 6 years. Now is therefore the right time for us to consider what we need to do, now and in the future, to deliver it.

I am pleased to introduce our strategy for the next 5 years. This will be the first time that MFT has a single strategy that covers everything that we do as an organisation. We have developed it with support from our staff, patient and community groups and our partners in the health and care system. We believe that having one strategy for the whole of MFT will help us to be clear about what we want to achieve as an organisation, and the things that we will focus on to deliver this.

We have called our strategy *Where Excellence Meets Compassion* because it describes in a few words what we aim to be as an organisation. We aim for excellence in everything that we do, from the care our teams provide in people's own homes and in our hospitals, the education and training we provide, through to the research and innovation work we do to help shape the healthcare of tomorrow. And we are a caring organisation – we care for people from before they are born to the end of their life.

We have already achieved a lot as an organisation, and we have grown as we have welcomed North Manchester General Hospital and our Local Care Organisations to the MFT family. Our teams have done some remarkable work in the last few years, and in the most difficult circumstances possible through the Covid pandemic. It will not always be easy, but I know that we will all work together to deliver this strategy for all of our communities and patients in the coming years.

Kathy Cowell OBE DL, Chairman

Foreword

As I look back on my first year as Group Chief Executive of MFT, I am proud of our achievements and have a great deal of optimism for the future.

MFT's distinction lies not merely in our size but in the passion and dedication of our staff, the strength of our partnerships across health and social care, and the diverse range of services we uniquely provide.

Our strategy has been developed through extensive collaboration and is a testament to our collective vision to improve the health and quality of life for the people of Greater Manchester and beyond over the next five years. The connection between the communities we serve, the diversity of our staff, and the distinct identities of our hospitals and Local Care Organisations, has been a recurring theme during the many conversations we have had over recent months. This strength of alignment presents the perfect opportunity to make our shared vision a reality.

This is, without doubt, a challenging time for the NHS as it responds to some of the most significant issues it has faced since its inception at Trafford General Hospital over 75 years ago. I strongly believe the strengths and capabilities we have developed over the years make MFT one of the best-placed organisations to respond to these challenges and deliver the scale of improvement we can and want to make for our patients and communities.

Our strategic aims are rightly ambitious, but they also reflect the reality of the issues our teams experience and our patients face today. I am delighted with the breadth of perspectives that have helped us to shape our future direction and together we have the opportunity to make a significant difference to people's lives:

- to help people to live well;
- to provide high quality, integrated care;
- to be a place that people enjoy working and building their career;
- to deliver greater value for our patients and communities; and
- to lead world-class research and innovation.

I am confident that we can deliver the scale of ambition set out in our strategy and I look forward to working with you as we implement *Where Excellence Meets Compassion* over the years to come.

Mark Cubbon, Group Chief Executive

Introducing MFT: *Where Excellence Meets Compassion*

Manchester University NHS Foundation Trust was created in 2017 to ensure that everyone who needs our services receives the same high standard of equitable care regardless of where they are treated. Whilst our organisation is still relatively young, our hospitals and services have been working to improve the health of people in Greater Manchester and beyond since 1752.

1752

Dr Charles White opens the Manchester Infirmary with 12 beds in a small house in the city centre.

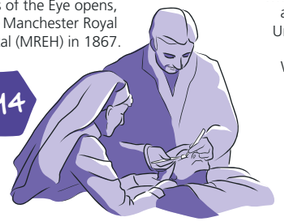
This will one day move to a bigger site and become the Manchester Royal Infirmary (MRI).

1790

The Lying-in Hospital, now known as St Mary's Hospital, is founded.

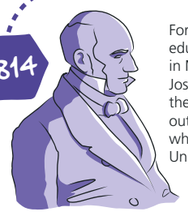
1814

The Manchester Institution for Curing Diseases of the Eye opens, becoming the Manchester Royal Eye Hospital (MREH) in 1867.



1814

Formal medical education begins in Manchester when Joseph Jordan opens the first anatomy school outside of London, which later become the University of Manchester.



1829

The Dispensary for Children is founded at Ridgefield, Manchester. It moves to Pendlebury Hospital in 1873 – becoming the first hospital in the country dedicated to treating children –later becoming part of the Royal Manchester Children's Hospital.

1853

Lloyds Fever Hospital established, later rebuilt as Altrincham Provident Dispensary and Hospital.

1853

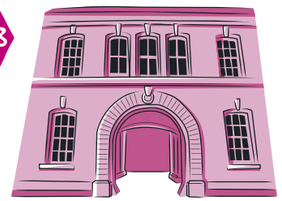
Springfield Hospital is built.

1865

Florence Nightingale writes to commend the architect of Chorlton Union Hospital, which would later become Withington Hospital.

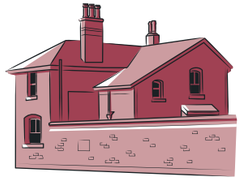
1868

The Prestwich Union Workhouse is built, later becoming part of North Manchester General Hospital (NMGH).



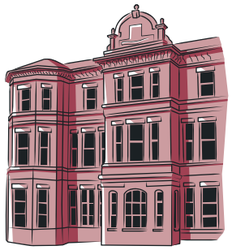
1871

Monsall Hospital opens in North Manchester for people with infectious diseases.



1876

Crumpsall Hospital is built.

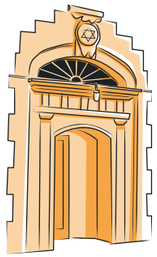


1902

Baguley Sanatorium is established for the treatment of infectious diseases.

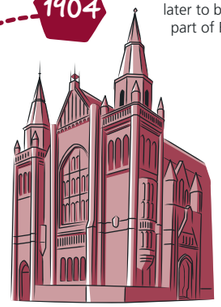
1904

The Victoria Memorial Jewish Hospital is opened in Cheetham Hill.



1904

Victoria University (later to become the University of Manchester) is the first in Britain to offer an honours degree in pharmacy.



1908

Booth Hall Infirmary is built, later to become part of RMCH.

1883

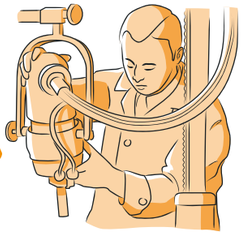
Manchester Dental Hospital is established, later becoming University Dental Hospital of Manchester.

1914

The Manchester Babies Hospital is founded by Dr Catherine Chisolm.

1914

The Manchester and District Radium Institute, which later becomes The Christie Hospital, is established at the MRI.



1929

Davyhulme Park Hospital opens to the public, later to become part of Trafford Hospital.

1939

Baguley Emergency Hospital is built to house the Emergency Hospital Service for WW2. In 1952 this becomes Wythenshawe Hospital.

1948

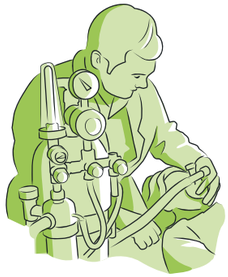
The National Health Service (NHS) is established. The first NHS hospital opens at what is now Trafford General.

1953

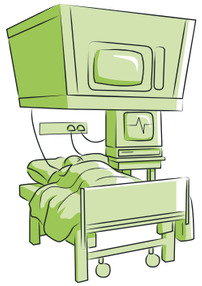
The first specialist children's burns unit in the country opens at Booth Hall Children's Hospital.

The first full-time child psychiatrist appointed at Booth Hall Children's Hospital.

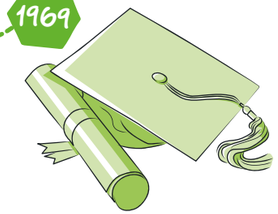
1956 The world's first use of a volatile anaesthetic at Crumpsall Hospital.



1965 The first intensive care unit in Manchester opened at Crumpsall Hospital.

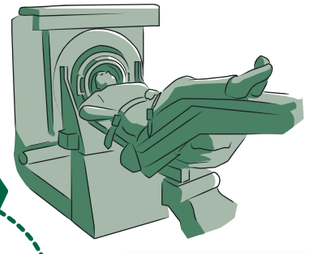


1969 The Manchester School of Nursing Studies becomes the first in England to establish a nursing degree.



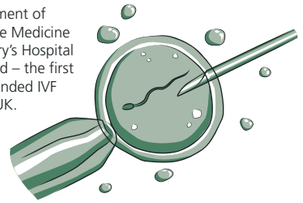
1970 Withington Hospital becomes the University Hospital of South Manchester.

1972 The MRI becomes the first hospital in the world to install a commercially available CT scanner.

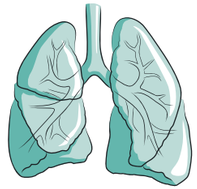


1977 Crumpsall Hospital, Delaunay's Hospital and Springfield Hospital merge to form North Manchester General Hospital.

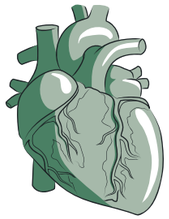
1982 The Department of Reproductive Medicine at Saint Mary's Hospital is established – the first fully-NHS funded IVF unit in the UK.



1987 Wythenshawe Hospital completes its first lung transplant, one of only six hospitals in the country to perform these procedures.



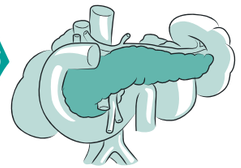
1992 Wythenshawe Hospital becomes one of four designated heart transplant centres nationally and carries out its first heart transplant procedure.



1994 University Hospital of South Manchester NHS Trust established, incorporating Withington and Wythenshawe hospitals.

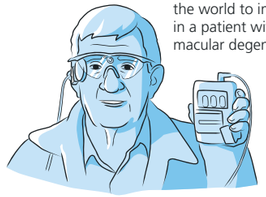
The UK's first auditory brainstem implant performed at the MRI.

2005 UK's first DCD (donor after circulatory death) pancreas transplant performed at the MRI.



2007 Withington Community Hospitals opens.

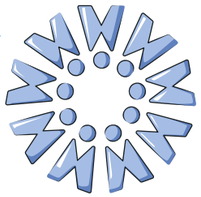
2015 A team at the Manchester Royal Eye Hospital becomes the first in the world to implant a bionic eye in a patient with age-related macular degeneration.



2009 Royal Manchester Childrens Hospital opens on the Oxford Road campus becoming the busiest children's hospital in the country.

2012 Trafford General Hospital becomes part of Central Manchester NHS Foundation Trust.

2017 Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), merged to form Manchester University NHS Foundation Trust (MFT).



2017 The Manchester Lung Health Check pilot is launched to improve lung cancer treatment and is later rolled out nationally.

2018 The Manchester Local Care Organisation is established, bringing together community health and social care services for people in Manchester.

2019 MFT takes on responsibility for running community services for people in Trafford, establishing the Trafford Local Care Organisation.

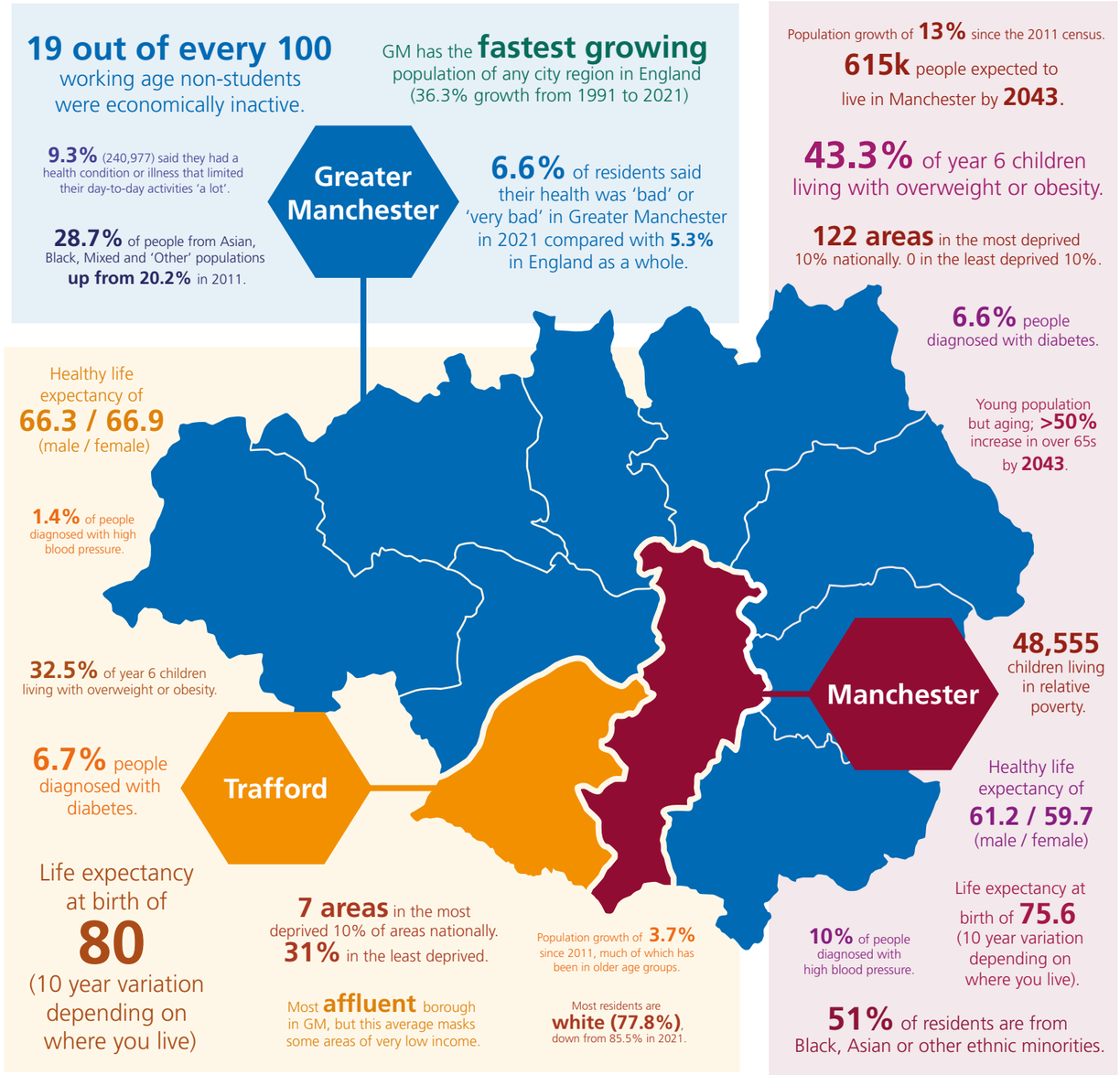
2020 MFT recruits the first patient in the world to a trial for a Covid-19 vaccine.

North Manchester General Hospital becomes part of MFT.

2021 A 19-month-old baby became the first child in the UK to receive a life-saving gene therapy treatment for the fatal disorder metachromatic leukodystrophy.

2022

Today, MFT is made up of ten hospitals and two Local Care Organisations. Together, they provide a wide range of hospital and community services to the people of Greater Manchester and beyond.



Our Communities

Whilst we provide services to people from all over England, the majority of people using our services come from Greater Manchester, particularly Manchester and Trafford. Greater Manchester is a vibrant and diverse place. Over the years it has led the world in social, cultural, technological and industrial revolutions. Today, it has a thriving local economy and has been one of the country's fastest growing city regions in recent years. But it is also a place of significant inequality, with some of the most deprived areas in the country and health outcomes that are worse than the England average. Our strategy will build on the strengths of our city region and will need to address some of the challenges that it faces.

- Manchester is the most deprived borough in Greater Manchester whereas Trafford is the most affluent. Manchester has some of the poorest health outcomes in the country. In Manchester, Trafford and the surrounding areas there are significant inequalities in wealth and health outcomes.
- The number of people living in Greater Manchester is growing. Significant growth is expected, particularly in the City of Manchester.
- The population is getting older. Whilst the proportion of people aged 65 and over is expected to grow everywhere in the coming decades, the birth rate in Manchester is also rising, signalling an increase in the number of children and young people in the coming years.
- Greater Manchester is becoming more diverse, with people from a wide range of identities and backgrounds making it their home. Almost 200 languages are spoken by Greater Manchester residents.
- In Manchester and the surrounding areas, people die younger and spend more of their lives in poor-health than in the rest of the country. In both Manchester and Trafford life expectancy and healthy life expectancy are significantly lower for the most deprived people than they are for the least deprived.
- Some health conditions are more common, particularly in Manchester, than in other parts of the country. Adults in Manchester are more likely to have conditions such as heart and lung disease, cancer, diabetes, and musculoskeletal (e.g. back and joint pain). Children in Manchester are more likely to be living with overweight or obesity, have asthma, diabetes and dental decay than young people elsewhere in England.

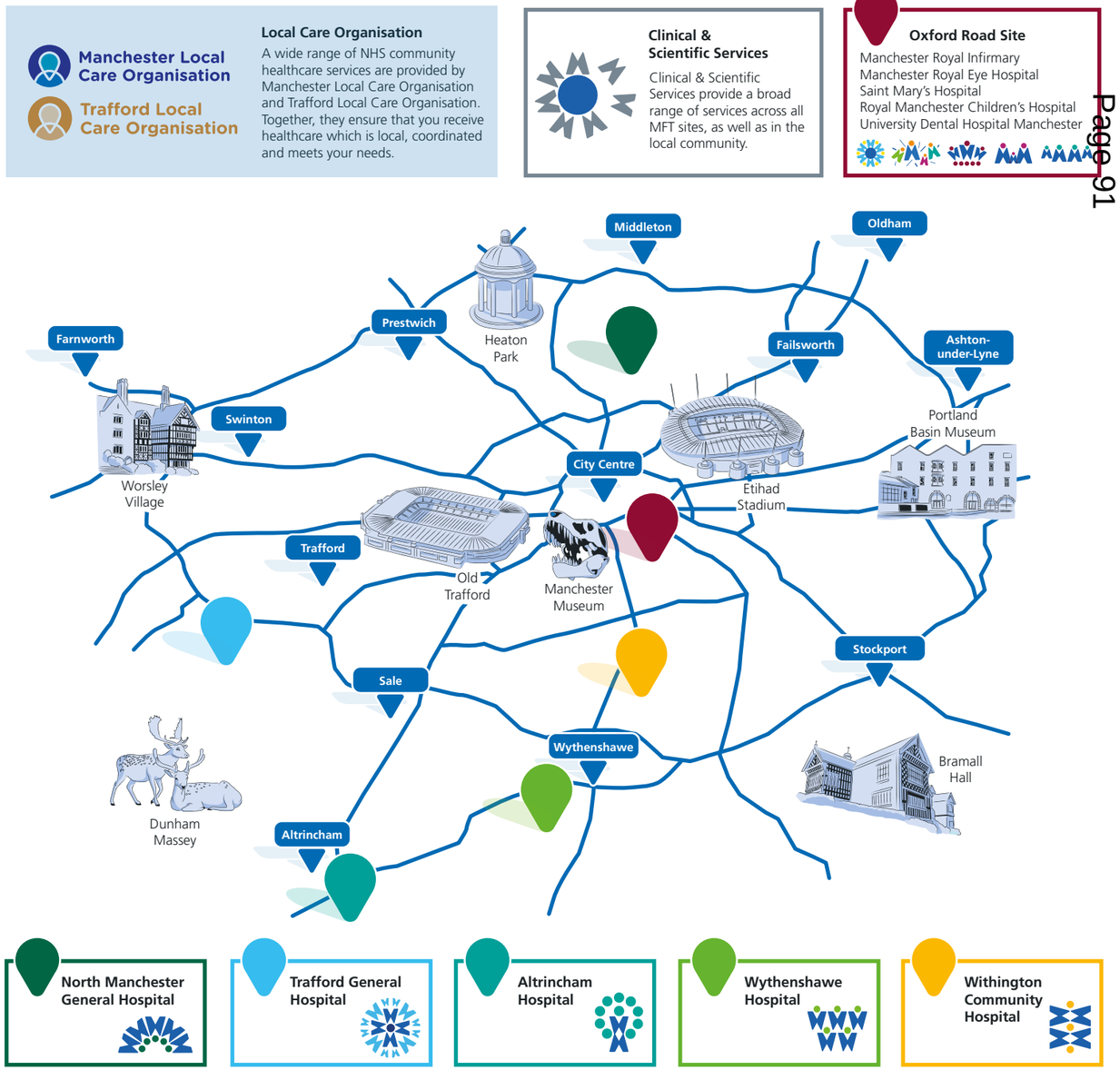
The Services We Provide

Our teams provide a full range of community and hospital services to the people of Greater Manchester and beyond:

- We provide integrated community care to people in Manchester, Trafford through our Local Care Organisations and Integrated Neighbourhood Teams.
- We provide local hospital services to almost 1 million people, including accident and emergency, diagnostic tests, outpatient appointments and day case surgery.
- We are the biggest provider of specialised services in England – which includes major surgery and highly specialised medicine. People come from across the United Kingdom to receive care at our hospitals.
- Our teams support people with both their physical and mental health, including mental health services for children and young people.

We provide care for people before they are born right through to the end of their lives.

MFT has a strong reputation as a leading trust for research in the North West of England, recruiting more people to research studies than any other provider in the region, with the second highest number of participants recruited nationally. This allows us to give the people who access our services and our communities access to the very latest treatments and innovations.



Our People and Partners

As a provider of health and care services it is our people – our staff – who make MFT the organisation that it is.

As one of the largest acute trusts in the UK we are a big team with over 28,000 staff including more than:

- 9,500 nurses and midwives
- 6,000 admin and clerical staff
- 2,600 medical and dental staff
- 2,000 allied health professionals (such as physiotherapists)
- 1,000 healthcare scientists

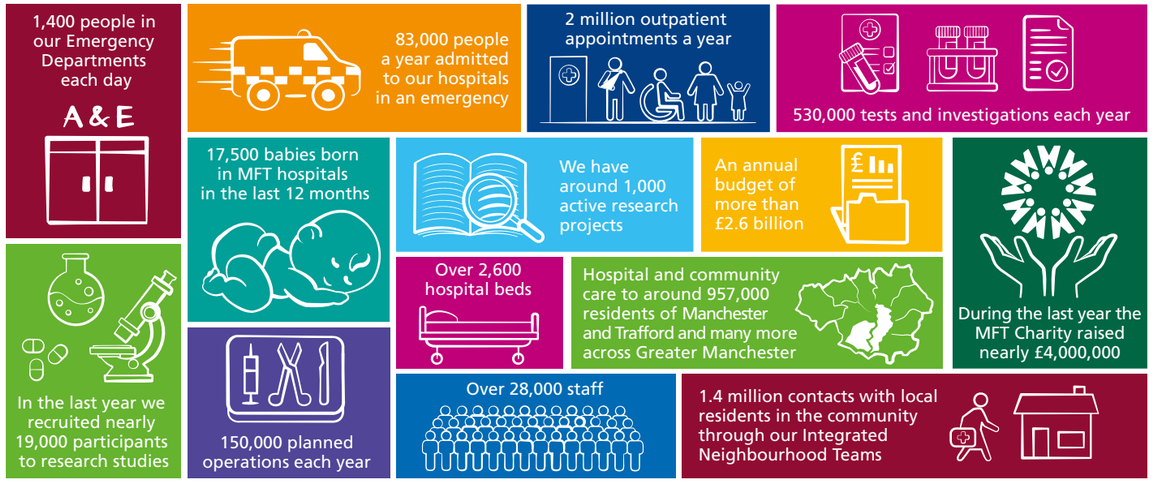
There are also 8,000 people who either work or train at MFT but are employed by other organisations, including healthcare professionals who are with us as part of their education and training. This includes:

- 1,900 catering, portering, security, domestic and other staff
- 6,400 student nurses, midwifes and allied health professionals
- 800 medical students
- 1,200 doctors in training

Whilst we are a big team here at MFT, we cannot do what we do without working closely with other organisations. These partnerships are key and involve collaboration with colleagues from across primary care (for example, GPs), other hospitals, and Local Authorities, as well as from the voluntary, charitable, and social enterprises sector, through the Greater Manchester Integrated Care Partnership.

- Manchester and Trafford Local Care Organisations work alongside Local Authority colleagues to provide NHS and adult social care to local people. Through our Neighbourhood Teams and Hospital at Home services, we collaborate with primary care networks to establish more streamlined services and outcomes for patients.
- We work closely with local NHS and voluntary, community and social enterprise (VCSE) colleagues as part of locality boards in Manchester and Trafford, as well as with other Greater Manchester localities.
- We are part of the Greater Manchester Trust Provider Collaborative which brings together NHS providers from across the city-region.
- We have strong relationships with our university partners, working together on research and education.

- Our size, scale and expertise allow us to proudly host organisations such as:
  - > Health Innovation Manchester, with which we work closely on research an innovation
  - > Various National Institute for Health Research (NIHR) programmes including The Manchester NIHR Biomedical Research Centre, The Manchester NIHR Clinical Research Facility, the NIHR HealthTech Research Centre and NIHR North West Regional Research Delivery Network
  - > The North West Genomic Laboratory Hub and Genomic Medicine Service Alliance.
- We work with a range of strategic partners on research, innovation and local development, for example through our CityLabs developments.



With our strong community connections; wide range of services; and fantastic staff and partners, MFT is uniquely placed to provide equitable high quality care, offer rewarding careers and training opportunities, and deliver world-class research and innovation.

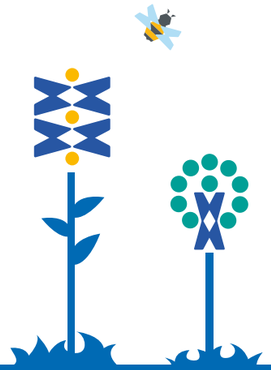
Why Have We Developed This Strategy?

A lot has changed since MFT was formed back in 2017: the Covid pandemic, changes to the way the NHS is organised and the addition of both North Manchester General Hospital and the Trafford LCO to the MFT family.

The effects of the pandemic in particular mean that the NHS is now arguably in a more difficult position than at any time before. But whilst the challenge has grown since 2017, so have the opportunities. All of this means that we are going to have to work differently as an organisation to deliver for our patients, our communities and our people. We talk more about some of these specific challenges and opportunities later in this document.

Now is therefore the right time for us to consider what we need to do in the coming years to deliver our mission: to work together to improve the health and quality of life of our diverse communities.

We believe that having a single strategy for our organisation will help to provide the clarity we need for ourselves, our communities and our partners about what we are trying to achieve and where we will focus our efforts over the next five years.



How Have We Developed Our Strategy?

Over the past six months, we have developed our strategy through conversations with our staff, governors, members, partners and patient groups. Through the process we have asked three key questions:

1. What are we trying to achieve as an organisation – what are our aims?
2. What are the key challenges and opportunities that might help or stop us from achieving these aims?
3. How should we respond to these challenges and opportunities – what action should we take?

We established 4 reference groups that met several times during the process and brought different points of view to the work:

Patient Representatives Reference Group

Our Patient Representatives Reference Group brought together representatives of different groups and communities from across our population. The group emphasised the importance of the local services that we provide, the need for people to be able to trust us as an organisation, the accessibility and equity of our services.

Staff Reference Group

Our Staff Reference Group brought together colleagues from across our organisation, including our staff governors and staff side representatives. It emphasised the need for our strategy to be simple and meaningful, to make clear that colleagues are valued and supported, and that we live by our MFT values.

How Have We Developed Our Strategy?

Clinical and Academic Reference Group

Our Clinical and Academic Reference Group was made up of clinicians and academics from within MFT and also partner organisations such as universities and Health Innovation Manchester. The group emphasised the ambition and confidence that we should show in our strategy. It stressed that being 'world-class' can apply to the delivery of local services as well as our specialised services. Emphasising our role in education and training in our strategy was another key message, as was the connection that service users and colleagues have with our individual hospitals.

External Partners Reference Group

Our External Partners Reference Group was made up of colleagues from other health and care organisations, including GM Integrated Care Board, Manchester and Trafford Local Authorities and NHS England. It emphasised the important role that MFT can play in preventing ill health and that we can use our influence to benefit the whole health and care system locally.

We invited a number of leading experts from outside our organisation to talk to us about topics such as health inequalities, national policy, primary care and digital technology, which helped to inform and challenge our thinking.

We also surveyed our colleagues and members at key points in the process to get their views on what our aims should be as well as the key challenges and opportunities facing MFT. Our leadership teams and our team of change agents also supported a range of additional local conversations to help reach as many people as possible.

All of these discussions and the feedback we have received have helped us to form our strategy.

Challenges and Opportunities

As we developed our strategy we identified the challenges and opportunities to which we will need to respond if we are going to be successful. Doing this gave us some key areas to focus on as we considered our objectives and actions.

Challenges

- Demand for our services is high and is expected to keep rising. If we cannot keep up with the rising demand, it is likely to affect the quality of care that we provide, the satisfaction of our staff, our finances and our research and innovation work. Reasons for the high demand include:
  - > The overall health of people in Greater Manchester is worse than it is in other parts of the country
  - > The gap between people with the best health and those with the worst is also wider than other parts of England and has worsened in recent years. The Covid pandemic exposed and added to inequalities in health and wider society
  - > People are expected to live longer, with more time spent in poor health and with more than one illness, increasing the demand for our services
  - > The number of people living in Greater Manchester is expected to rise significantly in the next decade. Wider public services, such as General Practice (GPs) and social care, are also under pressure
  - > We had to pause a lot of our services during the pandemic so we could treat people with Covid. Despite a lot of hard work over the last few years, we still have more people on our waiting lists and longer waiting times than we would want
  - > Wider public services such as social care are experiencing increasing demand and funding pressures. This is forecast to continue in the coming years.
- It has been a difficult few years for our staff with the Covid-19 pandemic and the massive efforts that have been made to recover our services since. Whilst a lot has been done to improve the support we give to staff, this has affected people's health and wellbeing.
- There is a limited number of healthcare professionals and, whilst we have been successful in attracting people to work at MFT, there is a global shortage in some key areas such as nursing. Sickness rates at MFT are higher than we would want – in part reflecting the health of our local communities – as are our turnover rates.

Challenges and Opportunities

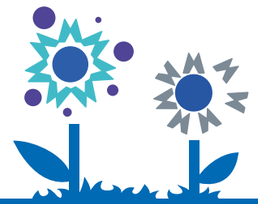
- Whilst we have people from all backgrounds and identities working at MFT, the diversity of our workforce still does not match the diversity of our communities. We know, for example, that people from ethnic minority backgrounds and those with disabilities have poorer experiences at work and are under-represented at senior levels.
- Public finances are under pressure. Our funding has grown more slowly than our costs. We expect this pressure to continue in the coming years, as well as the difficulties we experience in accessing capital funding (which is used to pay for building work and equipment, for example). All of this means that our financial position is now the most challenging it has been for years.

Opportunities

- Advances in science and technology (such as digital technology, artificial intelligence and genomic medicine) offer ways to make services more personalised, and to improve outcomes, patient experience and our value for money.
- We have a new Electronic Patient Record (EPR) which is transforming how we deliver our services and gives us the opportunity to become a truly information-driven organisation.
- An increased focus on supporting healthy living and preventing illness can help to improve people's lives and reduce demand on healthcare services.
- There is an opportunity to further integrate care. Integrated Care Systems have been introduced across the NHS which are supporting closer working with primary care (e.g. GPs), city councils and the voluntary sector.
- There is an increased focus an energy around tackling inequalities that exist for our patients and in our communities.
- Proposed changes in the NHS Long-Term Workforce Plan offer opportunities to increase the number and skills of NHS workers, and to introduce innovative new roles. Creating a more diverse workforce at all levels can help to improve outcomes for people using our services.

Challenges and Opportunities

- We can be more productive, getting better value for our patients and communities by working differently.
- Involving people, from all backgrounds, in their care and how we deliver our services can make them more equitable, effective and personalised.
- The size of MFT and range of services that we deliver gives us opportunities to improve outcomes, address inequalities, reduce variation, increase value for money, and make our services more seamless. It also means we can influence plans at a national and regional level for the benefit of our communities.
- We have welcomed colleagues at North Manchester General Hospital to MFT – and have plans to build a new hospital there – giving us more opportunities to improve lives in our local communities through new jobs, housing and high-quality services.
- As well as our Manchester Local Care Organisation (LCO), we have established the Trafford LCO, giving us the opportunity to support people to live well in Trafford, and to better co-ordinate care when it is needed.
- Our strength in research and innovation can help us to improve our services, improve health outcomes, address inequalities and attract staff.
- Our role as a large employer and training organisation, as well as the money we spend each year, gives us the opportunity to contribute to local health and wellbeing by providing high quality local jobs; supporting local economic development; and contributing to a greener, more environmentally-friendly future.



What Does Our Strategy Say?

Our strategy confirms our mission to work together to improve the health and quality of life of our diverse communities.

It sets out:

- Five **strategic aims** and the difference that we will make in delivering them.
- 11 **objectives** that describe the things that we will do in the coming years to deliver our aims.
- Specific **actions** under each objective that we will prioritise as we deliver our strategy.

Our aims, objectives and action will shape the work that we do over the next five years as an organisation, both as teams and as individuals. The appendix on page 64 explains in more detail how we will make sure that everyone feels part of delivering our strategy together and understands their role.

A summary of our strategy and our values can be found on page 34-35.

Refreshing Our Values

At the same time as developing our strategy we have refreshed our MFT values

– the principles that guide the way we work each day. Given the scale of the challenge – and of our ambition – it is important that we create the right conditions for our staff to do what we ask of them. Refreshing our values is just one part of an important piece of work we are doing to change and improve the culture of our organisation.

Our organisational values were originally developed as part of MFT's creation back in 2017, with input from our staff and local people. We have recently engaged further with people from across our organisation to refresh these values so that they reflect the things that are important to us today. People told us that they believe in the values that we have but wanted to make them more meaningful, both in how we describe them and how we all demonstrate them in our actions.

Set out below are the refreshed values that we have developed through this engagement:

A fifth value – we are curious – has been added. It reflects how we are always searching for ways to learn and improve, as well as the work we do on research, innovation, education and training.

We have used these values to inform the aims, objectives and values that make up our strategy.

OUR MISSION Working together to improve the health and quality of life of our diverse communities

OUR VALUES

Our mission is underpinned by our five core values.

We Are Compassionate | We Are Curious | We Are Collaborative | We Are Open & Honest | We Are Inclusive

Work with partners to help people live longer, healthier lives

More people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way.

We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.

We will improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so people are cared for in the most appropriate place.

Provide high quality, safe care with excellent outcomes and experience

More people recommending MFT as a place to be treated.

We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.

We will strengthen our specialised services and support the adoption of genomics and precision medicine.

We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.

Be the place where people enjoy working, learning and building a career

More people recommending MFT as a place to work.

We will make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential.

We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.

Ensure value for our patients and communities by making best use of our resources

Make the biggest possible difference with the resources we have by delivering our financial plans.

We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.

We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.

Deliver world-class research & innovation that improves people's lives

More people participating in and benefitting from world-class research and innovation.

We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.

We will apply research and innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide.

Our Aims

Through engagement with our members, governors and staff, we have developed five strategic aims for our organisation. They describe the outcomes that we want to achieve for our communities, patients and the people we work with over the next five years.

For each aim, we have described what they will mean for you – as someone who uses our services, or as a member of staff – and for us as an organisation.

We have also identified the difference we want to make in delivering our aims. This will help us to measure how successful we have been in putting our plans into action. Where possible, we will also measure how well we are delivering our aims in an equitable way for all people, whatever their background or identity. For example, we will look at the experience of people from ethnic minorities, with disabilities and with other identities or backgrounds through our staff surveys.

Our aims are ambitious. They describe the improvements we want to make over the next five years. Some of these will take more time to deliver than others, and progress might not always be straightforward, but we are committed to working together to improve the services that we offer.

1

Work with partners to help people live longer, healthier lives

What this means for you:

We will work with you to support you to stay healthy and avoid illness so that you can live longer, with more of your life spent in good health.

What this means for us:

We will work together with patients, our communities and our partners – in primary care, localities, Local Authorities, and the VCSE sector for example – to support healthy living in its widest sense and prevent illness in a joined-up way.

The difference we aim to make:

More people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way.

2

Provide high quality, safe care with excellent outcomes and experience

What this means for you:

When you are ill, we will work with you to understand what is wrong and the options that you have. If you want treatment, we will treat you as quickly as possible, with care and compassion, helping you to get back to good health or to live your life well with your condition. Our services will be of the same high standard in all our communities and across all our hospitals.

What this means for us:

We will engage our communities and patients in the planning and delivery of our services, finding new ways of delivering equitable, safe, high-quality care. We will take pride in delivering excellent local and specialised services, organising ourselves so that we can provide the best possible care across the whole of MFT to address health inequalities.

The difference we aim to make:

More people recommending MFT as a place to be treated.

3

Be the place where people enjoy working, learning and building a career

What this means for you:

If you work or train here, you will feel valued and supported to deliver the best possible services to our patients and colleagues. You should feel supported to stay here and to build a career. If you are looking for a new job, you will want to come to work here.

What this means for us:

We will listen to our colleagues and make sure they feel supported by acting on their feedback. We will embrace diversity and strive for inclusion so that all our communities can trust us and everyone feels that they can truly belong at MFT. We will offer people different ways to start and develop their career with us.

The difference we aim to make:

More people recommending MFT as a place to work.

4

Ensure value for our patients and communities by making the best use of our resources

What this means for you:

You will receive the best possible support and care because we get the most out of every pound that we spend.

What this means for us:

We will make the biggest possible difference to people's lives as one of the most productive NHS providers, finding ways to continually improve our services. We will deliver on our financial plans, making the best use of our people's time, technology and our buildings.

The difference we aim to make:

Make the biggest possible difference with the resources we have by delivering on our financial plans.

5

Deliver world-class research and innovation that improves people's lives

What this means for you:

It will be easier for you to take part in research and innovation, and we will work with our communities to make sure that it is aimed at the things that are important to you. When you use our services you can access the latest treatments to improve your health. If you work here, you can be involved in a wide range of research and innovation which helps to transform healthcare locally, nationally and internationally.

What this means for us:

We will work with our diverse communities and our teams to make sure that research and innovation helps us to address the challenges that we face, and that we improve the diversity of those involved. We will make it easier for colleagues to take part, with more people leading research and exploring careers as clinical academics. We will apply our research, innovation and technology to improve the services that we deliver.

The difference we aim to make:

More people, from all backgrounds, participating in and benefitting from world-class research and innovation.

Our Objectives and Actions

To help deliver our aims we have agreed 11 objectives and identified a small number of priority actions under each objective. These actions do not cover everything that we are doing as an organisation, but they will be our areas of focus in the coming years as we believe they will make the biggest difference.

Because we want to be specific about the things that we will do, the actions focus more on what we want to achieve over the next two to three years. We will therefore review our actions each year as part of our annual planning process, and formally refresh them after two years so that our strategy stays up-to-date and relevant.

Whilst our objectives and actions refer to specific services and programmes of work, they also provide a framework to guide all our plans across the whole of MFT. Different objectives and actions might be more relevant for some of our teams than others, but everyone across our organisation should see something in the strategy that reflects the important work they do at MFT.

1

We will work with partners to target the biggest causes of illness and inequalities, supporting people to live well from birth through to the end of their lives, reducing their need for healthcare services.

To deliver this objective, we will prioritise the following actions

- Improve equity, access and the quality of care in our maternity services by developing personal care pathways for women and families who we know have poorer outcomes. For example, black and Asian women, those from other minority ethnic backgrounds and from more deprived areas.
- Play a leading role in delivering joined-up physical and mental health services for families, children and young people, working with Local Authority partners to develop and deliver integrated plans.
- Increase the number of public health interventions that we deliver across MFT, such as referrals to smoking cessation and other preventative services, making every contact count.
- Support earlier detection and better outcomes by improving the uptake of our screening programmes – such as Targeted Lung Health Checks – in an equitable way. Ensure that the right diagnostic and treatment capacity is in place to support people who need subsequent care.
- Improve the identification of people with frailty through better links with Neighbourhood Teams so that we can improve the support we provide. Support older people accessing our services to live a full and healthy life by offering improved information and educational resources.
- Make sure that people who tend to experience poorer outcomes are appropriately prioritised on our waiting lists, using public health intelligence to inform clinical prioritisation.
- Address health inequalities by working with under-served communities to improve things like bowel cancer screening, hypertension and diabetes services, fully embedding our Integrated Neighbourhood Teams and their work with primary care, Local Authority and VCSE colleagues. Extend this approach to asthma in children and young people, and to other screening and immunisation programmes.

2

We will improve the experience of children and adults with long-term conditions, joining-up primary care, community and hospital services so that people are cared for in the most appropriate place.

To deliver this objective, we will prioritise the following actions

- Work with commissioners and locality partners to roll out our Hospital@Home services for adults and children, and to demonstrate how these services can improve care and reduce demand on local services by delivering care and support in people's own homes.
- Improve the identification of patients with multiple long-term conditions so that we can better co-ordinate appointments and care across multiple specialties, providing a more personalised experience.
- Work with colleagues in primary care to develop and implement plans to improve the interface with MFT services, improving the experience for patients and reducing steps that may contribute to delays.
- Work with commissioners and locality partners to ensure that access to services across our communities is consistent, whilst being tailored to local need, embedding a core community health offer that fits with wider community services.
- Offer a greater range of tests and pathways to people closer to their home by fully establishing our Community Diagnostic Centres.
- Build on research and innovation work to implement wearable and implanted devices to monitor patients with long-term conditions such as mental health, respiratory, heart disease and diabetes.

3

We will provide safe, integrated, local services, diagnosing and treating people quickly, giving people an excellent experience and outcomes wherever they are seen.

To deliver this objective, we will prioritise the following actions

- Improve the way that we routinely involve people with decisions about how we plan and deliver our services by establishing a network of patient and communities groups across the organisation. Build on our relationships with external groups, including through our VCSE leaders forum, to ensure broader community involvement.
- Increase the number of patient safety representatives attending key meetings, and the number of safety champions we have in post across the organisation.
- Improve patient experience through a focus on better communication, food and hydration and pain relief.
- Ensure that every patient-facing team at MFT has a process through which they analyse feedback from people that use our services and make changes to improve the service they offer.
- Reduce episodes of avoidable harm in our hospitals through a focus on preventing pressure ulcers, falls and missed doses of critical medicines.
- Improve patient outcomes and reduce the burden of antimicrobial resistance by promoting the prompt switching of intravenous to oral antibiotics and reducing the use of 'watch and reserve' antimicrobials across MFT.
- Continue to review harm to patients waiting for planned care and use the learning to identify and appropriately prioritise patients on our waiting lists with known risk factors.
- Make the best use of our outpatient capacity by supporting attendance, and maximising advice and guidance services, virtual clinics and patient-initiated follow-up.
- Reduce the time that people wait for diagnostic tests and for these tests to be reviewed by a clinician by better balancing our capacity with demand across MFT, improving our booking and scheduling processes and the use of technology.
- Reduce waiting times for planned treatment through improved utilisation and productivity of our theatre lists, allowing us to treat more patients within MFT. Complete the establishment of the Trafford Elective Hub and roll-out good practice on patient pathways across other MFT sites and beyond.
- Reduce the amount of time people stay in our hospitals and waiting times for urgent care, working with partners on key programmes to improve flow through hospital and community services.

4

We will strengthen our specialised services and support the adoption of genomics and precision medicine.

To deliver this objective, we will prioritise the following actions

- Help to deliver high quality, sustainable regional services by centralising care in some areas, for example, in Cardiac Surgery and Vascular Surgery.
- Use the range and scale of services that we offer to develop high quality specialised services, for example, in Cancer Surgery and Transplant services.
- Maintain our regional centres, providing leadership and support across Greater Manchester and beyond in areas such as Children's, Ophthalmology and Respiratory services.
- Increase adoption of genomic medicine across specialties at MFT, bringing genomic testing earlier in patient pathways and applying pharmacogenomics. Support wider regional adoption through hosting the North West Genomic Medicine Service Alliance.
- Build on our position as being at the forefront of genomic testing nationally by developing new services such as circulating tumour DNA testing and leading work on pharmacogenomics. Develop plans in other advanced diagnostic disciplines such as metabolomics, proteomics and integrative diagnostics.
- Continue to be a leading provider nationally of cell and gene therapies, and other advanced therapies, in both service and research. Develop a long-term plan to consider our future capacity and potential strategic partnerships.
- Develop our strategy for robotic assisted surgery across MFT and deliver a viable short-term plan to maximise the use of our existing surgical robots and grow our robotic capacity in the future.

5

We will continue to deliver the benefits that come with our breadth and scale, using our unique range of services to improve outcomes, address inequalities and deliver value for money.

To deliver this objective, we will prioritise the following actions

- Ensure equitable access and outcomes for patients across MFT by establishing networked or single services in key specialties. Finalise the integration of services at North Manchester General Hospital, delivering models of care that meet people's needs, address inequalities and are financially sustainable.
- Work together with other providers, the Trust Provider Collaborative and other partners to help make sure that services across Greater Manchester are sustainable.
- Maximise clinical effectiveness and efficiency, whilst ensuring local access wherever possible, by agreeing and implementing our plans for which services will be delivered from which MFT sites.
- Develop an effective operating model for MFT that will help us to deliver the benefits that come with our size and scale.

6

We will make sure that all our colleagues feel valued and supported by listening well and responding to their feedback. We will improve staff experience by embracing diversity and fairness, helping everyone to reach their potential.

To deliver this objective, we will prioritise the following actions

- Ensure that every team has effective ways of engaging and involving all staff in decisions which affect them, to listen to their ideas and learn from their experience, so that we can improve services for patients and their families and the working lives of staff.
- Respond to issues raised in staff surveys, workforce equality standards, and listening events by co-producing MFT-wide improvement plans, with an initial focus on food provision, car parking, flexible working, health and wellbeing, support for managers and career development.
- Promote a safe, open and transparent working environment which encourages staff to raise concerns directly within their team, whilst ensuring that other routes are available for staff to raise concerns where necessary.
- Update priorities and plans within the MFT Equality, Diversity and Inclusion (ED&I) strategy *Diversity Matters*, ensuring that everyone has a personal objective on ED&I appropriate to their role, creating a working environment where everyone has a sense of value and belonging.
- Implement plans to reduce pay gaps with respect to race, disability and gender, fulfilling and, where possible, exceeding obligations for all staff with protected characteristics.
- Embed our values and behaviours across the organisation so that they are understood and role-modelled by all staff, promoting compassionate leadership and teamwork in all areas through the *Civility Saves Lives* programme.
- Deliver our ongoing culture change programme, working with our team of Change Agents on three-year cycles of cultural improvement.
- Implement, monitor and enhance compliance against our Violence Response and Sexual Conduct Charters, ensuring colleagues receive the training and support required, including our approach to trauma informed care.
- Support healthy living, address health inequalities and improve attendance by promoting staff health and wellbeing services through initiatives such as Health and Wellbeing Champions and the *Colleague Community* initiative. Increase the range of preventative services available to staff such as on-site cancer screening.

7

We will offer new ways for people to start their career in healthcare. Everyone at MFT will have opportunities to develop new skills and build their careers here.

To deliver this objective, we will prioritise the following actions

- Develop a workforce planning framework and associated skills to help predict our future workforce needs to deliver high quality care now and, in the future, aligned to MFT strategy and annual plans.
- Co-design a workforce, education and training plan which ensures we have the appropriate mix of skills within teams (utilising apprentice, assistant, advanced and associate practitioner roles), making best use of the apprenticeship levy to improve development opportunities and career pathways for our current and future employees.
- Build a supportive environment for our students and professionals-in-training, responding to feedback and developing innovative ways to increase capacity for supervision.
- Work with local schools and colleges to promote careers in health and care, continuing to build an inclusive community-based approach to recruitment, on-boarding and induction.
- Embed fair and inclusive recruitment practices that promote diversity at all levels, target under-represented groups, and ensure that careers in healthcare are open to all. Improve representation of people from an ethnic minority background at senior levels.
- Work with managers to ensure proactive and efficient processes are in place for recruitment, onboarding and induction, so that all vacancies are filled as swiftly as possible. Develop a tailored approach for colleagues joining from overseas.
- Invest in collective and compassionate leadership and team development models so that our managers at all levels are confident in demonstrating the knowledge, skills and behaviours expected of them and can be the best versions of themselves in their jobs.
- Improve our understanding of avoidable staff turnover to help find ways keep retain the people and skills that we need.

8

We will achieve financial sustainability, increasing our productivity through continuous improvement and the effective management of public money.

To deliver this objective, we will prioritise the following actions

- Use our new Hive EPR system to help get the best value for patients from our clinical activity, for example, ensuring that the diagnostic tests that we provide have a strong evidence base and will help in clinical decision-making.
- Work with partners across the system to make the best use of all the resource available, for example, by supporting work to improve prescribing and the use of medicines within in hospitals, community services and primary care.
- Standardise policies and practice across MFT where this can help to deliver value. Identify opportunities to use our scale to deliver better value on products that we buy with an initial focus on theatres, urgent care and maternity services.
- Deliver a programme of engagement for staff so that everyone understands the part they can play and is engaged in making the best use of our resource.
- Carry out post-implementation reviews on all major projects and investments to ensure that the benefits forecast in business cases are delivered.
- Continue to develop strategic partnerships with suppliers through our Procurement Partners Programme and exploring ways that these partnerships can deliver additional value.
- Maximise the value and income delivered by our MFT Charities, learning from approaches taken elsewhere, to strengthen the brands of our hospitals and Local Care Organisations, and improve our services.
- Develop and deliver plans to increase commercial income for MFT to support the delivery of our services, including the development of a commercial estates plan.

9

We will deliver value through our estate and digital infrastructure, developing existing and new strategic partnerships.

To deliver this objective, we will prioritise the following actions

- Deliver the Hive benefits case around clinical quality, patient experience, productivity and research and innovation, supporting staff the get the most out of the system. Maximise the use of the MyMFT app to improve engagement with communities, information sharing about our services and healthy living, and the involvement of individuals with their care, whilst mitigating the risk of digital exclusion.
- Develop an infrastructure plan for community services, covering both estates and digital.
- Deliver a data strategy which makes better use of our data to improve patient care and, with appropriate safeguards, supports innovation and commercial partnerships. Strengthen our cybersecurity to make sure our data and the patient data we hold is safe.
- Complete the redevelopment of North Manchester General Hospital as part of the New Hospitals Programme, and the wider campus as part of the North Manchester Strategy.
- Work with national and local partners to identify alternative sources of capital funding to support the development of our estate and facilities, for example, our plans for the development of Wythenshawe Hospital and the surrounding area.
- Develop and deliver plans to reduce our overall estates footprint by making best use of the facilities that we have. Put in place the right governance and oversight arrangements to deliver this.
- Continue to invest in, maintain and develop our estate, making the best use of the capital funding that is available to us.

10

We will strengthen our delivery of world-class research and innovation by developing our infrastructure and supporting staff, patients and our communities to take part.

To deliver this objective, we will prioritise the following actions

- Help to create protected time for people across the organisation to pursue external funding opportunities and carry out research and innovation activity.
- Make research and innovation more accessible to staff through leaner, more proportionate administrative processes.
- Support people to develop the skills to deliver world-class research and innovation by creating a careers framework that supports people at all levels to become involved and succeed in research. Work closely with universities to identify areas of joint interest in which clinical academic roles can be created.
- Develop and deliver plans to improve access for research studies to services such imaging, pharmacy and laboratory medicine.
- Fully integrate research and innovation into the annual planning process so that we can better plan for sustainable growth.
- Prioritise the delivery of research programmes and the strategic themes that are part of our NIHR hosted infrastructure, supporting them to meet and surpass the required outputs.
- Develop strong relationships with our communities so that we can work together on research and innovation which addresses the issues that matter most to people and improve the diversity of people participating. Co-create our engagement strategy to ensure research remains relevant and more accessible.
- Look for opportunities to further develop our research and innovation infrastructure, helping to drive forward research and innovation in new areas – such as children and young people, social care, primary and community care and health inequalities.
- Develop strong links with clinical and operational teams across MFT, and partners such as Health Innovation Manchester, to make sure that our research and innovation work addresses the challenges and opportunities within the organisation.
- Use digital channels, including Hive and MyMFT, to identify opportunities for patients and our communities to get involved in research and innovation, and to make it easier for people to stay involved with research once they are recruited.

11

We will apply research and innovation, including digital technology and artificial intelligence, to improve people's health and the services we provide.

To deliver this objective, we will prioritise the following actions

- Develop the MFT secure data environment and its interfaces with other datasets, ensuring that the data we hold is secure and is curated and structured in such a way that it can be harnessed to improve services for patients and power cutting-edge medical research.
- Develop a framework to support the appropriate adoption of safe and effective AI solutions for clinical and operational use in healthcare. Explore the opportunity to appoint at least one strategic partner to help us prepare for more widespread adoption.
- Understand and exploit opportunities to evaluate and apply new technologies that will improve the efficiency and quality of the services and care that we provide, whilst mitigating any risk of digital exclusion.
- Increase the number of impactful, formalised industry partnerships year-on-year to generate new research and innovation activities and new income streams as appropriate.
- Formalise our approach to identifying and adopting proven innovations that will help us to address the challenges faced by our communities and our organisation.
- Work with higher education institutions (e.g. universities) to explore the opportunities for bespoke collaboration which strategically matches MFT's ambition with individual partners' expertise.

Living Our Values

Our values help to shape everything that we do, including our strategy.

There are some important themes that run throughout our strategy which reflect how we will turn our values into action:

Because we are compassionate we will…

- Care about people, focusing on the needs of all our patients and staff.
- Reduce our impact on the environment.
- Support local people and the local economy in our role as a large local employer and consumer.

Because we are we are curious we will…

- Use digital technology and other innovations to improve the way we work for patients and our colleagues.
- Use data, insight and evidence to inform the way we deliver services and make decisions.

Living Our Values

Because we are collaborative we will…

- Involve patients and our communities in the planning and delivery our services.
- Work together as one team across MFT.
- Work together with partners across Greater Manchester.
- Use our influence locally and nationally to the benefit of our patients, our communities and our partners.

Because we are open and honest we will…

- Listen and respond to feedback from staff, patients, communities and partners.
- Celebrate our successes.
- Be honest about where things can be better and share learning to make improvements.

Because we are always inclusive we will…

- Address health inequalities, ensuring everyone can get the care they need and the best possible outcomes whatever their identity or background.
- Build a diverse workforce at all levels in which everyone can belong, and which reflects the people who use our services, helping us to deliver better care and build trust with our communities.

These themes have helped to inform the actions that we set out in Our Objectives and Actions (page 44). More detail on how the actions in our strategy support our values can be found in the appendix on page 64.

Delivering Our Strategy and Measuring Success

Writing a strategy is just the start of the process. If we are to make a difference to our communities and our organisation, we must make sure that we turn our words into action. To do this, we will make our strategy central to the way we do things at MFT and ensure that every team and every individual is supported to play their part in delivering it.

How does the strategy feed into our plans?

Each year, we agree what our priorities will be over the next 12 months and develop our plans to deliver them. Every part of our organisation is involved in this process, as teams across MFT develop their plans and local priorities. This, in turn, helps to shape the objectives that each person in the organisation has for the year.

For the next five years, this strategy will inform our priorities in this yearly planning process.

How will we know if we have been successful?

We have the opportunity to become a truly information-driven organisation, using data and evidence to identify ways to improve the services that we offer.

In Our Aims on page 36 we set out the difference that we want to make in delivering each of our five strategic aims:

- More people being supported to live health lives in the community with fewer people needing to use healthcare services in an unplanned way.
- More people recommending MFT as a place to be treated.
- More people recommending MFT as a place to work.
- Make the biggest possible difference with the resources we have by delivering our financial plans.
- More people participating in world-class research and innovation.

Over the five years of this strategy, we will measure our performance against a headline indicator for each of our five strategic aims, for example, the percentage of people who recommend MFT as a place to be treated in patient surveys. There will also be a wider range of measures that we track which will help us to know whether the actions we are taking are having the impact we are aiming for, for example, our waiting times for planned treatment, or episodes of avoidable harm.

We will refresh our performance reports to make sure that the things that we measure on a day-to-day basis are the things that we have said are important in this strategy.

How will we report on our progress?

We already have processes in place to monitor the delivery of our annual plan and report progress to our Council of Governors and Board of Directors. Having made sure that our aims, objectives and actions from this strategy are reflected in our plan, we will ask teams to share their progress in delivering the actions from the strategy that that they own.

We will put together regular updates on their delivery and make them public. Every year, we will provide a formal update on the delivery of our strategy to our Governors and Board of Directors.

Delivering Our Strategy and Measuring Success

How will we work differently to deliver this together?

To implement this strategy we must build a culture of inclusive, compassionate leadership and continuous improvement at MFT:

- We will make sure that we have a shared purpose as an organisation by ensuring that our strategy informs the plans of every team across MFT
- We will continue the engagement that we have started in developing our strategy and refreshing our values so that we are all supported to play our part in delivering them
- We will use data and information to measure our progress and identify new ways of improving our services
- We will report our progress publicly, to our Governors and our Board of Directors on a regular basis.

Working together, we can improve the health and quality of life of our diverse communities.

Appendix: How Our Actions Support Our Values

Our values run through everything that we do as an organisation and they have helped to shape the actions in this strategy. Some actions will link to more than one of our values, but the pages below provide an example of the ways in which this strategy will help us to live the values that we have as an organisation.

Because we are compassionate we will…

Care about people, focusing on the needs of our patients and staff.

- Support older people accessing our services to live a full and healthy life by offering improved information and educational resources.
- Improve the identification of patients with multiple long-term conditions so that we can better co-ordinate appointments and care across multiple specialties, providing a more personalised experience.
- Improve patient experience through a focus on improving our communication, food and hydration and pain relief.
- Ensure that every team has effective ways of engaging and involving all staff in decisions which affect them, to listen to their ideas and learn from their experience, so that we can improve services for patients and their families and the working lives of staff.
- Embed our values and behaviours across the organisation so that they are known and role-modelled with a zero-tolerance approach to a lack of civility between colleagues and teams. Embed the Civility Saves Lives programme across the organisation.

Appendix: How Our Actions Support Our Values

Because we are compassionate we will…

Support local people and the local economy in our role as a large local employer and consumer.

- Increase the number of people that we employ through our Widening Participation Charter, encouraging greater recruitment from our local population with improved engagement on career opportunities.
- Engage with schools and colleges to promote careers in health and care, continuing to build an inclusive community-based approach to recruitment and induction.
- Increase the number of formalised industry partnerships year-on-year to generate new research and innovation activities and new income streams.

Reduce our impact on the environment.

- Embed the Green Plan among the MFT workforce, continuing to reduce the carbon footprint per patient contact through the full decommissioning of nitrous oxide manifolds at our main hospital sites, and engage 10% of the workforce through sustainability communications and training.

Because we are curious we will…

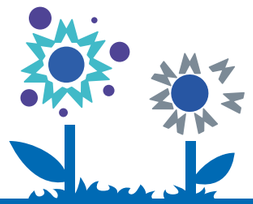
Use data, insight and evidence to inform the way we deliver services and make decisions.

- Make sure that people who tend to experience poorer outcomes are appropriately prioritised on our waiting lists, using public health intelligence to inform clinical prioritisation.
- Deliver a data strategy which makes better use of our data to improve patient care and, with appropriate safeguards, supports innovation and commercial partnerships. Strengthen our cybersecurity to make sure our data and the patient data we hold is safe.
- Develop the MFT secure data environment and its interfaces with other datasets, ensuring that the data we hold is secure and is curated and structured in such a way that it can be harnessed to improve services for patients and power cutting-edge medical research.

Because we are curious we will…

Use digital technology and other innovations to improve the way we work for patients and our colleagues.

- Build on research and innovation work to implement wearable and implanted devices to monitor patients with long-term conditions such as mental health, respiratory, heart disease and diabetes.
- Develop our strategy for robotic assisted surgery across MFT and deliver a viable short-term plan to maximise the use of our existing surgical robots and grow our robotic capacity in the future.
- Use our new Hive EPR system to help get the best value for patients from our clinical activity, for example, ensuring that the diagnostic tests that we provide have a strong evidence base and will help in clinical decision-making.
- Deliver the Hive benefits case around clinical quality, patient experience, productivity and research and innovation, supporting staff the get the most out of the system.
- Maximise the use of the MyMFT app to improve engagement with communities, information sharing about our services and healthy living, and the involvement of individuals with their care, whilst mitigating the risk of digital exclusion.
- Develop a framework to support the appropriate adoption of safe and effective artificial intelligence solutions for clinical and operational use in healthcare. Explore the opportunity to appoint at least one strategic partner to help us prepare for more widespread adoption.
- Understand and exploit opportunities to evaluate and apply new technologies that will improve the efficiency and quality of the services and care that we provide, whilst mitigating any risk of digital exclusion.
- Formalise our approach to identifying and adopting proven innovations that will help us to address the challenges faced by our communities and our organisation.



Appendix: How Our Actions Support Our Values

Because we are collaborative we will…

Involve patients and our communities in the planning and delivery our services.

- Establish network of patients and communities reference groups across the organisation so that we have forums in which we can routinely involve people with decisions about how we plan and deliver our services.
- Build on our relationships with external groups, including through our VCSE leaders forum, to ensure broader community involvement.
- Increase the number of patient safety representatives attending our meetings.
- Develop strong relationships with our communities so that we can work together on research and innovation which addresses the issues that matter most to people and improve the diversity of people participating. Co-create our engagement strategy to ensure research remains relevant and more accessible.

Work together as one team across MFT.

- Ensure equitable access and outcomes for patients across MFT by establishing networked or single services in key specialties.
- Finalise the integration of services at North Manchester General Hospital, delivering models of care that meet people's needs, address inequalities and are financially sustainable.
- Maximise clinical effectiveness and efficiency, whilst ensuring local access wherever possible, by agreeing and implementing our plans for which services will be delivered from which MFT sites.
- Develop an effective operating model for MFT that will help us to deliver the benefits that come with our size and scale.

Appendix: How Our Actions Support Our Values

Because we are collaborative we will…

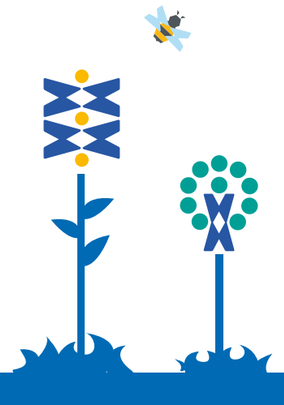
Work together with partners across Greater Manchester.

- Fully embedding our Integrated Neighbourhood Teams and their work with primary care, Local Authority and VCSE colleagues.
- Play a leading role in delivering joined-up physical and mental health services for families, children and young people, working with Local Authority partners to develop and deliver integrated plans.
- Work with commissioners and locality partners to roll out our Hospital@Home services for adults and children, and to demonstrate how these services can improve care and reduce demand on local services by delivering care and support in people's own homes.
- Work with commissioners and locality partners to ensure that access to services across our communities is consistent, whilst being tailored to local need, embedding a core community health offer that fits with wider community services.
- Work with colleagues in primary care to develop and implement plans to improve the interface with MFT services, improving the experience for patients and reducing steps that may contribute to delays.
- Work together with other providers, the Trust Provider Collaborative and other partners to help make sure that services across Greater Manchester are sustainable.
- Work with partners across the system to make the best use of all the resource available, for example, by supporting work to improve prescribing and the use of medicines within in hospitals, community services and primary care.

Because we are collaborative we will…

Use our influence locally and nationally to the benefit of our patients, our communities and our partners.

- Increase adoption of genomic medicine across specialties at MFT, bringing genomic testing earlier in patient pathways and applying pharmacogenomics. Support wider regional adoption through hosting the North West Genomic Medicine Service Alliance.
- Build on our position as being at the forefront of genomic testing nationally by developing new services such as circulating tumour DNA testing and leading work on pharmacogenomics.
- Continue to be a leading provider nationally of cell and gene therapies, and other advanced therapies, in both service and research. Develop a long-term plan to consider our future capacity and potential strategic partnerships.
- Work with national and local partners to identify alternative sources of capital funding to support the development of our estate and facilities, for example, plans for the development of Wythenshawe Hospital and the surrounding area.



Appendix: How Our Actions Support Our Values

Because we are open and honest we will…

Listen and respond to feedback.

- Ensure that every patient-facing team in MFT has a process in place through which they analyse feedback from patients and make changes to improve the service they offer.
- Increase the number of safety champions we have in post across the organisation.
- Ensure that every team has effective ways of engaging staff and learning from their experiences, supporting senior leaders to create a climate of meaningful staff engagement and involvement.
- Respond to issues raised in staff surveys, workforce equality standards, and listening events by co-producing MFT-wide improvement plans.

Celebrate our successes.

- Continue to recognise the brilliant work of our people and our teams through staff recognition and awards programmes.
- Publicise the work of our teams externally so that people get the recognition that they deserve nationally and internationally.

Be honest about where things can be better and share learning to make improvements.

- Continue to review harm to patients waiting for planned care and use the learning to identify and appropriately prioritise patients on our waiting lists with known risk factors.
- Complete the establishment of the Trafford Elective Hub and roll-out good practice on patient pathways across other MFT sites and beyond.
- Promote a safe, open and transparent working environment which encourages staff to raise concerns directly within their team, whilst ensuring that other routes are available for staff to raise concerns where necessary.

Appendix: How Our Actions Support Our Values

Because we are inclusive we will…

Address health inequalities, ensuring everyone can get the care they need and the best possible outcomes whatever their identity or background.

- Improve equity, access and the quality of care in our maternity services by developing personal care pathways for women and families who we know have poorer outcomes. For example, black and Asian women, those from other minority ethnic backgrounds and from more deprived areas.
- Work with under-served communities to improve things like bowel cancer screening, hypertension and diabetes services. Extend this approach to asthma in children and young people and to other screening and immunisation programmes.
- Support earlier detection and better outcomes by improving the uptake of our screening programmes – such as Targeted Lung Health Checks – in an equitable way.
- Support healthy living and address health inequalities by promoting health and wellbeing services available to our staff, increasing the range of preventative services available, such as on-site cancer screening.

Build a diverse workforce in which everyone can belong, and which reflects the people who use our services, helping us to deliver better care and build trust with our communities.

- Embed fair and inclusive recruitment practices that promote diversity at all levels, target under-represented groups, and ensure that careers in healthcare are open to all. Improve representation of people from an ethnic minority background at senior levels.
- Develop a tailored approach to recruitment and onboarding of colleagues joining from overseas.
- Implement plans to reduce pay gaps with respect to race, disability and gender, fulfilling and, where possible, exceeding obligations for all staff with protected characteristics.
- Update priorities and plans within the MFT Equality, Diversity and Inclusion (ED&I) strategy *Diversity Matters*, ensuring that everyone has a personal objective on ED&I appropriate to their role, creating a working environment where everyone has a sense of value and belonging.


NHS
Manchester University

Acknowledgements

We would like to thank everyone who helped us to develop our strategy, including our staff, governors, members and partners.

Thank you to members of our reference groups and their organisations for giving their time and views throughout the process. This included colleagues from other NHS organisations, local authorities, patient and the public representatives, the VCSE sector and universities.

Thanks also to our external speakers for sharing their expertise as we developed our strategy.

Finally, thanks to the MFT Clinical Photography Team in Medical Illustration and the MFT Group Communications team for the photography used in this document, and to Jennifer McMahon in the MFT Patient Services Team for the design work.

Contact Us

If you have any questions, or would like to find out more about our strategy please contact us by email at Group.Strategy@mft.nhs.uk

If you, your family, friends or colleagues are interested in becoming a public member of MFT we would be delighted.

Membership is completely free and it's easy to join. Simply complete a public membership application form – available online through the link: https://secure.membra.co.uk/Join/MFT

Alternatively, contact our Membership Office by email at ft.enquiries@mft.nhs.uk

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Approve
Item No.	12	**Confidential**	No
Title	WorkWell Partnership Vanguard		
Presented By	Jon Hobday, Director of Public Health		
Author	Tracey Flynn, Service Manager – Business and Investment Directorate of Business Growth, and Infrastructure		
Clinical Lead			

Executive Summary
The attached briefing note outlines Bury's local approach to deliver the GM Working Well Programme.

Recommendations
The Locality Board receives the report . The Locality Board endorses the approach.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☒		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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: A Bury Council EIA will be required.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
The Bury Council EIA is in draft to be signed off.						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

BURY INTEGRATED CARE PARTNERSHIP

WorkWell Partnership Vanguard

Introduction

1.1 National Programme

1.1.2 The national programme will support 59,000 people between 1st October 2024 and 31st March 2026 underpinned by £57million of national funding, and there will be 15 WorkWell Partnership vanguard sites who have 3 objectives:

1. Provide evidence-based, low intensity work and health assessments and interventions that support individuals to overcome health-related barriers to work.
2. Develop and implement an integrated work and health strategy for the ICB footprint.
3. Be part of a national evaluation and learning programme.

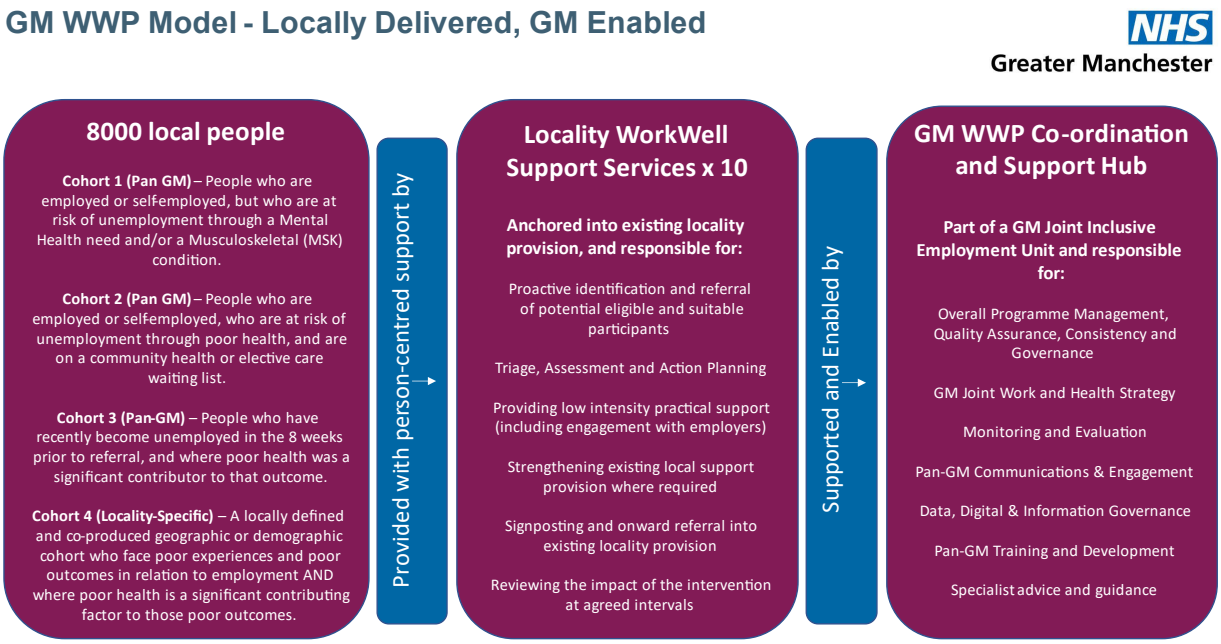
1.1.3 It differs from other employment support programmes in that it is a preventative programme to support those people who are recently unemployed or at risk of becoming unemployed due to health related barriers. Work Well focuses on early identification, triage and action planning with light touch support. The rational is that early intervention may address health related barriers which may enable people to stay and remain in work without accessing services that may have long waiting lists. Across GM, WW is viewed as part of the wider Working Well suite of programmes with overlap with Live Well and connectivity to VCSE assets in localities.

1.2 GM Locality Programme

1.2.1 NHS Greater Manchester has been named as 1 of 15 national WorkWell Partnership Vanguard sites following an Expression of Interest process that involved all ten GM localities.

Under the GM **'Locality Led, GM Enabled'** proposals between a '*go live*' date of **1st October 2024** and 31st March 2026 GM aim to support 8,000 people who are at risk of becoming economically inactive through poor health and have been allocated up to £7million to achieve this. This will be by strengthening our focus on prevention and building upon our existing locality work and health provision with a particular focus on the 4 target cohorts contained within the EOI.

1.2.2 The GM WW model and the 4 cohorts are within the image below:



2.1 Bury - Progress to Date

2.1.2 Bury with support from the NHS Project team and Price Waterhouse Cooper have hosted 2 local workshops. The workshops covered the following with additional local discussion:

- Shared how current employment and health services are provided and the interaction between them for the target cohorts.
- Considered who is a priority local cohort and explore how the service could function in a locality and help shape what that looks like.
- Thinking about the key elements or parameters of what a WorkWell locality model should focus on e.g. low level, early intervention, integration with local services.
- Consider how Management Information and outcomes will be gathered.

2.1.3 Bury's two workshops took place on the 12th June and 1st August with a range of partners invited from across the local system including colleagues from Live Well, local Work, Health and Wellbeing providers, DWP, Public Health and NHS colleagues. The Bury discussion focused on agreeing in principle a locality specific cohort. A locality specific cohort allows for focus on a geographic or demographic cohort who may face poor experience and poor outcomes in relation to employment due to significant health related barriers. The attendees at the Bury workshop agreed a focus on working age young people up to 35 years and over 50's, although it was strongly recommended retain a flexible approach. Within the Bury focused cohort it was agreed that veterans and those with learning difficulties would naturally be in scope though not the entirety of the Bury focus.

2.1.4 The rational for supporting young people as a priority was reflected in the proportionate number of

young who are unemployed in Bury and the increase in economic inactivity in the over 50's population. The local evidence also showed the disparity in Bury between the number of young people and in the workforce and an ageing population.

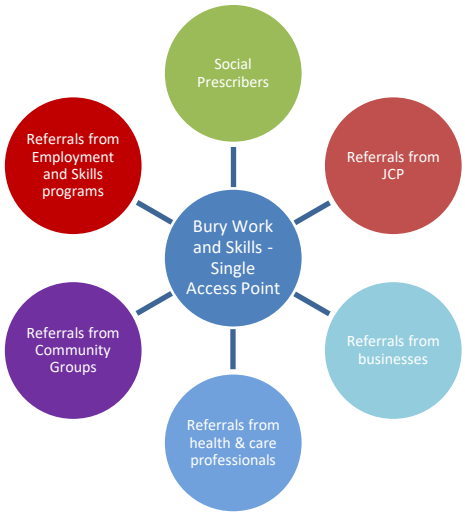
2.1.5 GM LAs were required to submit a final local delivery plan by 16th August.

3.1 Bury WW Model

3.1.2 Bury's delivery model is based on the creation of a single access point (SAP) for all enquiries and referrals relating to work, health, skills and wrap round support available to Bury residents. The model is based upon a successful, impartial service delivered in Oldham and Rochdale and also Bury Council's SAP for business engagement.

3.1.3 The model will work for all available funded support that can assist residents to access the right support at the right time.

3.1.4 Referral pathways can come from all part of the Bury system:



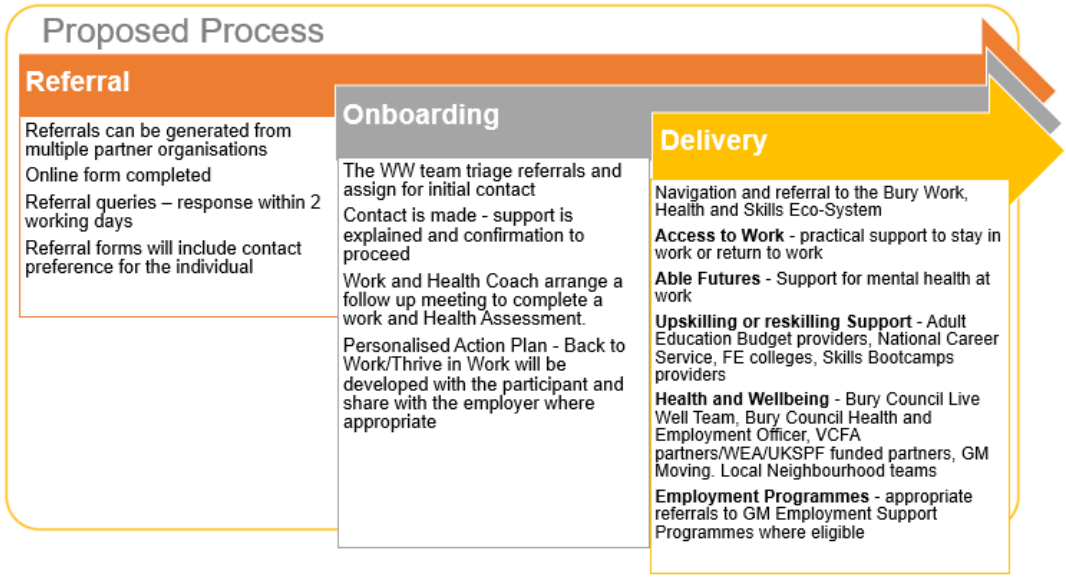
- Not exhaustive

Example Case Study - William (Billy)

- Worked in manufacturing for 30 years – highly skilled/valued employee
- MSK preventing him working at capacity/in pain
- Billy is overweight with other health issues
- Referred to service
- W & HC liaise with employer & supports Billy to access Live Well
- Billy's health improves but his capacity for heavy machinery may never be resolved
- Employer supports Billy to gain a teaching/training qualification
- Billy passes on his skills to apprentices within the organisation

3.1.5 Referrals to WorkWell will come through the SAP which will enable initial triage to ensure WorkWell is the appropriate support. It will also facilitate the WorkWell service to connect to other support for their clients.

3.1.6 The proposed referral and onboarding process is demonstrated within the diagram below:



4.1 Funding

4.1.2 Funding allocations to district is based on a 'fair shares' model reflecting population size. ***(attached at appendix 1)***

4.1.3 Fair shares funding allocation for Bury is £432,927 over 18 months. The funding is split 60%/40%. Localities can claim eligible expenditure in arrears every quarter up to 60% of the total funding. For Bury this would be quarterly claims for delivery of the programme up to a maximum of £259,756, 40% of the funding equates to a maximum of £171, 171 which can be claimed when a participant is engaged and an action plan/thrive in work plan is agreed.

4.1.4 Bury's funding model will by hybrid procuring an organisation with the relevant skills and experience to deliver up to 336 participants. The rational for procurement is to address the following risks:

- Recruitment of Work and Health Coaches could take up to 4 months to go through agreement to recruit, evaluation and moderation, recruitment and interviews and any notice periods. The delivery or WorkWell starts 1st October 2024 until March 31st, 2026. (18 months).
- A fixed term contact of 18 months is a risk
- The programme will be behind schedule and may not deliver the right help to residents and be a reputational risk to Bury Council
- Bury Council cannot fully participate in piloting the service with our LA partners, NHS ICB and GMCA.

Benefits of the procurement route:

- Attract an experienced provider with proven track record to deliver
- Providers are able to recruit at speed
- Providers usually offer full time contracts
- Provider will manage the recruitment, onboarding, training, monitoring and development

4.1.5 In anticipation of a start later than October 2024 a proportion of the budget will be allocated to Bury Council's Live Well team to add additional capacity through their service to allow referrals to be accepted from 1st October or as near that date as possible. The Live Well Team will deliver the service to 200 participants over a 12 month period with an option to extend should the funding allow.

4.1.6 The Live Well team have established relationships with GP practices and community organisations and will be supported through the SAP process for wider support outside of their offer.

5.1 Finance Flow

5.1.2 WW funding is not given to GM in advance, this is common of DWP funded activity. Funding is paid quarterly in arrears subject to our WW activity submitting the data returns by due dates. The data return will be compiled locally and submitted to the pan-GM programme team, who will then collate the total GM WWP response and submit it to DWP.

5.1.3 The quarterly income from will be paid directly from DWP to NHS GM (as the accountable body) who, in turn, will distribute it to the NHS GM locality teams. NHS GM locality teams will be responsible for ensuring that arrangements are in place for moving funding to where it needs to be at a local level.

Tracey Flynn
Service Manager – Business and Investment
Business, Growth and Infrastructure
t.flynn@bury.gov.uk
August 2024

Locality	Population Size	% of GM Population	Total GM Participants 2024/25	Total GM Funding 2024/25	Proposed Locality 2024/25 Participants	Maximum Locality Funding 2024/25	2024/25 Basic Funding Amount - 60% of (G)	2024/25 Maximum Participant Dependent Funding Amount - 40% of (G)	Total GM Participants 2025/26	Total GM Funding 2025/26	Proposed Locality 2025/26 Participants	Maximum Locality Funding 2025/26	2025/26 Basic Funding Amount - 60% of (M)	2025/26 Maximum Participant Dependent Funding Amount - 40% of (M)	Total GM Participants	Total Locality Participants (F) + (L)	Total Maximum Locality Funding (G) + (M)	Total Basic Funding Amount (H) + (N)	Total Maximum Participant Dependent Funding Amount (I) + (O)
Bolton	298,903	10.30%			247	£197,760	£118,656	£79,104			577	£467,785	£280,671	£187,114		**824**	**£665,545**	£399,327	£266,218
Bury	194,606	6.70%			161	£128,640	£77,184	£51,456			375	£304,287	£182,572	£121,715		**536**	**£432,927**	£259,756	£173,171
Manchester	568,996	19.50%			468	£374,400	£224,640	£149,760			1092	£885,612	£531,367	£354,245		**1560**	**£1,260,012**	£756,007	£504,005
Oldham	243,912	8.40%			202	£161,280	£96,768	£64,512			470	£381,494	£228,897	£152,598		**672**	**£542,774**	£325,665	£217,110
Rochdale	226,992	7.80%			187	£149,760	£89,856	£59,904			437	£354,245	£212,547	£141,698		**624**	**£504,005**	£302,403	£201,602
Salford	278,064	9.50%			228	£182,400	£109,440	£72,960			532	£431,452	£258,871	£172,581		**760**	**£613,852**	£368,311	£245,541
Stockport	297,107	10.20%			245	£195,840	£117,504	£78,336			571	£463,243	£277,946	£185,297		**816**	**£659,083**	£395,450	£263,633
Tameside	232,753	8.00%			192	£153,600	£92,160	£61,440			448	£363,328	£217,997	£145,331		**640**	**£516,928**	£310,157	£206,771
Trafford	236,301	8.10%			194	£155,520	£93,312	£62,208			454	£367,870	£220,722	£147,148		**648**	**£523,390**	£314,034	£209,356
Wigan	334,110	11.50%			276	£220,800	£132,480	£88,320			644	£522,284	£313,370	£208,914		**920**	**£743,084**	£445,850	£297,234
GM Total	**2911744**	**100.00%**	**2400**	**£1,920,000**	**2400**	**£1,920,000**	**£1,152,000**	**£768,000**	**5600**	**£4,541,600**	**5600**	**£4,541,600**	**£2,724,960**	**£1,816,640**	**8000**	**8,000**	**£6,461,600**	**£3,876,960**	**£2,584,640**

2024/25 Payment per Participant	£800
2025/26 Payment per Participant	£811

Total GM Delivery Budget	**£6,461,600**

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Approve
Item No.	13	**Confidential**	No
Title	Bury's Palliative & End of Life Care Service Model Development		
Presented By	Will Blandamer		
Author	Warren Heppolette/ Will Blandamer		
Clinical Lead	Dr Morris – PeoLC Consultant		

Executive Summary

Bury locality has been exploring an opportunity with both Macmillan Cancer Support and Social Finance to co-produce and test a new model for palliative and end of life care facilitated and supported through a social finance mechanism.

Social finance supports objectives to secure investment, design and progress solutions to complex and enduring social issues. The social investment underwrites the service and absorbs the financial risk should outcomes not be delivered in whole/part and service costs are only repaid in full if 100% of predicted outcomes are achieved. The approach seeks explicitly to identify the means to reduce non-elective demand, and release capacity through reducing the need for escalation wards, agency staff and private hospitals. Outcome payments are calculated from when the service is mobilised but allows for repayment to be delayed until 18 months into service delivery.

There are a number of reasons why this approach is attractive to public service bodies in the current environment:

- A clear route to investment resource not otherwise available;
- Informing and supporting processes to commission and design services for outcomes as opposed to activity;
- A means of designing financial flows to ensure that success in reducing demand can be realised and made sustainable through protected investment in the services which impact on those levels of demand; and
- Provides a template therefore for the investment and benefits realisation of a range of preventative and proactive care models which will be essential for the development of sustainable health and care services.

Bury's proposal aims to address the historic lack of cohesiveness between universal, targeted and specialist palliative services as part of an integrated approach to the delivery of services by palliative care providers. It will support the co- design, development and implementation of a system-wide Specialist PEoLC Hub and a Clinical Palliative Liaison Service, with stakeholders including providers, health care professionals, voluntary sector and community members. This service will create a robust whole system interface between Social, Primary, Community, Acute, Specialist and Generalist Palliative care services and will target the following system impacts:

- Increase in the total number of people identified in their last year of life.
- Increase in palliative patients achieving preferred place of death.

- Increase in identified patients appropriately accessing supportive services.
- Reduced bed days for people in last year of life.
- Reduce ED attendances and admissions.
- Increased collaboration with other health and social care disciplines in care delivery
- Increasing evidence of advance care planning discussions
- Evidence of improvement in communication between our team.

The estimated benefits see a return on investment of 1.48 (positive gross benefits against service costs). It will be enecessary to test the reliability and likely fulfilment of that assessment to ensure sustainability of the model over time and understand the nature of the benefits and whether they are cost reducing or cost avoiding.

The proposal fully supports the ICB PEoLC Strategy and National direction of travel for End of Life Care Closer to Home and Advanced Care Planning. Which aims to reduce crisis situations, call on Urgent Care,Primary Care services and meet patient choice of place of care.
Bury Locality PEoLC Board fully sponsors and endorses the proposal as an enabler to accelerating delivery of its refreashed PEoLC Strategy.
Locality transformation leads have engaged and collaborated with the GM Strategic Clinical Network and the Clinical Lead for GM for PEoLC, alongside GM PEoLC Senior Commissioning lead who respectively have expressed interest in capturing opportunities for widespread learning and rollout of any successful innovation which enhances the experience, quality of service delivery and care patients and families receive at such a significant time of life.

Recommendations
Bury Locality Board is asked to discuss the proposal and confirm support for further development.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☐

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

Macmillan End of Life Care Fund

An introduction to the Fund and social investment in end of life care

2024

Macmillan Cancer Support & Social Finance have worked in partnership since 2015

The Care & Well Being Fund was launched in 2015 to test social investment in health and social care, the success of which led to the Macmillan End of Life Care (EoLC) Fund being set up in 2021. So far, Macmillan & Social Finance have:

Improved outcomes	• Launched 9 services to support over 15,000 people at the end of their life • Partnered with Professor Fliss Murtagh to develop pioneering approach linking system value & outcomes
Delivered value	• Rolled out Social Impact Bonds (SIB) allowing systems to innovate, improve patient experience, track impact and sustain services • Supported £8.9M services w/£3.8M investment through first fund; which second fund will exceed • Worked with 22 systems across the UK, including our first SIB in Scotland
Supported system change	• Driven change in approach to service development, embedding social investment • Established social investment as ‘mainstream’ tool; included in NHS Commissioning Guidance 2022 • Facilitated collaboration across systems, pooling resources and sharing benefits • Created a Community of Interest for EOLC with a network of 100+ organisations

Together Social Finance & Macmillan have created a vehicle for longer term sustainable change

SOCIAL FINANCE | MACMILLAN CANCER SUPPORT

Using experience and lessons learnt from the past 8 years Macmillan & Social Finance have developed a new type of social investment

- Up front analytics to really understand your health and care system
- At risk investment to test new ideas
- Outcomes-based contracts with one investor who doesn't require a financial return
- Applied analytics to enable continuous quality improvement
- Free expert project, clinical, financial and data analyst capacity to support throughout the development and delivery phases

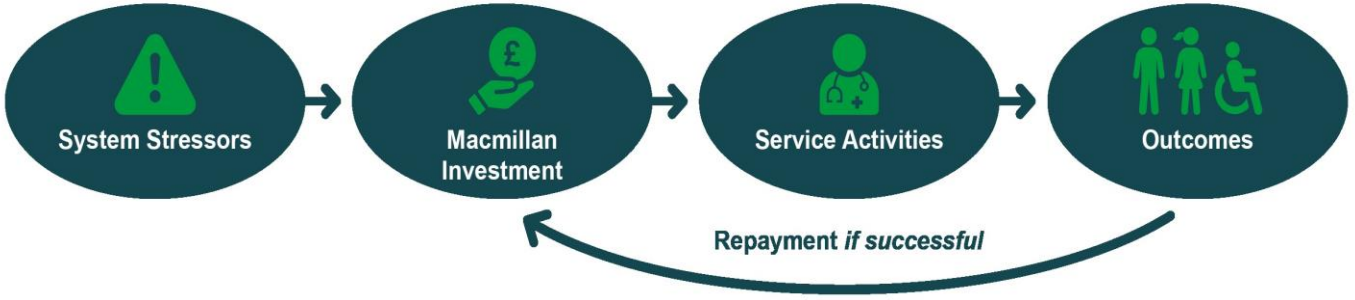
Macmillan can flex to meet the needs of patients and health & social care systems

Social investment support the delivery of national policy objectives

Delivering the NHSE Long Term Plan	Description	Social Investment
Doing things differently	Enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home	Provides low-risk opportunities to develop and scale innovative, proactive, personalised health services. To support people in the right place, at the right time. The investment is only repaid if, and when, outcomes are successful.
Preventing illness and tackling health inequalities	Focus on tackling some of the most significant causes of ill health e.g., smoking and Type 2 diabetes	Focus on co-production to develop proactive health services to reduce crises at end of life. Services are adapted to local community needs, address gaps and inequities in service provision and empower local delivery.
Backing our workforce	Increase the NHS workforce, training and recruiting more professionals and making the NHS a better place to work	Empower staff to deliver agile, continuous improvement. Reduce staff burnout by improving the patient journey and encouraging community-based service provision e.g. hospices, third sector, leisure facilities.
Making better use of data and digital technology	Improve access to services and health information for patients and use data to drive service improvements	Live data, patient related outcome measures and service dashboards inform and enable agile service delivery. Outcome repayments and KPIs evidence the value and impact on new ways of working.
Getting the most out of taxpayers' investment in the NHS	Reduce duplication in service delivery, leverage the NHS's purchasing power to deliver better VFM and reduce admin spend	Better coordination and communication across the system reduces duplication. Focusing on outcomes rather than activity ensures better value for money. Pro-bono programme management, clinical and financial expertise adds capacity.

As well as supporting local system priorities

Macmillan's social impact bond model that is changing practice, policy and funding

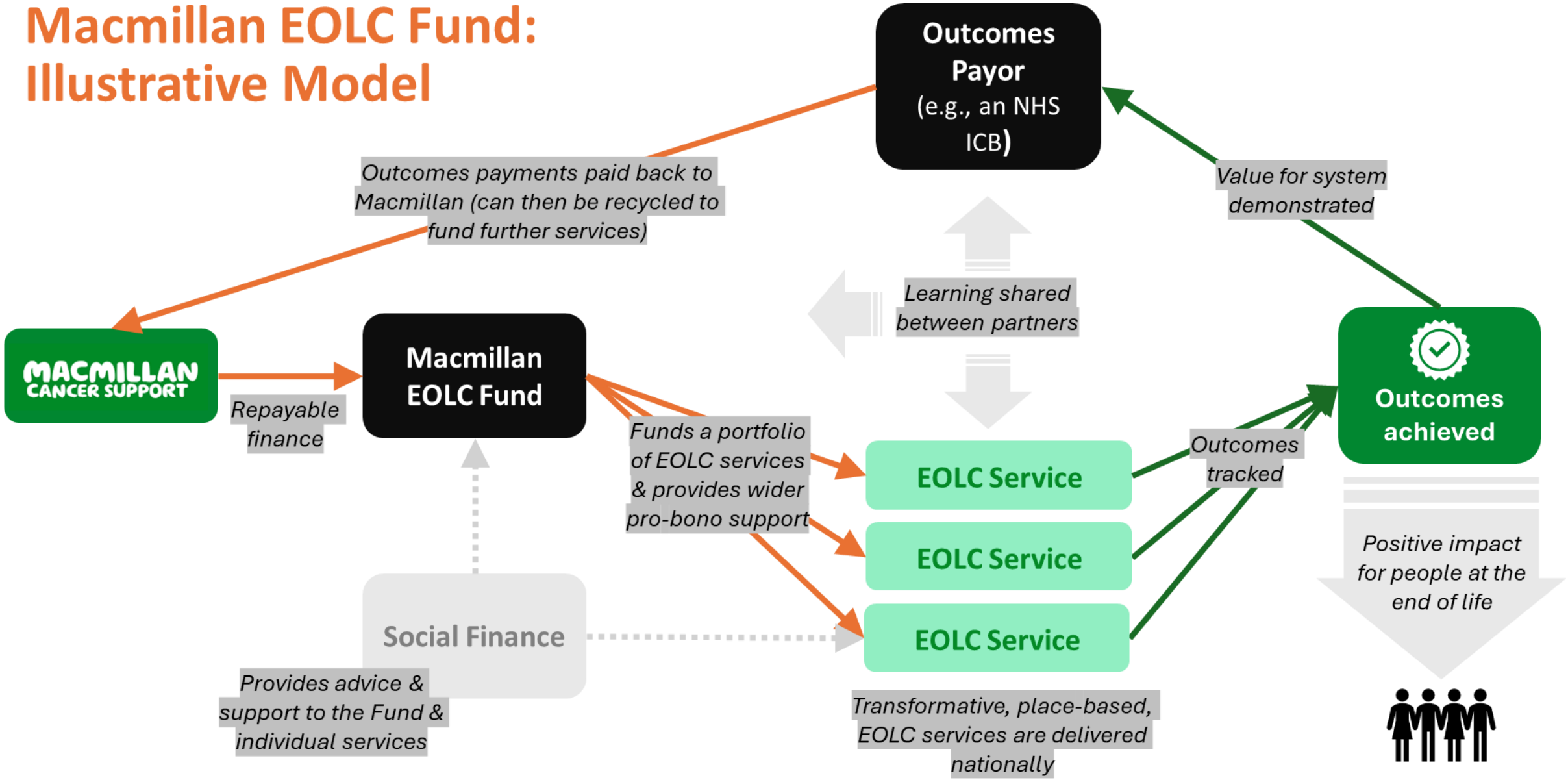


The model closely examines the **system stressors such as non-elective admissions, length of stay, ambulance conveyance**, as well as the requirements for success, and seeks to directly target these through developing personalised care services.

Macmillan holds the financial risk and caps repayments at the total service cost, additional benefits stay within the system.

Macmillan are also open to exploring other models of social investment

Macmillan EOLC Fund: Illustrative Model



Social investment will support systems to release value

- Macmillan EOLC Fund underwrites the service and absorbs the financial risk should outcomes not be delivered in whole/part
- Service costs will only be repaid in full if 100% of predicted outcomes are achieved
- The service will reduce non-elective demand, and will thereby release capacity through reducing the need for escalation wards, agency staff and private hospitals to deal with demand
- By reducing non-elective demand, more capacity can be made available for elective activity
- Outcome payments will be calculated from when the service is mobilised but repayment will be delayed until 18 months into service delivery
- The EOLC population is projected to significantly increase year on year. A reduction in activity for this cohort, will reduce pressures to increase respective spend at the same rate.

And ensure a better experience for patients and their carers

The Macmillan Fund Team provide a pro bono service to partners

Expertise

- Provide expertise on **business case development**, KPIs, contracting, service delivery and management
- Provide **clinical expertise** to support development of the service model, implementation and ongoing delivery
- Provide technical **finance expertise** regarding how to account for Social Investment
- Provide **access** to the expertise of the EoLC SI Operational Board, Strategic Clinical Advisors, and Community of Interest
- Provide **support** at the end of the contact to show impact and learning and plan for transition to business as usual

Data

- Provide rigour through effective **data collection and analysis**
- Develop **interactive dashboards** to show service key performance indicators and measures
- Develop automated dashboards to show **patient related outcome measures**
- Provide **support** to partner data teams

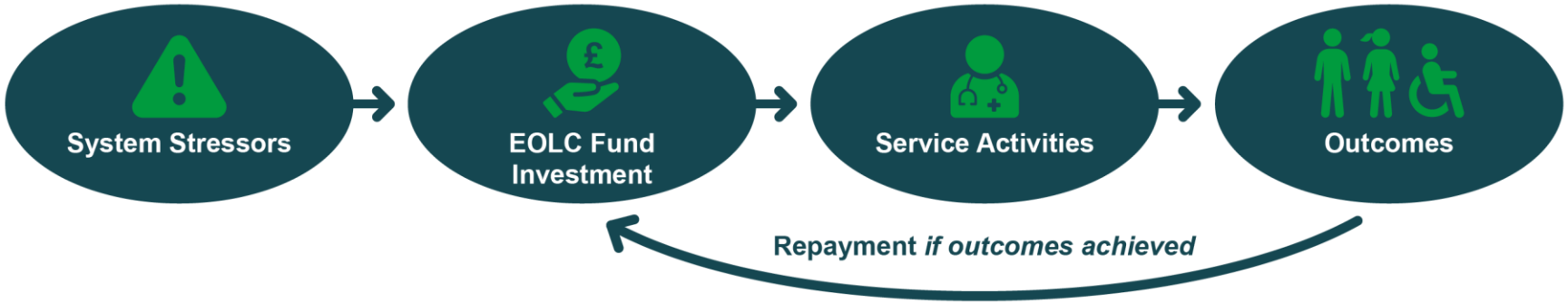
Adding capacity to your team throughout the development and the contract

Macmillan End Of Life Care Fund

Bury: Financial Modelling

June 2024

The most common social investment model used within the Macmillan EOLC Fund is a social impact bond



Repayments are only made to the fund based on the successful achievement of outcomes against an agreed baseline

System Benefit Analysis

- The Macmillan EOLC Fund Team worked with the ICB (BI team, clinicians, programme team) to analyse the ICB data about the End of Life population and their activity and to understand the potential reach (number of patients supported) and impact (number of bed days avoided) of the service in year one, year two and year three.
- The key assumptions used in the System Benefit Analysis are summarised in the next slide – “Data Summary.”
- How that information is used to analyse the benefit to the System is demonstrated on the subsequent slide – “System Benefit Analysis.” Please note notional service ‘reach’ and ‘impact’ assumptions have been applied for this analysis.
- The third slide shows how much each parameter can vary and still break even – “The parameters”
- Note- The maximum amount that can be repaid (when outcomes are achieved) is the total of the 3 years of service costs, no interest or additional fees will be charged. Any surplus benefits value will remain with the ICB

Data Summary: Key assumptions underpin the indicative system benefit analysis

Definition	#	Source	Comments
Total cost of the service over 3 years	£1,400,000	ICB	
Estimated End of Life Care population for **cohort with 1+ NELs in LYL**	1,138	ICB data	Based on 5-year avg of ICB data between 2018/19 – 2022/23; regions include North, East, West, Prestwich and Whitefield
Average days in hospital per NEL admission per EOLC patient	9.76	ICB data	As above
NEL admissions per EOLC patient in last year of life (LYL)	1.84	ICB data	As above
Average unplanned bed days in last year of life per EOLC Patient	18 (9.76 * 1.84)		
NELs for EOLC patients in LYL, per annum	2,090 (1,138 * 1.84)		
Days in hospital per annum for the EOLC in LYL	20,412 (2,090 * 9.76)		
Notional cost of a bed day	£450	Assumption based on average from other PEoLC projects	
Notional cost of a NEL	£4,394 (9.76 * £450)		
Total notional cost of NELs for EOLC population over 3 years	£27,556,740 (2,090 * 4,394 * 3)		

System Benefit Analysis: This demonstrates a gross Return on Investment (ROI) that increases year on year

	Year 1	Year 2	Year 3	Totals
Cohort and Current Activity				
People using the service ('Reach' = % of eligible population accessing the service)	341 (1,138 * 30%)	398 (1,138 * 35%)	398 (1,138 * 35%)	1,138
Current total NELS for users of the service (using 1.84 average unplanned NEL admissions in LYL)	627 (341 * 1.84)	732 (398 * 1.84)	732 (398 * 1.84)	2,090
Current total number of bed days for people reached by the service	6,124 (627 * 9.76)	7,144 (732 * 9.76)	7,144 (732 * 9.76)	20,412
System Benefit from This Service				
Proportion of NEL admissions avoided by service users ('Impact')	25%	30%	30%	
NEL admissions avoided for service users	157 (627 * 25%)	219 (732 * 30%)	219 (732 * 30%)	596
Unplanned Bed Days avoided for service users (using 9.76 average LoS per NEL per ICB data)	1,531 (157 * 9.76)	2,143 (219 * 9.76)	2,143 (219 * 9.76)	5,818
Bed capacity released per annum (excluding impact of population growth)	4 (1,531 / 365)	6 (2,143 / 365)	6 (2,143 / 365)	
System Value based on notional value of £450/bed day	£688,919 (1,531 * £450)	£964,486 (2,143 * £450)	£964,486 (2,143 * £450)	£2,617,890
Service cost	£466,667	£466,667	£466,667	£1,400,000
System Benefit : Net of Service Cost	£222,252 (£688,919 - £466,667)	£497,819 (£964,486 - £466,667)	£497,819 (£964,486 - £466,667)	£1,217,890
Gross Return on Investment (gross benefits/ service cost)	**1.48** (£688,919 / £466,667)	**2.07** (£964,486 / £466,667)	**2.07** (£964,486 / £466,667)	**1.87**

SOCIAL FINANCE | MACMILLAN CANCER SUPPORT

Linking Baseline and System Benefit Analysis

Outcomes (over 3 years)	
£1,400,000	Total service contract value
£450	Notional cost of a bed day
3,111 (£1,400,000 / £450)	Number of bed days to break even
1,138	Total number of service users to be supported
2.7 (£3,111 / £1,138)	**Number of bed days to break even per service user**
CBA (over 3 years)	
1,138	Patient Reach
5,818	Anticipated bed days saved over contract period
5.1 (5,818 / 1,138)	**Anticipated bed days saved per person**

The parameters from the business case have been stress tested

A single downward change of 46% in any single parameter generates a small surplus of £13,661

Parameter	Standard CBA Case	Breakeven Threshold Limit
Baseline : LYL NEL Days/Year	18	9.68
Population : Relevant LYL Deaths / Year	1,138	615
Service Reach - % of potential population	30% / 35% / 35%	16% / 19% / 19%
Service Impact - % activity reduction	25% / 30% / 30%	14 % 16% / 16%

Because flex in just one parameter is unlikely, the following scenario has been run to demonstrate a scenario where multiple parameters change which also returns a small surplus of £10,127

Parameter	Standard CBA Case	Stressed Scenario Level	% Reduction
Baseline : LYL NEL Days/Year	18	16.14	10%
Population : Relevant LYL Deaths / Year	1,138	1,081	5%
Service Reach - % of potential population	30% / 35% / 35%	23% / 26% / 26%	25%
Service Impact - % activity reduction	25% / 30% / 30%	21% / 25% / 25%	16%

Assumptions informing the population growth model

The population growth model is informed by:

ICB data:

- The Population Growth model uses the latest available actual activity and cohort size values for the end of life care population (i.e., including those who had no non-elective admissions (NELs) in their last year of life). The latest available data is for FY 2022/23.
- The CBA model uses a multi-year average for activity and cohort sizes, and for patients who had at least one NEL in their last year of life.
- The population growth model is intended to be a comparatively high-level model, commenting on general trends, whereas the CBA is modelled for a specific financial business case.

ONS data:

- ONS death data categorized by local authority was used to derive the End-of-Life Population growth rate in this model. At just over 3% this rate is lower than the ICB JSNA rate of 3.7%.

Assumptions of the growth model:

- The model assumes a constant 3% annual growth in the End-of-Life (EoL) population.
- The model assumes the opening (FY22/23) baseline values for the End of Life population (ie average NELs and average Length of Stay (LoS)) remain consistent over the term of the model.
- For the intervention scenario, the model applies the cohort reach and impact assumptions used in the CBA model. The CBA's assumptions span across the 3 years of the intervention, in the population growth model, the year 3 impact and reach assumptions are held constant for the following years.

Limitations:

- Given the assumptions and high-level nature of this model, it does not account for potential shifts in health care policies, technological advances or external economic factors, but it does give a reasonable projection of activity and bed use both with and without the new intervention.
- Because the growth model uses a growth rate derived from historic numbers of deaths, it takes no account of a change in future demographic patterns, meaning that as the population ages and deaths increase, the 3% growth rate from ONS will understate future deaths.

The impact of population growth and the service

The ICB data reports an initial EOL population of 1641 patients for the year 2022/23.

According to 2022/23 ICB data, this EoL population (including patients with no NELs in their LYL) has on average 14 unplanned bed days in their the LYL, which equates equating to 65 beds being occupied across a 12 month period.

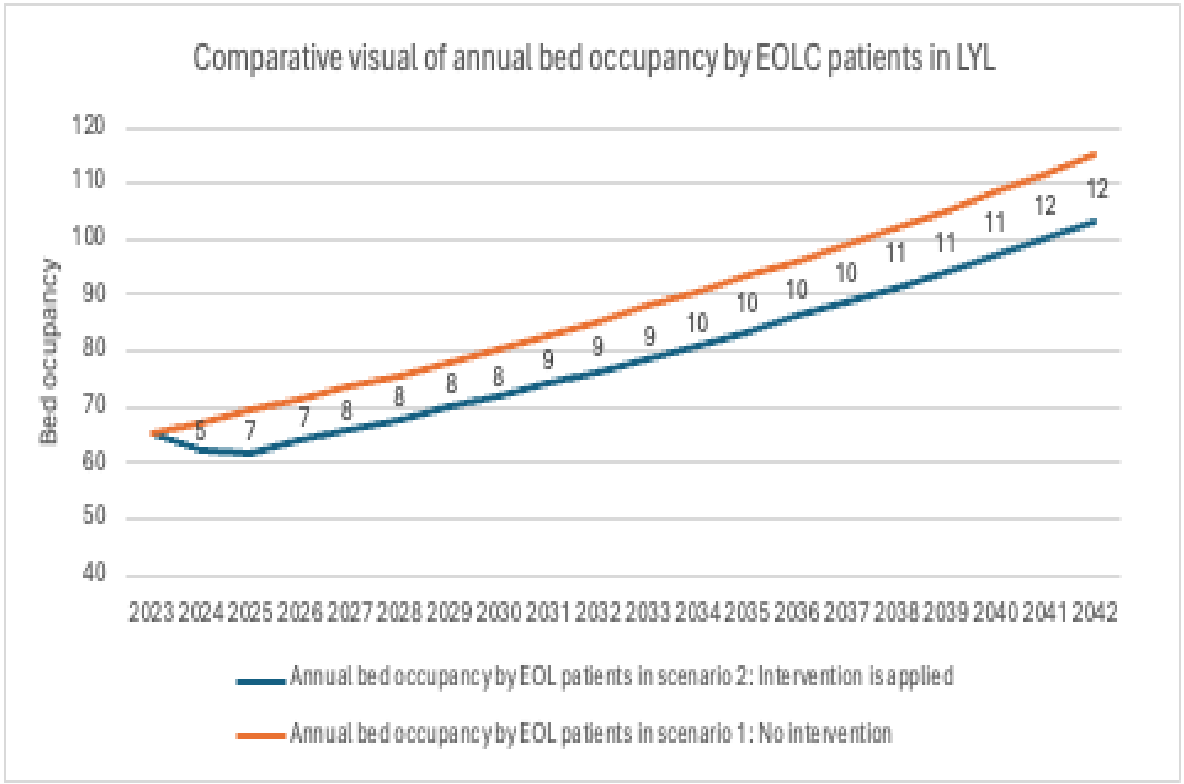
By applying the 3.0% rate of growth, future annual bed occupancy will become :

- In 2029 : 78 beds (+13) : a 20% increase in bed usage
- In 2035 : 93 beds (+28) : a 43% increase in bed usage
- In 2042 : 115 beds (+50) : a 77% increase in bed usage

The orange line on the graph shows the projected bed occupancy by EOL patients, reflecting the 3.0% population growth rate (ie the 'do nothing' scenario).

The blue line reflects the projected bed occupancy allowing for the introduction of the new service, in line with the values from the System Benefit Analysis.

The number between the two lines is the annual bed capacity released per annum.

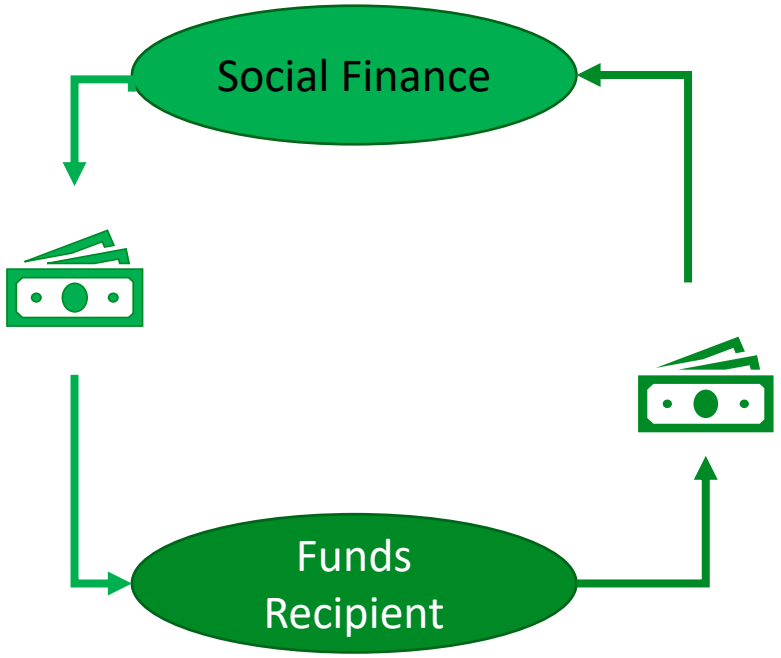


Accounting for Social Investment

Social Impact Bonds should be accounted for as two distinct elements.

1)<u>Part 1</u>

Funds Drawn Down from Macmillan should be recognized And reported as Income, much in the way that Grant Income would normally be recognized.



2) <u>Part 2</u>

Outcomes Payments are only due to the extent that Outcomes are evidenced. These may be treated as contingent liabilities until such time as a track record of outcomes has been established.

There is a choice between accrual and cash accounting. Most tend to accrue the potential liability from day one, ensuring that service budgets and accounting transactions align, and avoiding a potential for costs to shift to the right. This also ensures that these potential liabilities are not simply overlooked and is facilitated by the fact that potential Outcome Payments are generally immaterial.

Cash : Generally Outcome Payments are not made in the first 12-18 months. Due to data timing/validation, some of the Outcome Payments for Year 3 outcomes will be paid in Year 4.

Accounting : Accruals approach eliminates the potential for 'double cost' in Year 4. If it is decided to take more of a cash-based approach, then the 'double expenditure' of later years will be offset by a benefit in the early years of the service.

Bury's PEoLC

Service Model Development

Macmillan Social Investment Fund

Burys PEoLC Identified Need

- lack of cohesiveness between universal, targeted and specialist palliative services.

  absence of an integrated approach to the delivery of services by palliative care providers.

  lack of a system wide approach to the delivery of palliative and end of life care services

  Current collaborative working is often through an informal approach that relies on staff good will and can break down, impacting on patients and effective care delivery

  further exacerbated by the different points of patient access across the system in to siloed parts of the Palliative Care Service

  increased inequalities, duplicated work, varied the provision of care provided and created an inconsistent quality in patient experience.

Bury's Funding Proposal

NHS Greater Manchester Integrated Care

- To co- design, develop and implement a system-wide Specialist PEoLC Hub and a Clinical Palliative Liaison Service, with stakeholders that include providers, health care professionals, voluntary sector and community members.
- The Hub and Liaison service will create a robust whole system interface between Social, Primary, Community, Acute, Specialist and Generalist Palliative care services.
- To include links into Local Authority Services (social and Bereavement) and community supportive services including Voluntary Services.
- Alignment to the Bury Locality Plan principles which promote wellbeing, independence/self-management (where appropriate), prevention, integration, and carer support.

Main Key Performance Indicators

- Increase in the total number of people identified in their last year of life.
- Increase in palliative patients achieving preferred place of death.
- Increase in identified patients appropriately accessing supportive services.
- Reduced bed days for people in last year of life.
- Reduce ED attendances and admissions.
- Increased collaboration with other health and social care disciplines in care delivery
- Increasing evidence of advance care planning discussions
- Evidence of improvement in communication between our team.

Finance

Role/ Job Title This is just an idea (however, we would need to think on how we sustain the structure)	Band/Grade/ Salary (including high cost area supplement if appropriate – please indicate)	WTE Yr 1	WTE Yr 2	WTE Yr 3
Specialist Palliative Lead Manager (Hub/Liaison)	Band 8a		£70k	£70k
Project Manager	Band 7	£60k	£60k	£60k
Project Administer	Band 4	£40k	£40k	£40k
Palliative SPOA Team Leader	Band 6		£55k	£55k
Neighborhood Palliative liaison leads x 5	Band 4/5		£200k	£200k
Palliative SPOA facilitator x3	Band 3		£100k	£100
NON Spend (equipment/Training/set up cost)		£100k	£75k	£75
TOTAL		£200	£600	£600

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Recommend
Item No.	14	**Confidential**	No
Title	Mental health commissioning proposals		
Presented By	Will Blandammer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)		
Author	Ian Trafford, Head of Programmes - Bury Integrated Delivery Collaborative		
Clinical Lead	Dr Cathy Fines, Associate Medical Director - GM Integrated Care Board		

Executive Summary

NHSGM require all localities to submit their commissioning intentions by the end of August 2024. This paper sets out the recommendations of Bury mental health commissioners.

Recommendations

The Bury Locality Board is asked to:

1. Endorse the recommendations
2. Note the caveats set out

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

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

Implications						
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:

- Each of the services is delivering direct care to patients. The overall recommendation is to continue to commission most of the services to ensure continued provision.
- There has been engagement with the providers. All the providers in question collaborated in the required service reviews and have been sighted on the recommendations.
- The recommendations will be shared with the members of the Bury MH Programme Board for comment.
- The financial implications including potential for cost savings are set out below.
- Where there is a recommendation to decommission a quality and equality impact assessment will be completed prior to any final decision.

If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:

It has not been possible to complete fully for the service where the recommendation is to decommission because of the timescales for completing the commissioning intentions. This will be done before any final decision is taken

Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the NHS GM risk register?	Yes	☒	No	☐	N/A	☐

There are risks on the locality risk register that relate to a number of the service areas. These are:

1. The lack of a commissioned provider of Adult ADHD / autism assessment services
2. Compliance with SEND national framework requirements
3. Capacity within the CYP Sensory Processing Service

The commissioning proposalss are in part designed to mitigate the risks. For example the recommendation to procure a new provider of Adult ADHD and ASD assessments and ADHD treatment is part of the SEND improvement action plan.

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

Mental health commissioning intentions

1. Introduction

1.1. The paper sets out indicative commissioning intentions relating to currently commissioned mental health services. These services are either Bury specific services or on a pan-GM or multiple locality footprint. The majority of the services in question are delivered by VCSE organisations.

1.2. In all bar two cases [Optimise Healthcare and Talk Listen Change] the current contracts are due to end on 31st March 2024.

2. Background

2.1. The current commissioning picture is complex:

- There are different funding streams including core mental health funding, Service Development Fund (SDF) and Mental Health Investment Standard MHIS.
- Some services are effectively commissioned *locally* while others are commissioned centrally through NHSGM.
- Some services are commissioned to deliver only in Bury while others deliver across multiple localities or the whole of GM and there is a contribution from the local budget.
- In some instances, the services are highly interdependent:
    - Early Break work closely with PCFT CAMHS to deliver the CYP MH single point of access and early help hub.
    - The BIG Peer Led Crisis Service is highly integrated with the wider MH crisis pathway
    - The Creative Living Centre delivers services that will form a key element of the new MH Live Well model.

2.2. NHSGM are requiring all localities to submit their commissioning intentions by the end of August 2024. As part of the process there is a requirement to:

- Undertake a structured review of each service
- Complete and submit a 'decommissioning' template
- Complete and submit a Provider Selection Regime [PSR] form for each clinically led health care contract setting out the proposed means of procurement.
- Complete and submit a STAR form to seek approval for funding to commission the service.
- Undertake an Equality and Quality Impact assessment where decommissioning is being considered.
- Take recommendations through locality governance arrangements.

2.3. The requirements and expectations have not always been clearly articulated. For example it was initially understood that the new procurement regulations which came in to force in January 2024 [PSR] applied to all healthcare procurement but it has latterly been indicated that PSR only applies to clinical led services and that the Public Contracts Regulations 2015 (PCR) will apply in all other cases.

2.4. This has been a challenging and time-consuming process for local commissioners to navigate and complete. At present the service reviews, decommissioning templates and STAR form have been completed for all the services where Bury is the lead commissioner. The relevant forms will be submitted to NHSGM taking into account any feedback from Bury MH

Programme Board Members and Locality Board by 9th September.

2.5. We understand that the final decisions on which services are commissioned and via which [procurement] route will be made centrally by NHSGM.

3. Indicative commissioning intentions

3.1 In arriving at the recommendations commissioners have been informed by a number of factors including:

- The service reviews including performance, quality and service user experience evidence.
- Value for money.
- Contribution to the GMICB strategic missions for Mental Health and Wellbeing.
- Contribution to the priorities identified in the Bury MH Strategy and programme plan.
- Provider sustainability.
- The potential to realise savings in light of the locality and wider ICB financial pressures.
- The limited capacity available to undertake significant service or pathway redesign.
- The limited capacity to undertake competitive procurement processs this financial year.

3.2 In the main the recommendations are to recommission most existing services on a two or three year basis. This will enable some medium term stability.

3.3 Where the recommendation is for a two year contract award this relates to known wider developments as part of the Bury and GM Mental Health Strategy, that may impact on the nature of the services we require in the Borough.

3.4 There is a current review of crisis pathways and services, and there will be a further phase of this work focusing on services designed to deflect people from A&E / MH Liaison / admission avoidance. In addition, over the next year we will see the implementation of Right Person Right Care (October 2024) and the phased implementation across GM of MH Urgent Triage and other developments in crisis pathways. The Peer Led Crisis Service plays an important role in our locality crisis provision, but we will need to review whether we have the right pathways and service mix in place over the next 18 months or so.

3.5 Similarly Bury was part of wave 3 for the implementation of the MH Living Well model. The VCSE provision within that model has been initially commissioned as a two year pilot. Over that time, we will need to review and learn and make decisions around how the model evolves. The Creative Living Centre is one of the VCSE partners in the delivery of Living Well and its wider services, currently funded through a grant, closely align with the kind of services needed as part of the Living Well model. It therefore makes sense to align the timescale of any new grant agreement with that of the Living Well contract.

3.6 The recommendations do not assume that there will be no change or development in the services over the life of the contract or grant award. As part of the service review process commissioners have identified areas for improvement and development that will be reflected in any contract or grant agreement where appropriate. In addition, there will be the option to agree changes via contract variation during the life of the contract.

3.7 The proposals include the decommissioning of the following service:

3.7.1 The Getting Helpline currently delivered by Early Break. This was originally set up during COVID. In 2024.25 the opening hours were scaled back and c£58,000 of the

£167,446 annual budget was reallocated to provide additional workforce capacity for the Living Well Model. The line is used and valued but the NHS 111 dedicated mental health line went live in August 2024, PCFT have a 24/7 crisis line and there are multiple national and GM based helplines for people experiencing mental health problems. The proposal is to decommission at the end of 2024.25 and reinvest some of the resource into expanding the VCSE workforce aligned to the Living Well Model where we are significantly short on the recommended capacity. The proposal is to secure the required locality efficiency saving from the balance. The final decision will be subject to a quality and equality impact assessment.

3.8 The contract, Bury Council have with Talk, Listen, Change who provide support services to children and young people who have experienced domestic violence is due to expire at the end of September 2024. We understand that recurrent NHS funding is available for this service and a rapid process will be required to recommission this service. Any delays may mean that the service will need to continue on implied contract terms pending a contract award being made.

3.9 With respect to neurodevelopmental services for adults [across the North East Sector] there has already been local approval to a) seek to recontract with Optimise Healthcare for the current year to ensure continuity of care and b) go to procurement to commission a new provider of autism assessments and ADHD assessment and treatment from April 2024. In both cases the required paperwork has been submitted to NHS GM for finance and procurement approval.

3.10 In September the Joint Commisisoning Group for SEND will be re-established after a peiord in abeyance due to the SEND inspection and subsequent priority impact plan development. We will be working with partners including Bury2Gether to review commissioning arrangements, and evaluation processes for services relating to the SEND cohort. This will include consideration of the required model for sensory services.

3.11 Bury financially contributes to a number of pan GM or multi-locality service contracts and the current recommendation is to continue to invest in all of these services. However, we have not yet been sighted on all the service reviews and the recommendations reached by the lead commissioners. This is being followed up.

3.12 Note that additional investment has been made this year into:

- Early Break to expand the provision of CYP MH services.
- BIG and Creative Living centre to provide the VCSE workforce element of the MH Living Well model as part of a two year pilot. These contracts are not considered here as they do not end in the current year.

3.13 Appendix 1 provides a summary table of the commissioning proposals.

4 Risks and issues

4.1 The locality commissioning proposals will be subject to final decision via NHSGM governance arrangements.

4.2 The contract award process will be subject to compliance with relevant procurement regulations – either PSR or PCR. This raises a number of risks:

- The current messages from the GM Procurement Team is that waivers are unlikely to be a valid option. Having to go out to open procurement for all the services would be hugely destabilising and there is neither the capacity or the time to do this in the current financial

year.

- The Procurement Team are estimating a start to finish timeline of 9 months for new procurement exercises. This raises a risk for the procurement of a new Adult ADHD / ASD service for commencement in April 2025 when the existing contracts are due to expire.
- There is an indication that further changes to procurement regulations may be introduced in October this year. It is unclear what implications these changes will have.

4.3 The financial pressures on GMICB and the locality may mean that further savings are required. The current NHS GM STAR process dictates that where a locality is in an overspend position, that STAR forms will not be approved without a recovery plan to support delivery of a return to a break even position. Therefore given the pressures that exist in the locality budget this will present a challenge in these decisions progressing through NHS GM governance processes which could ultimately stop contracts being renewed.

4.4 It is recognised that a number of the services in question including Early Break CYP mental health services and the Alzheimer's Society Dementia Advisory Service have levels of demand which exceed the contracted capacity.

4.5 There is currently no funding stream identified to sustain the myHappymind and myMindcoach provision in schools after the end of March 2025. This is currently funded through the Local Authority. Further work is needed to try and identify a source of funding if possible.

4.6 It is recognised that we continue to have a number of gaps in mental health provision in the Borough including:

- Post diagnostic support for people with dementia
- Older people's core mental health services
- Secondary care therapeutic interventions
- Services for looked after CYP and care leavers
- 24/7 crisis resolution
- Culturally appropriate service provision
- Insufficient capacity in both CYP and adult neurodevelopmental services
- The right mix of step down accommodation for people being discharged from MH wards.

There is insufficient resource to address these gaps in this commissioning round and there is a need to work with providers and the wider GM system to identify how these gaps can be addressed in the future.

5 Recommendations

5.1 The Bury Locality Board is asked to:

1. Endorse the commissioning proposals as set out in the paper and appendix 1 for submission to NHSGM.
2. Note the risks and issues set out in section 4.

6. Next Steps

6.1. Subject to endorsement from the Locality Board and any additional feedback from members of the MH Programme Board commissioners will submit the required forms to NHS GM by 6th September 2024.

6.2. Further work will be undertaken to risk assess the impact of decommissioning the Getting Helpline and ensure appropriate mitigations are in place. The findings and re-investment proposals will be considered at the September MH Programme Board.

6.3. There will be further engagement with the GM Procurement Team regarding the commissioning intentions in relation to the Adult ADHD / ASD service.

6.4. Commissioners will continue to seek advice and guidance about the procurement route for the services we are seeking to recommission.

6.5. Commissioners will seek to identify options for sustaining the myHappymind and myMindcoach provision in schools.

6.6. Progress in relation to the recommissioning of services will be reported to the Bury MH Programme Board.

6.7. Key risks will be added to the MH programme risk register and monitored through the MH Programme Board with escalation to the Locality Board.

6.8. An update will be shared with the Locality Board.

Ian Trafford
Head of Programmes, Bury IDC
ian.trafford2@nha.nhs.uk
29th August 2024

Appendix 1

Provider	Service	Locality	Expiry	2024.25 value / Bury contribution	Recommendation	Rationale	Development	Efficiency / saving proposed
Kooth (Xenone Ltd)	Adult; CYP MH Online Support- online mental health support	GM wide	31/03/25	£86,307	Recommission. Contract term TBC	Part of GM-wide contract for online support services for CYP.		
BIG - Bury Involvement Group	Peer Led Crisis Service	Bury	31/03/25	£407,221	Recommission 2-year contract	Provides key element of MH crisis provision in Bury and meets elements of the GM crisis provision specification. Only community based open access provision in the Borough. Well integrated with PCFT and other VCSE provision. Good feedback from service users.	Review opening times – currently no provision at weekends. Develop plan to increase service use. Develop plan for improved reach and access for BAME communities. Improve impact evaluation. Review as part of wider GM review of MH alternative crisis provision no later than 2025.26 Q3.	
Early Break	Multiple CYP inc subcontracts: • First Point for - pre and post diagnostic support • Proud Trust – LGBT youth support	Bury [and HMR]	31/03/25	£548,872	Recommission 3-year contract	Provides key MH support services to CYP. High demand for services. Integral to development of CYP MH Early Help Hub.		
Early Break	Getting Helpline	Bury	31/03/25	£167,446 [NB service reduced in 2024.25 with c£58k reallocated to Living Well for additional worker to be employed by CLC]	Decommission Re-assign c£60,000 of resource to Living Well model for additional worker	Initially set up during COVID as temporary provision. Moderate usage of the service with relatively high cost per call. Alternative helpline provision available through NHS111/ PCFT Crisis Line and national MH support lines.		c£50,000

Talk Listen Change	DV support - CYP	Bury	30/09/24	£140,000	Recommission Contract term TBC	Provides important support services to children and young people who have experienced domestic violence. No alternative provision in the Borough.		
Creative Living Centre [CLC]	Community based mental health support	Bury	31/03/25	£144,359	Recommission 2-year grant	Provides a range of individual and group-based MH support services in *getting help* quadrant. Provider heavily dependent on grant for sustainability. Will provider some key holistic service elements aligned to the wider Living Well model. CLC's local offer aligns to Community Transformation work and will be connected to the Bury Living Well model launching in Oct 24.	Review in 2025.26 Q3 to ensure optimal alignment with Living Well model	
First Point Family Support Services Ltd	Sensory Pilot	Bury	31/03/25	£241,533	Review needs as part of the development of wider commissioning intentions in relation to SEND			
Homestart	Perinatal & Infant Mental Health	Multiple	31/03/25	£44,978	Recommission Contract term TBC	Key component of wider perinatal mental health service provision		
Optimise	Adult ADHD	NES	31/03/24	£301,000 [NES 2023.24 contract value] Costs will be re-negotiated once urgent award application has been approved.	Recommissioning for current year already approved. STAR submitted and approved. PSR urgent award application under consideration	Essential to maintain continuity of care for patients on shared care for ADHD medication and mobilising transitions pathway for CYP retained by CAMHS beyond 18th birthday,		

myHappymind	myHappymind schools programme	Bury	31/03/25	TBC	Recommission subject to funding being identified.	Positive evaluation and evidence of deflection from statutory services		
Alzheimer's Society	Dementia Advisory Service	Multiple	31/03/25	£81,456	Recommission 3-year contract	Essential service - no alternative for post dementia diagnostic support. Provider meeting all requirements of specification. Demand exceeds capacity.	Develop plan to achieve better reach to BAME communities. Review post diagnostic support provision in line with Bury Dementia Strategy	
NEW COMMISSION	Adult ADHD & ASD assessment & treatment	NES	NA	c £1,146,000 [NES] £448,000 Subject to final confirmation	Proposal to commission new service already approved through Locality Boards in the NES. STAR submitted.	Bury has no current provider of adult ADHD / ASD assessments. Contract with Optimise Healthcare for specialist oversight of patients on ADHD medication will end on 31st March 2025	Pathway for referral / assessment for ADHD may need to be amended to take account of any changes implemented by NHSGM.	

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	15.1	**Confidential**	No
Title	System Finance Group Update – September 2024		
Presented By	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Author	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Clinical Lead			

Executive Summary

The financial position of all partners continues to be very challenged in 2024/25. NHS Greater Manchester (GM) remains in undertakings with NHS England, and this brings additional scrutiny and rigour around finance, performance and quality.

In the latest financial planning submission to NHS England in early June, NHS GM had a deficit plan of £175m, which has improved from the previous submission. To enable this overall system position all organisations and functions within NHS GM have Cost Improvement Plans (CIP) of 5%. The delivery of these targets and overall financial positions is being rigorously monitored at a local, regional and national level.

The council has updated its Medium Term Finance Strategy for 2024/25 to 2026/27 and this has seen a reduction in the use of reserves to balance the 2024/25 position from £15.13m to £13.15m. The Finance Improvement Plan continues in 2024/25 to support the stabilisation of the financial position of the council.

The month 3 NHS GM position is a £17.4m adverse variance to plan, of which £15.4m is with NHS providers, but the NHS GM forecast out turn positon at month 3 remains on plan to deliver the £175m deficit tagrget agreed with NHS England. With regard to the budgets delegated to the Bury locality from NHS GM, the locality is currently forecasting a break even position both in year and to year end, with increased costs in ASD/ADHD assessments offset by underspends in mental health Out of Area Placements. It should be noted that a thorough review of complex cases and mental health placements is taking place to understand perceived risks to overspends in these areas, with an update to be brought to the next meeting.

At month 3 NHS GM is slightly behind plan in terms of Cost Improvement Plan (CIP) delivery, with actual delivery of £71.8m versus planned delivery of £76m, but full delivery for the year is still anticipated. In terms of CIP delivery on the budgets delegated to the locality, at month 3 £1.18m has been delivered against a full year requirement of £5.15m and it is anticipated that the full £5.15m will be delivered in 2024/25.

Virtual wards funding flows from NHS England to NHS GM and then on to the Northern Care Alliance for delivery of care at home, that would previously have taken place in a hospital setting. Based upon performance and experience it is the view of the programme team to adjust the current staffing mix and locality board are asked to approve this change. These changes do not give rised to any

additional expenditure, as the allocation will adjust in line with expenditure.
Recommendations
Locality board members are asked to: • Note the contents of this report • Approve the staffing changes to the virtual wards / hospital at home business case

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting

Meeting	Date	Outcome
N/A		

System Finance Group Update – June 2024

1. Introduction

1.1. The purpose of this report is to update members of the locality board on the financial position of the 4 statutory bodies who primarily serve the population of Bury, along with that of NHS Greater Manchester Integrated Care (NHS GM).

2. Background

2.1 As was reported throughout 2023/24 public sector finances were and remain very challenged in 2024/25. This is driven by a range of factors including increased demand across all sectors and age demographics, inflationary impacts upon both statutory bodies and residents personal finances and financial settlements for public sector organisations unable to keep pace with these.

2.2 Demand for services across all partners remains high and whilst the headline rate of inflation is reducing, the cost of supplies and services are significantly higher than they were 24 months ago and this dual impact is making remaining within budgets / allocations challenging.

3. Bury Council

3.1.1 Bury Council entered into 2024/25 having had a £6.5m overspend in 2023/24, which was offset by use of reserves, with an anticipated use of reserves of £15.13m in 2024/25 to support delivery of a break even position, with an overall gap of £30m across the 3 years to 2026/27. Since the last meeting further analysis and work has taken place and the in year requirement for use of reserves has fallen to £13.15m and the gap across the 3 year planning window has fallen to £27.92m.

3.2 NHS Greater Manchester

3.2.1 NHS Greater Manchester (GM) remains in undertakings with NHS England, and this brings additional scrutiny and rigour around finance, performance and quality.

3.2.2 In the latest financial planning submission to NHS England in early June, NHS GM had a deficit plan of £175m, which has improved from the previous submission.

3.2.3 To enable delivery of this, NHS GM has a savings plan to deliver £490m, with all organisations and functions within NHS GM have Cost Improvement Plans (CIP) of 5%, including the Northern Care Alliance (NCA), Pennine Care Foundation Trust (PCFT), Manchester Foundation Trust (MFT) and the Bury Locality.

3.2.4 At month 3 NHS GM is £17.4m plans adverse to plan but is forecasting recovery of this position by 31st March 2024, to allow delivery of the agreed £175m deficit. The drivers of the adverse performance are the impact of ongoing industrial action for providers, provider CIP under delivery and operational pressures around mental health, complex care and continuing healthcare placements. This position is shown below in table 1

Table 1

Month 3 2024/25	YTD Surplus / (Deficit)			Full Year Forecast Surplus / (Deficit)		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
GM NHS Providers	(78.5)	(93.9)	(15.4)	(175.0)	(175.0)	0.0
NHS GM	0.0	(2.0)	(2.0)	0.0	0.0	0.0
ICS total	**(78.5)**	**(95.9)**	**(17.4)**	**(175.0)**	**(175.0)**	**0.0**

3.2.5 Cost Improvement Plan (CIP) delivery at month 3 is slightly behind plan, with actual delivery of £71.8m versus planned delivery of £76m, but full delivery for the year is still anticipated.

3.3 NHS GM – Bury Locality

3.3.1 At month 3, the Bury locality is reporting an overall break even position both year to date and forecast on the budgets delegated from NHS GM. Within this there are overspends on ASD/ADHD assessments and certain activity bases community services which are offset by reduced cost in mental health out of area placements and non recurrent benefits brought forward from 2023/24. This is shown below in table 2.

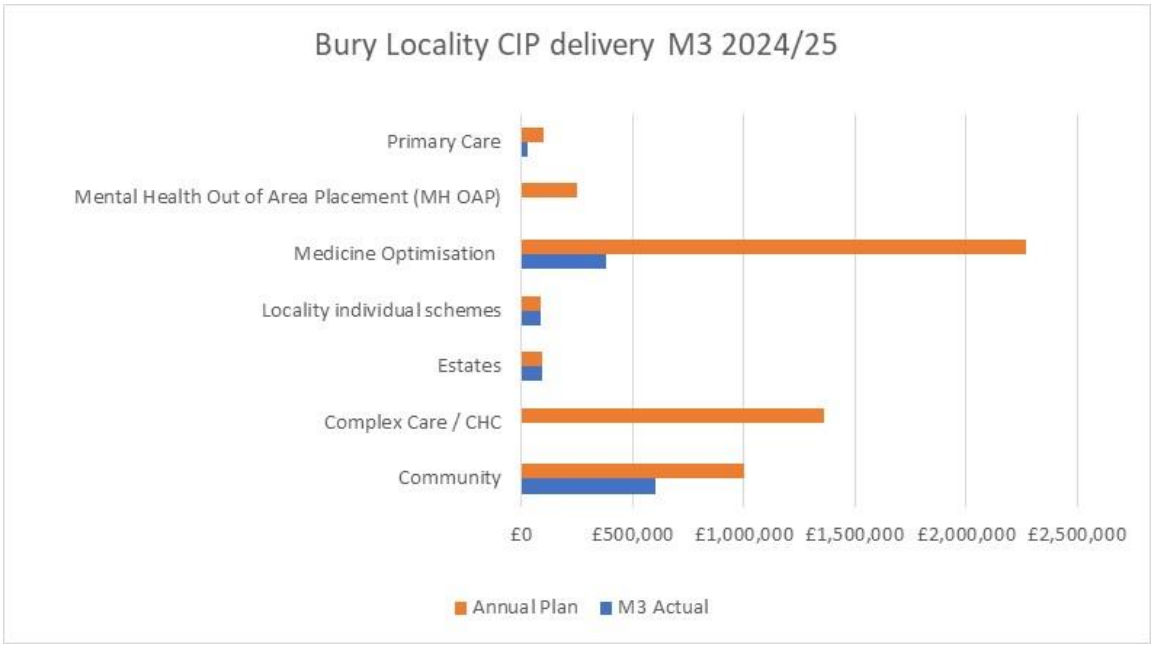
Table 2

Directorate	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
Acute	£198,747	£87,004	-£111,743	£1,146,633	£1,146,633	£0
CHC / Complex Care	£5,788,099	£5,787,690	-£409	£21,795,649	£21,795,649	£0
Community	£4,507,598	£4,539,070	£31,472	£17,306,284	£17,066,843	-£239,441
Mental Health & LD	£4,007,341	£4,027,025	£19,684	£16,029,264	£16,259,035	£229,771
Other	£248,492	£304,692	£56,200	£1,204,534	£1,204,534	£0
Primary Care	£1,156,515	£1,161,310	£4,795	£4,626,312	£4,635,982	£9,670
Prescribing	£9,535,758	£9,538,715	£2,957	£37,752,174	£37,759,021	£6,847
Grand Total	**£25,442,550**	**£25,445,507**	**£2,957**	**£99,860,850**	**£99,867,697**	**£6,847**

3.3.2 It should be noted that a thorough review of complex cases and mental health placements is taking place to understand perceived risks to overspends in these areas, with an update to be brought to the next meeting.

3.3.3 With regard to CIP achievement at month 3, the locality has achieved £1.18m of CIP delivery which is 23% of the annual plan and it is anticipated that full CIP delivery will be achieved in 2024/25. Delivery and annual plan values are shown below in graph 1, with Complex Care / CHC planned to start delivery from month 4 onwards.

Graph 1



4.0 Virtual Wards / Hospital at Home Business Case amendment

4.1 Virtual wards funding flows from NHS England to NHS GM and then on to the Northern Care Alliance for delivery of care at home, that would previously have taken place in a hospital setting. Based upon performance and experience it is the view of the programme team to adjust the current staffing mix and locality board are asked to approve this change. These changes do not give rised to any additional expenditure, as the allocation will adjust in line with expenditure. The business case is attached as appendix 1.

5.0 Conclusion

5.1 Locality board members are asked to:

- Note the contents of this report
- Note the work with MacMillan with regard to a social investment bond
- Approve the staffing changes to the virtual wards / hospital at home business case

Simon O'Hare
Locality Finance Lead – NHS GM (Bury and HMR Localities)
s.ohare@nhs.net
August 2024

Appendix 1

Virtual wards / hospital at home business case

BBC-149 Bury Hospital at Home Adc

Meeting: Bury Locality Board			
Meeting Date	02 September 2024	**Action**	Discussion
Item No.	15.2	**Confidential**	No
Title	Section 75 pooled budget 2024/25		
Presented By	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Author	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Clinical Lead			

Executive Summary

The purpose of this report is to update the Locality Board on the Pooled fund, section 75, budget for 2024/25 and seek approval of this.

The Local Authority approved a balanced 2024/25 budget at Budget Council on in February 2024 with the NHS Greater Manchester (GM) Integrated Care Board approving the NHS GM budgets, from which the locality budgets are delegated in March 2024.

The pooled budget will continue in the same manner as previous years, with the maximum amount of budgets that can be pooled by both organisations being pooled and as in previous years there is no risk share arrangements, with the resolution of any underspends being the responsibility of the relevant organisation. The Better Care Fund (BCF) remains included within the pooled fund even though elements of this do not sit at locality level as they are intra NHS GM, as the inclusion of all BCF budgets is mandatory.

The specific documentation around the section 75 has been standardised across the whole of NHS GM and therefore is different to that agreed in previous years. This documentation has been shared and approved by all parties.

In 2024/25 the opening NHS GM contribution to the pooled budget is £70.38m, made up on £63.34m of budgets formally delegated to the locality and £7.04m of intra NHS GM BCF budgets held centrally in NHS GM budgets. The council opening contribution pooled budgets is £133.99m, giving a total opening pooled budget of £204.37m.

Recommendations

Locality board members are asked to:

- Note and approved the contents of this report.
- Give delegated authority to the Chief Executive of the council to sign the documentation wth respect to council budgets and a member of the NHS GM Executive Team to sign the documentation with respect to the NHS locality budgets.
- Expect a quarter 2 monitoring update to the November meeting.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

Section 75 Pooled Budgets 2024/25 – September 2024

1. Introduction

1.1. The purpose of this report is to update the Locality Board on the Pooled fund, section 75, budget for 2024/25.

2. Background

2.1 The Local Authority approved a balanced 2024/25 budget at Budget Council on in February 2024 with the NHS Greater Manchester (GM) Integrated Care Board approving the NHS GM budgets, from which the locality budgets are delegated in March 2024.

2.2 The pooled budget will continue in the same manner as previous years, with the maximum amount of budgets that can be pooled by both organisations being pooled and as in previous years there is no risk share arrangements, with the resolution of any underspends being the responsibility of the relevant organisation. The Better Care Fund (BCF) remains included within the pooled fund even though elements of this do not sit at locality level as they are intra NHS GM, as the inclusion of all BCF budgets is mandatory.

3. Budgets for pooling

Bury Locality and NHS GM budgets

3.1 In previous years the budget for GP prescribing has formed part of this agreement, however in 2024/25 the prescribing budget is being managed centrally across all localities and therefore will not form part of the locality NHS budget within this agreement. This will mean that the budget will reduce by around £36m when compared to 2023/24.

3.2 There are certain budgets that are not able to be pooled due to national legal and technical clauses and for the NHS budgets in Bury this means that of the £63.9m of delegated budgets there are £0.6m of budgets that are not poolable, leaving a total for pooling of £63.34m. In addition to those budgets held locally there are also £7.04m of intra NHS GM BCF budgets to be pooled.

3.3 Therefore the total opening budget to be pooled with this arrangement by NHS GM is £70.38m and this is shown in table 1 below

Table 1 – NHS GM opening contribution to 2024/25 pooled budget in the Bury Locality

Budget Service Name	Commissioner Lead	ICB	Opening 2024/25 Budget
		£M's	£M's
Acute	ICB	£2.93	**£2.93**
Complex Care	ICB	£20.20	**£20.20**
Community	ICB	£16.76	**£16.76**
Mental Health	ICB	£16.03	**£16.03**
Other	ICB	£2.80	**£2.80**
Primary Care	ICB	£4.63	**£4.63**
Intra NHS GM Better Care Fund	ICB	£7.04	**£7.04**
Grand Total		**£70.38**	

Bury Council

3.3 As with the NHS, the council has pooled all budgets that are statutorily permitted and therefore the total opening budget to be pooled with this arrangement by Bury Council is £133.99m and this is shown in table 2 below

Table 2 – Bury Council opening contribution to 2024/25 pooled budget in the Bury Locality

Budget Service Name	Commissioner Lead	LA
		£M's
Care in the Community (Adults)	LA	£25.71
Other Adult Social Care Services	LA	£24.58
Care in the Community (Adult Mental Health & Learning Disabilities)	LA	£23.45
Other Adult Mental Health & Learning Disabilities Services	LA	£1.98
Public Health	LA	£10.53
Childrens Social Care	LA	£10.84
Other Childrens Services	LA	£11.47
Operational Services	LA	£3.26
Other Council Services	LA	£22.19
Grand Total		**£133.99**

Section 75 total opening budget value

3.5 The total opening budget for the section 75 pooled budget between Bury Council and NHS GM in the Bury locaility is £204.37m and is shown in table 3 overleaf

Table 3 – Total opening pooled budget 2024/25

Budget Service Name	Commissioner Lead	ICB	LA	Opening 2024/25 Budget
		£M's	£M's	£M's
Acute	ICB	£2.93		**£2.93**
Complex Care	ICB	£20.20		**£20.20**
Community Services	ICB	£16.76		**£16.76**
Mental Health & Learning Disabilities	ICB	£16.03		**£16.03**
Other	ICB	£2.80		**£2.80**
Primary Care	ICB	£4.63		**£4.63**
Intra NHS GM Better Care Fund	ICB	£7.04		**£7.04**
Care in the Community (Adults)	LA		£25.71	**£25.71**
Other Adult Social Care Services	LA		£24.58	**£24.58**
Care in the Community (Adult Mental Health & Learning Disabilities)	LA		£23.45	**£23.45**
Other Adult Mental Health & Learning Disabilities Services	LA		£1.98	**£1.98**
Public Health	LA		£10.53	**£10.53**
Childrens Social Care	LA		£10.84	**£10.84**
Other Childrens Services	LA		£11.47	**£11.47**
Operational Services	LA		£3.26	**£3.26**
Subtotal LA			**£133.99**	**£133.99**
Subtotal ICB		**£70.38**		**£70.38**
Grand Total		**£70.38**	**£133.99**	**£204.37**

4 Changes to section 75 agreement

4.1 The specific documentation around the section 75 has been standardised across the whole of NHS GM and therefore is different to that agreed in previous years. This documentation has been shared and approved by all parties and is included in the papers for the meeting.

5.0 Conclusion

5.1 Locality board members are asked to:

- Note and approved the contents of this report.
- Give delegated authority to the Chief Executive of the council to sign the documentation wth respect to council budgets and to a member of the NHS GM Executive Team to sign the documentation with respect to the NHS locality budgets.
- Expect a quarter 2 monitoring update to the November meeting.

Simon O'Hare
Locality Finance Lead – NHS GM (Bury and HMR Localities)
s.ohare@nhs.net
August 2024

Bevan Brittan | Lawyers for the public, private and third sectors

Dated **2024**

The Metropolitan Borough of Bury

and

NHS Greater Manchester Integrated Care Board

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES [1]

Toronto Square – 7th Floor | Toronto Street | Leeds LS1 2HJ
T 0370 194 1000 F 0370 194 5465

Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

Kings Orchard | 1 Queen Street | Bristol BS2 0HQ
T 0870 194 1000 F 0870 194 1001

Interchange Place | Edmund Street | Birmingham B3 2TA
T 0870 194 1000 F 0870 194 5001

www.bevanbrittan.com

Contents

THIS AGREEMENT is made on the _____ day of _____ 2024

PARTIES[2]

(1) **The Metropolitan Borough of Bury** (the **"Council"**)

(2) **NHS Greater Manchester Integrated Care Board** the "**ICB"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Bury.

(B) The ICB has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Bury.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support Local Objectives. It is a requirement of the Better Care Fund that the ICB and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund as has been the case with previous pooled funds between the council and the NHS commissioning organisation in Bury, starting in 2019.

(D) Section 75 of the 2006 Act gives powers to local authorities and integrated care boards to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering into this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives; [and]

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act *means the Freedom of Information Act 2000.*

2004 Regulations *means the Environmental Information Regulations 2004.*

2006 Act *means the National Health Service Act 2006.*

2018 Act *means the Data Protection Act 2018.*

Affected Partner *means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event*

Agreement *means this agreement including its Schedules and Appendices.*

Annual Report *means the annual report produced by the Partners in accordance with Clause 20 (Review)*

Approved Expenditure *means any expenditure approved by the Partners in writing or as set out in the Scheme Specification in relation to an Individual Service above any Contract Price, Permitted Expenditure or agreed Third Party Costs.*

Authorised Officers *means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.*

BCF Quarterly Report *means the quarterly report produced by the Partners and provided to the Health and Wellbeing Board*

BCF 2015 Agreement *means the agreement between the Parties in respect of the Better Care Fund for the period commencing 1 April 2023*

Better Care Fund *means the Better Care Fund as described on NHS England's website from time to time.*

Better Care Fund Plan *means the plan agreed by the Partners for the relevant Financial Year setting out the Partners plan for the use of the Better Care Fund [as attached as Schedule 6].*

Better Care Fund Requirements *means any and all requirements on the ICB and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health.*

Change in Law *means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date*

Commencement Date *means 00:01 hrs on 1 April 2024.*

Confidential Information *means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:*

(a) *which comprises Personal Data or Special Categories of Personal Data or which relates to any patient or his treatment or medical history;*

(b) *the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or*

(c) *which is a trade secret.*

Contract Price *means any sum payable under a Services Contract as consideration for the provision of goods, equipment, or services as required as part of the Services and which, for the avoidance of doubt, does not include any Default Liability.*

Default Liability *means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.*[3]

Financial Contributions *means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.*

Financial Year *means each financial year running from 1 April in any year to 31 March in the following calendar year.*

Force Majeure Event *means one or more of the following:*

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy, or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions *means the NHS Functions and the Health Related Functions*

Health Related Functions *means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.*

Host Partner *means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non Pooled Fund the Partner that will host the Non Pooled Fund*

Health and Wellbeing Board *means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.*

ICB Statutory Duties *means the Duties of the ICB pursuant to Sections 13Z32 to 14Z44 (inclusive) of the 2006 Act*

Indirect Losses *means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.*

Individual Scheme *means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.*

Integrated Commissioning *means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.*

Joint (Aligned) Commissioning *means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.*

Law *means:*

(a) *any statute or proclamation or any delegated or subordinate legislation applicable in England;*

(b) *any enforceable right, power, liability, obligation, restriction, remedy and/or procedure within the meaning of the European Union (Withdrawal) Act 2018 as amended by European Union (Withdrawal Agreement) Act 2020,;*

(c) *any guidance, direction, or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and*

(d) *any judgment of a relevant court of law which is a binding precedent in England.*

Lead Commissioning Arrangements *means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Health Related Functions.*

Lead Partner *means the Partner responsible for commissioning an Individual Service under a Scheme Specification.*

Locality Board *means the locality board responsible for review of performance and oversight of this Agreement as set out in Clause 19.2 and Schedule 2 or such other arrangements for governance as the Partners agree.*

Locality Board Quarterly Reports *means the reports that the Pooled Fund Manager shall produce and provide to the Locality Board on a Quarterly basis*

Losses *means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.*

Month *means a calendar month.*

National Conditions *mean the national conditions as set out in the National Guidance as are amended or replaced from time to time.*

National Guidance *means any and all guidance in relation to the Better Care Fund as issued from to time to time by NHS England, the Department of Communities and Local Government, the Department of Health, the Local Government Association either collectively or separately.*

NHS Functions *means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the ICB as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.*

Non Pooled Fund *means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.*

Non-Recurrent Payments *means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [8.4].*

Overspend *means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.*

Partner *means each of the ICB and the Council, and references to "**Partners**" shall be construed accordingly.*

Permitted Budget *means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.*

Permitted Expenditure *has the meaning given in Clause [7.3].*

Personal Data *means Personal Data as defined by the 2018 Act.*

Pooled Fund *means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations*

Pooled Fund Manager *means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].*

Provider *means a provider of any Services commissioned under the arrangements set out in this Agreement [including the Council where the Council is a provider of any Services].*

Public Health England *means the SOSH trading as Public Health England.*

Quarter *means each of the following periods in a Financial Year:*

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

*and "**Quarterly**" shall be interpreted accordingly.*

Regulations *means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).*

Scheme Specification *means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.*

Services *means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.*

Services Contract *means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the Services in accordance with the relevant Individual Scheme.*

Service Users *means those individuals for whom the Partners have a responsibility to commission the Services.*

SOSH *means the Secretary of State for Health.*

Special Categories of Personal Data *means Special Categories of Personal Data as defined in the 2018 Act.*

Third Party Costs *means all such third-party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Locality Board.*

Underspend *means any expenditure from the Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.*

Working Day *means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday, or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.*

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates, or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions, and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees, and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager, and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated, or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until 31st March 2027 or, it is terminated in accordance with Clause 22.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification or if not set out, for the duration of this Agreement unless terminated earlier by the Partners.

2.4 This Agreement supersedes the BCF 2015 Agreement without prejudice to the rights and liabilities of the Partners under the BCF 2015 Agreement

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission services. This may include one or more of the following commissioning mechanisms:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning

4.1.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

4.2 Where there is Lead Commissioning Arrangements and the ICB is Lead Partner the Council delegates to the ICB and the ICB agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 Where there is Lead Commissioning Arrangements and the Council is Lead Partner, the ICB delegates to the Council and the Council agrees to exercise on the ICB's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Services in accordance with their obligations under this Agreement.

5.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 1 Part 2.

5.4 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner [in accordance with the variation procedure set out in Clause 30 (Variations)]. Each new Scheme Specification shall be substantially in the form set out in Schedule 1 Part 1.

5.5 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.6 The introduction of any Individual Scheme will be subject to business case approval by the Locality Board in accordance with the variation procedure set out in Clause 30 (Variations).

6 COMMISSIONING ARRANGEMENTS

General

6.1 The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification

6.2 The Locality Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

6.3 The Partners shall comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned.

6.4 Each Partner shall keep the other Partner and the Locality Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

6.5 Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Services Contract being entered into the Partners shall agree in writing:

6.5.1 how the liability under each Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and

6.5.2 whether the Services Contract should give rights to third parties (and in particular if a Partner is not a party to the Services Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Services Contract should be afforded any rights to enforce any terms of the Services Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Services Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Services Contract and shall establish

how liability under the Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme.)

6.6 The Partners shall comply with the arrangements in respect of Joint (Aligned) Commissioning as set out in the relevant Scheme Specification, which shall include where applicable arrangements in respect of the Services Contracts.

Integrated Commissioning

6.7 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme:

6.7.1 the Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care, and attention.

6.7.2 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partner's Financial Contribution in respect of that particular Service in each Financial Year.

Appointment of a Lead Partner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Partner shall:

6.8.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.8.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.8.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.8.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partner;

6.8.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.8.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care, and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.8.7 undertake performance management and contract monitoring of all Service Contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

6.8.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

6.8.9 keep the other Partner and Locality Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as agreed by the Partners and set out in Schedule 1.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 Subject to Clause 7.4, it is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Locality Board

7.3.4 Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Locality Board

("Permitted Expenditure").

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner [or *Locality Board]*.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners in accordance with Clause 7.4.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager for each Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Locality Board as required by this Agreement and by the Locality Board;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Locality Board Quarterly Reports (or more frequent reports if required by the Locality Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Locality Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance;

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as may be required by it and any relevant National Guidance including (without limitation) supplying Quarterly Reports referred to in Clause 8.2.7 above to the Health and Wellbeing Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2, the Pooled Fund Manager shall:

8.3.1 have regard to National Guidance and the recommendations of the Locality Board; and

8.3.2 be accountable to the Partners for delivery of those responsibilities.

8.4 The Locality Board may agree to the viring of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established solely for the purposes agreed by the Partners. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that any Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the ICB Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the ICB and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation shall be as set out in Schedule 3.

10.2 The Financial Contribution of the ICB and the Council to any Pooled Fund or Non-Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners

10.3 Financial Contributions will be paid as set out in Schedule 1.

10.4 With the exception of Clause [13], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Locality Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 Unless set out in a Scheme Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any Service that they are Lead Partner or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular Service. These contributions shall be provided at no charge to the other Partners or to the Pooled Fund.

11.2 Each Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 There are no risk share agreements unless agreed by both parties, as set out in Schedule 3, which provides for risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

Overspends in Pooled Fund

12.2 Subject to Clause [12.3], the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Locality Board in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Locality Board is informed as soon as reasonably possible and the provisions of Schedule 3 and clause 12.1 shall apply.

Overspends in Non-Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicably inform the other Partner and the Locality Board.

12.6 Where there is a Lead Commissioning Arrangement the Lead Partner is responsible for the management of the Non-Pooled Fund. The Lead Partner shall as soon as reasonably practicably inform the other Partner and the Locality Board.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

13.1 Except as provided in Clause 13.2, neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

14 VAT

14.1 The Partners shall agree the treatment of each Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information, or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Locality Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16, the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement).

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

Conduct of Claims

16.6 In respect of the indemnities given in this Clause 16:

16.6.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

16.6.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters.

16.6.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The ICB is subject to the ICB Statutory Duties, and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

18.1 The Partners shall comply with the policy for the management of conflicts of interest set out in Schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Locality Board to:

Provide oversight and hold the management structures to account for the delivery of the schemes.

19.3 The Locality Board is based on a joint working group structure. Each member of the Locality Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Locality Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Locality Board shall be as set out in Schedule [2] as may be amended or varied by written agreed from time to time.

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Locality Board shall be responsible for the overall approval of the Individual Schemes and the financial management set out in Clause 12 and Schedule 3.

19.7 The Health and Wellbeing Board shall be responsible for ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.8 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Locality Board and Health and Wellbeing Board.

20 REVIEW

20.1 The Partners shall produce a BCF Quarterly Report which shall be provided to the Health and Wellbeing Board in such form and setting out such information as required by National Guidance and any additional information required by the Health and Wellbeing Board or National Commissioning Board

20.2 Save where the Locality Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and Non Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.3 Subject to any variations to this process required by the Locality Board, Annual Reviews shall be conducted in good faith.

20.4 The Partners shall within [20] Working Days of the annual review prepare an Annual Report including the information as required by National Guidance and any other information required by the Health and Wellbeing Board. A copy of this report shall be provided to the Health and Wellbeing Board and Locality Board.

20.5 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

21.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 6 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund Requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach.

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so.

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this.

22.6.3 the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Partner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 the Locality Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executives or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs, and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than [sixty (60) days], either Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving, and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

[The Partners will follow the information governance protocol set out in Schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 2018 Act**.] or** [The Partners will comply with the information governance protocol as agreed between the Partners from time to time]

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Metropolitan Borough of Bury, Town Hall, Knowsley Street, Bury BL9 0SW

and

29.3.2 if to the ICB, addressed to the Chief Executive 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN;

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners subject to approval by the Locality Board as set out in this Clause.

30.2 Where the Partners agree that there will be:

30.2.1 a new Pooled Fund;

30.2.2 a new Individual Scheme; or

30.2.3 an amendment to a current Individual Scheme,

the Locality Board shall agree the new or amended Individual Scheme and this must be signed by the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification may be made by any Partner but will require agreement from all of the Partners in accordance with the process set out in Clause 30.3. The notice period for any variation unless otherwise agreed by the Partners shall be 3 Months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

30.3 The following approach shall, unless otherwise agreed, be followed by the Locality Board:

30.3.1 on receipt of a request from one Partners to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Locality Board will first undertake an impact assessment and identify those Service Contracts likely to be affected;

30.3.2 the Locality Board will agree whether those Service Contracts affected by the proposed variation should continue, be varied, or terminated, taking note of the Service Contract terms and conditions, and ensuring that the Partners holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged;

30.3.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

30.3.4 should this not be possible, and one Partner is left financially disadvantaged as a result of holding a Service Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed, be [shared equally between the Partners.]

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform, and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not subcontract, assign, or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **THE METROPOLITAN BOROUGH OF BURY** was hereunto affixed in the presence of:)

_____

Authorised Signatory

Signed for on behalf of **[ ] INTEGRATED CARE BOARD**

_____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

Part 1 – Template Services Schedule

TEMPLATE SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

The table below reflects the opening budgets for Health and Social Care pooled funds budgets for the Bury Locality for 2024/25

Budget Service Name	Commissioner Lead	ICB £M's	LA £M's	Opening 2024/25 Budget £M's
Acute	ICB	£2.93		**£2.93**
Complex Care	ICB	£20.20		**£20.20**
Community Services	ICB	£16.76		**£16.76**
Mental Health & Learning Disabilities	ICB	£16.03		**£16.03**
Other	ICB	£2.80		**£2.80**
Primary Care	ICB	£4.63		**£4.63**
Intra NHS GM Better Care Fund	ICB	£7.04		**£7.04**
Care in the Community (Adults)	LA		£25.71	**£25.71**
Other Adult Social Care Services	LA		£24.58	**£24.58**
Care in the Community (Adult Mental Health & Learning Disabilities)	LA		£23.45	**£23.45**
Other Adult Mental Health & Learning Disabilities Services	LA		£1.98	**£1.98**
Public Health	LA		£10.53	**£10.53**
Childrens Social Care	LA		£10.84	**£10.84**
Other Childrens Services	LA		£11.47	**£11.47**
Operational Services	LA		£3.26	**£3.26**
Other Council Services	LA		£22.19	**£22.19**
Subtotal LA			**£133.99**	**£133.99**
Subtotal ICB		**£70.38**		**£70.38**
Grand Total		**£70.38**	**£133.99**	**£204.37**

SCHEDULE 2 – GOVERNANCE

1 Locality Board

1.1 The membership of the Locality Board will be as follows:

1.1.1 ICB:

or a deputy to be notified to the other members in advance of any meeting;

1.1.2 the Council:

or a deputy to be notified in writing to Chair in advance of any meeting;

2 Role of Locality Board

3 The Locality Board shall:

3.1.1 Provide strategic direction on the Individual Schemes

3.1.2 receive the financial and activity information;

3.1.3 review the operation of this Agreement and performance manage the Individual Services;

3.1.4 agree such variations to this Agreement from time to time as it thinks fit;

3.1.5 review and agree annually a risk assessment;

3.1.6 review and agree annually revised Schedules as necessary;

3.1.7 request such protocols and guidance as it may consider necessary in order to enable teach Pooled Fund Manager to approve expenditure from a Pooled Fund;

3.1.8 cooperate with the Pooled Fund Manager in meeting reporting requirements in accordance with relevant National Guidance.

3.1.9 report directly to the H&WB on a Quarterly basis in accordance with relevant National Guidance.

4 Locality Board Support

The Locality Board will be supported by officers from the Partners from time to time.

5 Meetings

5.1 The Locality Board will meet Quarterly at a time to be agreed within following receipt of each Quarterly report of the Pooled Fund Manager.

5.2 The quorum for meetings of the Locality Board shall be a minimum of [one representative from each of the Partner organisations].

5.3 Decisions of the Locality Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Locality Board. If no unanimity is reached on the second occasion it is discussed, then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

5.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

5.5 Minutes of all decisions shall be kept and copied to the Authorised Officers within [seven (7)] days of every meeting.

6 Delegated Authority

6.1 The Locality Board is authorised within the limited of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

6.1.1 to authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

6.1.2 to authorise a Lead Partner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

7 Information and Reports

Each Pooled Fund Manager shall supply to the Locality Board on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

The Locality Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

9 Locality Board Terms of Reference

The latest Terms of Reference for the Bury Locality Board are embedded below

Terms of Reference version 1i - Jan 24.do

SCHEDULE 3 – FINANCIAL ARRANGEMENTS, RISK SHARE AND OVERSPENDS

1 Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of Agreement.

2 Subject to any contrary provision in the relevant Scheme Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with this Schedule 3.

Financial Contributions

3 Quarterly reports will be presented to Locality Board and any changes to the budget position will be formally reported within these reports.

Contribution from Partners 2024/25	Commissioner Lead	ICB £M's	LA £M's	Opening 2024/25 Budget £M's
ICB	**ICB**	**£70.38**		**£70.38**
LA	**LA**		**£133.99**	**£133.99**
Total Contributions		**£70.38**	**£133.99**	**£204.37**

Pooled Fund Management

4 The Pooled Fund Manager, with full cooperation from each Partner, has the responsibility to report to the Locality Board any such potential Overspends and Underspends with options for addressing them at the earliest opportunity.

Actions could include:

• agreeing an action plan to reduce expenditure;

• identifying underspends that can be vired from any other Permitted Budget maintained under this agreement.

• consider additional contributions from one or both Partners

• consider decommissioning all or any part of a Service

• consider the application of reserves

Should there be a projected Overspend against any of the Areas of Provision as identified in Schedule 1, the respective budget holder will seek to rectify this in the first instance before any decision is taken to utilise Underspends on any other schemes.

The Locality Board must authorise any appropriate action. Any virement between schemes must be ratified by the Locality Board.

Overspend / Underspend

5 The Locality Board shall consider what action to take in respect of any actual or potential Overspends

6 The Locality Board shall act reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

6.1 whether there is any action that can be taken in order to contain expenditure;

6.2 whether there are any underspends that can be vired from any other fund maintained under this Agreement;

6.3 how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

7 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

8 Where is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the overspend relates save to the extent that such overspend is not the fault of the other Partner.

9 Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service of Individual Scheme where the Scheme Specification provides and where the Service does not form part of the Better Care Fund Plan.

10 Underspends for either party to this agreement will remain the responsibility of the party in whose budgets they have arisen and there is no expectation or circumstance where they would be shared with the other partner.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD PARTNER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Partner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2 The Lead Partner shall provide the other Partners with copies of any and all relevant:

2.1 Performance Reports;

2.2 Monthly Activity Reports;

2.3 Remedial Action Plans;

2.4 JI Reports;

2.5 Service Quality Performance Reports;

3 The Lead Partner shall not:

3.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

3.2 vary any Provider Plans (excluding Remedial Action Plans);

3.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

3.4 give any approvals under the Service Contract;

3.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

3.6 suspend all or part of the Services;

3.7 serve any notice to terminate the Service Contract (in whole or in part);

3.8 serve any notice;

3.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners, such approval not to be unreasonably withheld or delayed.

4 The Lead Partner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

5 The Lead Partner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

6 The Lead Partner shall share copies of any reports submitted by the Service Provider to the Lead Partner pursuant to the Service Contract (including audit reports)

Part 2– OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Partner shall (at its own cost) provide such cooperation, assistance, and support to the Lead Partner (including the provision of data and other information) as is reasonably necessary to enable the Lead Partner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired, or terminated pursuant to the terms of the relevant Service Contract;

2 No Partner shall unreasonably withhold, or delay consent requested by the Lead Partner.

3 Each Partner (other than the Lead Partner) shall:

3.1 comply with the requirements imposed on the Lead Partner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Partner of any matters that might prevent the Lead Partner from giving any of the warranties set out in a Services Contract or which might cause the Lead Partner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

Not Applicable

SCHEDULE 6 – BETTER CARE FUND PLAN

The table below reflects the budgets for BCF pooled funds budgets

Budget Service Name	Host Partner	ICB £000's	LA £000's	Opening 2024/25 Budget £000's
Additional G&A beds	ICB	£416.73		**£416.73**
Assistive Technologies and Equipment	ICB	£75.70		**£75.70**
Bury Local Care Organisation	ICB	£937.23		**£937.23**
Care of vulnerable Adults - Fairfield Raid	ICB	£711.11		**£711.11**
Crisis Response Community	ICB	£1,784.19		**£1,784.19**
Falls Prevention	ICB	£226.27		**£226.27**
Hospice	ICB	£352.14		**£352.14**
Integrated Intermediate Care	ICB	£1,826.40		**£1,826.40**
Integrated Neighbourhood Teams	ICB	£2,434.81		**£2,434.81**
Intermediate Tier	ICB	£2,798.05		**£2,798.05**
Nursing Home Training	ICB	£69.17		**£69.17**
Primary Care Support	ICB	£525.46		**£525.46**
Programme Management	ICB	£135.00		**£135.00**
Protection of Social Care	ICB	£3,801.27		**£3,801.27**
Rapid Response	ICB	£910.50		**£910.50**
Reablement Service	ICB	£3,716.98		**£3,716.98**
Same Day Emergency Care Frailty Ward	ICB	£342.00		**£342.00**
Staying Well Programme	ICB	£88.10		**£88.10**
VCSE Support	ICB	£288.43		**£288.43**
IBCF Building Resilience and Enabling Systems	LA		£7,628.45	**£7,628.45**
Disabled Facilities Grant	LA		£2,265.06	**£2,265.06**
Protection of Social Care	LA		£1,099.65	**£1,099.65**
Reablement Service	LA		£682.85	**£682.85**
Subtotal LA			**£11,676.01**	**£11,676.01**
Subtotal ICB		**£21,439.55**		**£21,439.55**
Grand Total		**£21,439.55**	**£11,676.01**	**£33,115.55**

SCHEDULE 7– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

NHS GM Conflict of Interest Policy v2.docx

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL


NHS GM Information Security Policy V1.2.pc

Meeting:			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	16	**Confidential**	No
Title	Primary Care Commissioning Committee update		
Presented By	Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Helen Marshall, Business Support Admin		
Clinical Lead			

Executive Summary

The Primary Care Commissioning update is provided as a highlight report from the meeting held on the 29th July 2024.

Recommendations

The Locality Board is asked to note the highlight report from the last Primary Care Commissioning Committee.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☐

Implications						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

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

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Adrian Crook
Reporting period: July 2024
Attendance: Acceptable

This report updates / informs the NHS Greater Manchester PCCC on the Bury PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates:

Bury LCS 2023/24 Appeals- PCCC were asked to approve the recommendations made in the paper and provide advice in relation to those appeals where the committee were asked for a view.

The Bury LCS – Neighbourhood targets finalised and contract variation issued with work commencing towards those targets from 1 July 2024

Quality Assured Spirometry- PCCC were notified of the current contract end date of 31st August 2024 and asked to approve continued commissioning of the service until 31 March 2025. PCCC noted that the STAR form for QAS has been approved and the PSR form is with GM procurement for sign off however, did not approve continued commissioning of the service.

General Practice Strategy Update (including Blueprint cross check) – PCCC received the paper and recognised the exceptional work going on in General Practice. Asked for paper to be finalised and then submitted to locality board and Health and Scrutiny Committee

In addition, PCCC were presented with updates regarding:

- Primary Care Programme/GP Leadership Collaborative update
- General Practice Strategy Update (including Blueprint cross check)
- Contracting Report Q1
- QoF Outcomes 2023/24
- General Practice Patient Satisfaction Survey
- Primary Care Risk Register

Priority actions in coming period:

The Bury LCS – Neighbourhood targets require some technical changes and updated contract variation will be issued.

Quarterly contractual update – All contracts

Quality Assured Spirometry – Risk to be added to register as there will be no Spirometry service for patients of Bury from 1 September 2024. Primary Care Team will liaise with NCA re CHC provision and GM re funding options however, neither of these are viable options at present

General Practice Strategy Update (including Blueprint cross check) – Paper to be finalised and then submitted to locality board and Health and Scrutiny Committee

GP Core Contract Arrangements- PCCC to be kept informed in terms of developments

Decisions made:

Bury LCS 2023/24 Appeals- PCCC Upheld the appeals they were asked to make a decision on and accepted recommendations for all other appeals presented as outlined in the appendix.

Quality Assured Spirometry- PCCC agreed to escalate the fact that no funding is available to deliver the QAS service at locality level after 31st August to GM to explore how the service will be delivered.

General Practice Strategy Update (including Blueprint cross check)- PCCC agreed the GP Strategy year and review and corresponding Blueprint Action plan subject to double checking some of the figures.

Top 3 risks & mitigation:	RAG rating
Recruitment and retention of the workforce including ARRS recruitment/spend – work is in hand in understanding the risks associated with any underspend and of future planning in anticipation of the allocation for 24/25.	
Estates - The lack of suitable PC estate is impeding the way in which providers work and services are delivered. No mitigations in place, currently working beyond core hours to deliver services where necessary	
Lack of Spirometry service for patients of Bury from 1 September 2024	

Meeting: Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	17	**Confidential**	No
Title	Bury Integrated Care Partnership System Assurance Committee summary report		
Presented By	Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury)		
Author	Carolyn Trembath, Head of Quality (Bury)		
Clinical Lead	Cathy Fines		

Executive Summary
This report provides the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee meeting that took place in July 2024.
Recommendations
The Locality Board is asked to receive the report and share any feedback to the System Assurance Committee for action

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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

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

Governance and Reporting		
Meeting	**Date**	**Outcome**
System Assurance Committee	08/07/2024	Summary to be provided to Locality Board

BURY INTEGRATED CARE PARTNERSHIP

System Assurance Committee Highlight Report – July 2024

1. Introduction

1.1. This report provides the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee meeting that took place in July 2024.

2. Background

2.1. This report is a summary of the System Assurance Committee held on 8th July 2024.

3. Headlines from the System Assurance Committee

3.1 Community Safety Partnership (CSP)

- The CSPs current priorities which were developed based on engagement with communities and how the Bury 2025-2028 plan was co-designed in the context of the 'Let's Do It' strategy.

- The best examples of lived experience are through the drug and alcohol work which was had a community led approach with young people through the circles of influence succession to enable them to share view to policy makers and how this can be used in partnership working.

- There is a focus on water safety messaging with links into the discussion at CDOP along with the Fire Service.

- Operation REVOKE is moving from the Serious Organised Crime Service in the neighbourhoods. Links also need to be made into INT, housing, primary care and any other place based colleagues. This will then lead to other inputs as appropriate from elsewhere in the borough.

- There is cohesion in the interfaces particularly Safeguarding Partnership, CDOP and CSP.

3.2 PRN01417 Patient Safety and quality of care in pressurised services.

- NHS England wrote to all localities following the Channel 4 Dispatches documentary filmed in the Emergency Department at Royal Shrewsbury Hospital aired in June 2024. Each locality has been asked to look at the different elements within the letter, which is around urgent and emergency care services and the care provided that is not necessarily in the right area of a hospital setting.

- The locality Urgent and Emergency Care Board has a very robust action plan; the Fairfield site performs very well compared nationally in terms of hospital flow and

discharges. Daily silver meeting take place with all the right escalations in place. There are lots of programmes of work to try to avoid hospital admissions, and to enable timely discharges.

- The process by which NCA assures their Board that care outside of a cubical or hospital bed is being managed; this will be picked up at the quarterly Clinical Quality Leads meeting with the NCA. Some questions will tie in with the CQC action plan and improvement plan.

- NCA is collating a response to the request from NHS England.

3.3 Quarter 4 Primary Care Contracting report 2023/24

- Achievement against the 23/24 Bury Locally Commissioned Service (LCS) was provided; one of the contracts commissioned from General Practice with a £2m financial envelope.

- Overall, there has been improvement against indicators within the contract but there has been some variation by practice.

- For 2024/225 the contract needs to revisted due to the requirements of the GM standards and reduction in the financial envelope. The risk with this is the potential to have to start again with a different indicator set rather than continue with what is currently in place.

- This is particularly disappointing given the significant work that has been done to improve health checks that improves people's lives and reduce pressures on NHS providers.

3.4 Bury Council Quality Assurance (QA) and Improvement Framework and Levels of Support Framework

- The framework demonstrates the QA undertake with its Adult Social Care providers as well as working alongside them and partners to continually improve the services in Bury. The framework includes documents such as feedback, engagement with users, its services, care providers, and also their staff, which is something that was missing from the framework previously.

- There has been significant work over the last 18 months or so to get back into the community to do quality checks and baseline providers.

- A robust governance process has been put in place that allows monitoring the performance of the providers proactively, tackle any issues and keep a grip on the improvements needed. This not only helps with requirements under the Care Act but supports preparations for CQC inspections.

- A performance management dashboard has been established to analyse provider risk proactively. Regular feedback will be received from users and improvements tracked year on year. This also tackles the 'so what?', in terms of what the Council does after the QA reviews, and what happens after analysing the data it has access to in the form of an annual provider development plan.

- The Levels of Support Framework aims to help identify concerns at the earliest opportunity and support the provider's improvement in particular areas and make sure the improvement is supported by the right people at the right time. This approach has been piloted with a couple of care homes and has worked exceptionally well, and so the Council will be looking to formally roll this out.

- The frameworks support and demonstrate the joint working across health and social care.

3.5 Adults Safeguarding update

- All the historic SARs have now been completed and have an action plan against them; there are two still open.

- The Multi-Agency Risk Management (MARM) Panel is established and there is a Strategic Panel being signed off by the Safeguarding Adults Board.

- 4 panels are planned with the 1st having taken place.

- Was useful for staff and the family of one individual knowing that the case was being discussed at a high level and the whole partnership had sight on what was happening and trying to work with that individual and family.

- Independent Adult Safeguarding Board Chair has been recruited to; this will give some independent scrutiny.

- There are proposals around safeguarding training in general for both adults and children as currently this is not a mandatory requirement within the council. However it was felt from a good practice perspective that this is something that should be looked at and introduced.

- The differences in the processes for MARM (adults) and MALM (multi-agency liaison meeting – children) where highlighted.

3.6 Catch-up clinic at Huntley Mount

- Developed on the back of the approach the practice took during COVID in making every contact count, this was applied during the MMR catch-up clinics, trying wherever possible to get height, weight, pulse, smoking status, alcohol status by offering longer

appointments as standard.

- It improves the experience of the admin and clinicians with the patients, as they are not being called back repeatedly if a one stop shop is offered. This is particularly beneficial given the location of the practice and the deprivation in the area.

- Work is now in hand to write up case studies for publication and promote more widely the benefits realised.

3.7 Risk update

- Work continues to develop the locality health risk management programme. This includes provision of some training, particularly for SROs and programme leads, but also tightening up on some of the documentation and putting some admin support in to ensure that the process is properly administered.

- The Risk Scrutiny Group will undertake a check and challenging process around the risk register prior to it being presented to the IDC Board and Locality Board there will also be consideration about which risks need to be escalated up to into the GM structure.

- There are approximately 50 risks which have been reviewed and graded. Those graded 12 and above are on the strategic risk register.

- The Terms of Reference for the Risk & Scrutiny Group were discussed at the Risk & Scrutiny Group meeting on the 15th August 2024. There had been a number of outstanding queries on the draft version that had been produced a number of months ago which have now been resolved. The Terms of Reference are attached at Appendix 1 of the report for information which will be submitted to the Integrated Delivery Collaborative Board for approval.

4 Associated Risks

4.1 None.

5 Recommendations

5.1 None

6 Actions Required

6.1 The Locality Board is asked to note the contents of the report and to raise any issues for the System Assurance Committee to address.

BURY
INTEGRATED CARE
PARTNERSHIP

Carolyn Trembath
Head of Quality
carolyntrembath@nhs.net
August 2024

BURY INTEGRATED CARE PARTNERSHIP

Risk & Scrutiny Group - Terms of Reference – August 2024

1. Purpose of the Risk & Scrutiny Group:

a. To provide the Bury Locality Board and Integrated Delivery Board with a clear understanding of the key risks across the partnership, what mitigation is in place to minimise risks, what risks have been accepted and how they will be managed.

b. To oversee the implementation of the Locality Risk Management Strategy/arrangements linked to the GM Risk Strategy and Policy.

c. Promote the development of a consistent approach to risk scoring across the partnership.

d. To provide formal review and scrutiny of the Bury system risk register (risks of 12+ and above).

e. To escalate to Integrated Delivery Collaborative Board and Bury Locality Board any issues for further discussion/mitigating action as required.

f. To agree the addition/removal of individual risks on the Bury system risk register in conjunction with the view of risk owners.

2. Scope of authority:

a. To agree areas of escalation to the relevant Locality Board and other Committees/Groups.

b. To approve the addition/deletion/amendment of individual risks on the Bury system risk register.

3. Functions:

a. To receive and scrutinise the Bury system risk register in respect of all risks 12 and above .

b. To consider next steps in relation to new and emerging risks including any risks escalated from individual work streams .

c. To provide regular reports to the IDC Board, System Assurance and Locality Board on Bury system risks on a bi-monthly basis.

d. To ensure a consistent approach to risk management processes in the Bury locality.

e. To ensure SROs/committee chairs/programme leads are aware of and are trained in the locality risk process.

4. Membership

Name	Role
Catherine Jackson (chair)	Associate Director for Nursing, Quality and Safeguarding, NHS GM Integrated Care (Bury)
Kath Wynne-Jones	Chief Officer, Bury IDC
Simon O'Hare	Associate Director of Finance, NHS GM Integrated Care (Bury)
Ian Trafford	Head of Programmes, Bury IDC
Carolyn Trembath	Head of Quality, NHS GM Integrated Care (Bury)
Imelda Barrington	Corporate Governance Officer, Bury IDC
Emma Kennett	Head of Locality Admin and Governance (Bury), NHS Greater Manchester
Miriam Butler	Risk Manager, GM ICP

Risk Owners and other subject matter experts/Programme leads will be invited to meetings as required.

5. Frequency of meetings

Meetings will initially be held on a monthly basis with view of reducing to bi monthly once all locality risk processes are in place.

6. Reporting/Governance

The group will be accountable to the Integrated Delivery Collaborative/Locality Board via internal governance structures. Following the establishment of the GM Integrated Care System, escalation routes are via the IDC Board, Bury Locality Board and to NHS GM ICP Board/Committees as required.

7. Minutes of Meetings

Minutes of meetings will be taken and circulated including any key actions.

8. Review of Terms of Reference

The Terms of Reference will be reviewed on at least an annual basis.

BURY INTEGRATED CARE PARTNERSHIP

Locality Performance Report August 2024

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Urgent Care	N/A	A&E 4 hour performance	Monthly	Jul 24	65.7%	65.5%	↗	76.0%	4,529	6,898	N/A
	N/A	A&E Attendances	Monthly	Jul 24	6,898	6,833	↗	N/A	N/A	N/A	N/A
	S123a	Adult general & acute bed occupancy adjusted for void beds (Type 1 Only) (NCA)	Monthly	Mar 24	87.2%	88.5%	↘	92.0%	1,335	1,531	Upper
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Jul 24	18.9%	19.0%	↘	N/A	2,173	11,484	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Jul 24	1,815	1,851	↘	N/A	N/A	N/A	Lower
Elective Care	EM07a	GP Referrals Made (General and Acute)	Monthly	Mar 24	2,869	2,919	↘	5,744	N/A	N/A	Lower
	EM07	Total Referrals Made (General and Acute)	Monthly	Mar 24	5,369	5,443	↘	10,411	N/A	N/A	Lower
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Annual	Dec 21	53.7%	51.7%	↗	75.0%	514	957	Inter
Mental Health & Learning Disabilities	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Jun 24	13.3%	8.1%	↗	75.%	157	1,178	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Jun 24	3,620	3,625	↘	5,125	N/A	N/A	Inter
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Jul 24	76.2%	76.7%	↘	66.7%	1,840	2,416	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Monthly	Mar 24	635	685	↘	0	N/A	N/A	Inter
	S125a	Long length of stay for adults (MH patients over 60 days)	Monthly	Jun 24	57.1%	62.5%	↘	0.%	20	35	Inter
	N/A	Number of MH patients with no criteria to reside (NCTR)	Monthly	Jul 24	15	15	→	N/A	N/A	N/A	Lower
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Jul 24	17.6%	17.2%	↗	N/A	15	85	Lower
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Jun 24	1,530	1,545	↘	3,625	N/A	N/A	Lower
	S081a	Talking Therapies: Access Rate	Monthly	Jun 24	310	330	↘	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Mar 24	160	150	↗	N/A	N/A	N/A	Lower
Community	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Monthly	Jun 24	95.9%	99.0%	↘	N/A	94	98	N/A
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 23	66.6%	54.7%	↗	77.%	19,957	29,979	Lower
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Mar 24	63.1%	61.7%	↗	62.1%	6,510	10,320	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Jun 24	83.9%	84.5%	↘	82.1%	71,301	84,977	Inter
Quality	S042a	E. coli blood stream infections	Monthly	Jun 24	163	160	↗	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	May 24	88.9%	89.2%	↘	87.1%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	May 24	6.1%	6.2%	↘	10.%	7,163	117,127	Upper

Bury - Oversight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality
Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	% patients describing their overall experience of making a GP appointment as good	Build in progress
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting

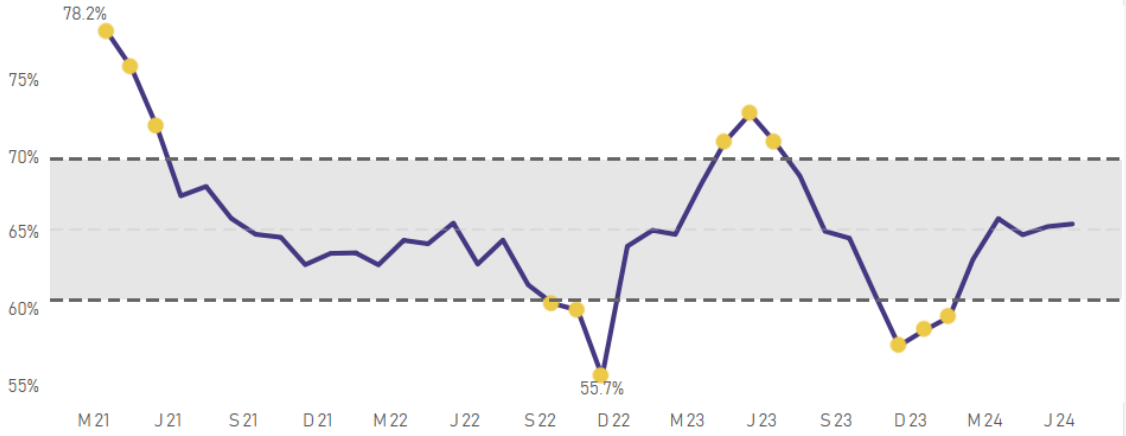
Bury

A&E 4 hour performance
Number of attendances at A&E departments, and of these, the number of attendances where the patient spent less than 4 hours from time of arrival to time of admission, or discharge, or transfer.

Source: Emergency Care Dataset (ECDS) (Monthly)

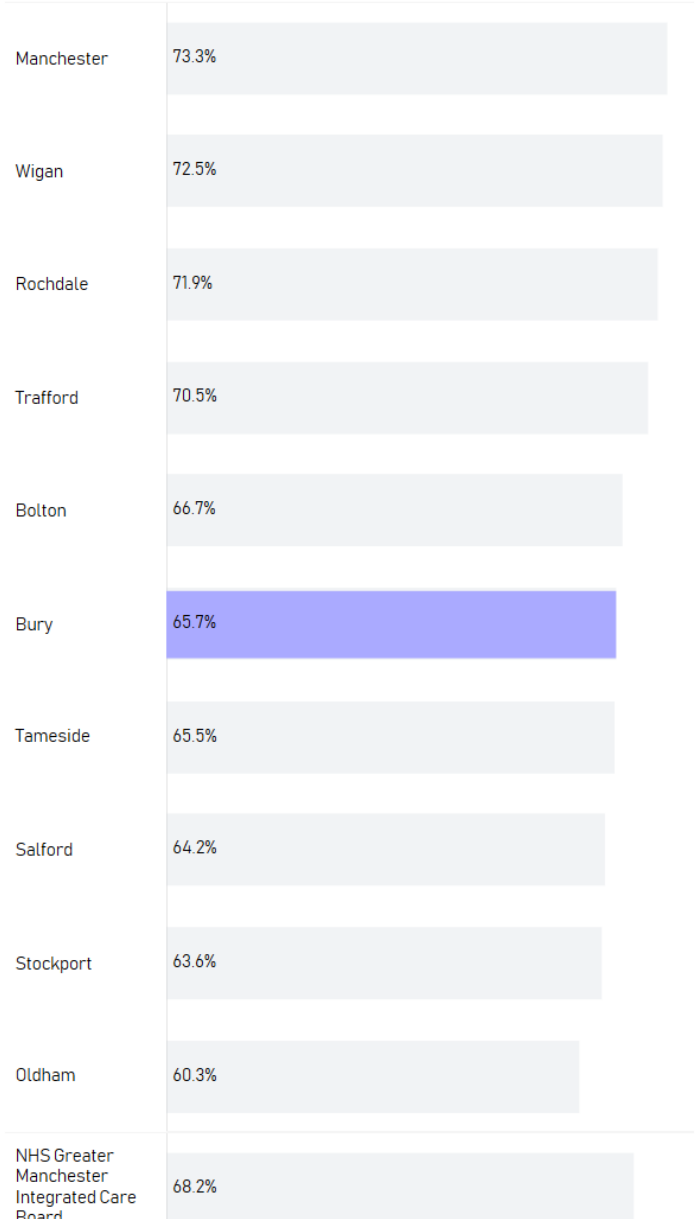
65.7%	65.5%	76.0%
July 2024	June 2024	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	78.2%	75.9%	72.1%	67.5%	68.1%	66.0%	65.0%	64.8%	63.0%	63.7%	63.8%	63.0%
2022-23	64.6%	64.4%	65.7%	63.0%	64.6%	61.7%	60.5%	60.0%	55.7%	64.2%	65.2%	65.0%
2023-24	68.2%	71.0%	72.9%	71.0%	68.8%	65.2%	64.7%	61.1%	57.7%	58.7%	59.6%	63.4%
2024-25	66.0%	65.0%	65.5%	65.7%								

Latest Value GM Benchmarking



Narrative

- 4-hour performance in July was 65.7%, an increase on the previous month's performance of 65.5%.
- July 24 performance is 65.7% which is lower than July 23 which was 71.0%.
- Bury performance is currently below the overall GM performance of 68.2% and is the 6th best performing locality in GM.

Bury

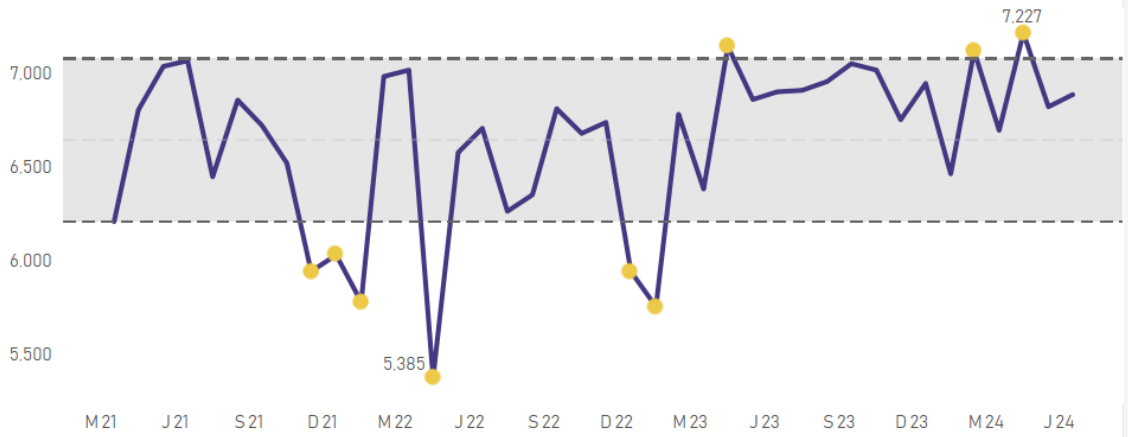
A&E Attendances
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

6,898
July 2024

6,833
June 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6,220	6,816	7,049	7,079	6,459	6,869	6,734	6,532	5,954	6,042	5,791	6,995
2022-23	7,029	5,385	6,589	6,718	6,275	6,363	6,823	6,691	6,750	5,953	5,766	6,793
2023-24	6,394	7,156	6,872	6,913	6,921	6,968	7,063	7,029	6,764	6,958	6,475	7,130
2024-25	6,707	7,227	6,833	6,898								

Selected measure at July 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
Attendances & Rate per 1000 population

Narrative

- There were 6898 A&E attendances from Bury registered patients in July 24, lower than July 23 (6913).
- Bury currently has 32.6 attendances per 1000 population and has the 6th lowest attendance rate for localities within GM.

NCA

Trust level - not locality

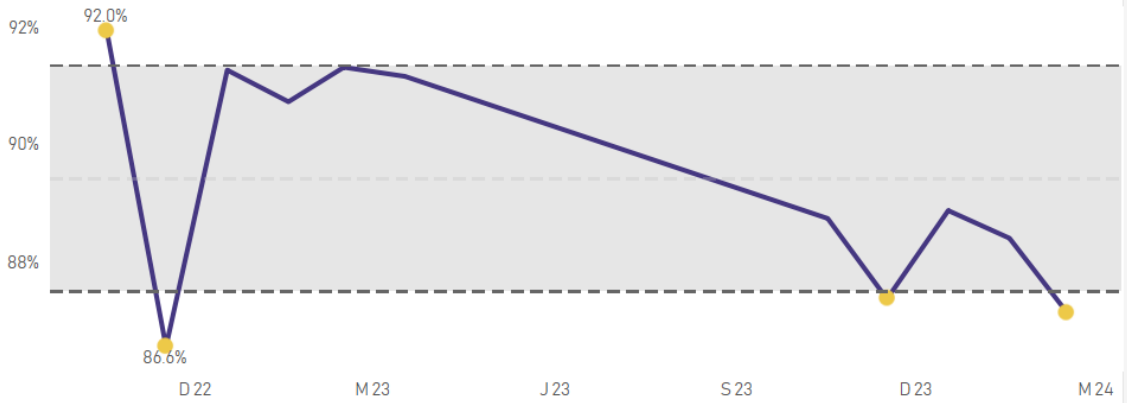
Adult general & acute bed occupancy adjusted for void beds (Type 1 Only)

The proportion of adult general and acute beds occupied (adjusted for covid void beds). Covid void beds are beds that are closed due to Covid, but which are unoccupied. These beds cannot accept new admissions unless the patient is covid positive.

Source: UEC Daily Sitrep (Monthly)

87.2%	88.5%	12/133	92%
March 2024	February 2024	National Rank Upper Quartile	Target to be below

Outliers more than 1 standard deviation from the mean

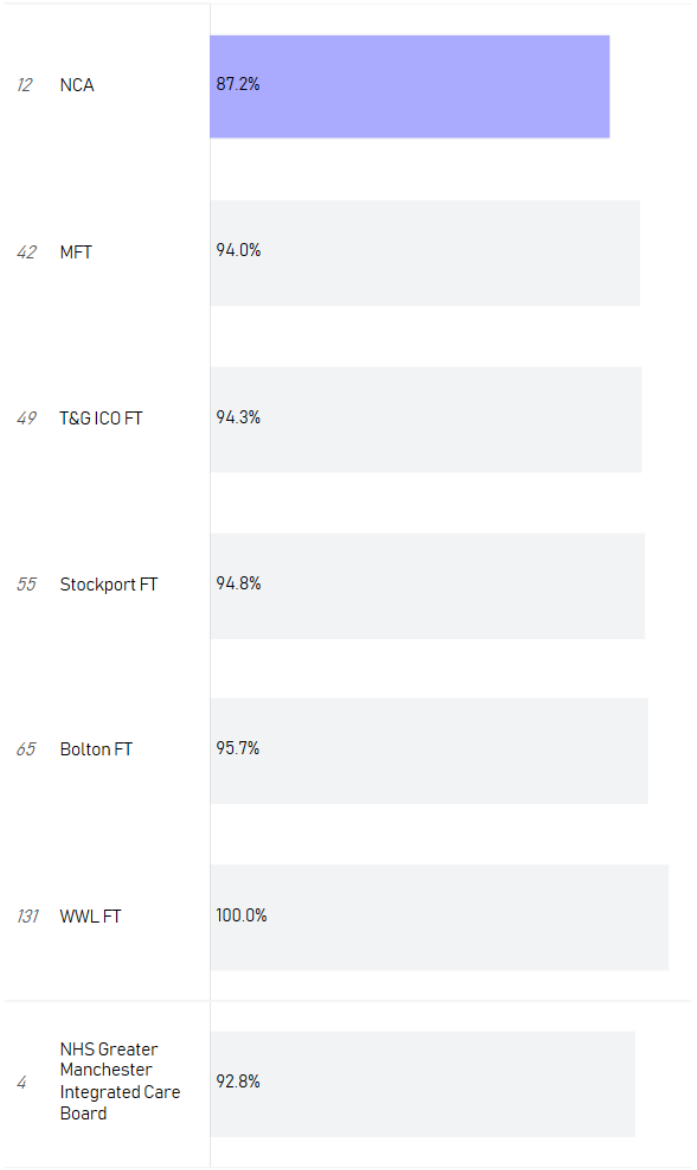


	Apr	Nov	Dec	Jan	Feb	Mar
2022-23		92.0%	86.6%	91.3%	90.8%	91.4%
2023-24	91.2%	88.8%	87.4%	88.9%	88.5%	87.2%

Selected measure at March 2024 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- NCA had an adult and acute beds occupancy rate of 87.2% in March 24. The lowest of the GM Trusts.
- This data shows NCA position across all NCA sites, not just FGH.
- Bury patients will also attend MFT.
- GM occupancy rate is 92.8% for March 24.

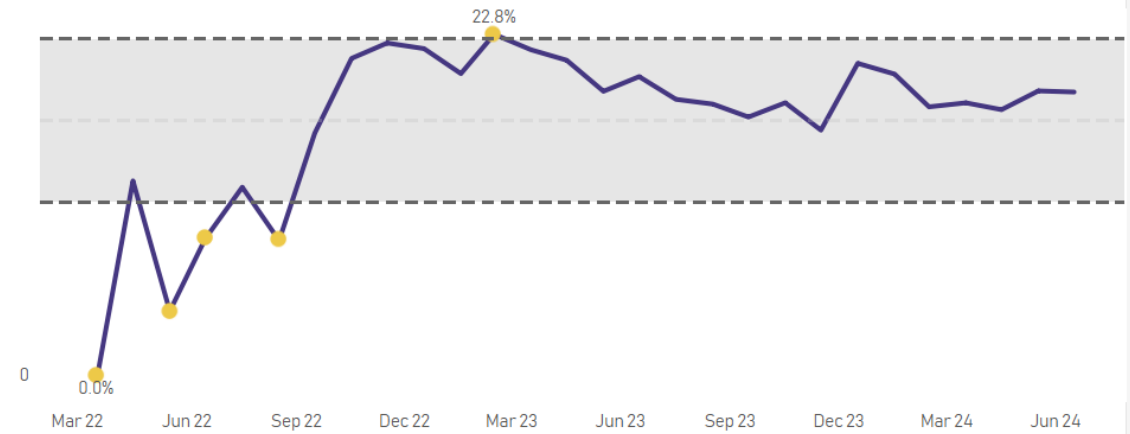
Bury

No Reason/Criteria To Reside patients (NCTR) as % of occupied beds
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

Source: GM Admissions - Local (Monthly)

18.9%	19.0%	No Target
July 2024	June 2024	

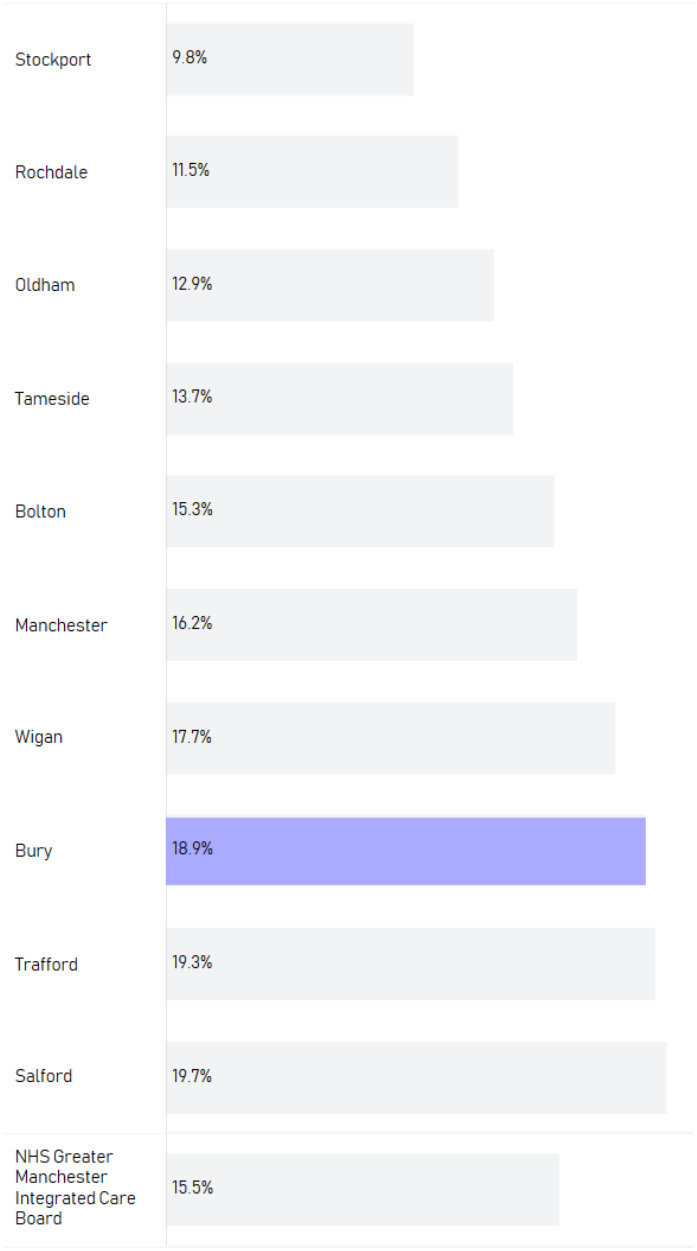
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	13.0%	4.3%	9.2%	12.6%	9.0%	16.2%	21.2%	22.2%	21.8%	20.1%	22.8%
2023-24	21.7%	21.0%	19.0%	19.9%	18.4%	18.1%	17.3%	18.2%	16.4%	20.8%	20.1%	17.9%
2024-25	18.2%	17.7%	19.0%	18.9%								

Selected measure at July 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- NCTR percentage for Bury in July 24 is 18.9% which is a decrease on June 24 which was 19.0%
- Bury is currently higher than the GM percentage of 15.5% and has the 8th highest percentage of the GM localities.

Bury

Total number of specific acute non-elective spells
Number of specific acute non-elective spells in the period (auto-calculated sum of E.M.11a and E.M.11b)

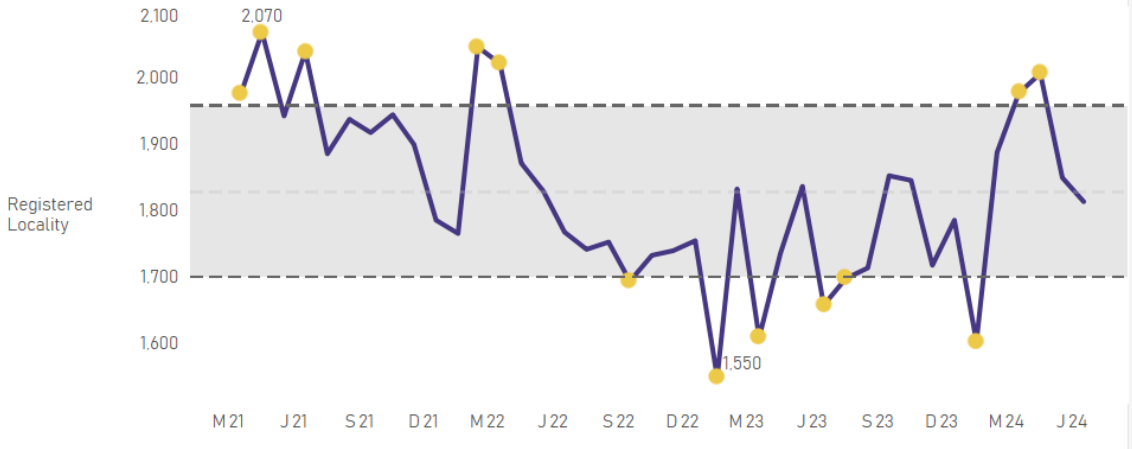
Source: National Flows APC (Monthly)

1,815
July 2024

1,851
June 2024

83/91
National Rank
Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,977	2,070	1,944	2,041	1,887	1,939	1,919	1,946	1,901	1,787	1,767	2,048
2022-23	2,023	1,873	1,831	1,769	1,743	1,754	1,695	1,734	1,741	1,756	1,550	1,834
2023-24	1,610	1,737	1,838	1,659	1,699	1,715	1,854	1,847	1,719	1,787	1,604	1,889
2024-25	1,979	2,008	1,851	1,815								

Selected measure at July 2024 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Count & Rate Per 1000 Population

Narrative

- There were 1815 specific acute non-elective spells from Bury registered patients in July 24, higher than July 23 (1659)
- Bury currently has 8.6 specific acute non-elective spells per 1000 population and has the 5th lowest rate per 1000 for localities within GM.

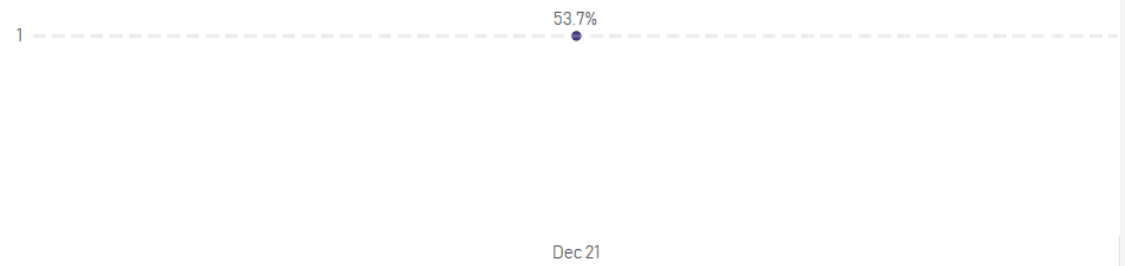
Bury

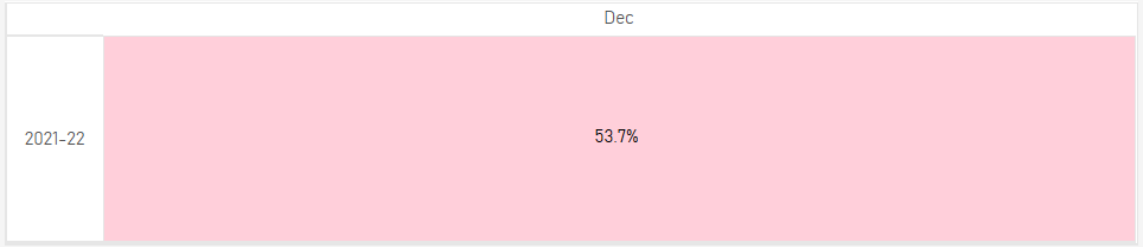
Cancers Diagnosed At Early Stage using Full Registration Data
Proportion of cancers diagnosed at stages 1 and 2 relative to the total cancers staged

Source: Cancer Early Staging Data Statistics via The National Disease Registration Service (NDRS) (Annual)

53.7%	51.7%	48/104	75.0%
December 2021	December 2020	National Rank Inter Quartile	National Ambition

Outliers more than 1 standard deviation from the mean





Latest Value GM Benchmarking
National Rank against other localities

4	Rochdale	58.0%
13	Trafford	56.2%
36	Manchester	54.3%
41	Tameside	54.0%
48	Bury	53.7%
53	Stockport	53.3%
66	Wigan	52.6%
87	Oldham	51.1%
88	Bolton	51.0%
89	Salford	50.9%
28	NHS Greater Manchester Integrated Care Board	53.5%

Narrative

- As of December 2021, 53.7% of cancers for the Bury population were diagnosed at stages one and two. This was an increase on December 2020 which was 51.7%

- Bury's proportion is currently slightly above GM's proportion of 53.5%. Bury has the 5th highest proportion for localities within GM.

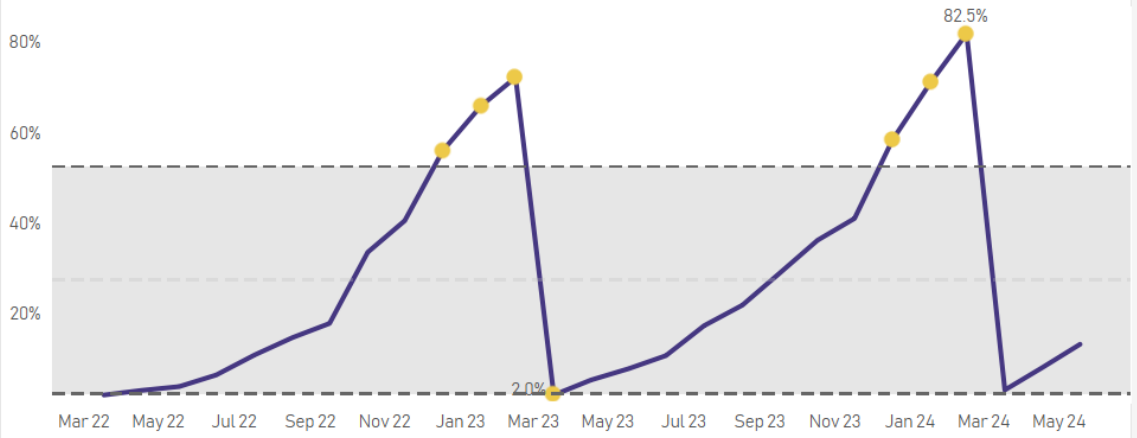
Bury

% of patients aged 14+ with a completed LD health check
The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)

13.3%	8.1%	35/106	75.%
June 2024	May 2024	National Rank Inter Quartile	National Target

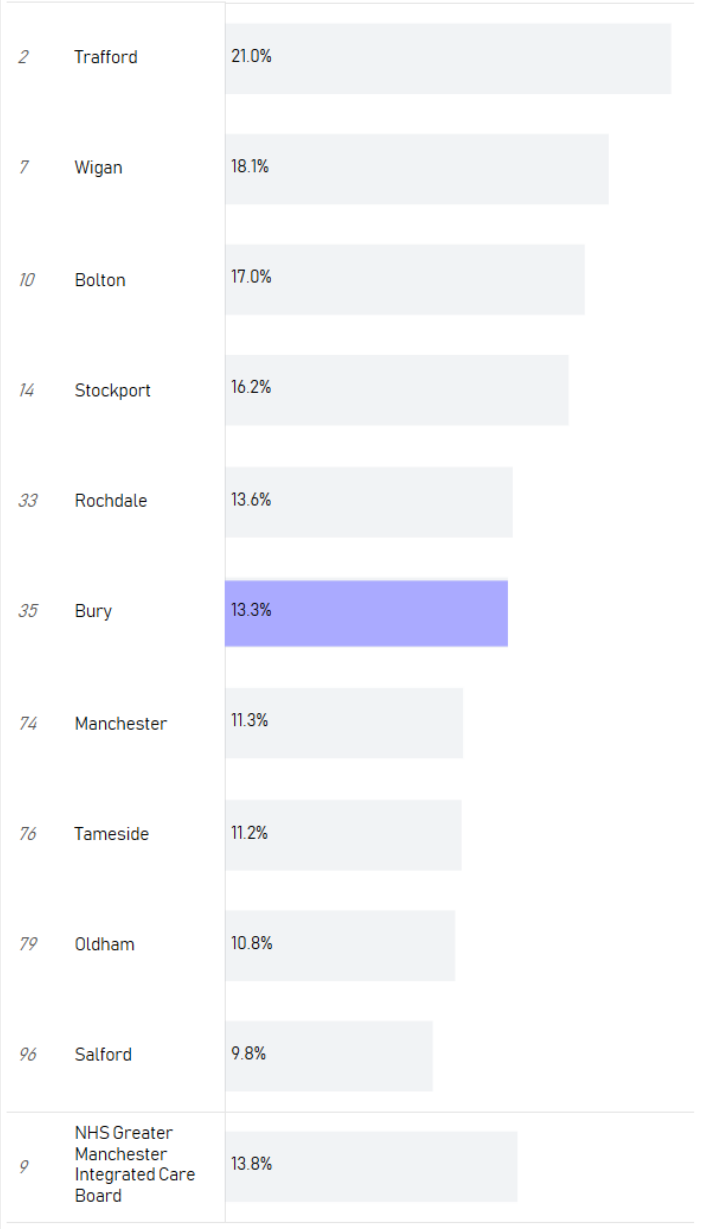
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%									

Selected measure at June 2024 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients aged 14+ having received an LD health check in June 24 is 13.3%, which is an increase on June 23 which was 7.9%.
- Bury is currently lower than the GM percentage of 13.8% and has the 6th highest percentage of the GM localities.
- Bury and GM have not met the national target of 75%.

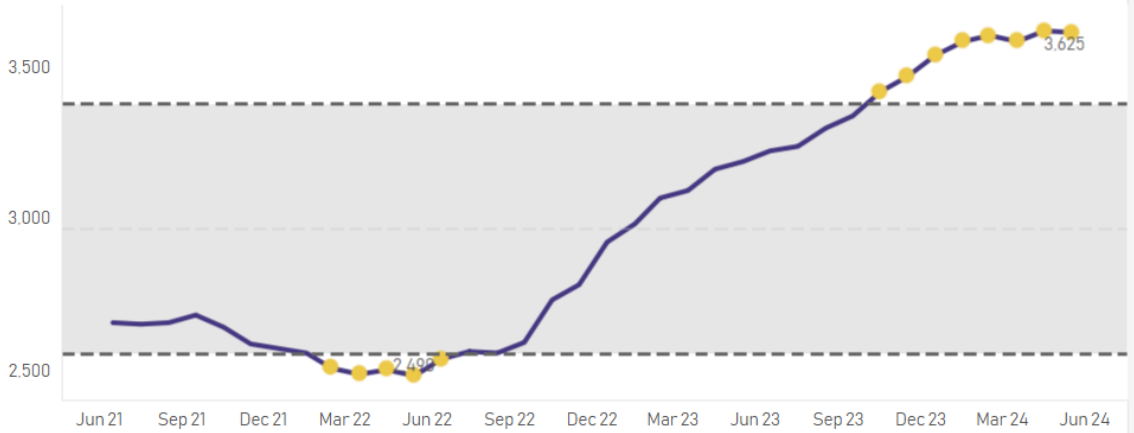
Bury

Access to Children and Young Peoples Mental Health Services
Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

3,620	3,625	78/106	5,125
June 2024	May 2024	National Rank Inter Quartile	National Median

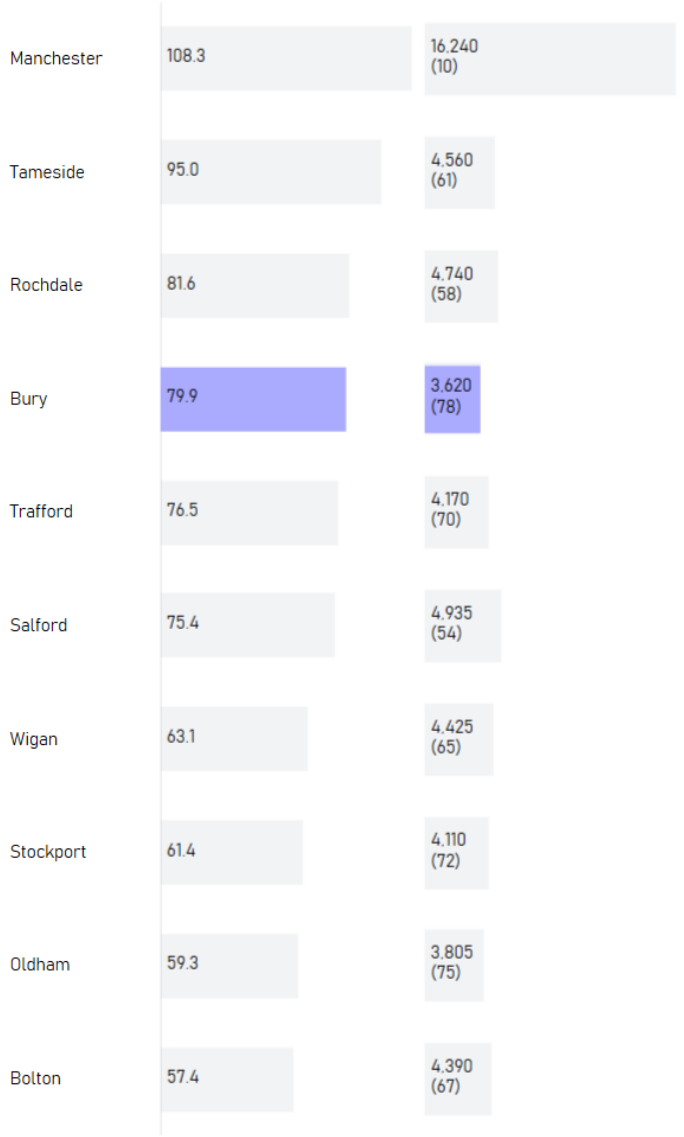
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				2.665	2.660	2.665	2.690	2.650	2.595	2.580	2.565	2.515
2022-23	2.495	2.510	2.490	2.545	2.570	2.565	2.600	2.740	2.790	2.930	2.990	3.075
2023-24	3.100	3.170	3.195	3.230	3.245	3.305	3.345	3.425	3.475	3.545	3.590	3.610
2024-25	3.590	3.625	3.620									

Selected measure at June 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank based on count)



The rate is calculated using the 0-17 population figure for each locality | Bury: 45,310

Narrative

- There were 3620 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in June 24, higher than June 23 (3195).
- Bury currently has 79.9 accesses made per 1000 population and has the 4th highest rate per 1000 for localities within GM.

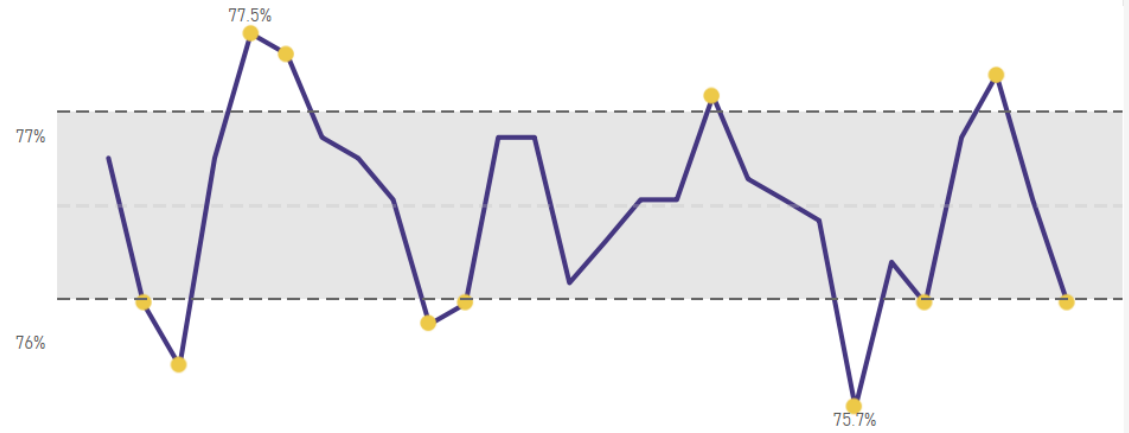
Bury

Dementia: Diagnosis Rate (Aged 65+)
Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)

76.2%	76.7%	9/106	66.7%
July 2024	June 2024	National Rank Upper Quartile	National Target

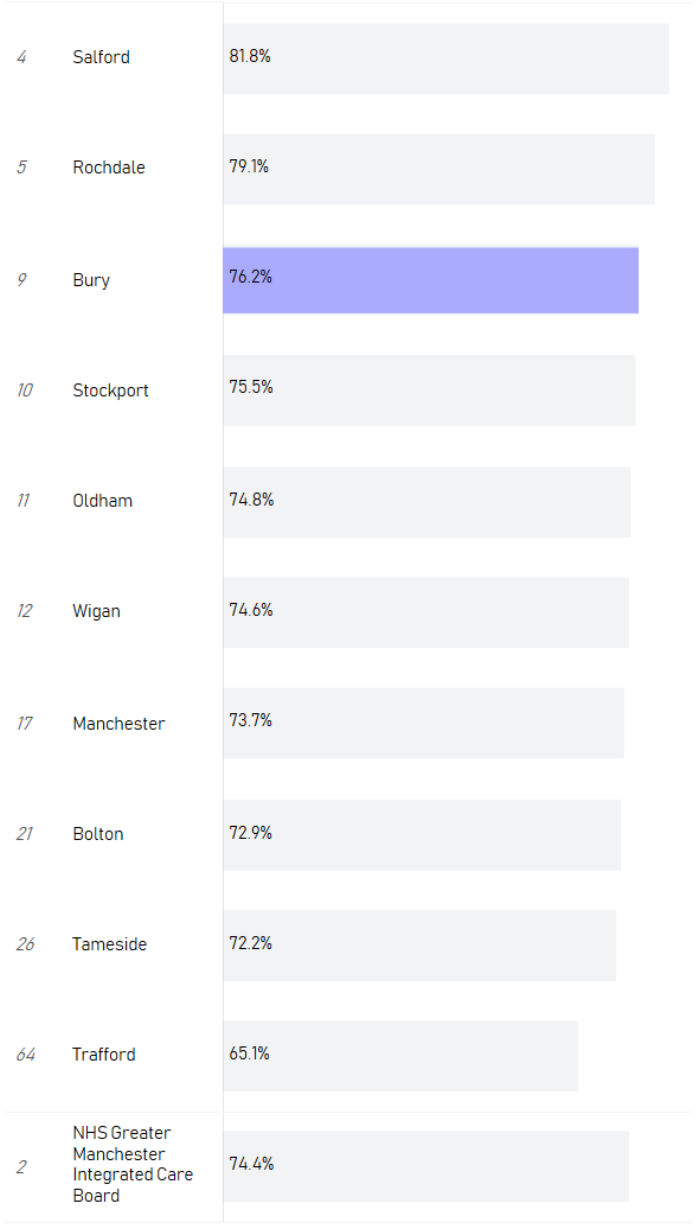
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	76.9%	76.2%	75.9%	76.9%	77.5%	77.4%	77.0%	76.9%	76.7%	76.1%	76.2%	77.0%
2023-24	77.0%	76.3%	76.5%	76.7%	76.7%	77.2%	76.8%	76.7%	76.6%	75.7%	76.4%	76.2%
2024-25	77.0%	77.3%	76.7%	76.2%								

Selected measure at July 2024 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients aged 65+ having received a dementia diagnosis as of July 24 is 76.2%, which is Lower than July 23 which was 76.7%
- Bury currently has a higher diagnosis rate than GM which has a rate of 74.4% and Bury has the 3rd highest dementia diagnosis rate of the GM localities.
- Bury and GM are both above the national target of 66.7%.

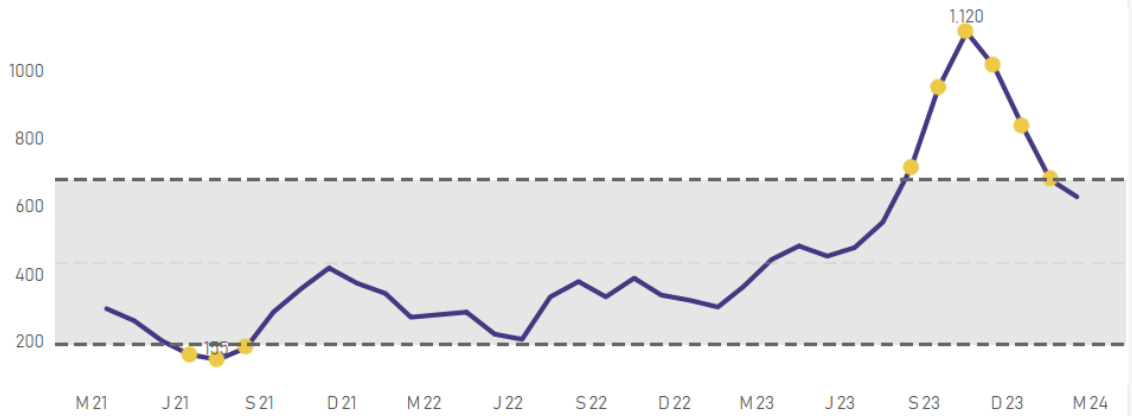
Bury

Inappropriate adult acute mental health Out of Area Placement (OAP) bed days
Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider

Source: Out of Area Placements in Mental Health Services Official Statistics (Monthly)

635	685	79/107	0
March 2024	February 2024	National Rank Inter Quartile	National Target

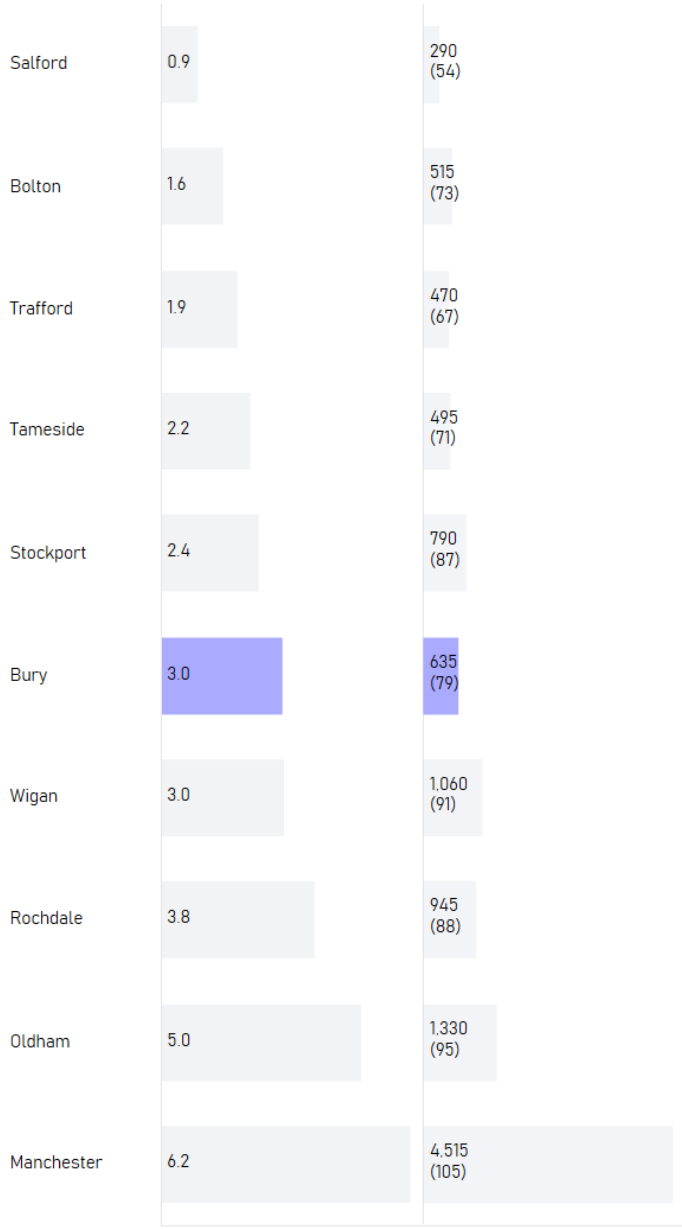
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	305	270	210	170	155	190	295	365	425	380	350	280
2022-23		295	230	215	340	385	340	395	345	330	310	370
2023-24	450	490	460	485	560	720	955	1,120	1,020	845	685	635

Selected measure at March 2024 has continuously decreased for 4 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National rank)



Narrative

- There were 635 inappropriate OAP bed days for Bury registered patients in March 24, higher than March 23 (370).
- These are subject to real time daily and weekly monitoring by multi-agency teams and there is a slight lag in the formally reported data.
- Bury currently has 3.0 OAP bed days per 1000 population and has the joint 6th highest rate with Wigan per 1000 for localities within GM.

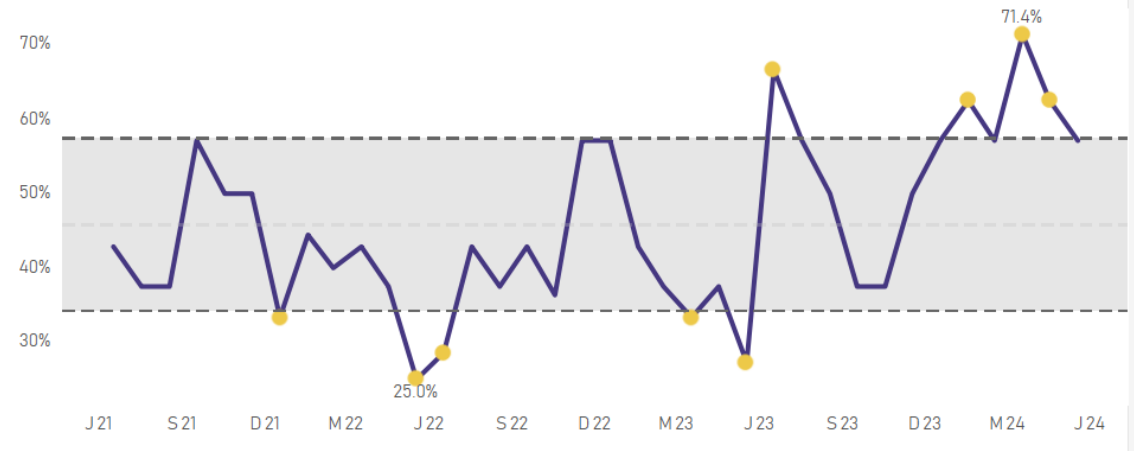
Bury

Long length of stay for adults - Mental Health Patients
Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)

57.1%	62.5%	74/87	0.%
June 2024	May 2024	National Rank Inter Quartile	National Target

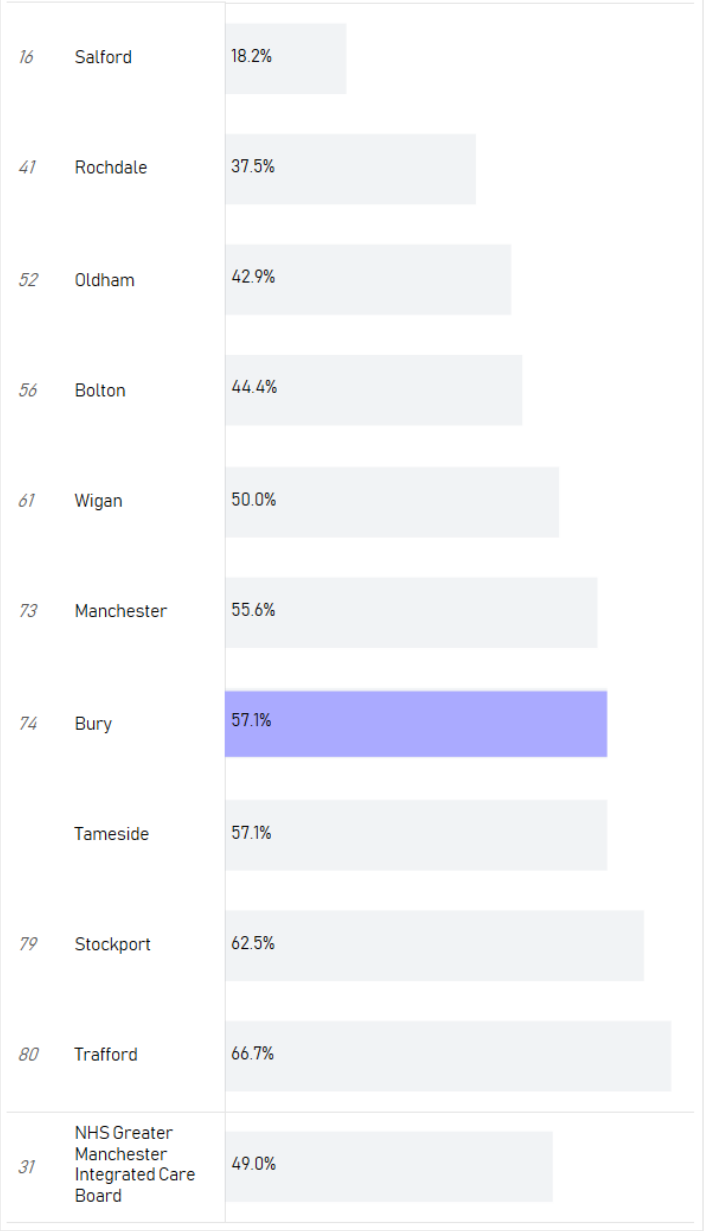
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				42.9%	37.5%	37.5%	57.1%	50.0%	50.0%	33.3%	44.4%	40.0%
2022-23	42.9%	37.5%	25.0%	28.6%	42.9%	37.5%	42.9%	36.4%	57.1%	57.1%	42.9%	37.5%
2023-24	33.3%	37.5%	27.3%	66.7%	57.1%	50.0%	37.5%	37.5%	50.0%	57.1%	62.5%	57.1%
2024-25	71.4%	62.5%	57.1%									

Selected measure at June 2024 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of discharges with a long LOS in June 24 is 57.1%, which is an increase on June 23 which was 27.3%.
- Bury currently has a higher proportion with a long LOS than GM which has a proportion of 49.0% and Bury has the 7th highest proportion of the GM localities.
- Bury and GM are above the national target of 0%.

Bury

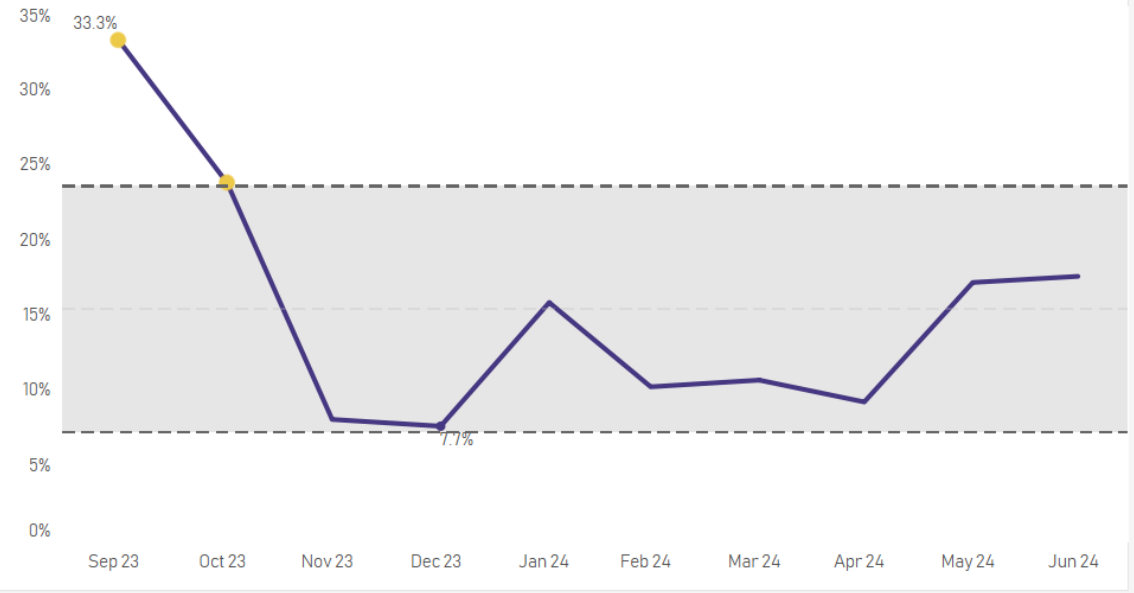
Percentage of MH patients with no criteria to reside (NCTR)
Percentage of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

17.6%
July 2024

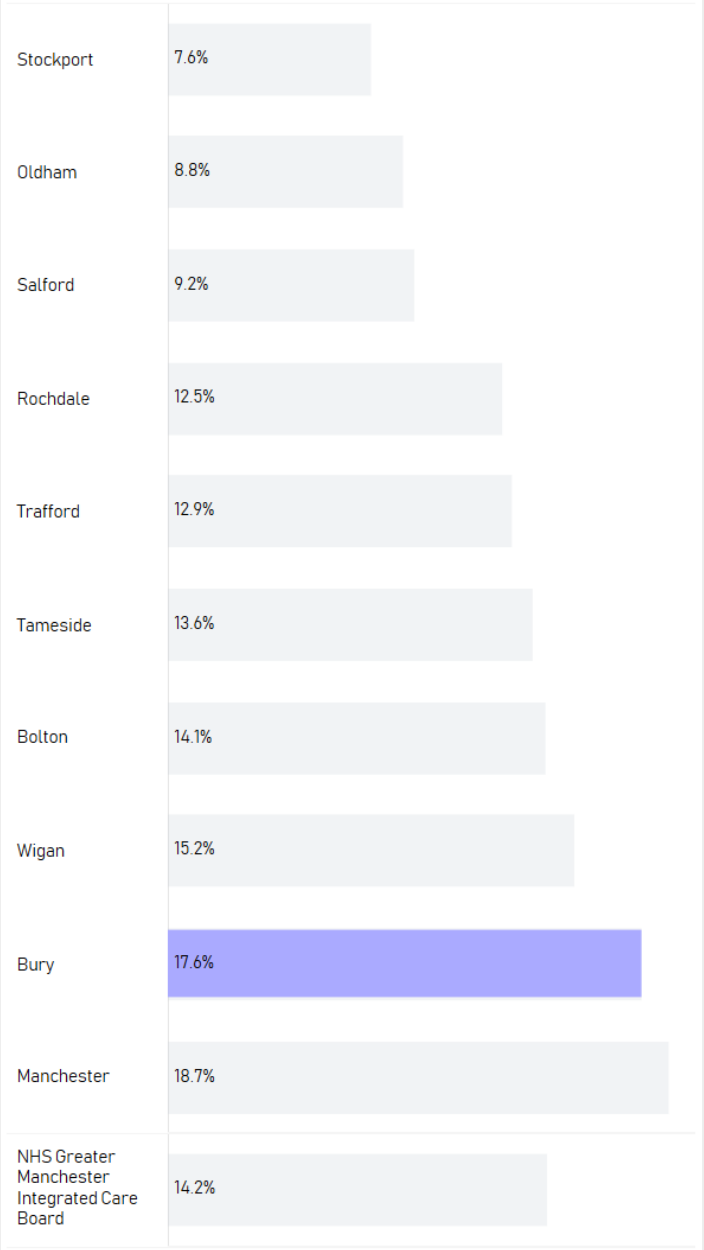
17.2%
June 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						33.3%	23.9%	8.1%	7.7%	15.9%	10.3%
2024-25	10.8%	9.3%	17.2%	17.6%							

Latest Value GM Benchmarking



Narrative

- The percentage of mental health patients with NCTR as of July 24 is 17.6%, which is an increase from June 24 which was 17.2%

- Bury currently has a higher percentage than GM which is 14.2% and Bury has the 9th highest percentage of the GM localities.

Bury

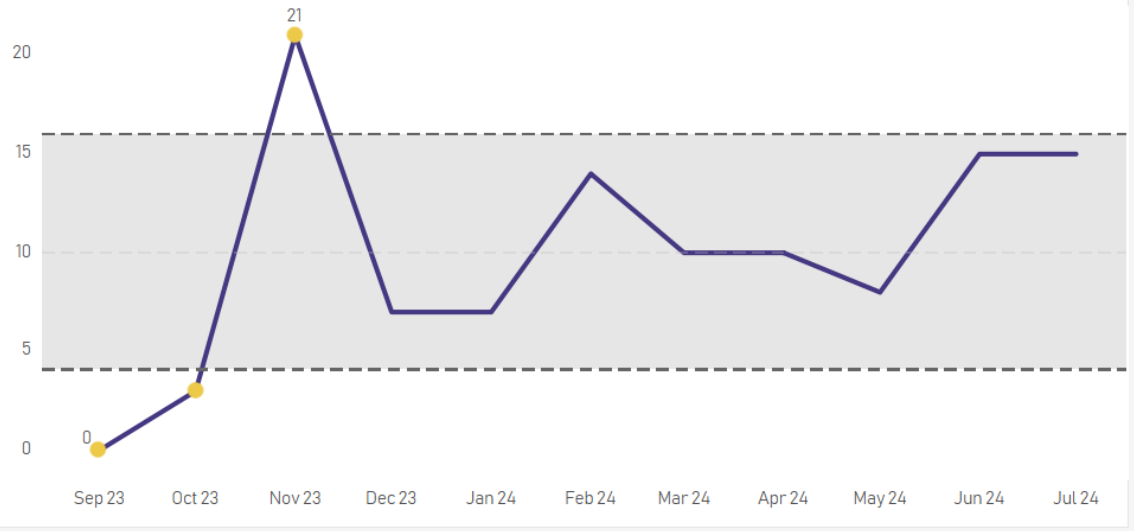
Number of MH patients with no criteria to reside (NCTR)
Number of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

15
July 2024

15
June 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24					0	3	21	7	7	14	10
2024-25	10	8	15	15							

Latest Value GM Benchmarking
Rate per 1000 / Count

Stockport	0.02	5
Oldham	0.03	7
Rochdale	0.03	8
Tameside	0.04	9
Trafford	0.04	9
Salford	0.03	10
Bolton	0.03	11
Wigan	0.03	12
Bury	0.07	15
Manchester	0.07	52
NHS Greater Manchester Integrated Care Board	0.04	138

Narrative

- The number of mental health patients with NCTR as of July 24 is 15, which matches the figure for June 24.
- Bury currently has 0.07 mental health patients with NCTR per 1000 population and has the joint highest rate alongside Manchester locality within GM.

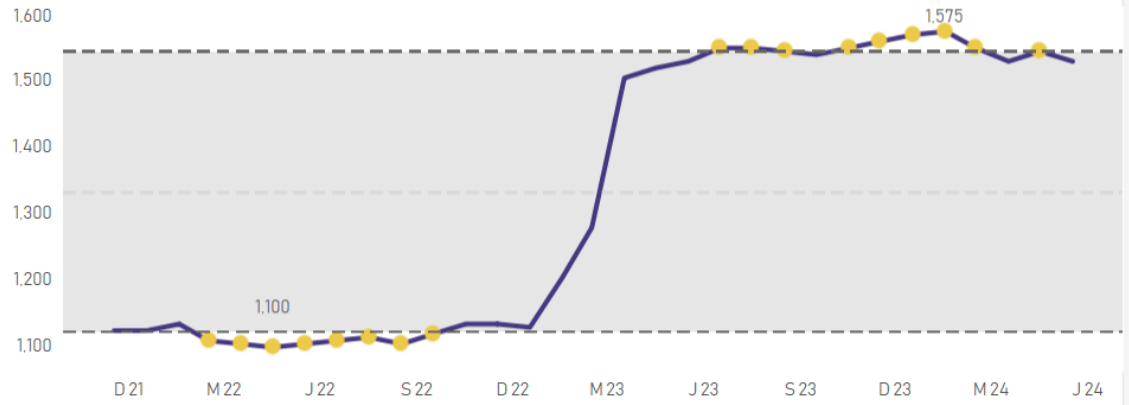
Bury

Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)

1,530	1,545	85/106	3,625
June 2024	May 2024	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22									1,125	1,125	1,135	1,110
2022-23	1,105	1,100	1,105	1,110	1,115	1,105	1,120	1,135	1,135	1,130	1,205	1,280
2023-24	1,505	1,520	1,530	1,550	1,550	1,545	1,540	1,550	1,560	1,570	1,575	1,550
2024-25	1,530	1,545	1,530									

Selected measure at June 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

The rate is calculated using the 18+ population figure for each locality | Bury: 166,400

Narrative

- There were 1530 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in June 24, less than May 24 (1545) but the exact same figure as June 23 (1530).
- Bury currently has 9.2 contacts per 1000 population and has the 5th lowest rate per 1000 for localities within GM.

Bury

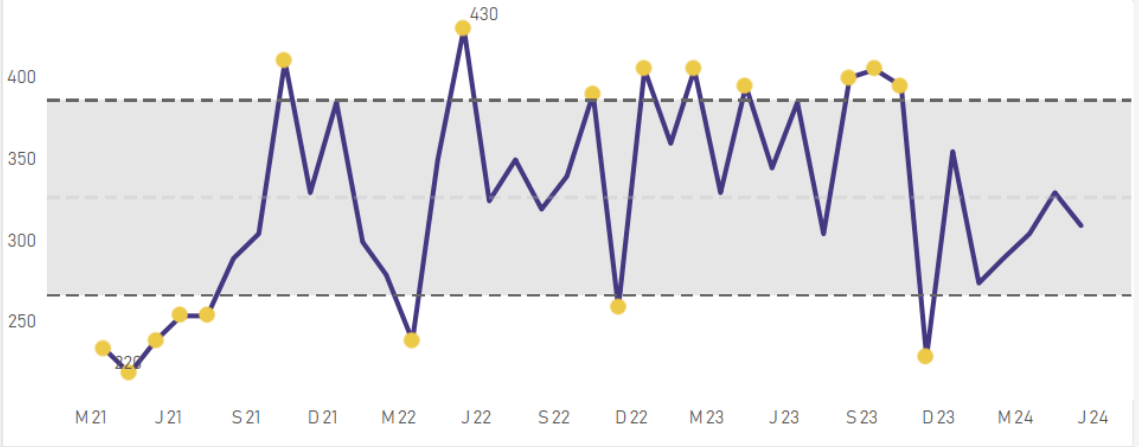
Talking Therapies: Access Rate

This indicator tracks our ambition to expand Improving Access to Psychological Therapies (IAPT) services, also known as NHS Talking Therapies. The primary purpose of this indicator is to measure improvements in access to psychological therapy (via IAPT) for people with depression and/or anxiety disorders.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

310	330	93/108	No Target
June 2024	May 2024	National Rank Lower Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	235	220	240	255	255	290	305	410	330	385	300	280
2022-23	240	350	430	325	350	320	340	390	260	405	360	405
2023-24	330	395	345	385	305	400	405	395	230	355	275	290
2024-25	305	330	310									

Selected measure at June 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)

Narrative

- There were 310 accesses to Talking Therapies for Bury registered patients in June 24, Lower than May 24 (330) and lower than June 23 (345)
- Bury currently has 1.5 accesses per 1000 population and has the 4th lowest rate per 1000 for localities within GM.

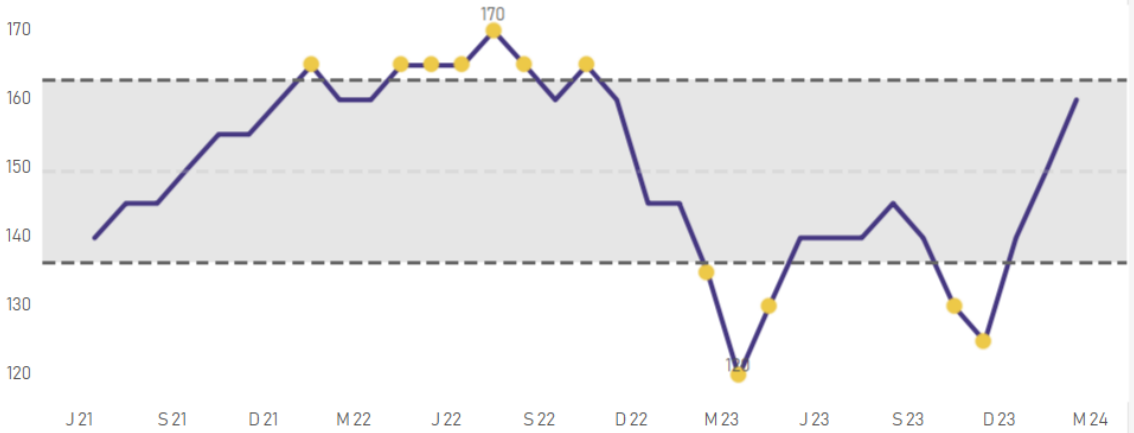
Bury

Women Accessing Specialist Community Perinatal Mental Health Services
Women Accessing Specialist Community Perinatal Mental Health Services (Rolling 12 mths)

Source: Published MHSDS (Quarterly)

160	150	91/107	No Target
March 2024	February 2024	National Rank Lower Quartile	

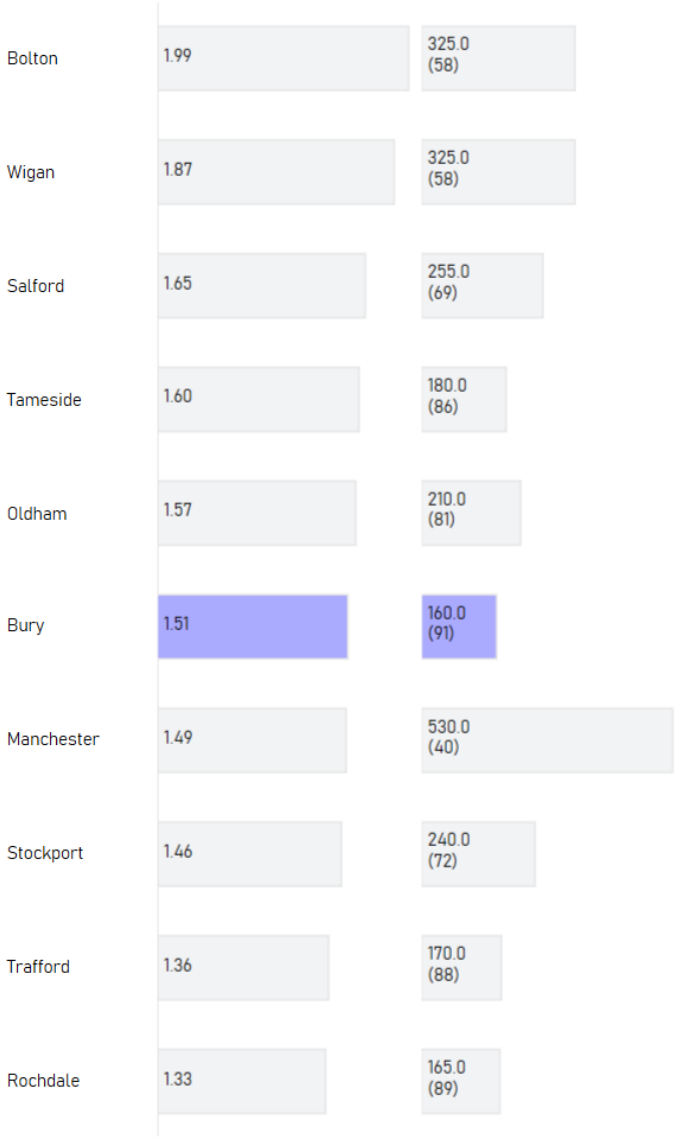
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	145	150	155	155	160	165	160
2022-23	160	165	165	165	170	165	160	165	160	145	145	135
2023-24	120	130	140	140	140	145	140	130	125	140	150	160

Selected measure at March 2024 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)



The rate is calculated using the female population figure for each locality | Bury: 105,754

Narrative

- There were 160 women accessing Perinatal Mental Health Services for Bury registered patients for the rolling 12 months to March 24, higher than March 23 (135).
- Bury currently has 1.51 accesses per 1000 population and has the 5th lowest rate per 1000 for localities within GM.

Bury

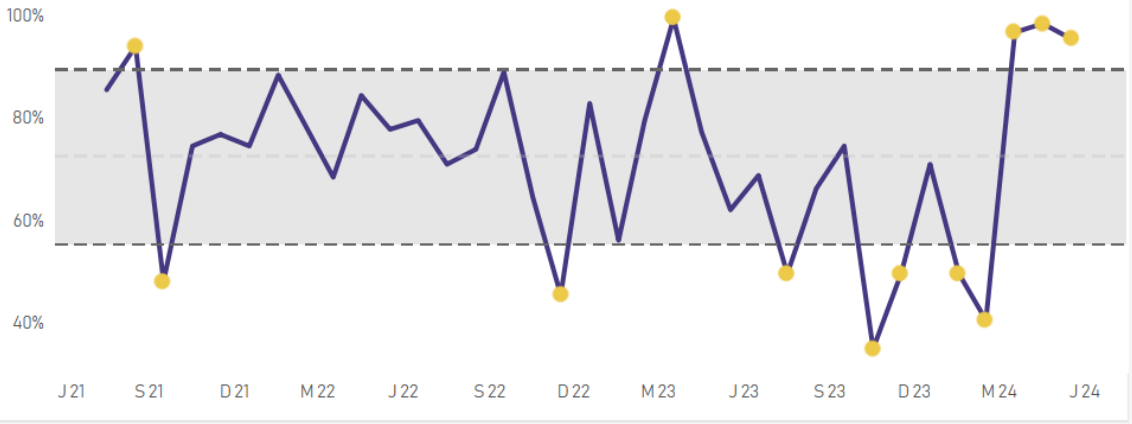
% 2-hour Urgent Community Response (UCR) first care contacts

Percentage of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standards

Source: Community Services Data Set (CSDS) (Monthly)

95.9%	99.0%	70%
June 2024	May 2024	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22					86.0%	94.5%	48.5%	75.0%	77.3%	75.0%	88.9%	79.4%
2022-23	68.9%	84.9%	78.3%	80.0%	71.4%	74.4%	89.5%	65.0%	45.8%	83.3%	56.5%	80.0%
2023-24	100.0%	77.8%	62.5%	69.2%	50.0%	66.7%	75.0%	35.3%	50.0%	71.4%	50.0%	40.9%
2024-25	97.3%	99.0%	95.9%									

Selected measure at June 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Narrative

- The percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in June 24 was 95.9%, which is an increase on June 23 which was 62.5%.
- Bury currently has a highest percentage than the other GM trusts and is currently above the National Target of 70%.
- Local authority reporting shows that 99.1% of Bury residents received a 2-hour response in June 24.

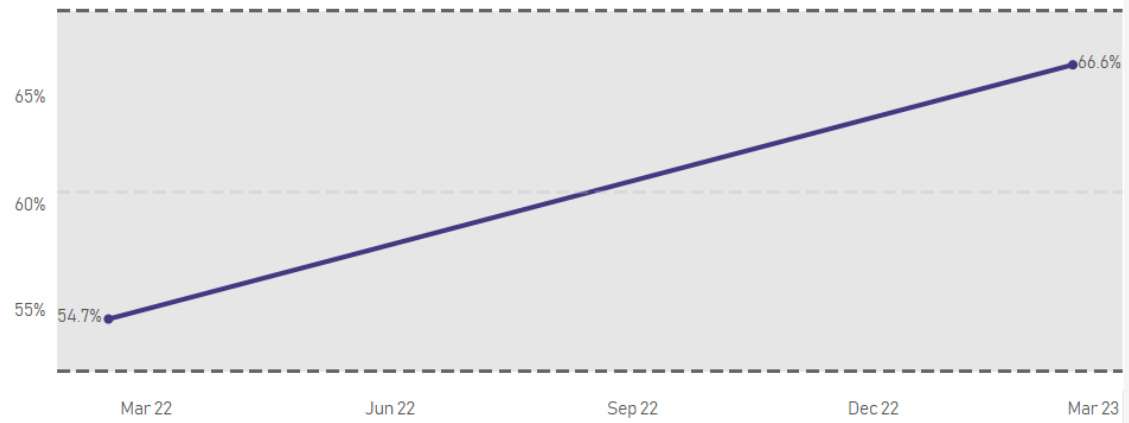
Bury

% of hypertension patients who are treated to target as per NICE guidance
% of hypertension patients who are treated to target as per NICE guidance

Source: NHS Quality Outcome Framework (Annual)

66.6%	54.7%	82/106	77.%
March 2023	March 2022	National Rank Lower Quartile	National Target

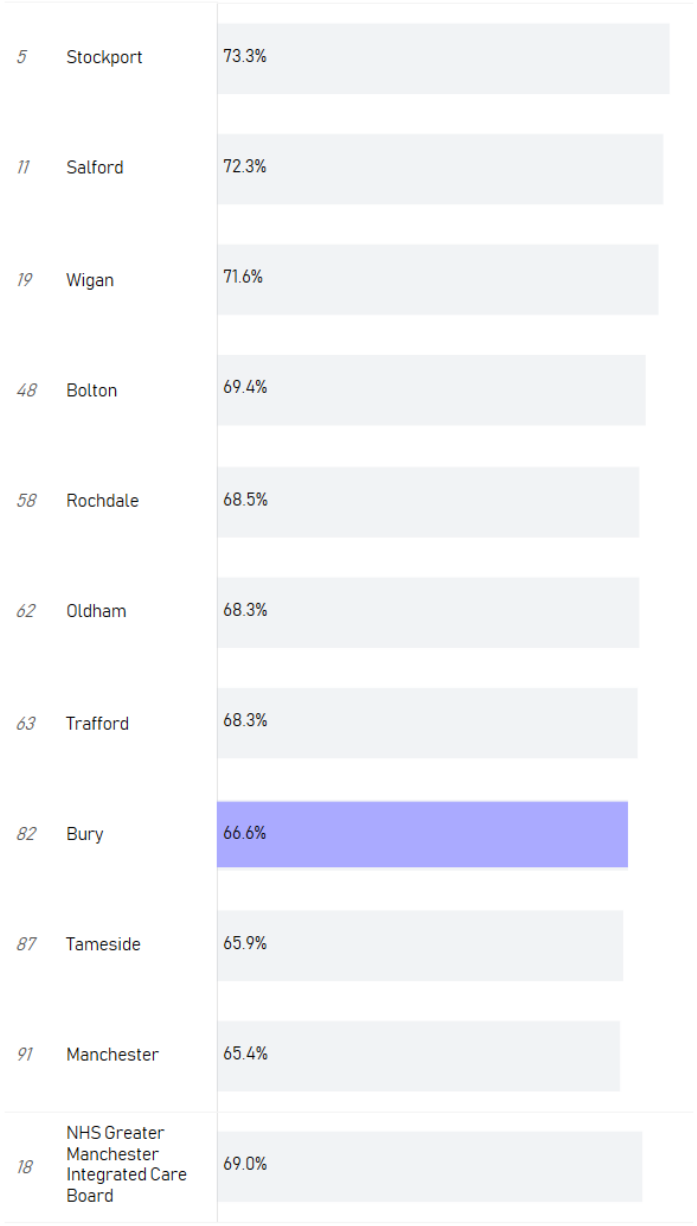
Outliers more than 1 standard deviation from the mean



	Mar
2021-22	54.7%
2022-23	66.6%

Selected measure at March 2023 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of hypertension patients treated to target as of March 23 is 66.6%, which is an increase on March 22 which was 54.7%.
- Bury currently has a lower percentage than GM which is 69.0% and Bury has the 3rd lowest percentage of the GM localities.
- Bury and GM are not currently meeting the national target of 77%.

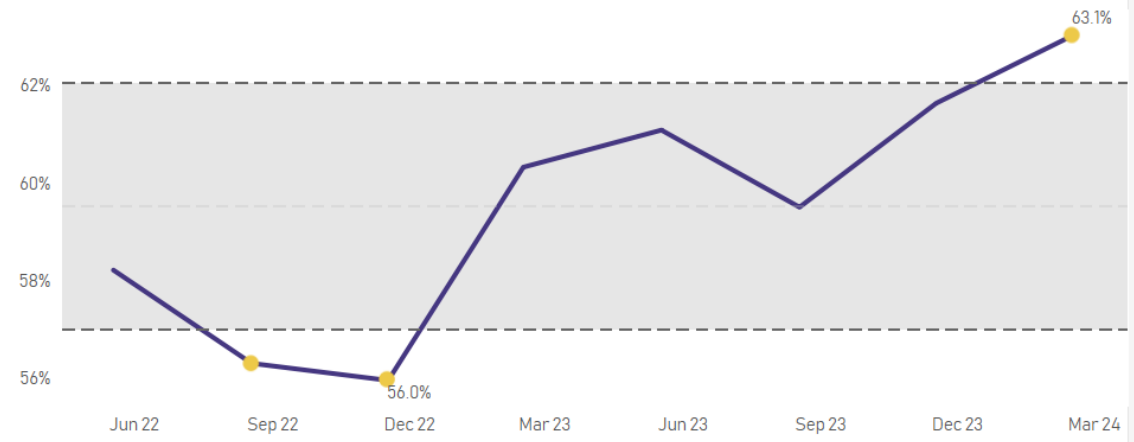
Bury

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins
% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins

Source: CVD Prevent (Quarterly)

63.1%	61.7%	39/106	62.1%
March 2024	December 2023	National Rank Inter Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	58.3%	56.3%	56.0%	60.4%
2023-24	61.1%	59.5%	61.7%	63.1%

Selected measure at March 2024 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

4	Tameside	69.7%
5	Oldham	69.6%
7	Manchester	68.8%
13	Trafford	67.0%
14	Rochdale	66.9%
25	Salford	65.6%
32	Stockport	63.7%
39	Bury	63.1%
40	Wigan	63.0%
46	Bolton	62.6%
6	NHS Greater Manchester Integrated Care Board	66.0%

Narrative

- The percentage of patients identified as having 20% or greater 10-year risk of developing CVD as of March 24 is 63.1%, which is an increase on March 23 which was 60.4%

- Bury currently has a lower percentage than GM which is 66.0% and Bury has the 3rd lowest percentage of the GM localities.

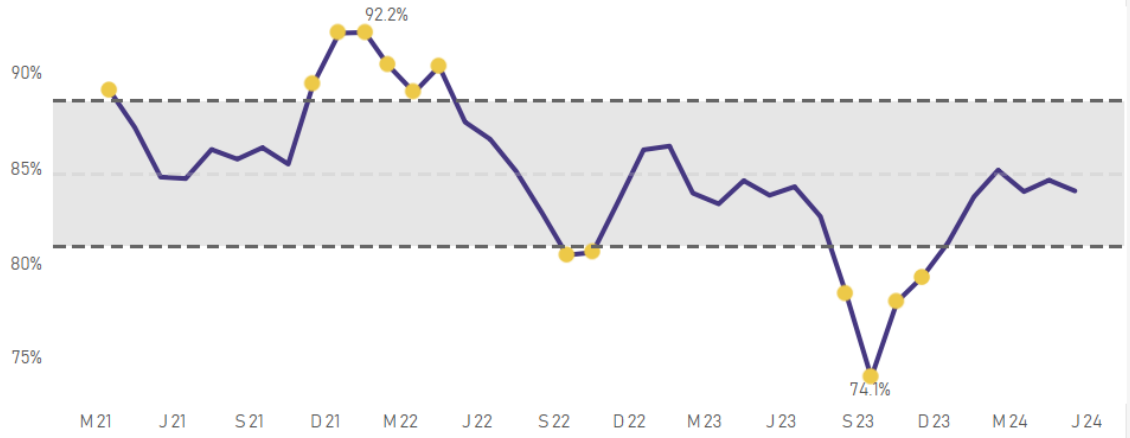
Bury

GP appointments - percentage of regular appointments within 14 days
Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'

Source: Appointments in General Practice (Monthly)

83.9%	84.5%	36/106	82.1%
June 2024	May 2024	National Rank Inter Quartile	National Median

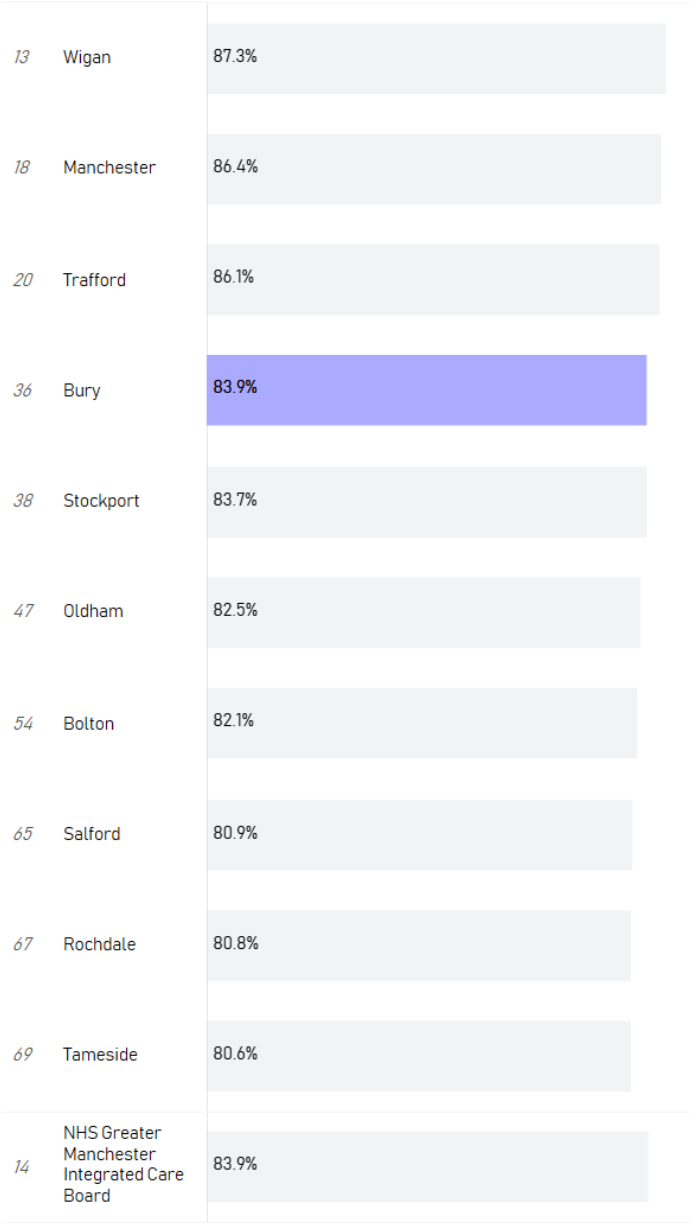
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	89.2%	87.2%	84.6%	84.6%	86.1%	85.6%	86.2%	85.3%	89.5%	92.2%	92.2%	90.5%
2022-23	89.1%	90.5%	87.5%	86.6%	85.0%	82.8%	80.5%	80.7%	83.3%	86.1%	86.3%	83.8%
2023-24	83.2%	84.4%	83.7%	84.1%	82.6%	78.5%	74.1%	78.1%	79.4%	81.2%	83.6%	85.0%
2024-25	83.9%	84.5%	83.9%									

Selected measure at June 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of GP appointments taking place within 14 days of booking in June 24 for the Bury population was 83.9%, which is a slight increase on June 23 which was 83.7%.
- Bury currently has the same percentage as GM which is 83.9% and is the 4th highest percentage of the GM localities.

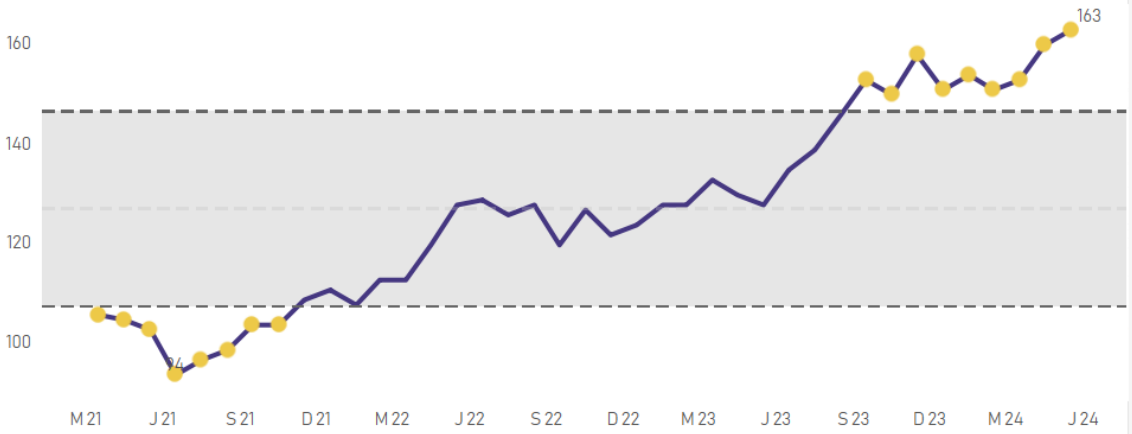
Bury

E. coli blood stream infections
12-month rolling counts of E. coli blood stream infections

Source: National Statistics: E. coli bacteraemia: monthly data by location of onset (Monthly)

163	160	25/107	No Target
June 2024	May 2024	National Rank Upper Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	106	105	103	94	97	99	104	104	109	111	108	113
2022-23	113	120	128	129	126	128	120	127	122	124	128	128
2023-24	133	130	128	135	139	146	153	150	158	151	154	151
2024-25	153	160	163									

Selected measure at June 2024 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

Bolton	0.53	175.0 (27)
Rochdale	0.57	142.0 (19)
Wigan	0.57	200.0 (38)
Salford	0.59	188.0 (30)
Manchester	0.61	443.0 (69)
Trafford	0.64	160.0 (24)
Oldham	0.67	179.0 (28)
Bury	0.77	163.0 (25)
Stockport	0.77	253.0 (47)
Tameside	0.85	192.0 (33)

Narrative

- There were 163 counts of E. Coli blood stream infections in the rolling 12 months to June 24, which is higher than June 23 (128).
- Bury currently has 0.77 counts per 1000 population and has the 8th highest rate per 1000 matching Stockport for localities within GM.

Bury

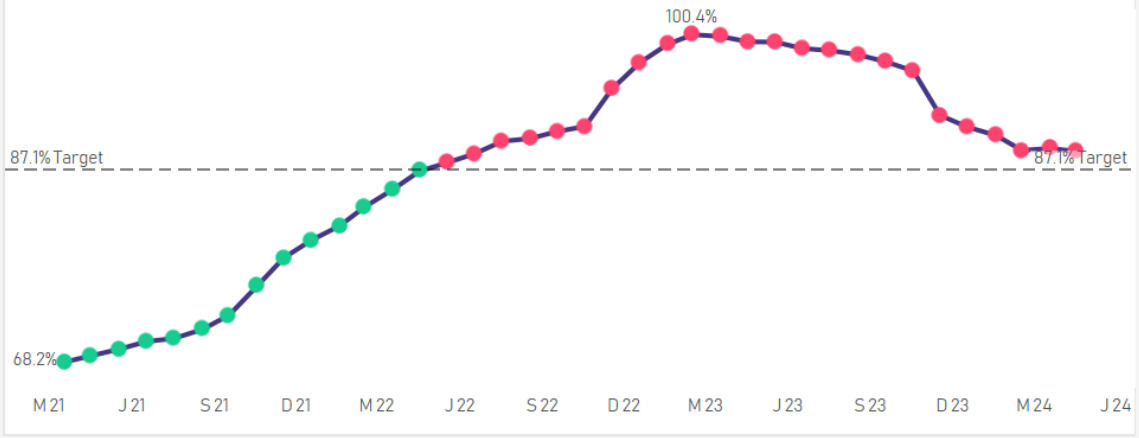
Antimicrobial resistance: total prescribing of antibiotics in primary care

The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU

Source: EPACT Prescribing Data (Monthly)

88.9%	89.2%	87.1%
May 2024	April 2024	National Target

Performance Against National Target of 87.1%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	68.2%	68.8%	69.5%	70.2%	70.6%	71.4%	72.8%	75.7%	78.5%	80.2%	81.6%	83.5%
2022-23	85.2%	87.0%	87.8%	88.7%	89.9%	90.2%	90.9%	91.4%	95.0%	97.6%	99.4%	100.4%
2023-24	100.2%	99.7%	99.6%	99.0%	98.8%	98.4%	97.7%	96.8%	92.5%	91.3%	90.5%	89.0%
2024-25	89.2%	88.9%										

Selected measure at May 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Narrative

- The percentage of total prescribing of antibiotics in primary care in May 24 for the Bury population was 88.9%, which is lower than May 23 which was 99.7%.
- Bury currently has a lowest percentage of the GM localities.

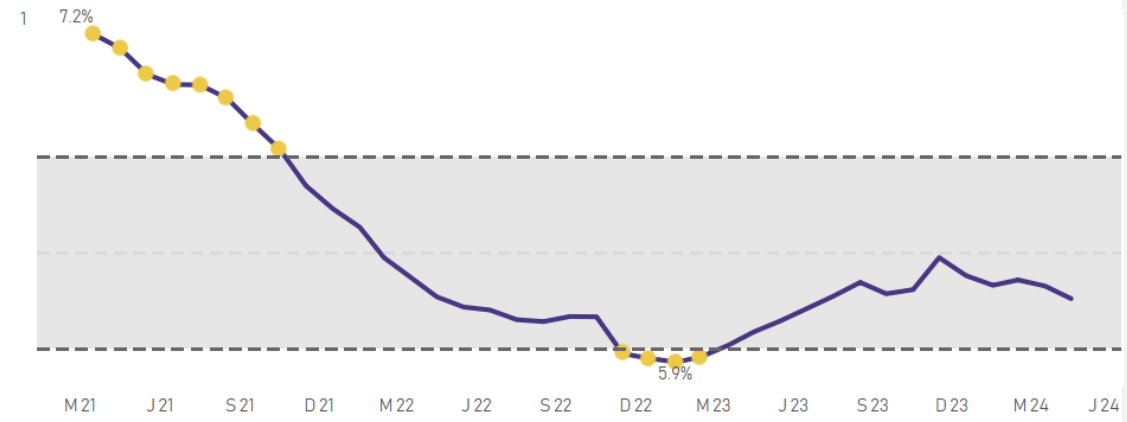
Bury

Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care
The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)

6.1%	6.2%	27/110	10.%
May 2024	April 2024	National Rank Upper Quartile	National Target

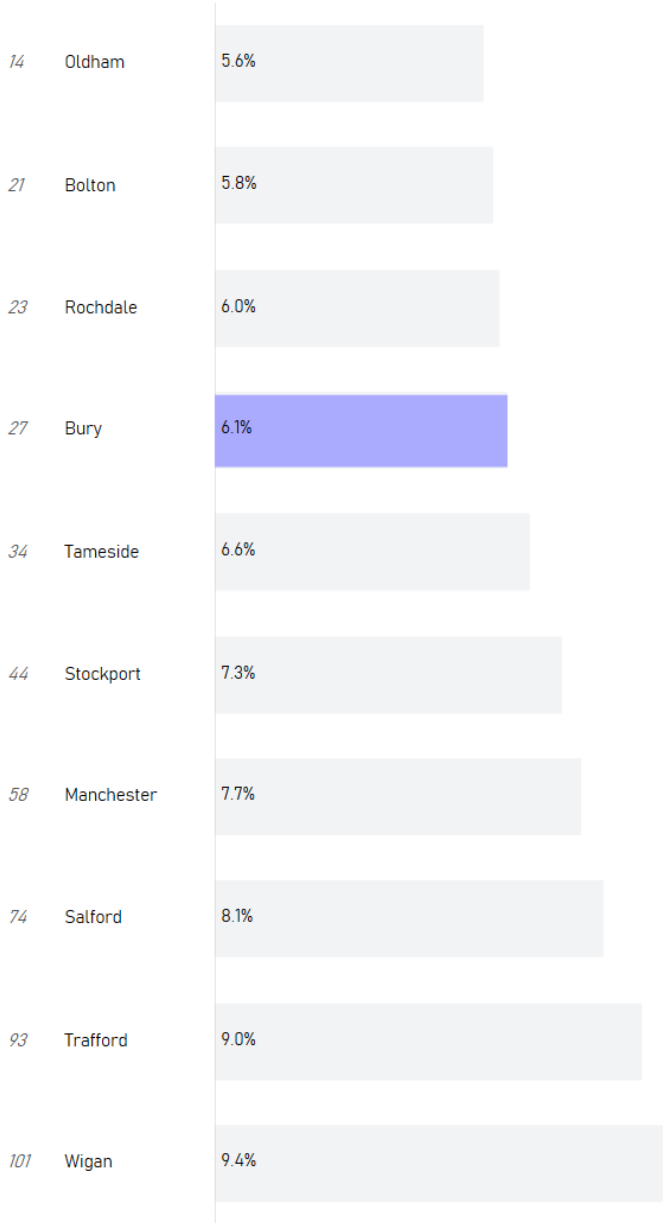
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%										

Selected measure at May 2024 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of broad-spectrum antibiotic prescribing in primary care in May 24 for the Bury population was 6.1%, which is an increase on May 23 which was 6.0%.
- Bury currently has the 4th lowest percentage of the GM localities.
- Bury is within the less than 10% target.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Elective Care	EB28	Diagnostics: % waiting 6 weeks+	Monthly	Jun 24	16.4%	15.1%	↗	1.%	723	4,412	Inter
	EB20	RTT incomplete: 65+ week waits	Monthly	Jun 24	218.0	190.0	↗	0.	218	N/A	Inter
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Monthly	Jun 24	75.9%	78.8%	↘	75.%	724	954	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 22	0.0	1.9	↘	1.5	0	2,014	Upper
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 22	4.0	3.8	↗	3.2	8	2,014	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 23	69.2%	70.0%	↘	N/A	15,249	22,036	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Mar 24	85.8%			95.%	513	598	Inter
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Mar 24	70.6%	70.4%	↗	80.%	38,155	54,020	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 23	75.1%	74.6%	↗	85.%	28,212	37,584	Lower

Bury - Sight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Cancer	Total patients waiting over 62 days to begin cancer treatment vs target	Build in progress
LD and Autism	Inpatients with a learning disability and/or autism per million head of population	Build in progress
Primary Care and Community Services	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Build in progress
Screening and immunisation	Bowel screening, aged 60-74, screened in the last 30 months	DQ issues

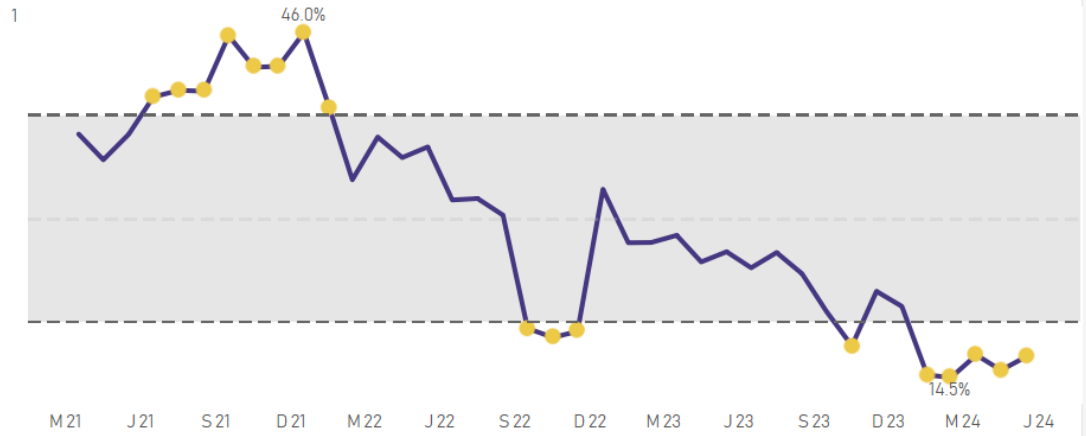
Bury

Diagnostics: % waiting 6 weeks+
Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over.

Source: Monthly Diagnostics Waiting Times and Activity Return - DM01 (Monthly)

16.4%	15.1%	37/107	1.%
June 2024	May 2024	National Rank Inter Quartile	National Target

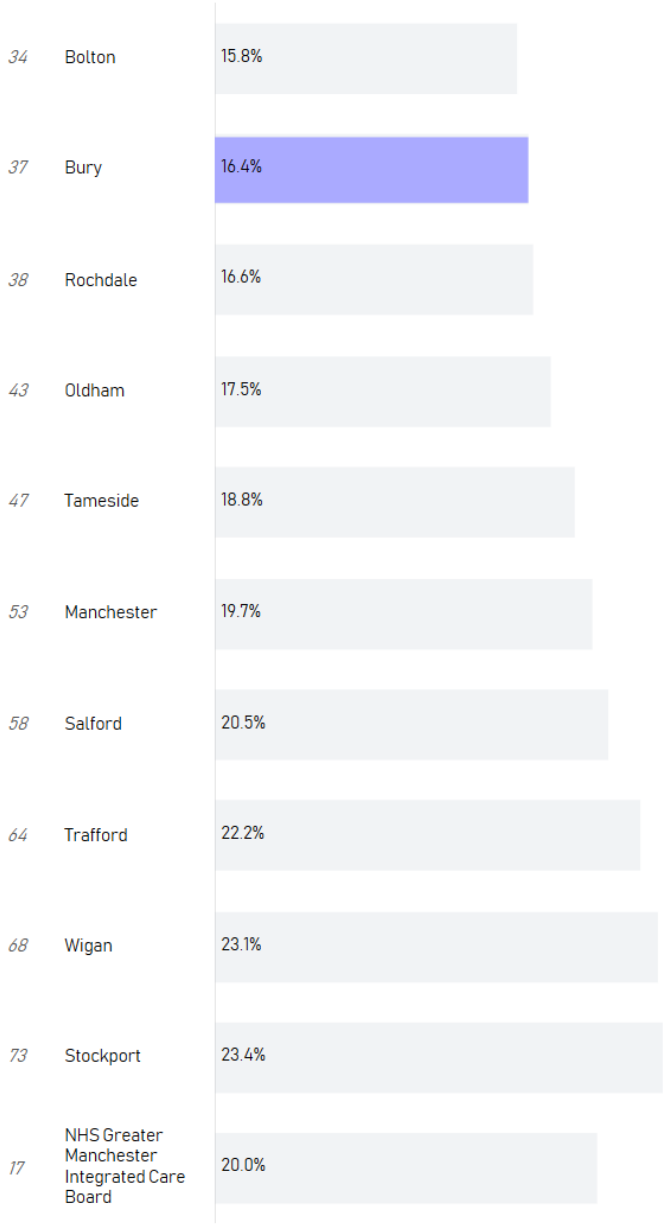
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%									

Selected measure at June 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- June 24 performance of 16.4% of patients waiting more than six weeks, this is a decrease on the June 23 figures (26.0%).
- Burys performance is better than GM's performance of 20.0% in June 24.
- Bury performance is the second best in GM.
- Bury and GM are both above the less than 1% target.

Bury

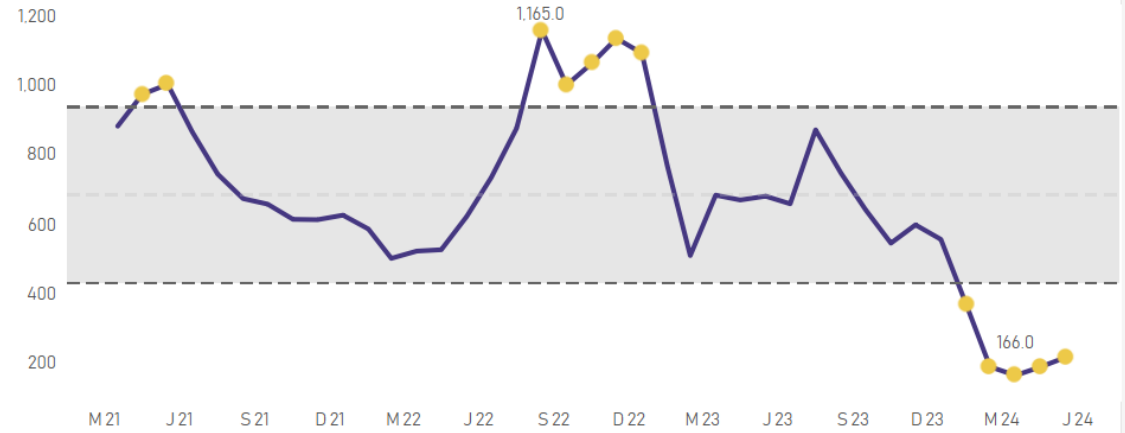
RTT incomplete: 65+ week waits

"The number of 65+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS.
The definitions that apply for RTT waiting times, as well as guidance on recording and reporting RTT data, can be found on the NHS England and NHS Improvement Consultant-led referral to treatment waiting times rules and guidance webpage."

Source: Consultant-led RTT Waiting Times data collection (National Statistics). (Monthly)

218.0	190	52/121	0.
June 2024	May 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

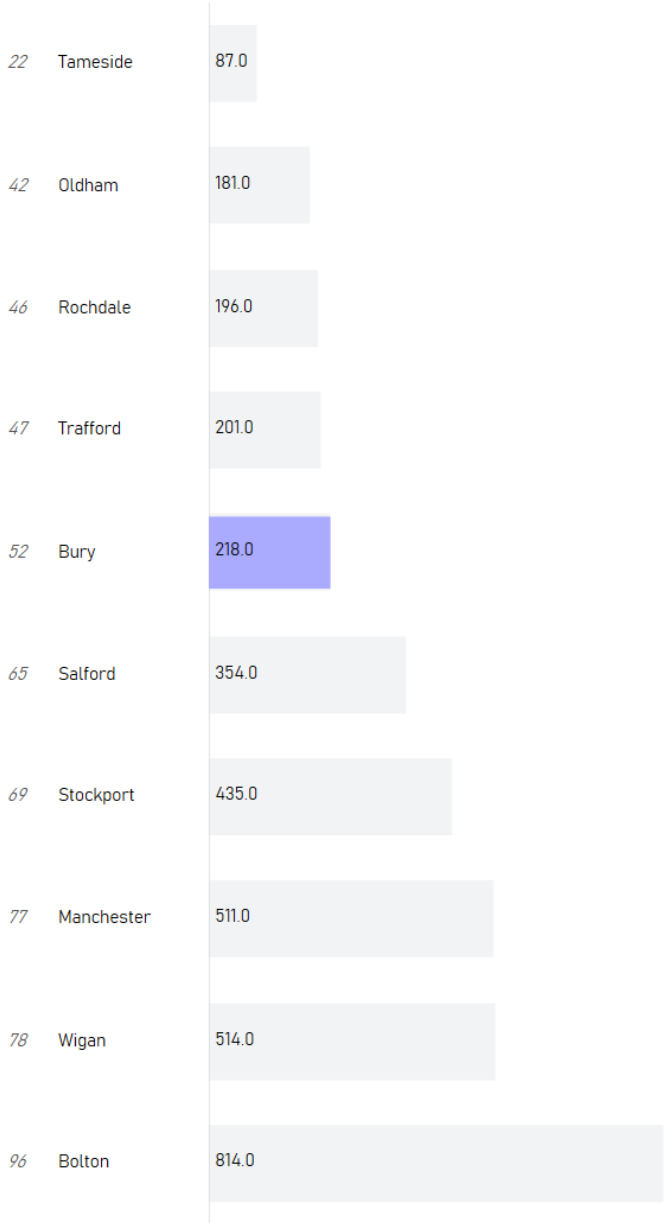


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218									

Selected measure at June 2024 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Published June 24 data shows an increase in 65+ Week Waits from May 24 (28 pathways). There was a large decrease in pathways in June 24 with 218 Pathways, Compared to June 23 685 pathways (- 467 Pathways)
- In June 24 Oral Surgery showing the highest increase with an extra10 pathways in June 24 when compared to May 24, Gynaecology Services also had an increase of 9 pathways.
- Dermatology Service had the largest decrease in pathways from 26 pathways in May 24 to 16 pathways in June 24.
- Bury locality currently has the 5th lowest number of 65+ Week waits out of all the GM localities.

Bury

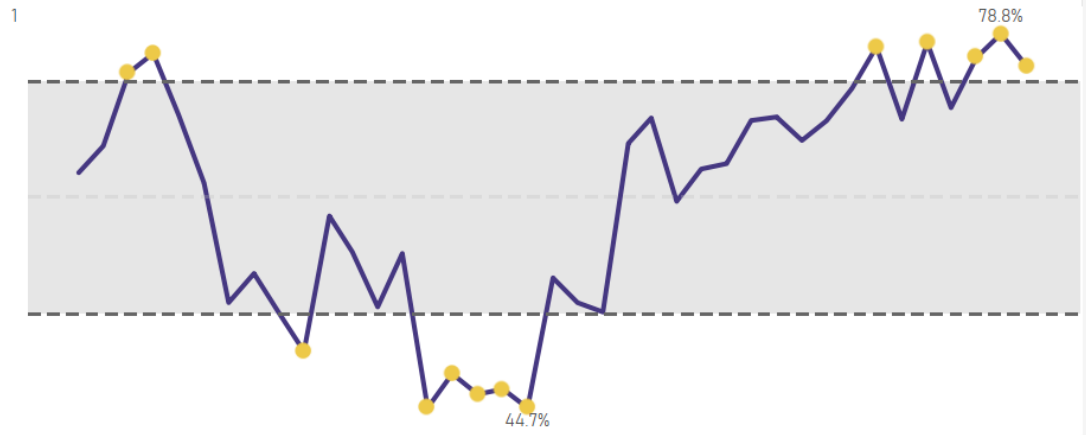
28 Day Wait from Referral to Faster Diagnosis: All Patients

Proportion of patients told cancer diagnosis outcome within 28 days of their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral

Source: National Cancer Waiting Times Monitoring Data Set (CWT) (Monthly)

75.9%	78.8%	69/114	75.%
June 2024	May 2024	National Rank Inter Quartile	National Target

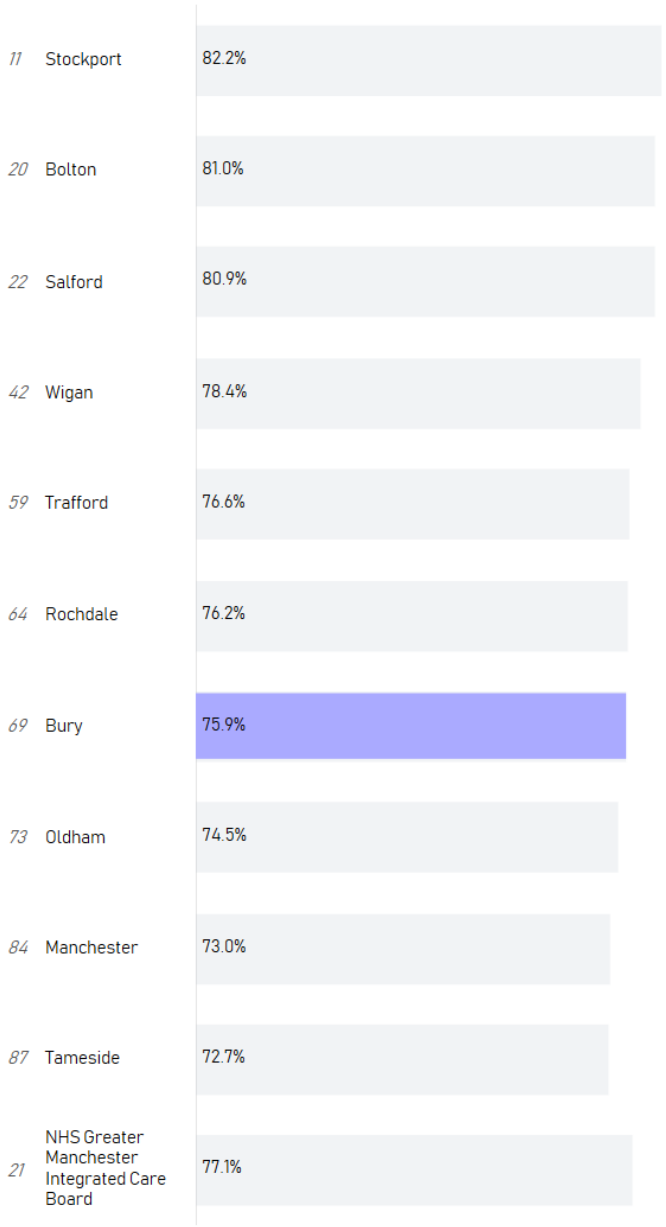
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	66.2%	68.6%	75.2%	77.0%	71.4%	65.2%	54.3%	57.0%	53.4%	49.9%	62.2%	58.9%
2022-23	53.9%	58.8%	44.7%	47.8%	46.0%	46.4%	44.7%	56.6%	54.3%	53.5%	68.8%	71.1%
2023-24	63.5%	66.5%	67.0%	70.9%	71.2%	69.1%	70.9%	73.8%	77.6%	71.0%	78.0%	72.1%
2024-25	76.6%	78.8%	75.9%									

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in June 24 for the Bury population was 75.9%, which is an increase on June 23 which was 67.0%.
- Bury locality currently has the 7th Highest performance out of all the GM localities.
- GM performance is currently 77.1%
- Bury is currently meeting the target of 75% or greater.

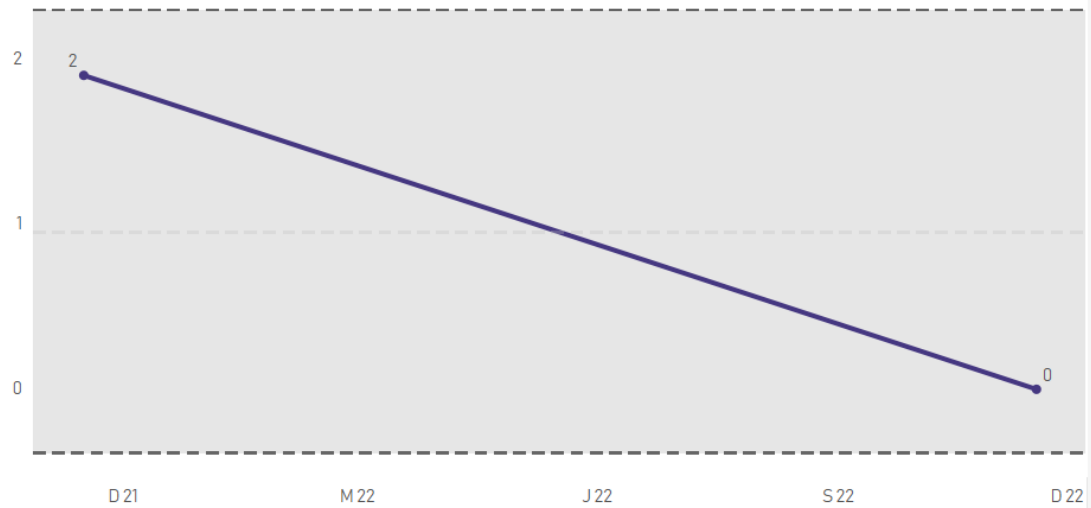
Bury

Number of neonatal deaths per 1,000 total live births
Number of neonatal deaths per 1,000 total live births

Source: MBRRACE-UK - Perinatal Mortality Surveillance Report (Annual)

0.0	1.9	1/150	1.5
December 2022	December 2021	National Rank Upper Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Dec
2021-22	1.9
2022-23	0.0

Latest Value GM Benchmarking
National Rank against other localities

Narrative

- The number of neonatal deaths per 1000 live births as of December 22 for the Bury population was 0.0
- Bury locality currently has the lowest rate per 1000 out of all the GM localities, alongside Rochdale.

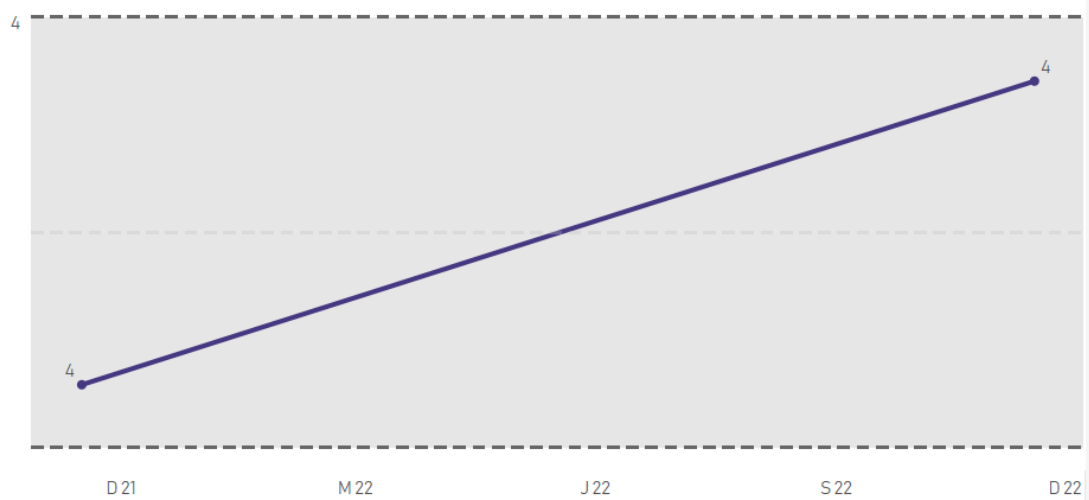
Bury

Number of stillbirths per 1,000 total births
Number of stillbirths per 1,000 total births

Source: MBRRACE-UK - Perinatal Mortality Surveillance Report (Annual)

4.0	3.8	110/150	3.2
December 2022	December 2021	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Dec
2021-22	3.8
2022-23	4.0

Latest Value GM Benchmarking
National Rank against other localities

Narrative

- The number of neonatal still births per 1000 births as of December 22 for the Bury population was 4.0
- Bury locality currently has the 4th highest rate per 1000 out of all the GM localities.

Bury

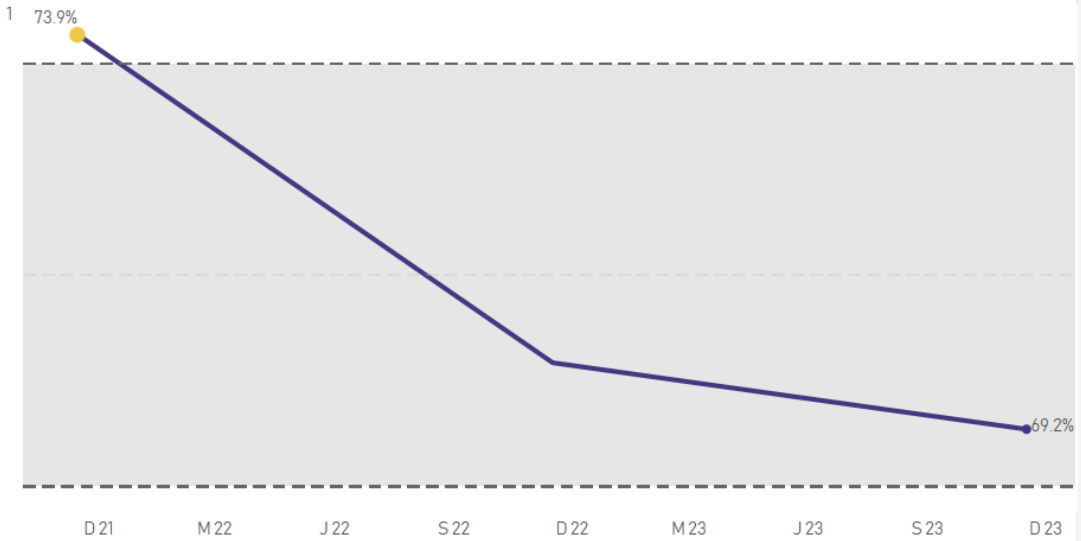
Breast screening coverage, females aged 53-70, screened in last 36 months

3-year screening coverage %: The number of females registered to the practice screened adequately in previous 36 months divided by the number of eligible females on last day of the review period

Source: Fingertips, Public Health Data, Public Health Outcomes Framework (Annual)

69.2%	70.0%	60%
December 2023	December 2022	No Target

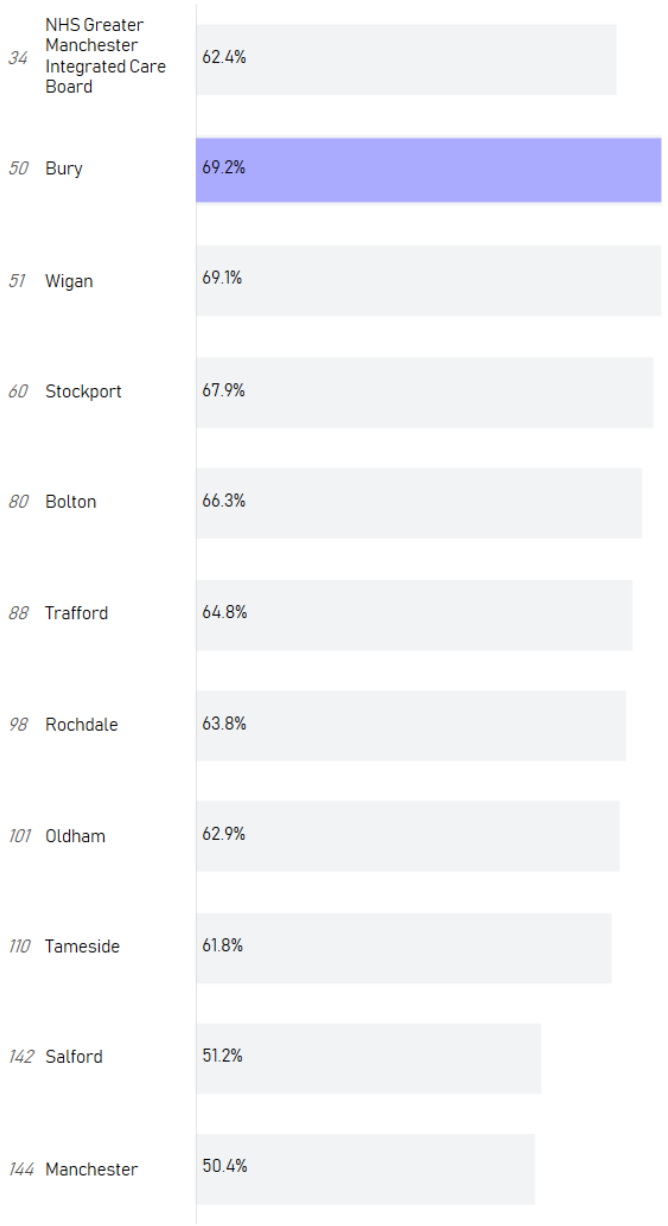
Outliers more than 1 standard deviation from the mean



	Dec
2021-22	73.9%
2022-23	70.0%
2023-24	69.2%

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The 3-year breast screening coverage to December 23 for the Bury population was 69.2% for eligible females.
- Bury locality currently has the highest percentage out of all the GM localities and is higher than the GM percentage of 62.4%.

Bury

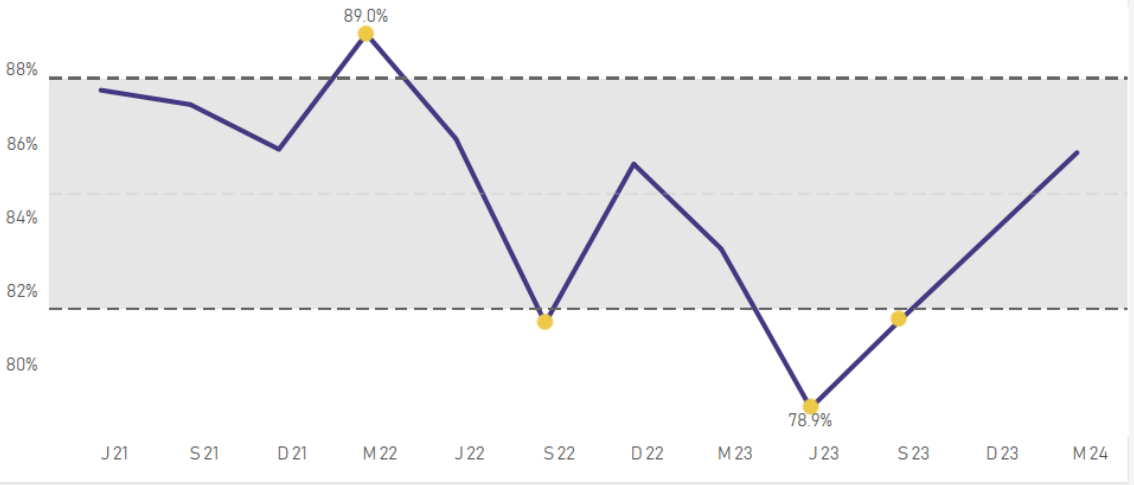
COVER immunisation: MMR2 Uptake at 5 years old
Population vaccination coverage – MMR for two doses (5 years old)

Source: Cover of vaccination evaluated rapidly (COVER) programme (Quarterly)

85.8%
March 2024

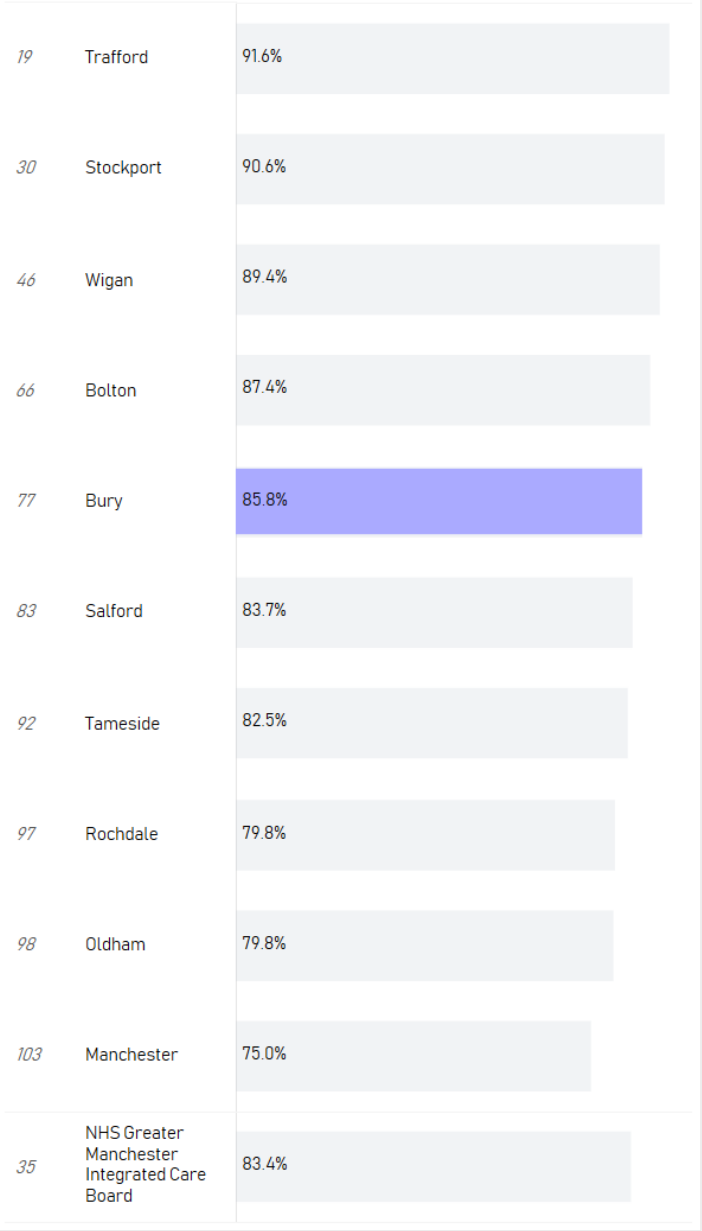
95.%
National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	87.5%	87.1%	85.9%	89.0%
2022-23	86.2%	81.2%	85.5%	83.2%
2023-24	78.9%	81.3%		85.8%

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of MMR2 uptake at 5 years old as of March 24 is 85.8%, which is an increase on March 23 which was 83.2%
- Bury currently has a higher percentage than GM which is 83.4% and Bury has the 6th lowest percentage of the GM localities.
- Bury and GM are not meeting the national target of 95%.

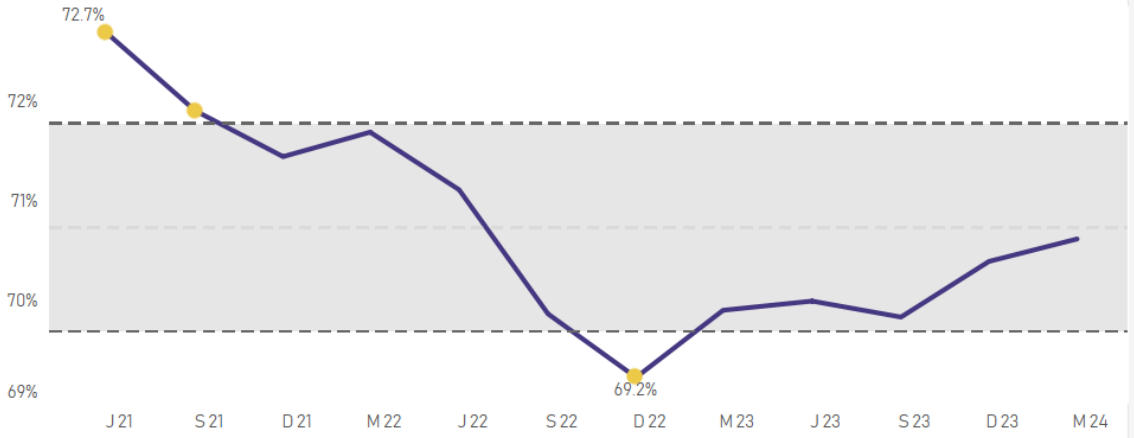
Bury

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)
The overall cervical screening coverage: the number of women screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64) divided by the number of eligible women on last day of review period.

Source: Cervical Screening Programme - Coverage Statistics [Management Information] (Quarterly)

70.6%	70.4%	69/106	80.%
March 2024	December 2023	National Rank Inter Quartile	National Target

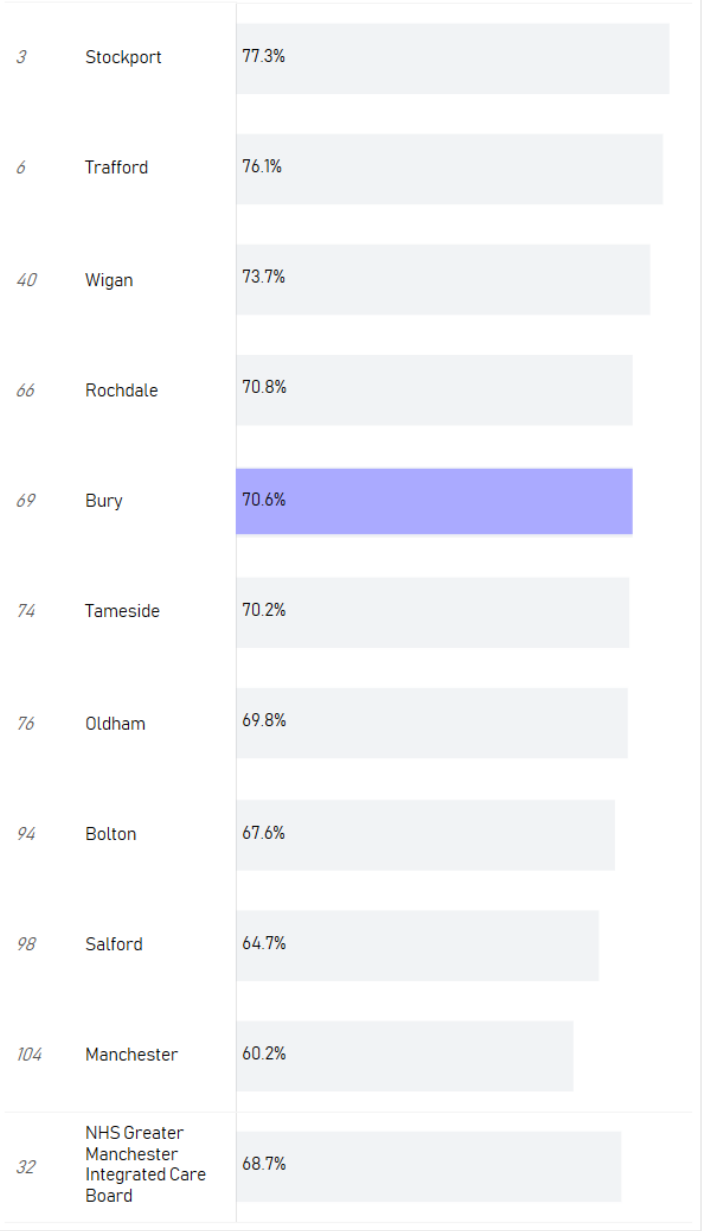
Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%

Selected measure at March 2024 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The cervical screening coverage to March 24 for the Bury population was 70.6% for eligible females.
- Bury locality currently has the 5th highest percentage out of all the GM localities and is higher than the GM percentage of 68.7%.
- Bury and GM are not meeting the national target of 80%.

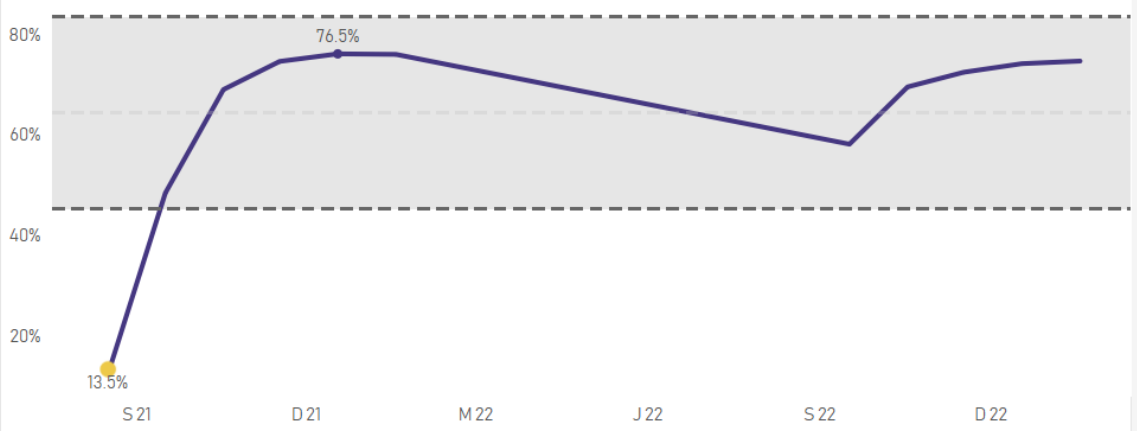
Bury

Seasonal Flu Vaccine Uptake: 65 years and over
The uptake of seasonal influenza vaccination among those aged 65 and over

Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 (Monthly)

75.1%	74.6%	86/97	85.%
February 2023	January 2023	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%

Selected measure at February 2023 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

2	Stockport	85.6%
32	Trafford	82.5%
65	Wigan	79.8%
71	Oldham	78.8%
74	Rochdale	78.0%
75	Bolton	78.0%
83	Tameside	76.1%
84	Salford	75.7%
86	Bury	75.1%
95	Manchester	69.8%
31	NHS Greater Manchester Integrated Care Board	78.0%

Narrative

- The seasonal influenza vaccination uptake to February 23 for the Bury population was 75.1% for those aged 65+.
- Bury locality currently has the 2nd lowest uptake out of all the GM localities and is lower than the GM percentage of 78.0%.
- Bury and GM are not meeting the national target of 85%.

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
Urgent Care	S123a	Adult general & acute bed occupancy adjusted for void beds (Type 1 Only)	Percentage of general and acute (G&A) day beds occupied (adjusted for covid void beds).	UEC Daily Sitrep	Monthly	Mar 24	1st	National Median	Decrease
	EM11	Total number of specific acute non-elective spells	Count of spells	National Flows APC	Monthly	Jul 24	1st	National Median	Decrease
	N/A	A&E Attendances	Number of attendances at A&E	Emergency Care Dataset (ECDS)	Monthly	Jul 24	1st	No Target	Decrease
	N/A	A&E 4 hour performance	A&E attendances seen within 4hrs	Emergency Care Dataset (ECDS)	Monthly	Jul 24	1st	No Target	Increase
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Null	GM Admissions - Local	Monthly	Jul 24	1st	No Target	Decrease
Elective Care	EM07	Total Referrals Made (General and Acute)	Total GP & Other Referrals made for 1st Consultant led OP appointments in specific acute treatment functions	Monthly Referral Return (MRR)	Monthly	Mar 24	2nd Thursday	National Median	Increase
	EM07a	GP Referrals Made (General and Acute)	Total GP Referrals made for 1st Consultant led OP appointments in specific acute treatment functions	Monthly Referral Return (MRR)	Monthly	Mar 24	2nd Thursday	National Median	Increase
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	Cancer Early Staging Data Statistics via The National Disease Registration Servi..	Annual	Dec 21	2nd Thursday	National Median	Increase
Mental Health & Learning Disabiliti..	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	Mar 24	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Jun 24	2nd Thursday	No Target	Increase
	EA0S1	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Jul 24	2nd Thursday	National Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Jul 24	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Jun 24	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in ..	Published MHSDS	Monthly	Jun 24	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Jun 24	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Jun 24	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Mar 24	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Jul 24	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Jul 24	1st	No Target	Decrease
Commun..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	Jun 24	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 23	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	Jun 24	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Mar 24	2nd Thursday	National Median	Increase
Quality	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by location of onset	Monthly	Jun 24	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	May 24	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	May 24	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code		Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	2	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Jun 24	National Target	0
	146	EB28	Diagnostics: % waiting 6 weeks+	Number waiting over 6 weeks/Total waiting	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Jun 24	National Target	1%
Cancer	62	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Jun 24	National Target	75%
Maternity	230	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 22	National Median	3
	460	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 22	National Median	1
Screening and Immunisations	150	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 23	National Target	85%
	468	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Mar 24	National Target	95%
	473	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme - Coverage Statistics [Management Information]	Quarterly	Mar 24	National Target	80%
	499	S048a	Bowel screening coverage, aged 60-74, screened in last 30 months	% of eligible men and women, age 60-74 yrs, with an adequate screening result in previous 30 mths	NHS population screening programmes: KPI reports	Quarterly	Sep 23	National Target	60%
	514	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 23	No Target	

PIA Locality Report

File created on: 8/16/2024 8:30:41 AM

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 September 2024	**Action**	Receive
Item No.	19	**Confidential**	No
Title	Clinical & Professional Senate Update		
Presented By	Kiran Patel		
Author	Kiran Patel		
Clinical Lead	Kiran Patel		

Executive Summary
This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place in August 2024.
Recommendations
The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

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	☐

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

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

BURY INTEGRATED CARE PARTNERSHIP

Clinical and Professional Senate Highlight Report – August 2024

1. Introduction

This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place on 28th August 2024.

Agenda

Skin Cancer Referrals - Commissioning Team and NCA

a. Substantial increase in referrals from Bury and HMR - Bury has 2nd highest increase in 2ww referrals at 42% increase
b. However, 5th highest 2ww referral per 100k population
c. Conversion rate - referrals that turn out to be cancer is the 2nd highest at 14%. Although really good should be lower.
d. Some variation at practice level - probably in line with deprivation and ethnicity
e. Current provider (NCA) unable to meet demand
f. New model being designed
   - single point of access - new software will be required
   - dynamic referral template
   - teledermatology - building on pilot undertaken in Bury
   - expanded community offer - Only 6 out 10 localities have a Tier 2 service - procurement of a single service to cover all localities
g. This shows that primary care is performing well but there is insufficient capacity for referrals
h. Increasing incidence - public health messages; sunbeds
i. However, mortality not changing.

2. Shanley Report - Catherine Jackson

a. Report shared with Senate including recommendations
b. Professionals need to have remain open to feedback from patients about services

3. Death Certification Process - Cathy Fines

a. New process comes into place on the 9th September
b. Independent Medical Examiner (ME) will review all deaths - pilot has been in place for several months in Bury

i. Implement recommendations from the Shipman Inquiry
ii. reduce (unnecessary) referrals to Coroner
iii. interim voluntary solution in place for faith deaths over the weekend - with weekend provision of ME.
iv. However, not all GPs will be available over weekend

4. Major Conditions Board - Kath Wynne-Jones

a. rational for the board and high level priorities shared
b. links with wider system including primary care and neighbourhoods described
c. Transformation work described

5. GM Updates - Cathy Fines & Salina Callighan

    a. shared minutes and feedback from
    b. GM Procedures of low clinical value
    c. GM Clinical and Professional Leadership Group
    d. GM Medicines Management Group (GMMMG)

2 Recommendations

2.1 The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

Kiran Patel
Medical Director IDCB
kiran.patel5@nhs.net
August 2024