NHS
Bury
Clinical Commissioning Group

Meeting: Strategic Commissioning Board

Meeting Date	07 December 2020	**Action**	Consider
Item No.	12	**Confidential**	No
Title	Consideration of future arrangements for the provision of Community Health Care Services		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning Julie Gonda, Director of Community Commissioning		
Author	Julie Gonda, Director of Community Commissioning		
Clinical Lead	Howard Hughes		

Executive Summary

This paper sets out the background to how the current provision of community services came into being and summarises the considerable work which has taken place to develop strong local collaborative provider working across the sector.

It introduces the current contract which enables the community services to be delivered through the Northern Care Alliance and makes the case for the critical time currently required in order to develop a confidence to specify and commission the community services for the future.

This paper makes a recommendation to continue the current service model for a further year, being supported through an award of an interim contract for 12 months.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Support the proposal to award a further interim contract for a period of 12 months from 1 July 2021 to 20 June 2022, with a potential for a further 12 month extension. Enacting any extension beyond June 2022 would be brought back to SCB for approval;
- Agree that the interim contract should take the form of a direct award to the Northern Care Alliance in line with the current arrangements in place;
- Authorise for the publishing of a Contract Award Notice through OJEU to ensure lawful compliance in regard to market transparency.

Links to CCG Strategic Objectives	
SO1 People and Place To enable the people of Bury to live in a place where they can co-create their own good health and well-being and to provide good quality care when it is needed to help people return to the best possible quality of life	☒
SO2 Inclusive Growth To increase the productivity of Bury's economy by enabling all Bury people to contribute to and benefit from growth by accessing good jobs with good career prospects and through commissioning for social value	☐
SO3 Budget To deliver a balanced budget for 2020/21	☒
SO4 Staff Wellbeing To increase the involvement and wellbeing of all staff in scope of the OCO.	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	

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:						
The EIA has been completed and signed off.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Finance Contracting & Procurement Committee	19/11/2020	The Committee supported the paper, but requested that any further extension beyond June 2022 is re-presented to the Committee for sign off.

1. Purpose

This paper sets out the background to how the current provision of community services came into being and summarises the considerable work which has taken place to develop strong local collaborative provider working across the sector.

It introduces the current contract which enables the community services to be delivered through the Northern Care Alliance and makes the case for the critical time currently required in order to develop a confidence to specify and commission the community services for the future.

This paper makes a recommendation to continue the current service model for a further year, being supported through an award of an interim contract for 12 months.

Informal discussions around the approach outlined within the paper have taken place with NHSE and NHS Shared Services.

2. Background

In 2010, national policy for Transforming Community Health Services stressed the need for the externalisation of community health services from commissioning bodies, with the aim of separating PCT commissioning from the provision of services. This had to be achieved by April 2011. The options permitted at the time nationally included consideration of vertical integration with acute trusts, as well as horizontal integration with other NHS providers.

Whilst most areas separated out community health services to become stand-alone contracts, the North East Sector (of Greater Manchester) PCTs, made up of Bury, HMR and Oldham, took the joint decision to transfer these services to Pennine Care NHS Foundation Trust (PCFT), formed in 2002 as a mental health trust, and the transfer was completed by April 2011. The PCTs believed that this would allow community health services to retain autonomy and reflect their unique local focus, whilst focussing on transformation of care pathways to support delivery of local care outside hospitals rather than concentrating on a new organisational form. Community health services were subsequently hosted by PCFT until July 2019, at which point, they were transferred to the acute care provider in Bury, the Northern Care Alliance (NCA).

3. Development of the Bury Local Care Organisation (LCO) to date

During the time that PCFT hosted community health services, place based integration of health and care services within Bury was being driven forward.

In February 2015, NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement with the government to take charge of health and social care spending and decisions in the city region. The development of Local Care Organisations as instruments of care delivery became the heart this pioneering approach, bringing together NHS community health providers, mental health providers, primary care and social care.

The Bury Locality Plan (2017) and Locality Plan Refresh (2019) set out Bury's approach to

population health being at the heart of our communities, with targeted, integrated, asset based health and care provision at a neighbourhood level for those who need it. The ambition was to enable people to get joined up, quality care closer to home, as well as helping them stay out of hospital and manage their own wellbeing.

The plan described the need for community health services to be integrated with other community based services to maximise the benefits delivered to Bury people. Key to the delivery of this vision was the establishment of the Local Care Organisation (LCO), a partnership of providers which has been in place since September 2017.

The LCO has played a significant role in respect of whole system leadership to organise and deliver care locally to people in Bury acting as a single provider voice, which works in collaboration to deliver effective integrated health and social care services. Its members are made up the major health and care providers in Bury:

BARDOC
Bury Council - Adult Social Care Operational Services
The GP Federation
Northern Care Alliance – Bury Care Organisation
Pennine Care Foundation Trust
Persona Care & Support
The Voluntary, Community & Faith Alliance (VCFA)

The agreed priorities for the LCO for the past three years have been focussed on:

- establishing the five Integrated Neighbourhood Teams, with core teams made up of GPs, community nurses and social workers, working together to deliver joined up care to people on a neighbourhood footprint serving between 30,000 – 50,000 people;

- driving the transformation and expansion of Intermediate Care, to be more home based and establish a fully integrated health and care model, made up of teams with community health services and social care operational services;

- developing palliative and end of life care across the health and care system, with a real focus on an out of hospital approach for support.

At the time of writing, the further strengthening of integrated care delivery led by the LCO is beginning to show some real evidence of success on how a difference is being made to people's lives. This means that we are beginning to grow an evidence base to demonstrate how, in future, health, voluntary, and social care partners should work even more closely together to deliver the right care at the right time and in the right place for Bury residents.

The recent consideration of the LCO Programme Board to move towards a lead provider model, whilst now on pause due to the resurgence of Covid 19 in our community, remains a significant aspiration, to be revisited during 2021. The agreement of all partners that form should follow function means that whilst partnership governance will remain as is for now, partnership relationships can be strengthened and developed to become even more robust in the interim.

Whilst living with and beyond Covid19, we look forward to accelerating working in partnership to further integrate services and ensure that local people are cared for and supported by integrated teams of professionals in their own homes or local communities, led by the Bury LCO.

4. Transfer of Community Health Services in 2019

As stated above, community health services were hosted by PCFT until July 2019, working within the collaborative arrangements of the LCO. The further transfer of services arose from a change in direction for PCFT. In December 2018, the Trust announced its strategic intent, via a Board Paper entitled 'Trust Strategy 2019-22: Maximising Potential, to concentrate its business solely on the delivery of mental health and wellbeing services.

In January 2019, in order to ensure the safe ongoing delivery of community health services, the Finance Procurement and Contracting Committee of NHS Bury CCG recommended to the Governing Body to support a waiver to a procurement process. Again, this was in line with the other NES CCGs. A number of factors were considered as part of the decision making process, but the overriding rationale was clearly the need to continue to operate community health services within the framework of the developing LCO to support effective integration and service transformation of health and care services for the people of Bury.

The CCG then wrote to the LCO Board inviting them to consider which partner was the most appropriate to act as a host provider for community health services for a period of two years, which would involve becoming the new employer of the community service staff and becoming responsible for service delivery and performance.

The LCO Board made the decision against a set of assessment criteria and the Northern Care Alliance (with Salford Royal Foundation Trust as the legal entity) was confirmed as the preferred interim provider of community health services for Bury and the other NES areas.

On 1 July 2019 community health services transferred to Salford Royal Foundation Trust, a significant transfer, which supported the continuing integration of services within Local Care Organisations.

5. Current position - value and scope of current services, impact of Covid19

The services transferred continue to operate under the arrangements established in July 2019. The range of services currently within scope of this contract are listed in Appendix 1 of this report, they are very diverse and cover both children's and adult services.

For Bury, the opening value of the current contract for community health services would have been £19.2m for 2020/21 in respect of these core services, notwithstanding different financial arrangements or payments made due to either Transformation funding or funding received as a result of managing the Covid pandemic.

Much work has been undertaken by the Northern Care Alliance in improving core quality of services and reviewing and strengthening clinical governance since July 2019, with clinical reporting now established within NCA arrangements. At the end of January 2020, a new Managing Director of Community Health Services was appointed by the NCA to lead effective transformation of services, with a focus on place-based delivery and working into the LCO management team, alongside the Assistant Director of Social Care and Director of Transformation & Delivery, reporting to the Chief Officer of the Bury LCO.

Work on integrated clinical pathways, especially those which have undergone transformation such as Intermediate Tier services, where therapy delivery at home had

been identified as lacking, has demonstrated the clinical value of delivering services on a place-based basis, with integration across the system where possible, to ensure an improved patient journey.

However, due to the Covid pandemic, since March 2020, services have been operating differently, with some services stood down in line with Covid-19 national guidance, others operating differently under NCA business continuity arrangements, with re-deployment of clinical staff to areas of pressure; the NCA are, at the time of writing, outlining plans to respond to the second wave of Covid, incorporating the learning from the first wave. Details of how this will impact community health services moving forward are awaited, as of the beginning of November 2020.

6. Current position - drivers for integration

Community health services are central to plans for the future of the health and care system. The NHS's long-term plan (January 2019) reaffirmed the NHS commitment to the integration of health and care, and the shift towards a population health approach. It set out ambitions to 'boost "out-of-hospital" care, and finally dissolve the historic divide between primary and community health services'. It also committed to increasing the share of the NHS budget going to community and primary care services.

The ambition to deliver more and better health services in the community is not new, and ensuring they are delivered in an integrated way means better services for patients with a number of real advantages:

- more possibilities for person-centred rather than condition focussed care
- genuine integration of primary care and community health care delivery
- reduced numbers of professionals going into someone's home
- care delivered closer to or within someone's home through the neighbourhood delivery model.

In Bury, we have been working on our programme of health and care transformation for 3 years now, and there is still much to do. The Covid pandemic has brought a different dynamic to this work, and has shown the value of the reform work previously done, in genuine cross system working as part of the response for people in Bury.

Looking forward, place based integration and person centred reform continue to be the mainstays of our transformation programme; key to this is the delivery of services on a neighbourhood footprint. The Bury 2030 strategy sets out how wider public service support will be delivered in neighbourhoods, building on the success of health and care delivery in this way.

The health and care integrated teams are therefore a key component of future neighbourhood delivery, working together to deliver joined up services, supporting people with chronic, long term physical and mental health conditions; they will actively case manage the most complex cases, and focus on early intervention and prevention and the avoidance of unplanned care. This will support people even with complex conditions, to be in control of their care and their lives and enable them to live well at home.

7. Procurement considerations

The current interim provider arrangements regarding the transfer of community health services to NCA are due to end on 30 June 2021, which is the end of the 2 year agreement originally put in place. This two year period was agreed on the basis of local arrangements becoming more mature during that time, with each locality in the NES identifying its own long term approach and organisational form. This would have meant that there would be clarity around what exactly should be commissioned moving forward.

If the current service provision is to continue, the CCG will is unable to further extend the existing contract, but will need to establish a new contract. Given the nature and value of the contract, there will be application of the prevailing procurement regulatory framework.

Whilst the normal expected strategy would be for the CCG to assess the appropriateness of market testing these services, , there are a number of issues that require further consideration before the CCG can gain a confidence as to what community services are to be commissioned and how this should best be put into place. The considerations set out within the next section below point to the need for the CCG to create additional time before having a confidence to commit to a longer term contractual solution which might be expected to be secured through market testing.

8. Considerations to inform an optimal contractual solution

8.1. Covid pandemic and transformation

Firstly, from both a commissioner and service delivery point of view, we cannot ignore the Covid pandemic. Given the impact on health and care services, it has to be a significant factor in determining how and when community health services are put out to tender. Since mid-March 2020, services have been operating very differently from usual, often under direct guidance from the DHSC, to ensure that support to people in respect of Covid is delivered consistently across the whole of England. This means that effectively, the NCA only had 8 months (from July 2019 to March 2020) of the 24 months originally planned to work through transformation and integration with partners in Bury. As indicated above, things may soon change again, due to business continuity arrangements in respect of the second wave of Covid.

By default therefore, the transformation journey of community health services in Bury has, to a significant extent, been paused and consequently substantially delayed as a result of the Covid pandemic. The clarity of what is needed from the health and care system from community health services has therefore not yet been worked through, due to the need to prioritise Covid arrangements. In reality, both commissioner and provider services have lacked the capacity to simultaneously manage the pandemic and review services to the extent required to inform a confidence to commission the services which will be fit for purpose for the future.

8.2. Data

In addition, health trusts are currently exempt, under NHS Covid guidance, from having to undertake data reporting at this time; therefore the metrics needed to evidence what improvements, changes and future outcomes would be required within a Bury health and

care system would need are not currently in place.

8.3. Financial considerations

The financial arrangements in respect of the current contract have been revised in line with national requirements put in place as a result of the Covid pandemic, which are block funded arrangements for 2020/21. For 2021/22 there is to date no indication as to what NHS planning guidance will require in respect of funding arrangements at this point. This uncertainty needs to be addressed before we can commission a longer term service solution.

Withdrawal of services from the NCA may also cause financial uncertainly for the Trust as an organisation.

8.4. Workforce considerations

Staff within all health and care services have been going the extra mile in supporting Bury residents with Covid for the past 9 months. This is set to continue for the unforeseeable future as the UK deals with the second wave of Covid through the Autumn and into Winter, with significant system pressures already evident.

This same staff group within Community Health Services, who have only recently undergone the transfer into the NCA from PCFT at the same time as working through the Covid pandemic, will benefit from a continuation of the existing service provision whilst the CCG works with system providers to define the future service model for Bury.

8.5. Commissioning outcomes

It is recognised that the CCG has several critical commissioning outcomes to achieve through the provision of community health services, including:

- Ensuring all available investment contributes to the system bottom line and overall system sustainability
- Development of integrated care pathways across acute, community and primary care – achieving optimal “efficiencies” for both the system, and also for patients and how they are supported
- Supporting integration of the local provider landscape.

For Bury, place based delivery of health and care services underpins the future direction of delivering safe, effective and sustainable services in the future; this direction has been clearly articulated in the Bury Locality Plan (2017), the Locality Plan Refresh (2019) and more recently as part of the Bury 2030 Strategy which considers wider public service reform, with health and care within it.

In order to assure effective system working, the alignment of acute and community health services and the ability to transfer better between services will become more significant as transformation progresses and integrated delivery becomes the norm. Such an approach may therefore strengthened through retaining services within the NCA at this time.

9. Conclusions and proposal

To summarise, the delivery of services on a neighbourhood footprint is fundamental to transforming health and care services to become sustainable for the future.

There is significant uncertainty at this time in respect of both future operational and financial requirements in respect of community health services, due to Covid and future planning requirements of the NHS.

Capacity of both the CCG and provider services should be considered, and recognition given to the benefit of ensuring that these currently stretched resources are not distracted from continuing to deliver optimal outcomes for Bury residents at this time.

There is clear benefit from maintaining continuity of current services within the structure of the Northern Care Alliance at this time: to ensure continuity for staff and patients, to avoid uncertainty, to minimise risk of ineffective or unsafe delivery of care and to ensure leadership of the ongoing development of the Bury LCO. In addition, an extension to current arrangements would ensure robust planning can be undertaken to formulate the long term future requirements of these services.

Given the issues described above it is considered that the most appropriate way to progress is to continue with the current contractual arrangements to allow sufficient time to explore and document these future requirements, and create the blueprint for future community health service in Bury.

To support this continuation, it is proposed that the CCG establishes an interim contract with the Northern Care Alliance to secure the ongoing delivery of community health services in its current form. This interim basis should be for a period of 12 months from the expiry of the current arrangements, with a reservation of rights for this to be extended for up to a further 12 months if needed, given that the longer term impacts of Covid are not yet known.

10. Next steps

The CCG recognises its lawful obligations to ensure a transparency with the provider market in regard to this contract decision. Publishing a Contract Award Notice (CAN) through the Official Journal of the European Union (OJEU), detailing the rationale for re-establishing current contractual arrangements through this interim contract will fulfil this requirement. There is recognition that whilst the CCG assesses the necessity of this interim contract at this time, there is potential for the market to question and potentially seek to challenge this decision. As such a *standstill* period of at least 30 days will be allowed between notifying the market and entering into this new contract with the NCA in order to flush out any such potential market response.

11. Recommendations

It is recommended that the Strategic Commissioning Board:

- Support the proposal to award a further interim contract for a period of 12 months from 1 July 2021 to 30 June 2022, with a potential for a further 12 month extension.

Enacting any extension beyond June 2022 would be brought back to SCB for approval;

- To agree that the interim contract should take the form of a direct award to the Northern Care Alliance in line with the current arrangements in place
- To authorise for the publishing of a Contract Award Notice through OJEU to ensure lawful compliance in regard to market transparency.

End
Julie Gonda
10 November 2020
V1.2

Appendix 1 – List of Services commissioned within the block contract for Community Health Services

Adult Speech & Language Therapy
Adults Occupational Therapy
Audiology
Community Eye Service
Community Nursing
Continence and Stoma
Trial Without Catheter (TWOC)
Community Cardiac
Community IV Therapy
Dietetics
Physiotherapy
Posture and Mobility
Respiratory Team / COPD
Bealey Community Hospital
Discharge Liaison
Early Discharge Team/Neuro Rehab/Stroke Team
Community Equipment Store
Rapid Response / Crisis Response
Children's Community Nursing Team
Children's Occupational Therapy
Children's Speech & Language Therapy
Special School Nursing
Bury Walk-in Centre
Prestwich Walk-in-Centre
Safeguarding/ LAC
Specialist Palliative Care
Resettlement
Special School (A002)
Paediatric Physiotherapy Service
Neuro Rehab (A019)
Woundcare and Lymphoedema
Podiatry
VAC Therapy

Equality Analysis Form		
	The following questions will document the effect of your activity on equality, and demonstrate that you have paid due regard to the Public Sector Equality Duty. The Equality Analysis (EA) guidance should be used read before completing this form.	
	To be completed at the earliest stages of the activity and before submitted to any decision making meeting and returned via email to GMCSU Equality and Diversity Consultant for NHS Bury CCG akhtar.zaman4@nhs.net for Quality Assurance:	
Section 1: Responsibility (Refer to Equality Analysis Guidance Page 8)		
1	Name & role of person completing the EA:	Julie Gonda (Director of Community Commissioning)
2	Directorate/ Corporate Area	Commissioning
3	Head of or Director (as appropriate):	Will Blandamer (Exec Director of Community Commissioning)
4	Who is the EA for?	NHS Bury CCG
4.1	Name of Other organisation if appropriate	Northern Care Alliance
Section 2: Aims & Outcomes (Refer to Equality Analysis Guidance Page 8-9)		
5	What is being proposed? Please give a brief description of the activity.	In respect of community health services commissioned by the CCG, a direct award of a contract for 1 year (with a possible 12 month further extension if absolutely required).
6	Why is it needed? Please give a brief description of the activity.	It is considered that the most appropriate way to progress is to continue with the current contractual arrangements to allow sufficient time to explore and document future commissioning requirements, in light of transformation leading to integrated health and care delivery.
7	What are the intended outcomes of the activity?	It is intended that a full procurement is undertaken so that transformed services can be delivered from July 2022. In order to do this, much work needs to be undertaken around the commissioning outcomes in respect of community services, namely: overall system sustainability, further developing integrated services to deliver better outcomes for patients and achieving optimal efficiencies.

8	Date of completion of analysis (and date of implementation if different). Please explain any difference	Date of completion of EIA: 12/11/2020 Implementation date: July 2021
9	Who does it affect?	All patients accessing community health care services

Section 3: Establishing Relevance to Equality & Human Rights
(Refer to Equality Analysis Guidance Page 9-10)

10 **What is the relevance of the activity to the Public Sector Equality Duty? Select from the drop-down box and provide a reason.**

	General Public Sector Equality Duties	Relevance (Yes/No)	Reason for Relevance
	To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010	Yes	All patients would have equal access to services through referral mechanisms already agreed. Not subject to change through this piece of work, but possibly through transformation programmes, for which separate EIA would be undertaken.
	To advance equality of opportunity between people who share a protected characteristic and those who do not.	Yes	All community practitioners should provide care of a consistent standard, based on clinical need of the individual. This in essence should allow equality of opportunity between people who share a protected characteristic and those who do not.
	To foster good relations between people who share a protected characteristic and those who do not	Yes	Ensure where people are referred to services they are treated in agreed and safe time scales

10.1 **Select and advise whether the activity has a positive or negative effect on any of the groups of people with protected equality characteristics and on Human Right**

	Protected Equality Characteristic	Positive (Yes/No)	Negative (Yes/No)	Explanation
	Age	Yes		All age groups will be accessing services based in the community
	Disability	Yes		Ensure where people are referred to services they are treated within in agreed and safe time scales
	Gender	Yes		

	Pregnancy or maternity	Yes		Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales All patients should have services delivered in an accessible, compassionate and safe way.
	Race	Yes		
	Religion and belief	Yes		
	Sexual Orientation	Yes		
	Other vulnerable group	Yes		
	Marriage or Civil Partnership	Yes		
	Gender Reassignment	Yes		
	Human Rights **(refer to Appendix 1 and 2)**	Yes		
	If you have answered No to all the questions above and in question 10 explain below why you feel your activity has no relevance to Equality and Human Rights.			

	Section 4: Equality Information and Engagement (Refer to Equality Analysis Guidance Page 10-11)	
11	**What equality information or engagement with protected groups has been used or undertaken to inform the activity. Please provide details. (Refer to Equality Analysis Guidance Page 11-12)**	
	Details of Equality Information or Engagement with protected groups	**Internet link if published & date last published**
11.1	**Are there any information gaps, and if so how do you plan to address them**	No
	Section 5: Outcomes of Equality Analysis (Refer to Equality Analysis Guidance Page 12)	
12	**Complete the questions below to conclude the EA.**	
	What will the likely overall effect of your activity be on equality?	No significant impact at this time, given that services are expected to continue as they currently operate
	What recommendations are in place to mitigate any negative effects identified in 10.1?	None
	What opportunities have been identified for the activity to add value by advancing equality and/or foster good relations?	Neighbourhood delivery of community health services should support the delivery of services based on needs within the particular

		neighbourhood, especially through Integrated Neighbourhood Teams for health and care. Improved staff and team morale for a team that can respond in a timely manner, and ensure effective outcomes for the individuals treated.
	What steps are to be taken now in relation to the implementation of the activity?	The intention is to review all services during the timeframe of the one year extension, to ensure that long term planning for Community Health Services is fit for purpose for the future.
Section 6: Monitoring and Review		
13	If it is intended to proceed with the activity, please detail what monitoring arrangements (if appropriate) will be in place to monitor ongoing effects? Also state when the activity will be reviewed.	
The proposed extension is for 12 months and it is anticipated that learning through service reviews, in order to shape the future service specification, would be in-depth, robust and outcomes focussed. In the meantime, ongoing monitoring, in line with national requirements, will continue.		

Protected Group	**Explanation**
Race	There is currently no data in relation to Race collected nationally for this service. JSNA data for Bury CCG: According to the 2001 Census, 93.9% of Bury's population is white with 'White British' representing 90.7% (compared to 87% nationally). The remaining 6.1% is made up of ethnic communities with the largest group being Pakistani at 3% of the population. Indians are the second largest group representing 1.4% of the population. The largest concentration of non-white residents is in East Ward where ethnic groups make up over 20% of residents. The Census however was produced in 2001 recent estimates (2006) suggest that the white population has fallen to 87.9% (compared to 84% nationally), with the largest proportional increase being in the Bangladeshi community. This data shows a decreasing white population and a substantial increase in the Asian heritage community although it has to be considered that the Pakistani community is predominantly young (with 65% of the population aged under 30) and that many of the migrant workers settling in Bury may not be represented. Local Area Profile (Rochdale) 2011 for HMR CCG: Population Profile Rochdale (HMR CCG) 2011 vast majority of people in Rochdale Borough are from a White British ethnic background, equivalent to 83.5% of the total population. People of a Pakistani background make up the largest minority ethnic group, with 17,200 people (8.3%). A significant proportion of the Bangladeshi, Pakistani and Mixed ethnic groups are aged between 0-15 years old. In comparison to the White British ethnic group, the minority ethnic groups have a much younger age structure, with fewer older people (Irish and White Other are the exceptions).

	The 2011 Census revealed that in Rochdale Borough 166,481 people identify as White British which makes up 78.6% of the local population. The largest ethnic minority group is Pakistani which makes up 10.5% of the local population (22,265), and the second largest is Bangladeshi with 2.1% of the population (4,342). *Source: 2011 Census.*
Disability	Data from Bury BC gives a comparator between residents who are disabled compared to their non-disabled neighbours: **Area** / **All people in thousands** / **disabled based on the DDA definition** / **work-limiting disabled** **Bury** 12.7% 4.8% 2.9% **ONS da** Data from Rochdale Borough (HMR CCG) indicates: The number of Rochdale Borough residents reporting a long-term health condition or disability is 44,359 (21%). *Source: 2011 Census*
Gender	Bury CCG: In the 2011 census the population of Bury was 185,060 and is made up of approximately 51% females and 49% males. HMR CCG: According to the 2015 Mid-Year Estimates there are slightly more women than men in the Rochdale borough; with approximately 108,841 people identifying as female compared with 105,354 of the local population identifying as male.
Gender Reassignment	*At present, there is no official estimate of the trans population. The England/Wales Census and Scottish Census have not asked if people identify as trans…"* Equality and Human Rights Commission. The GIRES (2009) report on Gender Variance in the UK estimated that around 20 in every 100, 000 people had sought medical care for gender variance. Using 15+ ONBS data of current list size of 163,013 (ONS 2015-16) the Gender Reassignment figure for Bury would be approximately 33 Bury Residents and 34 Residents in HMR CCG.
Age	**BURY CCG:** The Bury population can be split by the following c ategories(JSNA 2015): **Year** / **0-4** / **5-15** / **16-24** / **25-44** / **45-64** / **65+** / **85+** **2015** / **12,430** / **25,630** / **18,910** / **48,100** / **49,420** / **33,410** / **3,950** JNSA for Bury CCG: Bury has an estimated resident population of 182,600 (ONS 2009 mid year population estimates) but a registered (with a Bury general practice) population of 194,350 as at 31st March 2010. The resident population of Bury is expected to increase to 193,000 by 2022 (5.5% increase) mainly due to more births than deaths. By 2022, the number of people aged under 25 years old is expected to increase by only 2,600 so that their proportion of the population will decrease by 4%, whereas there will be 9,000 more people aged over 65 (29% higher proportion of the population) with 2,000 more people aged over 85 (54% higher

	proportion of the population).
Sexual Orientation	In 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015. The population who identified as LGB in 2015 were most likely to be single, never married or civil partnered, at 68.2%. In 2015, the majority (93.7%) of the UK population identified themselves as heterosexual or straight, with 1.7% identifying as LGB, the remainder either identifying as "other", "don't know" or refusing to respond. Young adults (16 to 24 year olds) 3.3% are more likely to identify as LGB compared with older age groups, and a higher proportion of males identify as LGB than females. Of those they were most likely to be single, never married or civil partnered, at 68.2%. There are no accurate statistics available regarding the profile of the lesbian, gay and bisexual (LGB) population either in the UK as a whole. Sexuality is not incorporated into the census or other official statistics. It's acknowledged that approximately 6-10% of any given population will be LGB. *Source: MYE 2015 and Stonewall*
Religion or Belief	Bury CCG: 88.9% of people living in Bury were born in England. Other top answers for country of birth were 1.9% Pakistan, 1.2% Scotland, 1.0% Ireland, 0.6% Wales, 0.5% Northern Ireland, 0.4% India, 0.3% Iran, 0.2% Hong Kong , 0.2% South Africa. 95.1% of people living in Bury speak English. The other top languages spoken are 0.9% Urdu, 0.8% Polish, 0.7% Panjabi, 0.2% Persian/Farsi, 0.2% Pashto, 0.2% Arabic, 0.1% All other Chinese, 0.1% Italian, 0.1% French. Religion is given as The religious make up of Bury is 62.7% Christian, 18.2% No religion, 6.1% Muslim, 5.6% Jewish, 0.4% Hindu, 0.2% Buddhist, 0.2% Sikh. 11,069 people did not state a religion. 476 people identified as a Jedi Knight and 42 people said they believe in Heavy Metal.
Pregnancy and Maternity	Public Health England March 16 Child Health Profile gives a live birth figure for Bury (2014) as 2,329. Children and young people under the age of 20 years make up 24.9% of the population of Bury. 23.6% of school children are from a minority ethnic group. The health and wellbeing of children in Bury is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is better than the England average with 17.1% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average. Children in Bury have better than average levels of obesity: 7.8% of children aged 4-5 years and 17.2% of children aged 10-11 years are classified as obese. There were 295 children in care at 31 March 2015, which equates to a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.

Married/ Civil Partnership	Bury CCG: 46.6% of people are married, 11.5% cohabit with a member of the opposite sex, 0.8% live with a partner of the same sex, 24.3% are single and have never married or been in a registered same sex partnership, 9.4% are separated or divorced. There are 10,162 widowed people living in Bury.
Other Groups: Asylum Seekers Travellers Military Veteran Carers	Asylum Seekers/ Refugees - **Asylum seeker:** a person who enters a country to claim asylum (under the *1951 UN Convention and its 1967 Protocol*).2 Individuals undergo the asylum process to have their claim assessed. **Refugee:** "… *a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country*...". (5) Refugee status, or temporary 'leave to remain' (sometimes granted on humanitarian grounds) is awarded by the Home Secretary and affords the same welfare rights as other UK citizens. Entitlement to health and social care for asylum seekers and refugees is complex and dependent on their stage in the asylum process. Rules on entitlement are also subject to review and up to date advice should therefore be sought (see also footnote). However, there are some principles that generally apply: • necessary or urgent medical treatment should never be denied to any person, regardless of whether or not they are resident in the UK, or are able to pay in advance; • for life-threatening conditions and for the purpose of preventing any conditions from becoming life-threatening the appropriate treatment is normally given regardless of ability to pay; • maternity services should always be classed as 'immediately necessary treatment Whilst many asylum seekers do arrive in the UK in relatively good physical health, health problems can rapidly develop whilst they are in the UK.7 Reasons for this include: • difficulty in accessing healthcare services; • lack of awareness of entitlement; • problems in registering and accessing primary and community healthcare services, particularly if their claim has been refused; • language barriers. However, some asylum seekers can have increased health needs relative to other migrants. There are several reasons for this: • a number have faced imprisonment, torture or rape prior to migration, and will bear the physical and psychological consequences of this; • many may have come from areas where healthcare provision is already poor or has collapsed; • some may have come from refugee camps where nutrition and sanitation has been poor so, placing them at risk of malnourishment and communicable diseases; • the journey to the UK can have effects on individuals through the extremes of temperatures, length of the journey, overcrowded transport and stress of leaving their country of origin; • health needs of asylum seekers can be significantly worsened (and even start to develop in the UK) because of the loss of family and friends' support, social isolation,

	loss of status, culture shock, uncertainty, racism, hostility (eg. from the local population), housing difficulties, poverty and loss of choice and control. Travelers - The literature specific to the Gypsy and Traveller population indicates that, as a group, their health overall is poorer than that of the general population and poorer than that of non-Travellers living in socially deprived areas (Parry *et al*., 2004; Parry *et al*., 2007). They have poor health expectations and make limited use of health care provision (Van Cleemput *et al*., 2007; Parry *et al*., 2007). Van Cleemput *et al*. (2007) refer to many Gypsies and Travellers sense of fatalism with regard to treatable health conditions and low expectations of enjoying good health (particularly as they age). They also mention the commonly held belief that professionals are unable to significantly improve patients health status and may in fact diminish resilience by imparting bad news, such as a diagnosis of cancer. The impact of such beliefs is a heightened suspicion of health professionals and a reluctance to attend for screening or preventative treatment. The report by Parry *et al*. (2004), entitled *The Health Status of Gypsies and Travellers in England*, shows that both men and women often experience chronic ill health, frequently suffering from more than one condition; that carers experience a high level of stress; and that secrecy about depression keeps it hidden and increases the burden on both the individual and the family as they try to manage. Many Gypsies and Travellers face high levels of bereavement, which is also a precipitating factor of depression. Poor psychological health is often found in the context of multiple difficulties, such as discrimination, racism and harassment, as well as frequent evictions and the instability caused by this. Military Veterans A veteran is someone who has served in the armed forces for at least one day. There are around 2.6 million veterans in the UK as a Regular or Reservist or Merchant Navy serving in an active theatre of war. Estimates for the Bury population by the British Legion are 12,000-14,000 Veterans currently resident within the Borough. This figure does not include the Spouses or close family members of those who have served who may have specific needs due to service life. Taken as a whole, the ex-Service population, which has been estimated at around 3.8 million for England, has comparable health to the general population. The current generation of UK military personnel (serving and ex-serving) have higher rates of heavy drinking than the general population. However, this difference may attenuate with age. The most common mental health problems for ex-Service personnel are alcohol problems, depression and anxiety disorders. In terms of the prevalence of mental disorders, ex-Service personnel are like their still-serving counterparts and broadly like the general population. Military personnel with mental health problems are more likely to leave over a given period than those without such problems and are at increased risk for adverse outcomes in post service life. The minority who leave the military with psychiatric problems are at increased risk of social exclusion and on-going ill health. The British Legion 2012 gave estimates of the Military Veteran population of circa 12,000 (Bury) and 14,000 (HMR). Carers The role of the carer is especially important when the person who receives care (the care recipient) is unable to live independently without the carer's help. A young carer is a child or young person under the age of 18, carrying out significant caring tasks and assuming a level of responsibility for another person that normally would be undertaken by an adult.

	Underpinning the caring role may be life-long love and friendship, together with an acceptance of the duty to provide care. Carers can derive satisfaction and a sense of well-being from their caring role, receive love and affection from the care recipient, gain a sense of achievement from developing personal attributes of patience and tolerance, and gain satisfaction from meeting cultural or religious expectations (Cassell *et al*, 2003). Caring responsibilities may arise at any time in life. Carers may have to adapt and change their daily routine for work and social life, perhaps incurring personal and financial costs. They may become isolated from other members of their family, friends and work colleagues. In an ageing population, family members are expected to undertake complex care tasks, often at great cost to their own well-being and health (Schulz & Matire, 2004). The role of carer can be demanding and difficult, irrespective of whether the care recipient has a mental disorder, learning disability or a physical disability, either separately or combined. A survey of over 1000 carers in contact with carers' organisations found that just less than 50% believed that their health was adversely affected by their caring role (Cheffings, 2003). Mental health problems included stress and tension (38%), anxiety (27%) and depression (28%). Physical health problems included back injury (20%) and hypertension (10%). Back injury was associated with caring for individuals with physical disabilities. Similar figures were found in a survey by Carers UK (2002), in which the most frequently experienced negative emotions in carers were: feelings of being mentally and emotionally drained (70%), physically drained (61%), frustration (61%), sadness for the care recipient (56%), anger (41%), loneliness (46%), guilt (38%) and disturbed sleep (57%). Carers who are more vulnerable to health problems are women, elderly or very young people, those with pre-existing poor physical health, carers with arduous duties and those with few social contacts or support. Carers may attribute symptoms of an illness to their work as a carer and fail to recognise the onset of an illness. In Bury alone, we currently know of 3,320 adult carers but we acknowledge that there may be many more who do not receive any support to undertake their caring role (6). References (1) Gender, age, society, culture, and the patient's perspective inthe functional gastrointestinal disorders." *Gastroenterology* (April 2006): 130-35. Web. 17 July 2007 (2) Epidemiology, demographic characteristics and prognostic predictors of ulcerative colitis." *World J Gastroenterol* (2014): 20-28. Web. 17 July 2017. (3) Matthews, Z. (2008). *The health of gypsies and travellers in the UK*. London: Race Equality Foundation. (4) Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, C. (2004) *The Health Status of Gypsies and Travellers in England*, Sheffield, University of Sheffield. (5) The Health Needs of Asylum Seekers , Briefing Paper, The Faculty of Public Health (May 2008) (6) Bury Adult Carers Strategy Caring for Carers 2013-18