Meeting: Strategic Commissioning Board			
Meeting Date	04 January 2021	**Action**	Recommend
Item No	7	**Confidential / Freedom of Information Status**	No
Title	Next Steps to Integrated Health and Care		
Presented By	Geoff Little, Chief Executive & Accountable Officer Will Blandamer, Executive Director of Strategic Commissioning		
Author	Will Blandamer, Executive Director of Strategic Commissioning		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Bury, like the rest of Greater Manchester, has made good progress on creating integrated arrangements for commissioning and provision over recent years with the aim of improving outcomes for residents, reducing inequality and securing a financially and clinically sustainable health and care system.

The NHSE guidance of 27th October 2020 on 'next steps to integrated care systems' reflected much of our current work, but also highlighted potential legislative changes that could put an Integrated Care System (for us at a Greater Manchester level) on a statutory footing and repurpose CCGs from 1st April 2022.

This paper provides background and context to the work required to respond to this guidance, proposes an initial partnership model for Bury for consideration. The paper highlights some particular issues that need to be addressed in this next stage of maturity of our arrangements, including for example the necessity for mandated clinical leadership, working alongside political leadership in the borough.

The paper proposes the current System Board is recast as a Transition Programme Board and a number of programmes of work are established to address key elements of the transition.

The paper also provides context to the consideration by the Bury Strategic Commissioning Board on 4/1/2021 of the GM submission (including a stated preference of Option 2 for the configuration of the ICS at a GM level) to NHS England by 8/1/21.

Recommendations

It is recommended that the Strategic Commissioning Board: -

(i) confirms support for Option 2 as part of the GM response to the National

	consultation to be submitted by 8th January 2021, subject to implementation of financial, governance and staffing arrangements which would provide for accountability at Bury level for integrated community health, primary care, ASC, parts of children's social care, community mental health and medical acute services.
(ii)	endorses the GM response to the National Consultation to be submitted by 8th January 2021, subject to the caveats agreed above
(iii)	reviews these proposals as a basis for wider engagement and dialogue on the future of partnership working in the borough
(iv)	designates the System Board as the Transition Programme Board**,** to confirm the SRO for the Transition programme, and to establish and specify the task groups as outlined above.
(v)	Notes that responsibilities in relation to the Vision, Values and Strategic Direction of the CCG are delegated to the Governing Body with the SCB responsible for recommending a course of action. The Governing Body has therefore delegated final sign-off of this response to the Accountable Officer and Chair following review and recommendation by the SCB on the 4th January 2021 ahead of the final submission on the 8th January 2021.

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

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

Implications						
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☒	No	☐	N/A	☐
If yes, please give details below: See attached.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
LCO Board	16/12/2020	
System Board	16/12/2020	

Governance and Reporting		
Meeting	**Date**	**Outcome**
Governing Body (via Email)	18/12/20	

Next Steps to Integrated Health and Care in Bury

Discussion Document

Paper for the consideration of the:

- CCG Governing Body Membership 18/12/20
- Strategic Commissioning Board 4/1/21

Version Control

- Draft Version 1.1 11/12/20
- Draft Version 1.2 14/12/20
- Version 1.3 following review at PAG, LCO Board, and System Board. Includes final version of draft GM Submission.

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Executive Summary

Bury, like the rest of Greater Manchester, has made good progress on creating integrated arrangements for commissioning and provision over recent years with the aim of improving outcomes for residents, reducing inequality and securing a financially and clinically sustainable health and care system.

The NHSE guidance of 27th October 2020 on 'next steps to integrated care systems' reflected much of our current work, but also highlighted potential legislative changes that could put an Integrated Care System (for us at a Greater Manchester level) on a statutory footing and repurpose CCGs from 1st April 2022.

This paper provides background and context to the work required to respond to this guidance, proposes an initial partnership model for Bury for consideration. The paper highlights some particular issues that need to be addressed in this next stage of maturity of our arrangements, including for example the necessity for mandated clinical leadership, working alongside political leadership in the borough.

The paper proposes the current System Board is recast as a Transition Programme Board and a number of programmes of work are established to address key elements of the transition.

The paper also provides context to the consideration by the Bury Strategic Commissioning Board on 4/1/2021 of the GM submission (including a stated preference of Option 2 for the configuration of the ICS at a GM level) to NHS England by 8/1/21.

Summary of Recommendations for SCB

- **Recommendation 1** – The Bury is SCB is recommended to **confirm support for Option 2** as part of the GM response to the National consultation to be submitted by 8th January 2021, subject to implementation of financial, governance and staffing arrangements which would provide for accountability at Bury level for integrated community health, primary care, ASC, parts of chidrens social care, community mental health and medical acute services.

- **Recommendation 2**- **The Bury SCB endorses the GM response** to the National Consultation to be submitted by 8th January 2021, subject to the caveats agreed above

- **Recommendation 3**: **SCB is invited to review these proposals as a basis for wider engagement** and dialogue on the future of partnership working in the borough

- **Recommendation 4**; **It is recommended to designate the System Board as the Transition Programme Board,** to confirm the SRO for the Transition programme, and to establish and specify the task groups as outlined above.

1. Bury Health and Care System Strategic Intent

The Bury Locality plan 2019-2024 described a vision;

- for a step change in the health of the population of the borough,
- for residents and communities to be supported to be connected, well and independent from services if possible,
- for residents to have improved and joined up community based health and care services connected to primary care,
- for a joined up approach between the council and CCG on commissioning services that focus on the individual not the organisations,
- and securing for Bury residents best outcomes from health and care services.

This work was driven both by a shared moral imperative to improve opportunity and outcomes for all residents, and also a belief that financial sustainability of the health and care system was at least in part dependent on reducing unplanned and preventable and reactive health and care system cost.

This vision still holds true, and can be supplemented by an appreciation of the key characteristics of any future system we seek to deliver

- Residents in control of their health and the way services are organised around them
- Population Health and Inequality should be core to our work
- Neighbourhood Working is 'currency of integration' and as a foundation for scaled prevention and early intervention – in health and care, with wider public services, and with communities
- Services delivered closer to home/in home where possible
- Person and Community Centred Care is central to health and care transformation
- Clinical and political leadership should be central – not advising but leading
- Collaboration at a North East Sector and across GM required to transform hospital wide services
- Timely and effective access pathways for more specialist health and care services when required.

2. Partnership Architecture

In order to deliver the vision and system characteristics described the partnership arrangements in the Bury health and care system have developed over time to become more collaborative, locally sensitive, and focused. At this point we have:

- Joined up commissioning arrangements between the council and CCG including the operation of an integrated care fund (pooled, aligned and 'in view'), a joint strategic commissioning board of political and clinical leadership, joint executive level appointments, and the philosophy of a 'one commissioning organisation' with increasingly consistent operating protocols, working arrangements and joined up teams.
- The Bury Local Care Organisation – independently chaired focal point for joined up working arrangements in the provision of community based health and care, with a small dedicated management team and leading on a number of key implementation plans such as Urgent Care reform. The LCO –operating as an alliance - includes representation from key partners including Pennine Acute, Pennine Care, Bardoc, GP Federation, Council, CCG, VCFA, and

Persona. LCO membership have been working though proposals for future scope and future organisational form include potential transition to a lead provider model.

- An increasing focus on neighbourhood working as a unit of delivery and common currency for service design for integrated health and care (through the LCO), the alignment of wider public services, and the role of community and voluntary capacity (e.g. community hubs)
- The establishment of 4 Primary Care Networks, supporting resilience and service delivery for primary care and building maturity and working relationships to respond to national expectations on future role.
- A Health and Wellbeing Board, recently recast as focusing on the wider population health system – working with and challenging partners on the wider determinants of health, on behavioural change, on community connectedness, and on the operating of preventive public services.
- NCA refocused on a place based footprint with named senior management and clinical leadership at a 'Care Organisation' for each borough
- PCFT has also introduced a local leadership structure with Bury having a named / dedicated AD for MH , the NES having a dedicated leadership triumviratem and a dedicated Exe link to Bury
- A whole System Board meeting for key stakeholders in the health and care system, with oversight of the comprehensive health and care recovery and transformation programme.
- System wide enabling programmes reflective of key health and care partners e.g. Strategic Finance Group, Strategic Estates group, and others.
- Bury Voluntary and Community and Faith Alliance VCFA as a key partner on System Board, Health and Well Being Board and LCO
- Active partnership with CCGs in the North East Sector of GM
- High quality clinical leadership leading transformation of services and pathways

3. COVID 19 Response

These arrangements, and the partnership working and relationship building they represent have served Bury residents very positively during the Covid 19 pandemic. New working relationships have been forged, new ways of working delivered, and rapid implementation of new protocols and pathways. Examples included the establishment of the COVID management service and the PCN role in developing local COVID vaccination services.

Covid has also increased the focus on physical health needs for those with Mental Health and Learning Disabilities including good example of collaboration between NCA and PCFT.

In addition a real appreciation has developed of the important of connecting directly with vulnerable residents and communities, and the capacity of communities to support each other.

4. National Context

The environment within which we endeavour to deliver our ambition for Bury is evolving as listed below:

- Growing health, social and economic, inequalities to respond to as a result of COVID-19.

- Further pressure on all NHS and care services to deal with subsequent waves and impact of COVID-19, vulnerable people at home, capacity gaps in hospital, , waiting list backlogs, increase in demand and acuity in mental health services etc.
- Long overdue Green paper on a social care reform/settlement
- Beneficial experience during COVID-19 of teams from different organisations, from commissioning and provision, working together and delivering at pace.
- Local Authorities and NHS organisations are all facing large financial challenges with the need to rapidly reduce expenditure, with potential for significant service disinvestments.
- The economic impact and potential supplies, workforce and logistical disruptions of Brexit.

5. Greater Manchester Context

The Greater Manchester Health and Care Partnership review commenced in early autumn, and deployed a mixture of independent expertise and reflections from within the partnership. The review sought clarify and support the next iteration of the ambition of 'Taking Charge'. The review identified 8 clear statements of intent:

- We are part way through a journey we are still committed to.
- The breadth of our ambition is broad but our delivery will be focussed on fewer objectives. These will address both the essentials of a high performing system and the unique opportunities which GM can excel at.
- Our GM model is consistent with the NHS ICS definition and provides us with the structures to ensure that we continue to work in a way that encompasses the widest possible definition of integrated public service delivery
- We believe there is merit in the establishment of a statutory entity at the GM level to provide a vehicle through which further delegation and devolution can take place
- We need to ensure that we have a consistent definition of our place based arrangements
- There are a limited, but critical, number of key enablers central the ambitions of collaboration and integration (these include Digital Transformation, Financial Flows and Reform, Workforce, Estates, Sustainability and Climate Change, for our Boards and Committees to reflect the communities we serve, engagement and involvement of our communities in our work)
- We strongly support an expanded role for Provider Collaboratives
- We will commit to a single decision making board (joint committee) in each locality, bringing together provision and commissioning that can deliver accountability for decisions and budgets at place level.

Work is progressing to develop the overarching proposition for the GM health and care system, linking work streams focusing on the locality construct, the provider collaborative construct, the GM wide construct,, population health and inequality (GM as a Marmot City), and innovation. This proposition is due for completion by the end of January 2021.

6. NHS England Guidance on next steps for Integrated Care Systems (27/11/20).

The NHS has in the meantime released a new proposal document on 'integrating care'. The proposal is badged as "the next steps to building strong and effective care systems across England" and the

document builds on the 'route map' that was originally set out in the NHS Long Term Plan, and that was published in January 2019.

The direction of travel indicated almost exactly mirrors the proposition emerging from the GM Health and Care partnership review, and reflects what would be a next stage of maturity of the local working relationships.

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care.
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale.
- Developing strategic commissioning through systems with a focus on population health outcomes.
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

Key elements of the document include the following

- An expectation that arrangements for operating as 'integrated care systems' (ICS) are in place from April 2021 – the integrated care system footprint for us is Greater Manchester (GM).
- Confirmation that provider collaboratives must be established to better join up services across systems.
- A plan for localised 'place-based' arrangements, with a 'place leader' who will work on behalf of the NHS and local partnerships
- An expectation that clinical leadership must continue to be at the forefront of both the system and place-based arrangements.
- Confirmation that the systems and places should continue to be publicly accountable.

7. Future Role of CCGs.

The guidance also indicates potential legislative changes that, subject to parliamentary approval, would be effective from April 2022 and would allow integrated care systems to have a 'firmer footing'.

Option 1:

- A statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2:

- A statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

Both options mean GM would take on the commissioning function of CCGs, and the CCG's Governing Body and 'membership' model would be replaced by a board consisting of representatives from the system partners.

8. The Greater Manchester Response to the NHS Consultation

The work done by all parts of Greater Manchester over the last 4 years, and in particular the development work of the last few months allows us to respond collectively and positively to the consultation (deadline 8th January). The draft of the submission is attached as Appendix 1, and is due for consideration by the Bury Strategic Commissioning Board on 4th January.

The particular issue for consideration is which of the two options above are supported. There is widespread consensus in Greater Manchester to pursue option 2, largely for the reasons outlined in the guidance note. Option 2 creates governance for the ICS that is clearer, sharper and less likely to be mired in organisational self-interest that has on occasion held GM back from delivering on significant reconfiguration proposals. The guidance note suggests that in option 2

- *The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations.*
- *The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.*
- *The ICS's primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.*

The proposed Greater Manchester response proposes option 2 for the following reasons.

- Option 1 risks creating confusion through a dual leadership for ICS level functions. Option 2 provides or a clearer structure which will minimise the potential or unnecessarily complicated governance which would undermine the means of supporting the system level collaboration.
- Option 2 would allow for a more streamlined arrangement to progress the commissioning and delivery of system level services where it is judged that those services are best planned and delivered at the system level for the whole population of 2.8m. Additionally it would confirm a clear vehicle for those services currently commissioned by NHSE to be done at a more local level through the ICS.
- Option 2 provides a clearer opportunity to reduce or remove the commissioner/provider separation at the system level and reduce both the associated costs and the time and delay embedded into those avoidable transactional processes. The ambition in localities is to establish local governance and financial lows which similarly reduces the transactional burden of the commissioner provider split and this should be replicated at the system level.

However, the Greater Manchester support for Option 2 needs to be conditional on our expectations of the way in which the GM system will work – the operation of local system boards and the GM ICS reflective of the 10 localities and not operating as an unconnected additional tier.

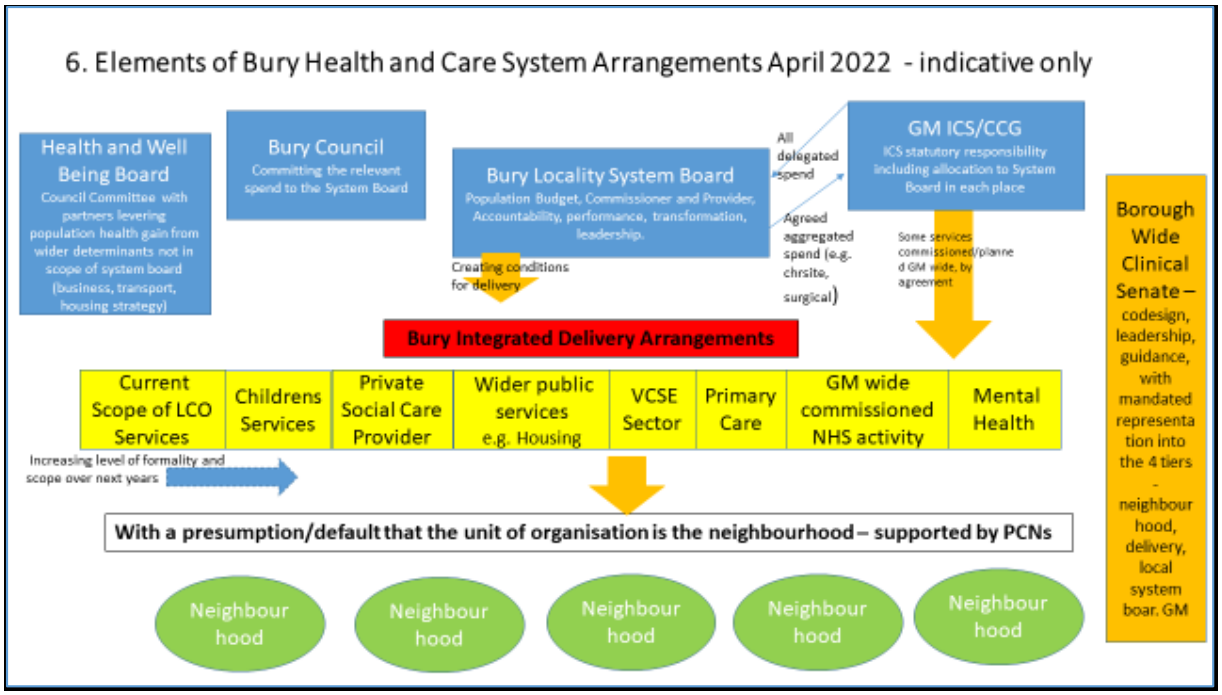
Recommendation 1 – The Bury is SCB is recommended to confirm support for Option 2 as part of the GM response to the National consultation to be submitted by 8th January 2021, subject to

implementation of financial, governance and staffing arrangements which would provide for accountability at Bury level for integrated community health, primary care, ASC, parts of chidrens social care, community mental health and medical acute services.

Recommendation 2- The Bury SCB endorses the GM response to the National Consultation to be submitted by 8th January 2021

9. Potential Partnership Arrangements in Bury

In the light of the solid foundation of partnership building in Bury, the GM health and care proposition, and the NHSE guidance on the next steps to integrated care, the following suggests an indicative framework for the partnership arrangements in Bury.



In summary this indicative picture highlights the following key elements of our future model of partnership working, and prompts the further work required.

1) It requires work to clarify the relationship between a GM ICS and a Bury Locality System Board
2) It recognises the role of a System Board in bringing together a commissioner (via the joint work council and CCG of the current strategic commissioning board) and provider perspective operating as the place based system leadership structure.
3) It recognises that service delivery and implementation in Bury needs to be more co-ordinated and connected, and also recognises the role of provider collaboration in the NHS and the intersection of its work with locality strategic and operational delivery
4) It recognises the current scope of the LCO, with oversight of some but not all of the delivery tier, and invites consideration of an extended scope of the LCO

5) It recognises that the delivery unit of the significant majority of health and care and wider public service delivery will take place at neighbourhood level, and the role of Primary Care Networks in that context is hugely important. Neighbourhood level by default.
6) It recognises that we need some mechanism to secure mandated clinical and particularly primary care clinical leadership into each of the tiers of the model in development – GM, system, delivery, neighbourhood.

10. Elements of the Proposals for Future Partnership Arrangements in Bury

We are at an early stage of engagement with key stakeholders on the nature of the working relationships in Bury moving forward, but because of the work done to date it is possible to propose some key elements for consideration.

10.1 Locality System Board

We should seek to establish a new Locality System Board for Bury operating in shadow format from 1/4/21 and fully operational by 1/4/22. This system board will be a development of the existing Strategic Commissioning Board by including key providers, and will operate as a single and transparent strategic forum. We would disestablish the current and relatively informal System Board, and reduce the number of members of the SCB that transition into the new Locality System Board. Its functions will be a relatively small board, setting strategic direction for the health and social care system in Bury

a. Recommitting and amplifying the key strategic direction and intent of health and care reform in the borough
b. Agreeing high level resource allocation based on the allocation from the GM ICS and the contribution of the Council to pooled budgets.
c. Agreeing transformation plan objectives (and having the current health and care recovery and transformation programme reporting to it)
d. Setting out and ensuring delivery of outcomes for borough residents.
e. Co-ordinating the intersection between GM wide provider collaborative strategic intent and locality strategy.
f. Align the borough strategic connection to Greater Manchester, North West, and national arrangements
g. A focal point for the alignment and integration of enabling functionality across the borough as described in the locality place – system estates group, system IM&T strategy, System workforce reform.

System Board Membership would be confirmed but could include but not be limited to for example

- Senior mandated clinical leadership
- Senior political leadership (Leader and Exec member health and care)
- LA Chief Executive
- Strategic Finance Group Chair (and until April 2022 the statutory CFO CCG role)
- Chair and Chief Officer of Integrated Delivery Board (see below)
- Chief Officer Bury Care Organisation (NCA)
- Senior Representative Pennine Care
- Representative PCN Chair,
- VCFA Chair
- Statutory Roles – DCS, DASS, DPH, Chief Nurse

Consideration should be given in future governance arrangements to the invaluable role Non Execs of Bury CCG have played in the check and challenge to decision making from an external perspective.

The System Board is essentially the apex of the health and care partnership in Bury – the design, delivery and assurance vehicle – a partnership (an integrated care partnership or ICP) convened by a place leader and governed by a formal committee with power, responsibility and accountability, and providing a mandated vote into the GM ICS.

10.2 Bury Health and Well Being Board

The board is a statutory function of the Local Authority. In Bury we have worked to recast the role of the Health and Well Being to focus on the steps required to create Bury as a Population Health System. This uses the Kings Fund 4 quadrant model of a population health system – wider determinants, behaviours and lifestyles, community, and the operation of public services.

Addressing population health and health inequalities is of course core to the work of the Locality System Board, but it is recognised the System Board is unlikely to provide the necessary air time for, for example addressing the crucial wider determinants of poor health – quality employment, freedom from abuse, clean air, health promoting environments, housing.

Health and Well Being Board membership has been recently refreshed to include representation from wider public services including Housing and GMP, and would benefit from wider representation from the business sector and other key stakeholders.

Health and Well Being has recently considered the establishment of a number of small sub groups, including one on a particular focus on inequalities and secondary care – access, outcomes etc.

10.3 An Integrated Delivery Board

A single system blind to provision and commissioning needs not only a single strategic authority (the proposed Locality System Board) but a single integrated delivery framework co-ordinating the delivery of services and the delivery of transformation programmes. This is essentially a place based provider collaborative for Bury.

In developing this it is recognised that the Bury LCO has made good progress in building improved working relationships between delivery partners in health and care, in leading particular transformation programmes, and in creating strong foundations and emergent proof of concept for neighbourhood working. However it should be recognised that both the scope and formality of the LCO has some limitations, including for example;

- The limited connection to Primary Care Networks
- The lack of connection to childrens services
- Some potential duplication of management capacity with providers and OCO

An integrated delivery board could be an extension of the current LCO Board and would recognise it operates across the breadth of the system including those services not necessarily currently considered to be in the scope of the LCO. It would recognise that the opportunity of binding partners together more formally (though joint assurance and formalised financial risk and gain share arrangements) for a particularly subset of all service delivery (e.g. the urgent care system), and the scope of such formality may increase over time. However the ambition of the LCO as the co-ordinator and integrator of services in the collaborative tier is not limited only to those services that are within its formal scope and accountability agreement.

It must be recognised that the current alliance arrangement of the LCO is dependent on staff working for it being hosted through partner organisations. This may be satisfactory or LCO membership may prefer to continue the conversation of autumn 2020 on a potential lead provider model for the Bury LCO.

An important role of the Integrated Delivery Board would be to take responsibility for creating the conditions for neighbourhood working to develop and thrive, connected to the Primary Care Networks

10.4 Neighbourhood Delivery

The focus on neighbourhood as the unit of currency for integrated health and care and connections to communities and wider public services is recognised by our own locality plan, by the NHSE Next Steps guidance, and by an increasing confidence in initiatives like integrated neighbourhood teams. In addition we recognise the weight being attributed by national guidance to the future role of Primary Care Networks;

- as a mechanism of securing the sustainability and clinical critical mass in primary care,
- the mechanism by primary care becomes central to the model of neighbourhood working
- Increasingly a mechanism for receipt of money directly from ICS to strengthen local and integrated functions.

To deliver fully on the opportunity of neighbourhood working we need to routinely conceive of neighbourhoods as comprised of three significant and related sectors

1) integrated and all age health and care,
2) wider public services such as DWP, GMP, Housing and others that have within their gift a significant influence on health and wellbeing and demand for health and care services
3) Community and voluntary sector capacity and connectedness – recognising its communities and voluntary organisations and friendships that keep people well, connected and safe.

It may be that we wish to recognise an ambition neighbourhood boards for health and social care that could themselves make decisions about neighbourhood resources, priorities and assets. Ultimately we might have a framework of delegated matters to neighbourhoods, the integrated provider board and the system board, based on the principle of transferring decision making closest to those affected by the decision.

10.5 A Clinical and Professional Senate for the Borough

One of the particular strengths of the CCG as a membership organisation has been the mandated and elected representation of GPs and other professional leaders into clinical leadership positions as clinical directors and clinical leads. The absence of a local CCG constitutes a significant risk to the continuation of such leadership – not only influencing but leading transformation and reform both locally and at a GM level.

Senior Clinical leadership can also be seen in professional groups such as LMC, LPC, LOC, and in the role of Medical Director in the LCO, as well as in the Primary Care Networks Clinical Directors and neighbourhood clinical leadership. Key providers such as Pennine Care and Pennine Acute have also worked to confirm borough based medical director leadership

In addition, clinical leadership recognises and respects other professional and statutory leadership such as in social care and public health.

In the absence of being able to confirm mandated and authoritative clinical leadership at both a local and GM level there is a risk of losing clinical and professional perspectives into service transformation proposals, and furthermore having clinical leadership that is not mandated, or connected to Bury making decisions on our behalf.

It is proposed that Clinical and Professional Senate for the borough is convened reflective of the breadth of such leadership in the borough, operating with a senior 'board' bringing together those with mandated leadership roles – e.g. PCN clinical directors, NCA Bury Care Organisation medical director, Bury Director of Adult Care, Director of Childrens Services – and with a wider membership reflective of all relevant stakeholders. A key function would be to secure mandated (through election) representation to all 4 tiers of the new partnership arrangements – neighbourhoods, integrated delivery board, locality system board, and the GM ICS.

10.6 Enabling Infrastructure

A single health and care system needs system wide collaboration and partnership on key enabling architecture. Progress has already been made in some of these areas but further work is required to assess their position and weight in relation to influence across the system and the connections to a revised governance. Key areas of focus include but are not limited to;

- Strategic Health and Care Finance Group
- Strategic Estates group – adopting a one public service estate mentality and in particular create opportunities for integrated hubs rooted to models of neighbourhood working
- Digital Board – driving compatibility between systems and also models of risk stratification and identification, and on securing patient/resident control of records.
- Strategic Workforce Group – exploiting opportunities across sectors and services to build sustainable, supported, and flexibly workforce deployment across the system
- System Information Governance Board

Recommendation 3: SCB is invited to review these proposals as a basis for wider engagement and dialogue on the future of partnership working in the borough

11.CCG Staff.

It will be recognised that this a very challenging time for CCG staff at all levels of the organisation. The NHS England guidance landed at a time of considerable anxiety, personally challenging circumstances, and staff who have worked above and beyond expectation in supporting the system response to COVID 19.

The NHS England Document states the following

> *4.19. Stable employment: As CCG functions move into new bodies we will make a '**continued employment promise' for staff carrying out commissioning functions.** We will **preserve terms and conditions to the new organisations (even if not required by law)** to help provide stability and to remove uncertainty.*
>
> *4.20. New roles and functions: For many **commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working**. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.*

The expertise of CCG staff will be required in the new system architecture even though the organisation itself may cease to exist from 1/4/2022. It is possible staff will move in a number of directions under the terms of the employment promise, including

- Some may work at a GM level for the GM ICS. This is a possibility for some staff connected to functions where a GM wide 'commissioning' functionality is proposed e.g. some aspects of cancer commissioning or mental health
- Some may need to be deployed into the emergent provider collaboratives, providing valuable service redesign knowledge and expertise
- Some may be deployed into the Primary Care Networks and connected to wider neighbourhood teams
- Some may need to be integrated into a single 'back office' functionality with the local authority providing whole system support.
- Some may be specifically aligned to the work of the LCO in the context of the Integrated Delivery Board
- There may be scope for deployment of staff to support closer collaboration between system boards across the North East sector.

It will be noted that that NHS England guidance highlights (4.21) that *"Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members).* The consequences of this for senior leadership in Bury CCG and in joint roles with the Council will need to be considered.

The SCB should note that steps are being taken to inform and engage with staff and staff side representative in taking this work forward - written communications, whole CCG/OCO staff meetings, departmental meetings and individual engagement as required.

12.Stakeholder Engagement

The following table is a summary of engagement proposed up to and beyond the Strategic Commissioning Board of 4th January. Further opportunities are being explored, and in additional follow up small group meetings are being convened (for example with CCG GP members through individual PCN level meetings).

DATE	ACTION
1.12.20	PCN Clinical Directors
2.12.20	LCO Board
2.12.20	Clinical Leads and Clinical Directors meeting
2.12.20	Clinical Directors meeting
3.12.20	Staff briefing with all OCO and wider Corporate Core CCG staff
3.12.20	CCG Recom meeting
7.12.20	Strategic Commissioning Board
9.12.20	GP members briefing
10.12.20	Council Employee Relations meeting
14.12.20	Policy Advisory Group
16.12.20	Informal cabinet
16/12/20	Bury System Board Meeting
16/12/20	LCO Board Meeting
4/1/21	SCB to sign off the GM response to consultation
20/1/21	Cabinet

It is recognised that work to engage with residents and patients in this transition to April 2022 is underdeveloped and needs to be addressed.

13.Timeline

The following are key milestones as we progress our engagement and development work (subject to approval and legislation)

- 4/1/21 SCB to consider and approve GM submission to consultation response
- 8/1/21 Closing date for consultation responses for NHS England
- 31/1/21 GM wide proposition for new partnership arrangements, confirming Expectations of the role of locality system boards, provider collaboratives, And preferred governance of the GM ICS
- 28/2/21 High level GM wide implementation plan for the shadow year 2021/21

- 1/4/21 Shadow partnership arrangements in each part of GM including Bury in Operation as far as possible
- 1/4/22 New statutory arrangements start

14. A Programme approach to system design -Transition Programme Board

This paper has proposed a framework for the future partnership arrangements in the Bury health and care system. This is intended to prompt conversation and consideration, and it is important we create mechanisms to take forward the work.

It is proposed the existing System Board operates as the Transition Programme board - tasking working groups, specifying expected outcomes, reconciling emergent themes, and holding all groups to account for delivery.

The SRO for the programme is Geoff little – CCG Accountable Officer/Bury Council Chief Executive, supported by Will Blandamer – Exec Director of Strategic Commissioning.

The following task and finish groups are proposed, reflecting some of the key themes of this document, and where possible drawing on existing partnership meetings.

14.1 Clinical and Professional Leadership.

Key Questions

- how do we ensure the clinical and professional voice leads and influences at all tiers of the proposed partnership arrangements – neighbourhood, implementation, system board, and GM,
- how do we ensure such voice has appropriate mandate. Does this require new forums for election
- is a clinical and professional senate the correct mechanism to ensure partnership and collaboration as well as securing

Forum

To be convened.

14.2 LCO role and Scope

Key Questions

- What will the LCO be doing in the neighbourhoods and across the borough in 2025
- What will be in scope of the LCO by 2025, and what will in scope mean?
- How will services move into scope over time to 2025?
- What organisational form requirements will need to be in place to enable all of the above?

Forum

Sub group already established by the LCO board

14.3 Integrated Delivery Arrangements and the connection to Provider Collaboratives

Key Questions

- How do we create a mechanism for integrated service delivery in the borough, beyond the specific scope of the LCO
- How do we manage the intersection of GM wide provider collaboration and locality delivery
- What is the role of collaboration across the North East Sector
- How do we ensure the full participation in integrated delivery of key supply partners such as the VCFA, BARDOC, Persona, Six Town Housing and others?

Forum

LCO board to convene

14.4 Neighbourhood Working

Key Questions

- How do we ensure neighbourhood working is the focal point for service delivery and integration across health and care ,wider public services and with communities
- How can we support the further maturity and development of Primary Care Networks in Bury and their contribution to neighbourhood working model
- What work does the integrated delivery board and the enabling groups need to do to create the conditions for neighbourhood working to flourish?
- What are the opportunities for the delegation of budget and accountability to integrated neighbourhood teams
- How do we infuse models of asset based working into neighbourhood approach, and ensuring strong connections to the resident and community voice

Forum

An existing OCO/ICO neighbourhood development group to be repurposed and accountable to the System Board as the Transition programme board.

14.5 CCG Staffing Transition

Key Questions

- How do we engage and inform staff and create opportunities for staff to contribute to future partnership arrangements
- How do we ensure the employment promise is delivered
- What are the transition points for current CCG and how are we supporting staff in the next stage
- Should there be a more formal agreement amongst partners that we commit to a principle of not recruiting from the open market before considering the employment needs of our existing work force?

Forum

To be confirmed

Recommendations; It is recommended to designate the System Board as the Transition Programme Board, to confirm the SRO for the Transition programme, and to establish and specify the task groups as outlined above.

15.Summary of Recommendations.

The following recommendations are made:

- Recommendation 1 – The Bury is SCB is recommended to confirm support for Option 2 as part of the GM response to the National consultation to be submitted by 8th January 2021, subject to implementation of financial, governance and staffing arrangements which would provide for accountability at Bury level for integrated community health, primary care, ASC, parts of children's social care, community mental health and medical acute services.

- Recommendation 2- The Bury SCB endorses the GM response to the National Consultation to be submitted by 8th January 2021 subject to the caveats agreed above

- Recommendation 3: SCB is invited to review these proposals as a basis for wider engagement and dialogue on the future of partnership working in the borough

- Recommendation 4; It is recommended to designate the System Board as the Transition Programme Board, to confirm the SRO for the Transition programme, and to establish and specify the task groups as outlined above.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Integrating care - Next steps to building strong and effective integrated care systems across England

RESPONDING TO THE NATIONAL ENGAGEMENT EXERCISE

14th December 2020

1 Introduction

This document proposes a GM response to the engagement questions in the national document, "Integrating care - Next steps to building strong and effective integrated care systems across England", published by NHSI/E on 26 Nov[1].

2 National Changes Proposed

2.1 NHSEI has now published its intentions for Integrated Care Systems across England. It details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective integrated care system (ICS) and the immediate and long-term challenges presented by the COVID-19 pandemic.

2.2 From April 2021 this will require all parts of the health and care system to work together as Integrated Care Systems, involving:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes;
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

3.3 This document also describes options for giving ICSs a firmer footing in legislation likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally.

3 Legislative proposals

[1] https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

- Current legislation[2] does not have a "sufficiently firm foundation for system working"
- NHSEI made recommendations on legislation change in Sep 2019 (the NHS Bill3). They are not detailed here (see paper, section 3.3) but NHSE believe they still stand.
- One of the recommendations was for a new statutory underpinning to establish ICS boards through 'voluntary joint committees' - "an entity through which members could delegate their organisational functions to its members to take a collective decision". Engagement about this raised questions as to whether such a voluntary approach would drive system working.
- The COVID-19 response has increased the desire from the system for clarity about ICSs and the organisations within them, and an NHS Bill was included in the Queen's speech in Jan 2020 and so NHSE believe the time is appropriate to achieve clarity and establish a legislative basis for ICSs.
- The paper outlines two options for "enshrining ICSs in legislation" without "triggering a top-down reorganization".
- Both options (models) have broad membership and joint decision-making, responsibility for the system plan, operating in accordance with a new 'triple aim' duty[4] for all organisations - 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer" - duty and a lead role in relating to national level bodies.
- Both models identify local government as an integral part of the ICS through planning and shaping services, delegation of functions to committees including NHS and local government and exploiting existing flexibility for pooling functions and funding.

3.1 Option 1: a statutory committee model

- This model would include an Accountable Officer (AO) and bind together current statutory organisations.
- The AO would be chosen from the board's mandatory members. Individual organisations would retain their own AOs/CEOS but the ICS AO would be a role recognised in legislation and would have formal duties in relation to delivering the ICS board's functions.
- This is close to the original proposal in Sep 19, and would enable joint decision-making
- There would be one aligned CCG per ICS footprint, and new powers to allow that CCG to delegate many of its population health functions to providers. Current accountability structures for CCGs and providers would remain.
- Downsides to this model include:
    - Lack of clarity of leadership and accountability – especially for patient outcomes and financial matters
    - An ICS and a CCG AO may add to this confusion
    - CCG governing body and GP membership is retained, but it is questionable whether these are sufficiently diverse to fulfil the different role of CCGs in an ICS

3.2 Option 2: a statutory corporate NHS body

- This model would bring CCG statutory functions into the ICS. Additional functions would be conferred on ICSs and existing CCG functions modified to create a new framework of duties and powers.

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[2] National Health Service Act 2006 and the Health and Social Care Act 2012

[3] https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf

[4] https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf

- CCG governing body/membership would be replaced by an ICS board consisting of representatives from system partners, without a power of individual organisational veto.
- Minimum board membership
    - Chair
    - Chief Executive
    - Chief Financial Officer
    - Representatives of NHS providers, primary care and local government
- ICS Chief Executive would be a full-time AO role, strengthening lines of accountability and with a key leadership role in system delivery.
- ICS would have a primary duty to "**secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations**" with the flexibility to make arrangements (through contracts with providers) or delegating responsibility for specified services to one or more providers.

3.3 Response requested

NHS organisations are asked to consider 4 questions relating to the legislative proposals in the paper (see Table) and to respond with views on the proposed options by 8 January 2021.

Table 1

3.3.1 Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4 Proposed Response

4.1 Colleagues across Greater Manchester believe the national document is a significant and positive contribution to the integration of health and social care and to meaningful action to improve health and improve healthcare. We strongly support the document's proposed characteristics for each ICS:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale;
- Developing **strategic commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

4.2 We also strongly support the four fundamental purposes of an ICS:

- **improving population health and healthcare**; because “decisions taken closer to the communities they affect are likely to lead to better outcomes”
- **tackling unequal outcomes and access**; because “collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people”
- **enhancing productivity and value for money**; because “collaboration between providers across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.”
- **helping the NHS to support broader social and economic development**.

4.3 The characteristics and purpose for ICSs proposed strongly match the ambitions for health and social care which each GM district has been pursuing locally over many years and which we have pursued together as the GM Health & Social Care Partnership since 2016. We believe therefore, that the proposals outlined in the document provide the basis for a positive next stage off our journey across Greater Manchester.

4.4 Engagement Questions

Q1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

We agree. In proposing the devolution agreement in 2015 we sought the means to bring the resources and decisions affecting care for local residents closer to them. We also elevated the value of collaboration across organisations, across sectors and between localities as a necessary characteristic of a system organised to pursue shared objectives or a population served jointly. We believe, that the proposals in the national document to establish those through statutory means recognise and fix those objectives for the long term.

The other legislative proposals we believe will help create the conditions for effective place based working both through the duty to collaborate and through the adjustment proposed for the consequent legislative framework.

However, the benefits of this change can only be fully realised if they are genuinely able to support models for comprehensive, place based working with the most local possible control of the range of resources to make that happen. The facility to establish locally accountable place based system boards with the authority and flexibility to jointly control the full range of resources for the populations they serve is the key condition the ICS should be expected to enable.

The risk without this recognition is that decision making actually becomes more distant from communities, is disconnected from those wider public and VCSE services which is the only way to unlock preventative potential and affect patterns of demand on formal health and care services.

Greater Manchester will continue to create the conditions for the deep integration of the local NHS, Local Government, wider public services, the VCSE and local communities in order to improve health as well as health services.

The establishment of the ICS on a statutory footing must therefore, be on the basis of bringing the 10 place based arrangements together in pursuit of shared system wide objectives. This could mirror the arrangement established across the Greater Manchester Combined Authority and the ten GM Councils. In the same way we would envisage an equivalent arrangement to establish the ICS Board to include the leadership in the ten localities. This is, we believe, the right means to

ensure a two tier system does not emerge; and to maintain an alignment between locality and system level activities and priorities.

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We agree, subject to the condition that the ICS Board model is constructed on the basis of place based membership alongside members representing system level accountabilities as proposed above. We believe that model is strengthened by being rooted in place and set to avoid the creation of a two tier, or hierarchical system. We would be concerned that option 1 risks creating confusion through a dual leadership for ICS level functions. Option 2 provides or a clearer structure which will minimise the potential or unnecessarily complicated governance which would undermine the means o supporting the system level collaboration.

The primary statutory duty to "secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations" is very helpful in supporting clarity on obligations to the NHS between the ICS and Parliament. This must not overlook the purpose and objectives however to improve health, reduce health inequalities and tackle unequal access and outcomes.

Option 2 would allow for a more streamlined arrangement to progress the commissioning and delivery of system level services where it is judged that those services are best planned and delivered at the system level for the whole population of 2.8m. Additionally it would confirm a clear vehicle for those services currently commissioned by NHSE to be done at a more local level through the ICS.

Option 2 provides a clearer opportunity to reduce or remove the commissioner/provider separation at the system level and reduce both the associated costs and the time and delay embedded into those avoidable transactional processes. The ambition in localities is to establish local governance and financial lows which similarly reduces the transactional burden of the commissioner provider split and this should be replicated at the system level.

Option 2 could be strengthened further by having clear recommendation about an enhanced role of local authority scrutiny functions to build these into place based whole system scrutiny of quality, finance and other mattes requiring more granular review than can occur at the level of the ICS.

Q3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

We agree. We have clear ambitions for the membership and governance to be broad and open to wider public services and civil service partners from the VCSE sector and welcome the opportunity that a permissive framework allows. This is true at both place/district level and at the GM level.

At the same time we have seen the value of blending political, clinical/professional, patient/resident and expert managerial leadership. This also, therefore, provides the necessary flexibility to allow us to establish and benefit from that breadth of leadership.

The potential for place based provider collaboratives is immense. New models spanning social, emotional, psychological and medical approaches are the key to public service transformation and the ability to improve health.

Those models maximising the social value they bring to local places over the coming decade will be central to the nation's recovery from the social and economic effects of the pandemic.

This is potentially a radical development of the FT model and will require regulators to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

Q 4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

We agree. Our ambition is to fully join pathways so that coordinated decisions are made locally and funding is used in the most effective way possible to improve outcomes for the population. When the Greater Manchester Health and Social Care Partnership (GMHSCP) formally took charge of the £6bn health and social care budget on 1 April 2016, it also assumed delegated responsibility for a wide range of specialised services.

Working through integrated local arrangements, including Lead Providers, we have been able to plan and build more comprehensive service models through wellbeing, integrated community provision, and GM models of service which span locality boundaries and more specialist services. This has already delivered benefits which we would hope to build on, including:

This plan has led to closer integration commissioning arrangements supporting acute and mental health service transformation to deliver:

- The Improving Specialist Care Programme Investments into Specialised Commissioned level 1 Neurorehabilitation to deliver the new standards within the Model of Care.
- GM Population Health Priorities such as supporting plans to roll out Lung Health checks in localities and joint planning for increased tertiary lung resections as a consequence of increased CCG screening initiatives. Specialised commissioning recommendations have also informed the case for change to reshape services for people living with HIV in GM within the GM Sexual and Reproductive Health Strategy.
- GM Mental Health Transformation Programmes through supporting the development of new delivery models for Tier 4 Child and Adolescent Mental Health Service and Adult Secure service provision.
- Regional and national specialised service developments (non-delegated services) within Greater Manchester such as the establishment of of the GM level 2 adult Congenital Heart Disease service as an integral part of a North-West CHD Network at MFT and establishing new CAR-T treatments therapies for children and young people with B cell acute lymphoblastic leukaemia.
- NHS England national policy service developments such as the implementation of 5 year delivery plans for Intra Arterial Thrombectomy (IAT) across GM to achieve a 24/7 service by 2021/22.
- New Innovations such as GM's Early Adopter Status for Primary Care-led Transgender Health Service development.

The delegation and transfer of responsibilities is the means rather than the ends of course. It should follow the broader principle outlined in the national document, and supported here, to continually seek to bring decisions as close to communities as possible and to bring together physical and mental, social and medical approaches to support comprehensive care and recovery focussed approaches.

5 Recommendation

5.1 Partnership Executive Board is asked to:

i. Discuss the proposed response and agree any amendments or additions.

ii. Agree intentions to confirm local and organizational support to the response.

EQUALITY ANALYSIS

This Equality Analysis considers the effect of Bury Council/ Bury CCG activity on different groups protected from discrimination under the Equality Act 2010. This is to consider if there are any unintended consequences for some groups from key changes made by a public body and their contractor partners organisations and to consider if the activity will be fully effective for all protected groups. It involves using equality information and the results of engagement with protected groups and others, to manage risk and to understand the actual or potential effect of activity, including any adverse impacts on those affected by the change under consideration.

SECTION 1 – RESPONSIBILITY AND ACCOUNTABILITY *Refer to Equality Analysis guidance page 4*	
1.1 Name of policy/ project/ decision	**Bury Response to NHS England Document 'next Steps for Integrated Care'**
1. 2 Lead for policy/ project/ decision	**Will Blandamer – Executive Director, Strategic Commissioning**
1.3 Committee/Board signing off policy/ project/ decision	**Strategic Commissioning Board**
1.4 Author of Equality Analysis	*Name: Will Blandamer* *Role: Executive Director, Strategic Commissioning* *Contact details: w.blandamer@bury.gov.uk*
1.5 Date EA completed	***11/12/20***

SECTION 2 – AIMS AND OUTCOMES OF POLICY / PROJECT *Refer to Equality Analysis guidance page 5*	
2.1 Detail of policy/ decision being sought	The paper describes supports the consideration of the SCB of the GM Response to the NHS England Cconsultaiton on next steps for integrated health and care. The paper also describes the development of a programme approach to the transition period for the Bury Health and Care System to April 2022
2.2 What are the intended outcomes of this?	To endorse the GM submission and to develop a robust transition process.

SECTION 3 – ESTABLISHING RELEVANCE TO EQUALITY & HUMAN RIGHTS *Refer to Equality Analysis guidance pages 5-8 and 11* Please outline the relevance of the activity/ policy to the Public Sector Equality Duty

General Public Sector Equality Duties	Relevance (Yes/No)	Rationale behind relevance decision
3.1 To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010	**No**	
3.2 To advance equality of opportunity between people who share a protected characteristic and those who do not.	**Yes**	To ensure the arrangements of the health and care system in Greater Manchester and in Bury make a rooted to principles of addresses health inequality included health inequaites of those with protected characteristics
3.3 To foster good relations between people who share a protected characteristic and those who do not	**No**	
3.4 Please outline the considerations taken, including any mitigations, to ensure activity is not detrimental to the Human Rights of any individual affected by the decision being sought.		

SECTION 4 – EQUALITIES DATA *Refer to Equality Analysis guidance page 8*			
Protected characteristic	**Outcome sought**	**Base data**	**Data gaps (to include in Section 8 log)**
4.1 Age		Bury has a relatively younger population profile, similar to England overall, with more people aged between 30-39, and 50-59 (2018 Office of National Statistics Mid-Year Estimates) By 2021 the number of people aged under 20 years old is expected to increase by 2%. The over 65 year old population is expected to increase by 6%. The over 80 year old population is expected to increase by 11%.	
4.2 Disability		Over 21,224 people in Bury have a limiting long-term illness, health problem or disability equating to 11.24% of our resident population, compared to 18.8% of the population of England and Wales (2011 Census). Instances of disability rise significantly with age. As life expectancy increases, the number of people with complex	

		care needs rises too. The number of people providing unpaid care is around 19,954, of which 2.5% care for 50 hours or more.	
4.3 Gender		The gender split within Bury is 51% female and 49% male. This is the same as the gender split for England and Wales (2011 Census).	
4.4 Pregnancy or Maternity		**Further detail to follow.**	
4.5 Race		Bury has a Black, Asian and Minority Ethnic (BAME) population of around 10.8% compared to 14.7% of the population of England and Wales (2011 Census). The Borough has a number of emerging communities' and data from the Government shows that there are 495 refugee and asylum seekers in Bury receiving section 95 support intended to meet essential living needs. In the North West region, the nationalities of those seeking asylum are predominantly from Pakistan, Iran, Iraq and Nigeria.	
4.6 Religion and belief		A majority of Bury's residents are Christian (62.7%), followed by Muslim (6.1%) and Jewish (around 5.6%). 18.6% identified as having no religion. This compares to the population of England and Wales as Christian (59.3%), followed by Muslim (4.8%), Hindu (1.5%), Sikh (0.8%) and then Jewish (0.5%). 25.1% identified as having no religion (2011 Census).	
4.7 Sexual Orientation		There is currently no national or local data on sexual orientation. However, estimates provided by the LGBT Foundation and Stonewall that	

		between 5% and 7% of the population identify as Lesbian, Gay or Bisexual nationally.	
4.8 Marriage or Civil Partnership		The Census 2011 showed those married as 70,088 and those in a registered same-sex civil partnership status as 253 in Bury.	
4.9 Gender Reassignment		There is currently no national or local data on gender identity. However, estimates provided by the Lesbian, Gay, Bisexual and Transgender (LGBT) Foundation that 1 in 4,000 people in the UK seek support to change their birth gender.	
4.10 Carers		**Further detail to follow.**	
4.11 Looked After Children and Care Leavers		As of the 31st March 2017 there were a total of **350** Children in Our Care from Bury (0 – 18 years). The largest cohort by age of our children (at 31 March 2017) was between 10 to 15 years at 35% of Children in Care, there are more males than females. Our children come from a range of backgrounds with the largest ethnicity cohort being White/British.	
4.12 Armed Forces personnel including veterans		**Information in development**	
4.13 Socio-economically vulnerable		**Information in development**	

SECTION 5 – STAKEHOLDERS AND ENGAGEMENT *Refer to Equality Analysis guidance page 8 and 9*		
	Internal Stakeholders	External Stakeholders
5.1 Identify stakeholders	Staff from Council and CCG and Governing Body Members	Key partners in the health and care system – NCA, Pennine Acute, Bardoc, GP Federation, Health wtch, VCFA, LCO
5.2 Engagement undertaken	On going process of engagement as detailed in report	On going process of engagement as detailed in report
5.3 Outcomes of engagement	To be reflected in development of transition programme	To be reflected in development of transition programme
5.4 Outstanding actions following engagement		

(include in Section 8 log)		

SECTION 6 – CONCLUSION OF IMPACT *Refer to Equality Analysis guidance page 9* Please outline whether the activity/ policy has a positive or negative effect on any groups of people with protected inclusion characteristics		
Protected Characteristic	**Positive/ Neutral Negative/**	**Impact (include reference to data/ engagement)**
6.1 Age	Further detail to follow.	
6.2 Disability		
6.3 Gender		
6.4 Pregnancy or Maternity		
6.5 Race		
6.6 Religion and belief		
6.7 Sexual Orientation		
6.8 Marriage or Civil Partnership		
6.9 Gender Reassignment		
6.10 Carers		
6.11 Looked After Children and Care Leavers		
6.12 Armed Forces personnel including veterans		
6.13 Socio-economically vulnerable		
6.14 Overall impact - What will the likely overall effect of your activity be on equality, including consideration on intersectionality?		

SECTION 7 – ACTION LOG *Refer to Equality Analysis guidance page 10*			
Action Identified	Lead	Due Date	Comments and Sign off (when complete)
8.1 Actions to address gaps identified in section 4			
8.2 Actions to address gaps identified in section 5			
8.3 Mitigations to address negative impacts identified in section 6			

8.4 Opportunities to further inclusion (equality, diversity and human rights) including to advance opportunities and engagements across protected characteristics			

SECTION 8 - REVIEW *Refer to Equality Analysis guidance page 10*			
Review Milestone	Lead	Due Date	Comments (and sign off when complete)