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

Executive Summary
This document confirms the partnership arrangements to be developed that have previously been agreed, and provides a suite of documents that support those arrangements to progress as soon as possible and by October 2021 in line with GM Expectations.
Recommendations
It is recommended that the Strategic Commissioning Board: • Endorses the documentation as indicated.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Yes
The risk of business continuity around the ICS transition arrangements.	

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

Implications						
from the proposal or decision being requested?						
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Fully aligned					
How do proposals align with Locality Plan?	Fully Aligned					
How do proposals align with the Commissioning Strategy?	Fully Aligned					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	Creates the conditions To continue our work on the integration of health and care services, and the focus on inequalities and population health gain.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above*					

Implications	
	implications.

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

Bury Locality Partnership Arrangements.

Paper for the System Board on 19th August,

to be subsequently revised for consideration by the

Strategic Commissioning Board on 6th September

Will Blandamer – Executive Director of Strategic Commissioning

Draft 3 – 20th August

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

Appendix 1 - Locality plan

Appendix 2a – Draft Locality Board Terms of Reference

Appendix 2b – Place Based Lead

Appendix 3 – Integrated Delivery Collaborative Board Terms of Reference

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

Appendix 5 – Clinical and Professional Senate Development and Transition

Appendix 6 – Towards a GP Collaborative for Bury

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

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

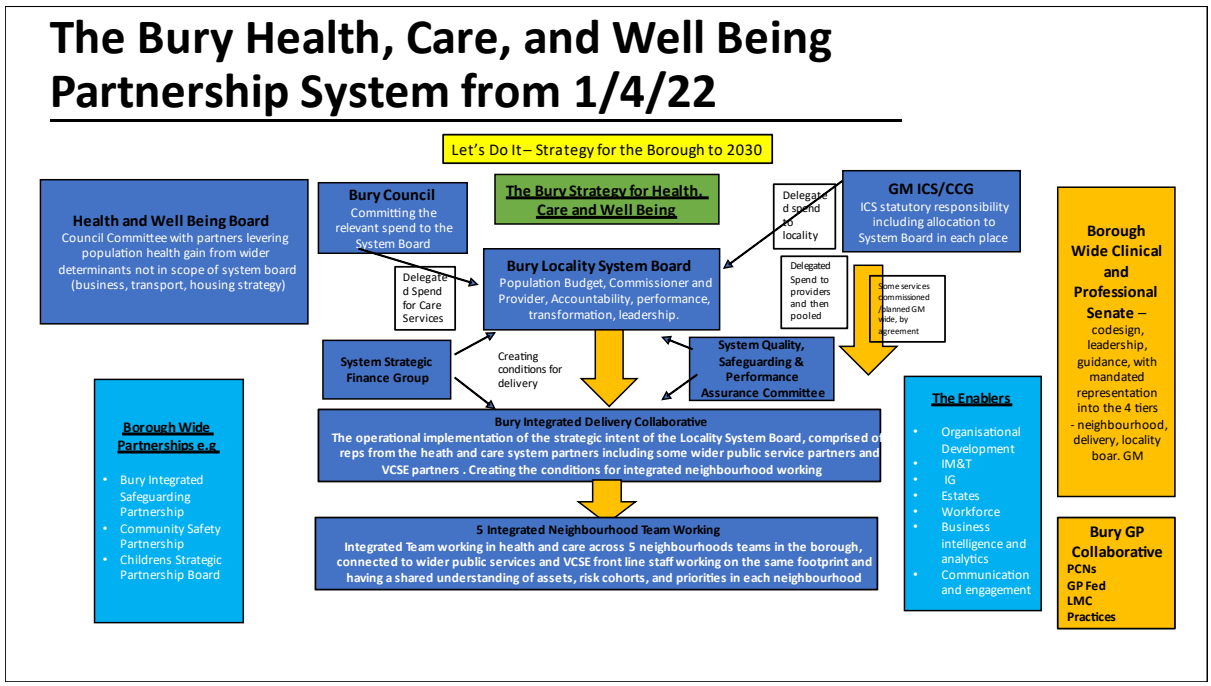
A. Background.

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

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

B. Partnership Arrangements - Update

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



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

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

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

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

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

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

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

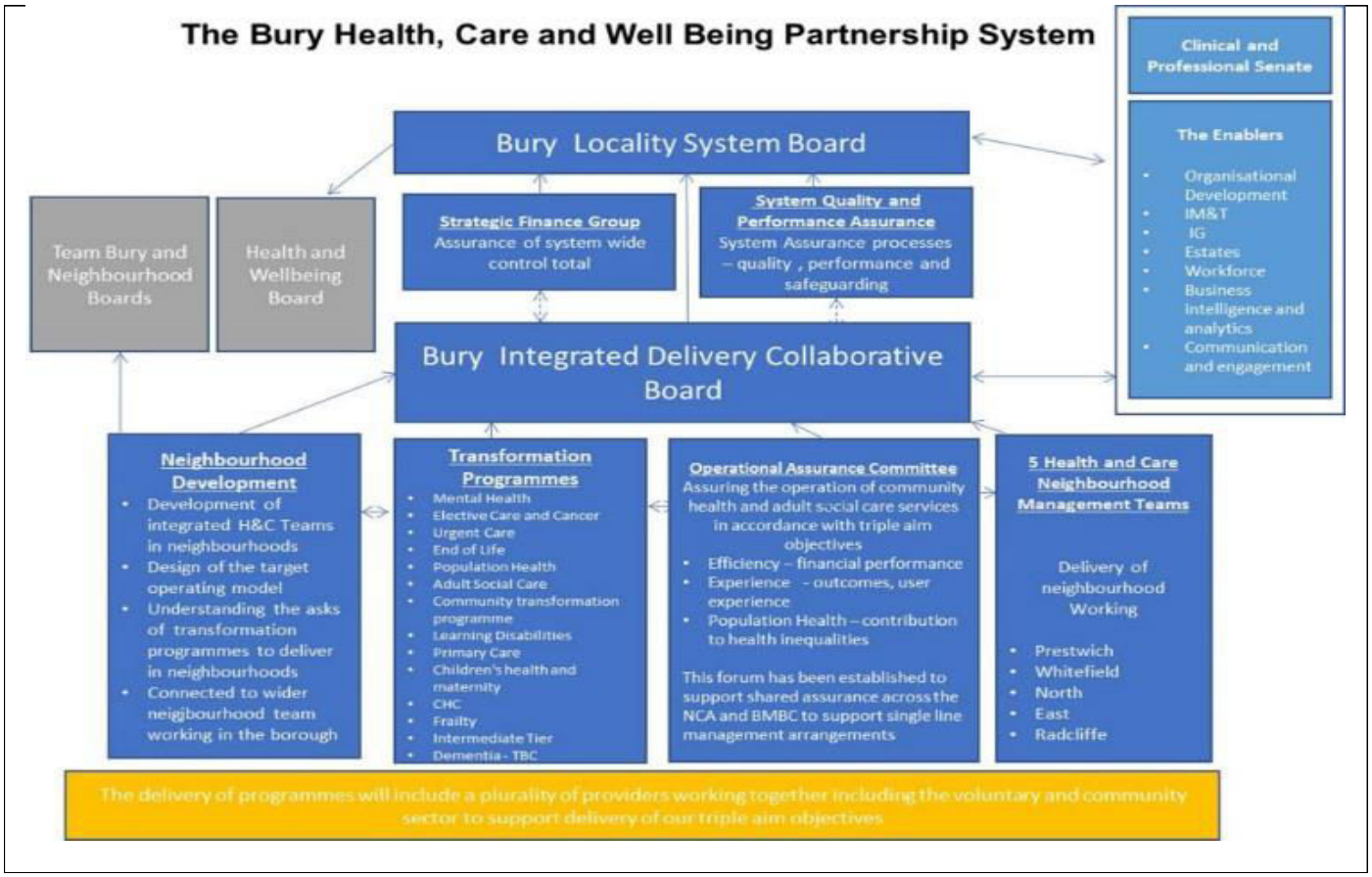
Recommendation: The SCB is asked to comment on the terms of reference including membership for the shadow locality board to operate from October 2021 but note further versions may be required as the precise obligations in terms of an accountability agreement with GM are confirmed. The SCB is invited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

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

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

3) Integrated Delivery Collaborative Board

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



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

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

4) The Health and Well Being Board

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

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

5) Clinical and Professional Senate

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

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

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

6) GP Collaborative

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

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

7) Strategic Finance Group

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

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

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

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

8) System Quality, Safeguarding and Performance Committee.

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

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

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

C) Partnership Arrangements – Transition.

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

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

a. Establish the shadow Locality Board from October.

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

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

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

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

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

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

Appendix A

GOVERNING BODY FORWARD PLAN TRACKER

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

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

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

Appendix B

SCB FORWARD PLAN TRACKER

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

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

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

Refreshed Bury Locality Plan

The Bury Strategy for

Health, Care, and Well Being

Draft Version 6

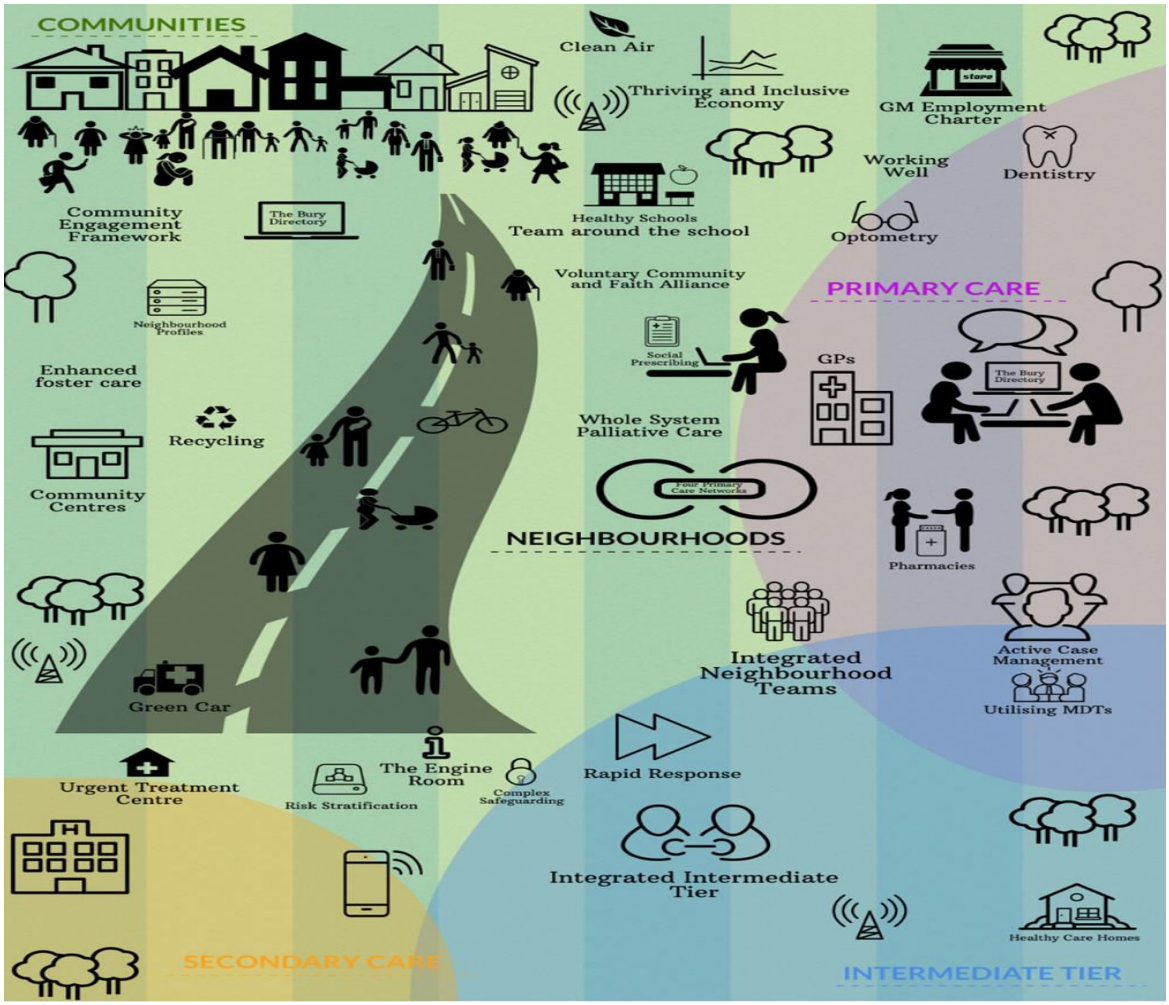
Endorsed at System Board 20/8/21

For approval at SCB

Will Blandamer

6/8/2021

For Review January 2022



Executive Summary

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

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

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

Contents

A. Background

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

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

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

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

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

B. Context

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

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

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

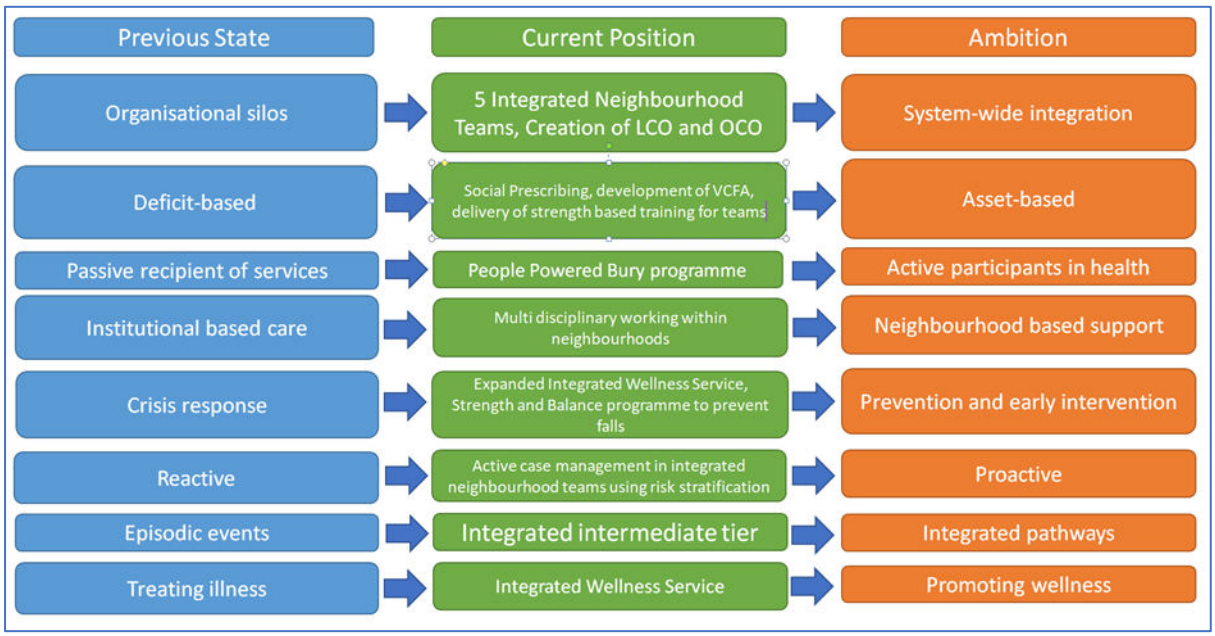
    c. The NHS White Paper of March 2021 has signalled a shift in the focus of the system – from competition to collaboration in the NHS, to a focus on 'place', to a blurring of the commissioning/provision distinction. It signals the end of CCGs from 31/3/22 to be replaced by a GM Integrated Care System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

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

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

C. Progression of the Health and Care System

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Financial Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

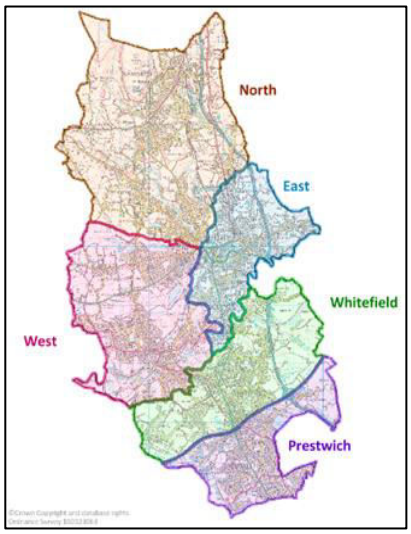
24. We have several excellent examples of co-design and co-production of transformed services that reflect these "I statements" with residents, carers and patients, for example in the SEND transformation programme, and in our work with residents with learning disabilities. However, we recognise that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

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

I. The Way we work – Neighbourhood Team Working

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

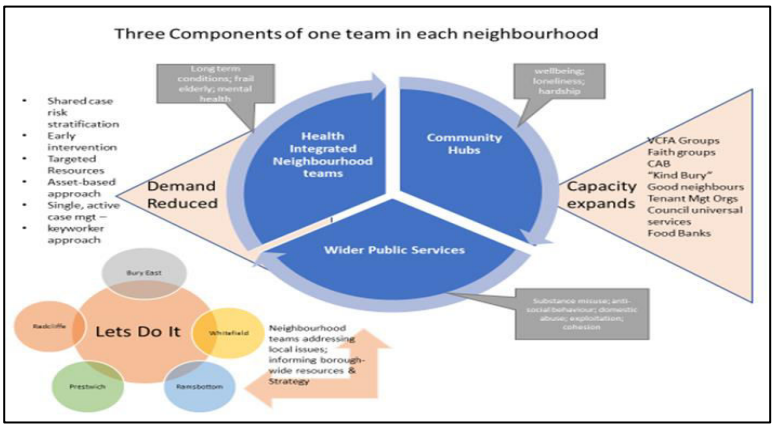
27. Integrated Neighbourhood teams (INTs) were created, providing unified management or a coordinating focus across community health services, adult social care and more recently community mental health services, and connected to communities. INTs have focused initially on delivering Active Case Management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



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

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

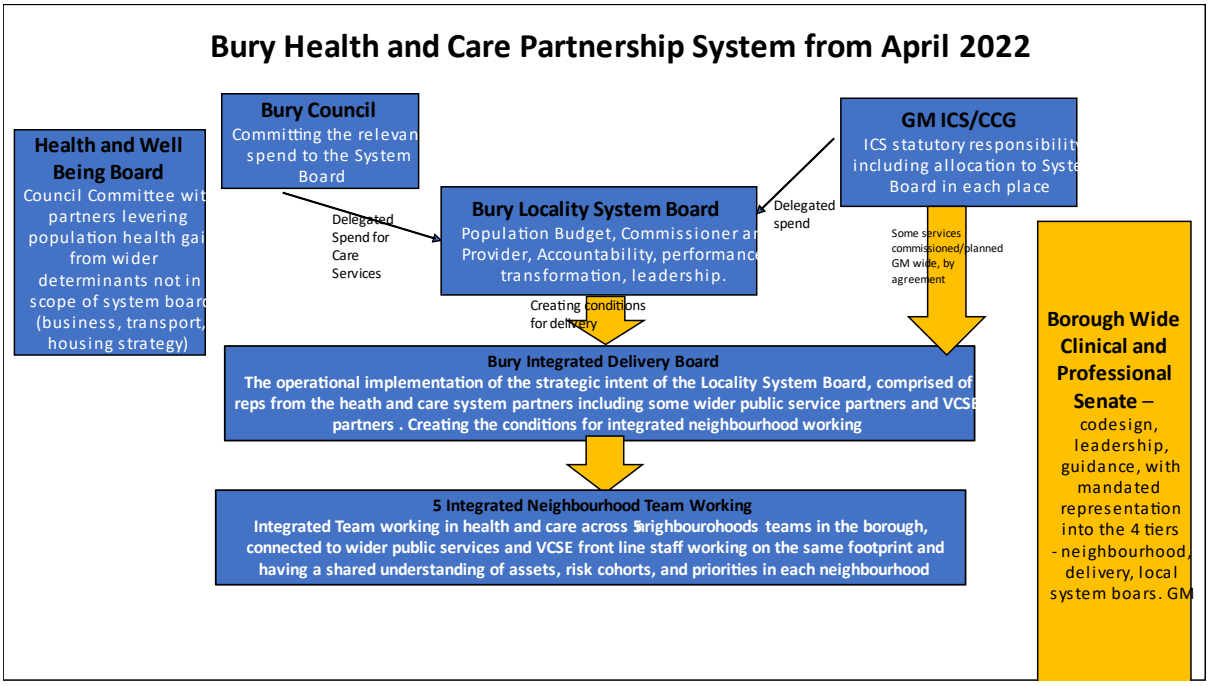
30. Neighbourhood team working in health and care is one part of a wider ambition in "Lets Do It" to build integrated teams of public services, working with communities differently. The other two parts – the work of community hubs, and the work to organise wider public services like GMP. DWP, housing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



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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

K. Our Transformation Programmes

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

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

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

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

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

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

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

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

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

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

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

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

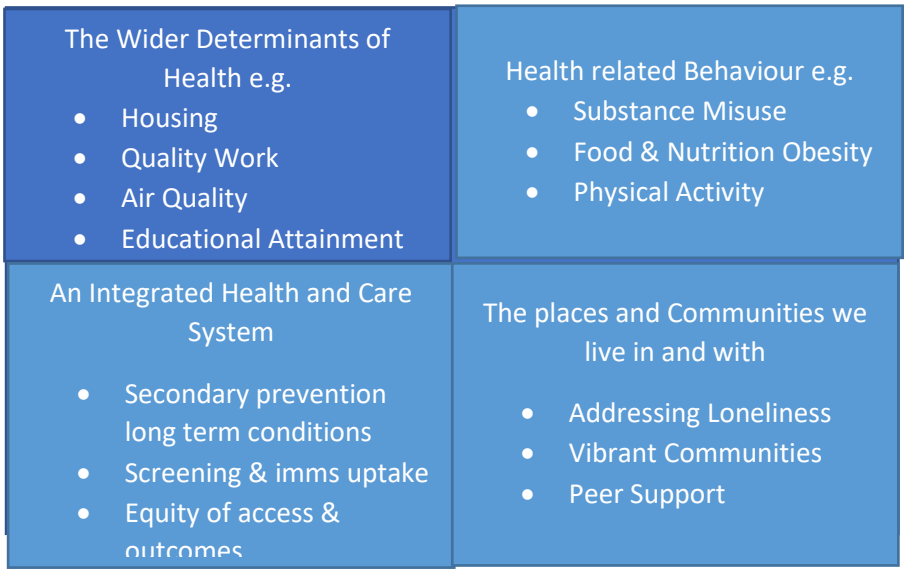
37. The programmes above are intended to transform the way key services work. There are, in addition, very many important programmes of work that reflect a business as usual – our work on safeguarding arrangements with partners and in the context of the Bury Integrated Safeguarding Partnership, or work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

L. A Population Health System Approach in Bury

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

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

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



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

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

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

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

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

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

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

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

The Bury Health, Care and Well Being Partnership

Bury Locality System Board

Draft Terms of reference

Draft Version 8 -24/8/21

Draft Version 7 – 20/8/21

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

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

Will Blandamer

For Review January 2022

1 Purpose

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

2 Status and authority

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

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

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

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

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

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

3 Responsibilities

3.1 The Locality Board will:

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

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

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

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

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

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

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

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

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

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

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

3.1.12 Agree policy as required.

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

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

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

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

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

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

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

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

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

4 Accountability

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

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

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

5 Membership and Quoracy

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

Voting Members

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

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

Clinical Representation (4)

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

Managerial Leadership (5)

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

Non Voting Members

Routinely attending (4)

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

In attendance as required (3)

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

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

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

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

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

6.1 to be confirmed

7 Conduct of business

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

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

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

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

8 Decision making and voting

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

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

9 Conflicts of interests

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

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

10 Confidentiality

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

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

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

11 Support

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

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

12 Review

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

Bury Health, Care and Well Being Partnership

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

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

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

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

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

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

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

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

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

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

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

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

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

11. The recommendation of the paper is therefore to;

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

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

Appendix 1

Extract of the ICS development framework – June 2021

Place-based partnerships

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

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

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

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

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

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

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

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

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

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

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

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

Schedule X

BURY HEALTH, CARE AND WELL-BEING PARTNERSHIP

Bury Integrated Delivery Collaborative

Integrated Delivery Board

Terms of reference

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

1. Purpose of the Board

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

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

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

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

2. Principles

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

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

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

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

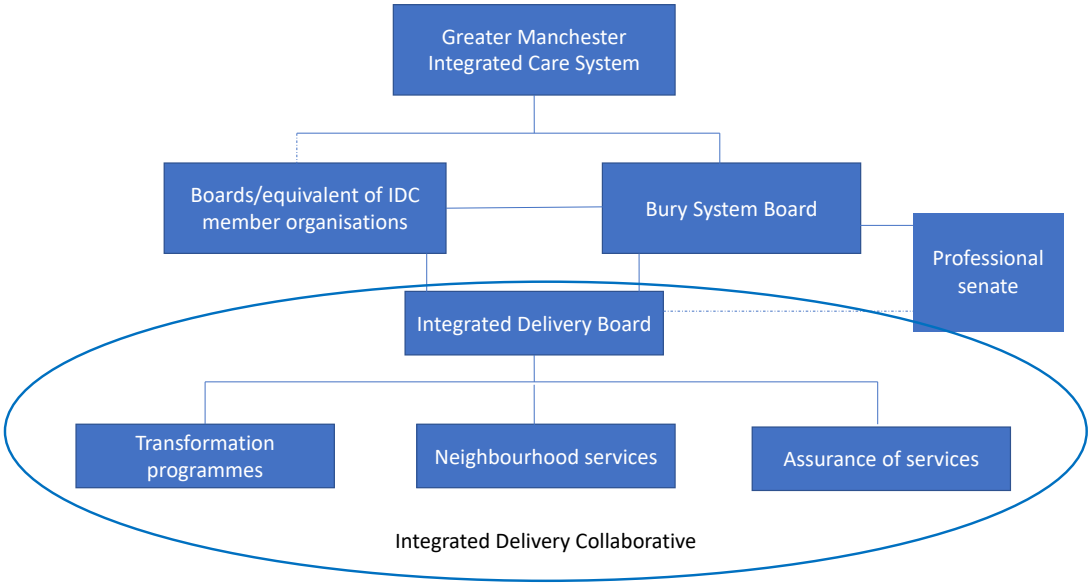
- Financial sustainability and the sustainability of the services which make up the health and social care system as a whole is essential to the success of the

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

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

3. Powers

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



4. Responsibilities

The responsibilities of the ID Board shall be:

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

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

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

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

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

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

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

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

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

5. Membership

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

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

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

The ID Board directors shall be:

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

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

The nominated ID Board deputy directors shall be:

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

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

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

c) Stakeholder members

Stakeholder members shall be as follows:

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

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

d) Executive members

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

a) Chief Officer

b) Director of Transformation and Delivery

c) Director of Finance

d) Associate Director of Finance

e) Governance Manager

e) Co-opted members

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

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

None specified

6. Meetings

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

7. Voting

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

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

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

8. Quoracy

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

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

9. Chairing

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

The Independent Chair shall not have a vote.

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

10. Accountability

The ID Board shall be accountable to:

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

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

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

11. Conduct of business

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

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

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

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

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

12. Conflicts of interests

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

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

13. Confidentiality

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

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

14. Review

These terms of reference shall be reviewed in March 2022.

The Bury Health, Care and Well Being Partnership

Bury Health and Well Being Board

Terms of reference

Note

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

1. VISION

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

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

2. MEMBERSHIP

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

Core voting members:

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

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

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

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

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

3. FUNCTION

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

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

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

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

4. KEY RESPONSIBILITES OF THE BOARD

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

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

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

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

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

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

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

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

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

- Ensure overarching actions to reduce health and social inequalities.

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

5. MEETINGS

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

The Health and Wellbeing Board will meet every six weeks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REPORTING STRUCTURES

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

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

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

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

Clinical and Professional Senate for Bury

Proposal and Next Steps

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

Version: **V4 – 220th August 2021**

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

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

Next Steps

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

1. Background.

The introduction of CCGs gave GPs control over local NHS spend. Within Bury this led to the creation of a Governing Body with an elected Clinical Chair and four elected Clinical Directors. The role of these clinicians was to provide clinical leadership to the organisation and ensure that grassroots clinical insight helped drive forward change.

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

A clinical cabinet was set up where the clinical leads came together with senior managers and some partners to make delegated decisions on commissioning priorities, approve strategies, peer review the work of the clinical leads and to provide wide ranging clinical advice to the system.

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

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

2. Current Context

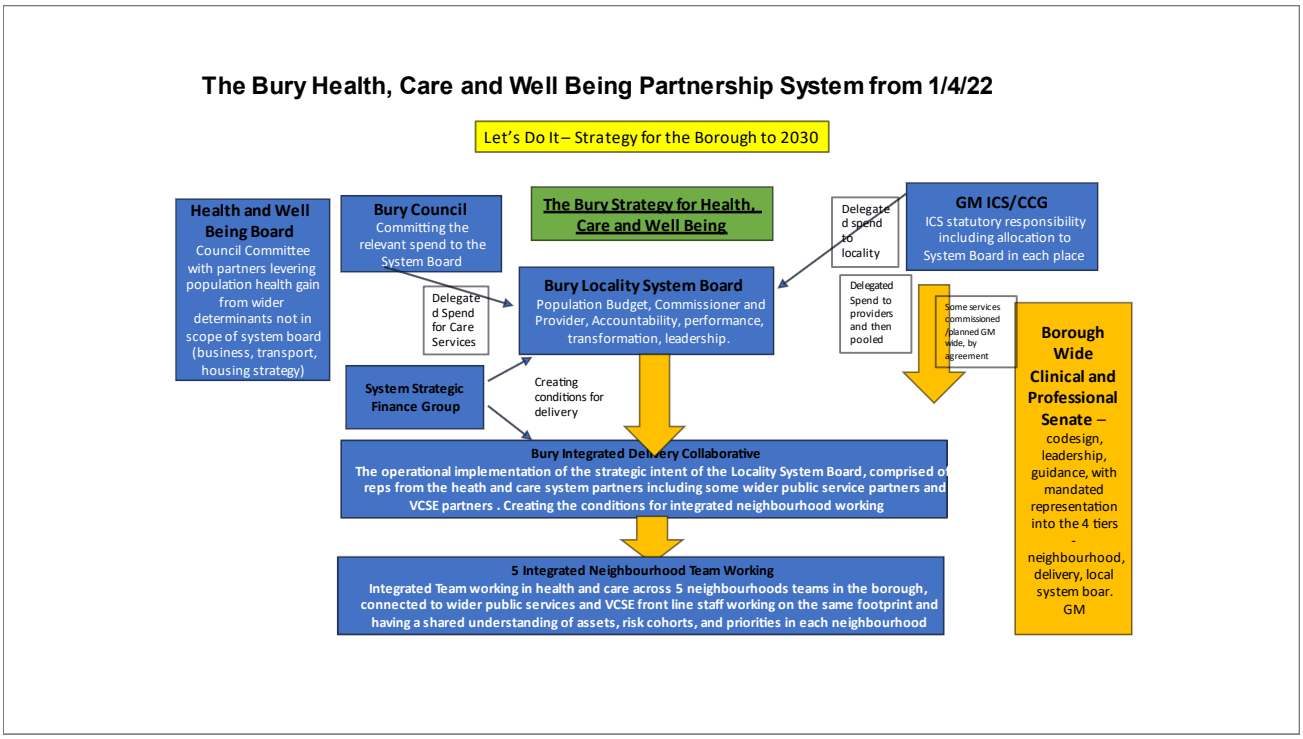
Subject to legislation expected in July 2021 the CCG will be disbanded from April 2022. This creates a risk that the considerable progress in ensuring clinical leadership is driving transformation and reform in the Bury partnership system could be lost.

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

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

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

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



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

3. Clinical and Professional Senate Role:

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

3.1 The Clinical and Professional Senate as a network

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

3.2 The Clinical and Professional Senate 'Board.

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

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

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

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

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

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

4. Clinical and Professional Senate Membership:

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

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

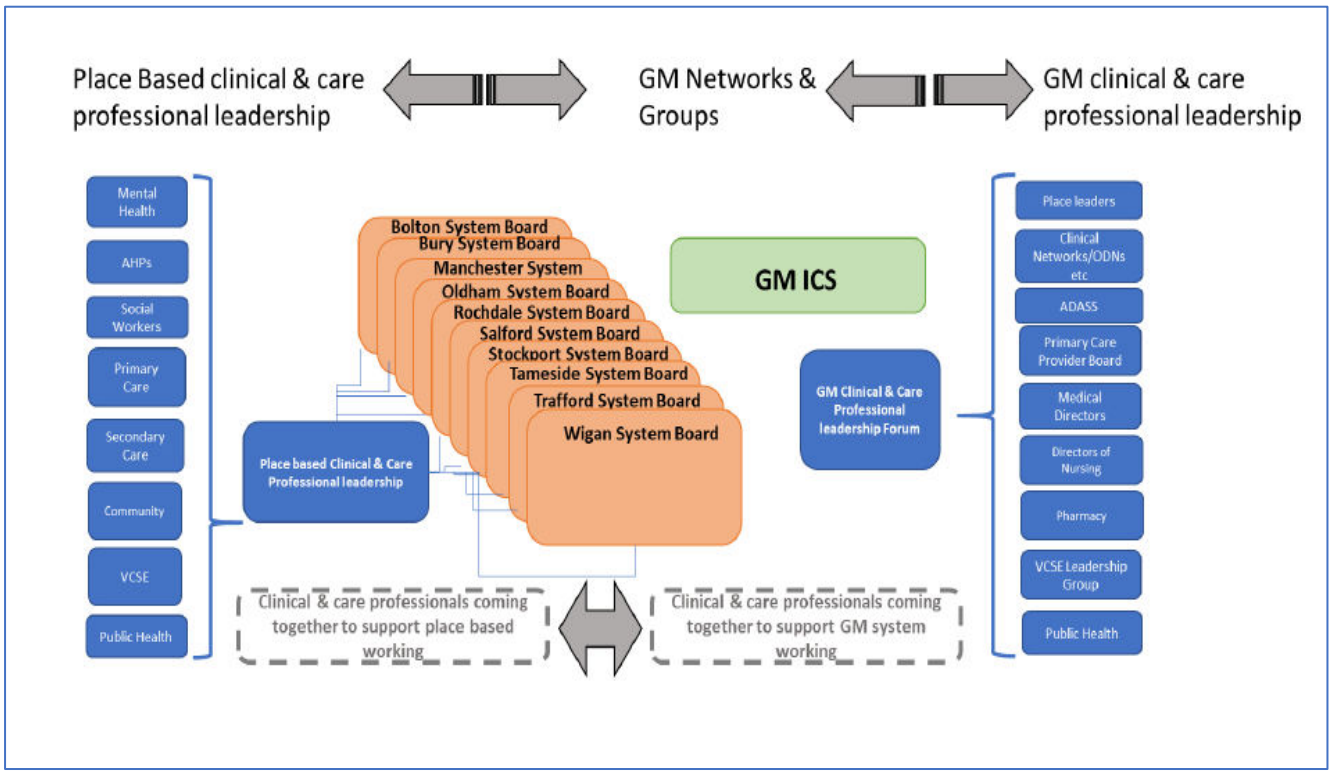
In practical terms this means that each member will be mandated by the section of the community they represent. This will be by election or another fair and agreed process, drawing on the managed network of practitioners established.

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

Proposed membership can be found in appendix 2

5. GM Clinical and Professional Senate

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



6. Next Steps

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

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

Appendix 1

Clinical and Professional Senate Proposed Roles

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

Aims:

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

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

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

Need to understand interaction with patient and public voice and safeguarding

Appendix 2

Clinical Senate Proposed Membership – draft for discussion

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

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

Towards a GP Collaborative in Bury?

Will Blandamer

9/8/21

Background.

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

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

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

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

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

Next Steps

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

Herefordshire General Practice Leadership Team

Who are we?

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

What is our role?

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

Working together to provide a single co-ordinated approach

How we work

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

We are committed to:

Engaging & communicating with GP practices and system partners

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

Being the voice of Herefordshire General Practice

Providing **Clinical Leadership**

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

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

Respecting LMC responsibilities, with LMC being our critical friend

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

Herefordshire General Practice
Taurus Healthcare

NHS
Bury
Clinical Commissioning Group

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

Review September 2021

Terms of Reference Document Control Sheet

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

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

Version Control

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

1.0 Purpose

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

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

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

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

2.0 Functions

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

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

3.0 Objectives

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

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

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

4.0 Membership

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

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

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

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

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

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

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

4.6 Frequency

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

5.0 Accountability and Reporting

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

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

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

6.0 Conduct of Meetings

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

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

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

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

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

6.6 Behaviours

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

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

7.0 Review

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

BURY HEALTH, CARE AND WELL BEING PARTNERSHIP

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

1. Executive Summary

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

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

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

2. Introduction

Why is system assurance important?

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

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

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

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

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

3. Opportunities

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

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

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

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

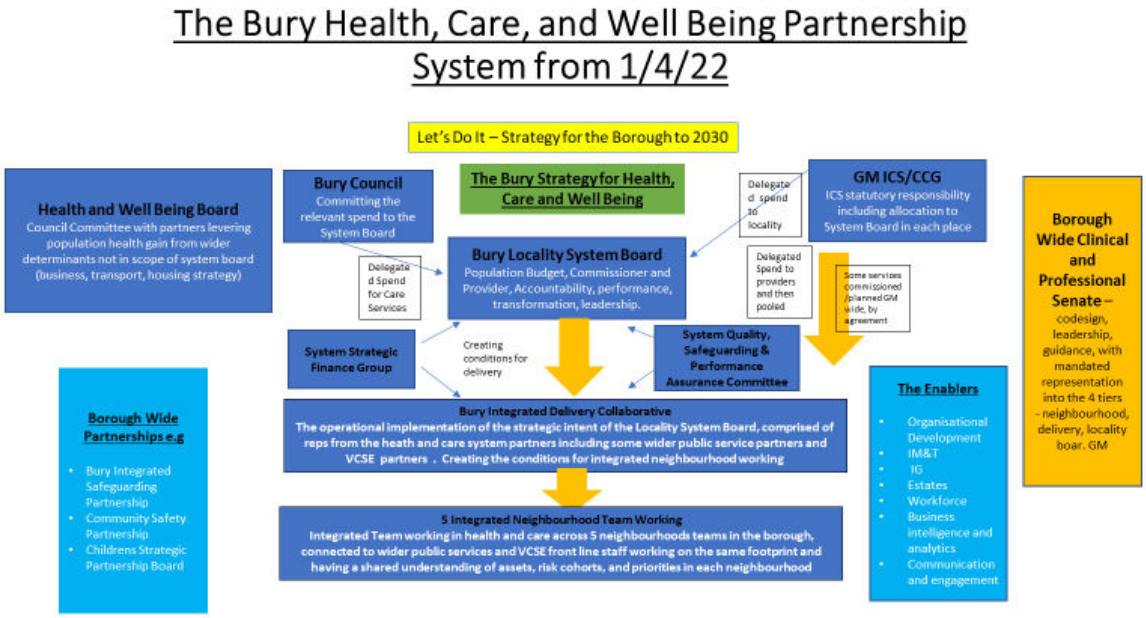
[6] https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf
[7] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version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

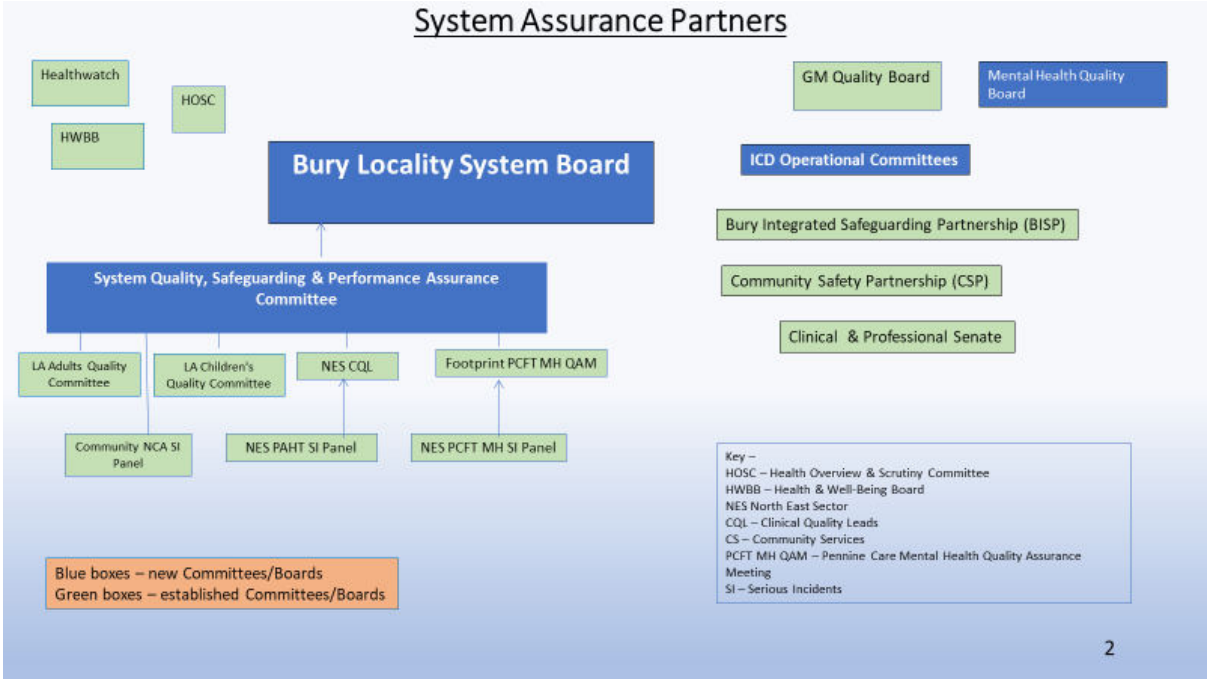
objectives. With this guidance we can begin to develop our local assurance model that will support the GM ICS but will ensure locally we can describe the quality of the local offer.

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

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

5. The Developing Locality Construct





6. Recommendations

The System/Transition Board are asked to:

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

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

Appendix 1

Local Authority Legislation

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

Plus functions in:

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

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

• Carers (Equal Opportunities) Act 2004

• Mental Capacity Act 2005

• Health and Social Care Act 2012

• Mental Health (Amendment) Act 1982

• Equality Act 2010

• Care Act 2014

Local Current Quality & Safeguarding Functions including statutory functions

Patient safety as directed by the Serious Incident Framework

Children & Young People and SEND assurance

Learning Disabilities and Autism assurance

Infection Prevention and Control policy and assurance

Mental Health Homicides/Independent Investigations oversight

Continuing Health Care process and assurance

Patient Experience & Commitment to Carers assurance

Care Home assurance

Coronial processes oversight including Regulation 28 orders

Development of Patient Safety Specialist Roles and oversight requirements

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

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

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

Continued oversight of Provider Mortality and Structured Judgement Reviews

Quality oversight of maternity services and standards including Ockenden standards

Harm reviews due to extended elective/cancer waits

Staff and patient engagement forums

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

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

Monitoring of Looked after Children (LAC) Key Performance Indicators

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

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

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

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

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

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

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

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

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

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

Small provider safeguarding assurance

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