BURY HEALTH, CARE AND WELL BEING PARTNERSHIP

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22.06.21	1.0	Jill Stott	Draft Minutes submitted to W.Blandamer for checking
25.06.21	2.0		With amendment by W Blandamer
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Signature:			.....

Bury System/Transition Board

MINUTES OF MEETING
17 June 2021, 10.30 – 12:45 Via Teams **Chair –** Cllr Eamonn O'Brien

Members Present:

Cllr Eamonn O'Brien, Leader of the Council (EO'B)
Mr Geoff Little OBE, Chief Officer, Bury CCG/Bury Council (GL)
Ms Kath Wynne-Jones, Chief Officer, Bury LCO (KWJ)
Cllr Andrea Simpson, Chair/Deputy Leader and Cabinet Member for Health and Wellbeing, Bury Council (AS)
Ms Lesley Jones, Director of Public Health, Bury Council (LJ)
Mr Will Blandamer, Executive Director of Strategic Commissioning, Bury CCG/Bury Council (WB)
Mr Howard Hughes, Clinical Director, NHS Bury CCG (HH)
Mr Chris O'Gorman, Independent Chair, IDC Board (CO'G)
Ms Lindsey Darley, Director of Transformation and Delivery, Bury LCO (LD)
Ms Catherine Jackson, Executive Board Nurse, Bury CCG (CJ)
Mr Tyrone Roberts, Director of Nursing & (Interim) Chief Officer, Bury Care Organisation (TR)
Mr Sajid Hashmi, MBE, Chair Bury VCFA (SH)
Ms Mui Wan, Associate Director of Finance, Bury LCO (MW)
Ms Sam Evans, Executive Director of Finance, NHS Bury CCG and Bury Council (SE)
Mr Ian Mello, Director of Secondary Care Commissioning, Bury CCG (IM)
Ms Catherine Wilkinson, Director of Finance, Bury Care Organisation (CW)

Others in attendance:

Ms Jill Stott, LCO Governance Manager (JMS) - minutes
Ms Vicky Clark, Assistant Director Public Service Reform, Bury Council (VC)
Ms Cath Tickle, Commissioning Programme Manager, Bury CCG (CT)

Apologies

Apologies for absence were received from:

Dr Jeff Schryer, Chair Bury CCG
Ms Sheila Durr, Executive Director Children and Young People, Bury Council
Dr Cathy Fines, Clinical Director, NHS Bury CCG
Dr Daniel Cooke, Clinical Director, NHS Bury CCG
Mr Keith Walker, Executive Director of Operations, PCFT
Dr Kiran Patel, Medical Director, Bury LCO
Ms Lynne Ridsdale, Deputy Chief Executive, Bury Council
Ms Sian Wimbury, Network Director of Operations: Mental Health, PCFT

MEETING NARRATIVE & OUTCOMES

1.	**Welcome and Apologies**
	EO'B welcomed those present to the Bury System/Transition Board and apologies were noted as outlined above.
2.	**Declarations of Interest**

	Members were asked to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Bury System/Transition Board. None were declared.
3.	**Minutes of Last Meeting (20 May 2021)**
	The minutes of the previous meeting were agreed as a correct record.
4.	**Review of Action Log**
	The Action Log was noted, and updates were recorded within the log accordingly.
	TRANSITION PROGRAMME
5.	**GM ICS Transition**
5(i)	**Update** GL referred to the ICS design framework document which had been released by NHSE/I on 16 June; he explained the context of the document and some of the background intentions around collaborative working, taking positives from the response to Covid and working at pace. He also outlined some of the challenges within the system, including increased waiting times, pressures on Primary Care, health inequalities and pressures on staff. He noted the ongoing commitment to joined up services and getting the maximum value for money across the system. **Action: link to the ICS Design Framework document to be share with Board (ref A/06/01)** From the document GL highlighted the proposed governance arrangements, which include a separate GM Partnership Board and an NHS Board. He explained that the Partnership Board will lead on strategy and will consist of members from the 10 GM localities. It will be led by NHS and local government leaders and will be charged with developing a health and care plan, including Children's and adult social care. The NHS board will be responsible for a health plan only and will be responsible for the allocation of resources to providers and place. This structure will allow commissioning at a place level. GL said that these new proposals did not preclude ICS monies joining with council funding, though further detail on the required parameters for pooled budgets is yet to be confirmed. **GM Programme of Work** GL reported on the position statement submitted to GM from all 10 localities and listed a core set of proposals from them: • All 10 localities to have their own local system board • Clinical/political/provider leadership to be part of the new boards • Integrated delivery collaboratives (IDCs) to be part of each locality system • Neighbourhoods to be at the core of the work • Pooled budgets to be retained • All localities to have a place-based lead (taking delegation from the GM ICS) • Relationship around accountabilities and local plans to be agreed

Action: An options paper on the place-based lead for Bury to come to a future meeting (ref A/06/02)

GL explained that discussions are still taking place on funding flows into localities, but that there is still the option for section 75 agreements at a locality level.

EO'B noted that there is still the option to keep close relationship between the new NHS board and councils and that the collaborative approach can continue in this new structure.

Responding to CO'G's question on the membership of the new boards GL said that the board would be constituted once the appointment of the chair, chief executive and chief finance officer have taken place. He said that discussions continue around the relationship between the partnership board and the NHS board.

5 (ii) **GM Founding Finance Principles**

SE had shared a paper on proposed finance principles in advance of the meeting. She explained that although this had already gone through a number of key committees this is still an iterative document. She highlighted that the decision-making process is key to this area and that funds should follow function.

She highlighted that:

- The intention is to reduce the number of transactions
- There will be 1 NHS ledger and that the ICS will need to produce 1 set of accounts
- How to get flows into localities is to be confirmed
- There is flexibility around section 75 arrangements
- The intention is not to lose what we already have in GM, but to build on this work

SE agreed to bring regular updates to this Board.

Responding to AS's question around retaining the financial status quo in order to avoid de-stabilisation in the system, SE agreed that it was likely that monies would flow as currently for the next year of so.

SE said the challenge would be to manage funding within a cost envelope and to be able to move funds across localities without a detrimental effect on any one locality. She said that decision making and the focus on addressing health inequalities are at the forefront of this work.

GL agreed with these sentiments, recognising the need to deal with pent up demand and to balance budgets. He said that this would not stop the development of work in communities and that a long-term financial strategy will be needed to ensure funds are directed where needed.

GL noted that it takes time for cashable reductions in demand to be realised as part of any transformation programme.

Responding to EO'B's query on the opportunity to test an element of our principles in practice, SE gave an explanation around the elective recovery fund and how these national additional monies could be used as a system. She confirmed that a paper on these proposals is due to go to the Strategic Finance Group.

	CW supplemented this explanation with an update on how Bury (Fairfield Hospital) is supporting NCA system priorities in its use of theatres. KWJ added that as part of the community services work INTs are looking at managing demand by looking at alternatives to surgery, e.g. MSK work, rehab programmes EO'B noted that it was important to have this type of conversation now so that opportunities are flagged early for future work across the system.
6.	**Bury Partnership Transition**
6(i)	**Bury ICS Update** WB had shared a slide deck in advance of the meeting giving the latest updates from a GM and Bury perspective. As GL had updated on the main GM developments WB concentrated on the local picture. He outlined progress on the committees within the new Bury architecture and explained that a wider framework for place-based work is being developed. WB explained that the governance around the new Locality System Board will be determined by the GM ICS model, but that it will replace the current SCB, CCG governing body and system board. He noted the change in membership and its future function and role, as a strategic forum and a place-based budget holder. WB noted the IDC Board's role in overseeing the operational elements within the system. He reported on an SCB development session scheduled for 5 July, designed to look at the transition of SCB functions into the new architecture. WB described progress around the Clinical and Professional Senate, referring to a vibrant network of colleagues who will inform decision making. Other areas highlighted were: • Further guidance received on employment commitments, with an expectation that CCG staff will move into the GM ICS, but be deployed back into localities • Clinical leadership roles to be included in the above • Paper due to go to SCB on patient engagement and Healthwatch's support to the patient engagement agenda and lived experience informing work on a systematic basis • CCG closedown, including a celebration of its achievements WB highlighted the work on operational assurance within the "pillars" slide. TR noted the need to avoid duplication, but to do this work as a system, whilst still fulfilling statutory commitments. TR reported that he had been part of some positive discussions on this topic. Referring to an issue that had arisen at Digital Board LD alerted the Board to the issue of system versus organisational decision making for some of the enabler programmes. WB noted that enablers are at different stages of maturity and TR suggested drafting an agreed set of principles in order to overcome some of these issues. LD agreed that this would be a good way forward.
6(ii)	**Refreshed Locality Plan – final version** The final version of the plan had been shared with Board; this now includes a section submitted by the Strategic Finance Group. WB suggested that the plan acts as a touchstone for the system and informs our way of working and our development of partnership working. **The Bury Locality Plan was approved by the Board**.

6(iii)	**Bury Locality Board – draft terms of reference** WB highlighted the political, non-executive and senior clinical leadership which will make up this new committee. He noted the need to avoid de-stabilising governance structures this year by running a transition governance system alongside the current one in the short-term. He explained that the outputs of the SCB development session will inform the terms of reference and that a draft version of these will come to next Board. **Action: Locality System Board ToR to come to the next meeting for review (ref A/06/03)**
6(iv)	**Update from the Integrated Delivery Collaborative** KWJ had shared her update paper with Board in advance of the meeting. She noted some of the main highlights from it: • The IDC's work on its purpose, values and principles and the need to connect the enablers into this piece • The IDC's role in being able to achieve what individual organisations can't do singly • Work on the broader place-based offer and a target operating model, working in conjunction with Vicky Clark and Lynne Ridsdale • "show and tell" sessions planned for the transformation and enabler programmes • Stocktake on recovery plans, including a review of economic requirements • Work on the critical success factors for the IDC • 2 x outcomes workshops scheduled, looking at population health, effectiveness, economics • New committees to be convened in July allowing for the necessary relationships and an environment for productive conversations to take place **Outcomes Framework** KWJ explained that this is in development at present and will comprise 2 parts: 1. Operational assurance on community services, including adult social care 2. Total system assurance, including the quality and safety of services EO'B highlighted the IDC's role as being at the heart of the system and WB paid tribute to the leadership of CO'G and KWJ and their embracing of the move from LCO to IDC.
6(v)	**Clinical and Professional Senate -update** HH updated the group on the latest developments of this group, explaining that an interim committee is due to start in September, with a final group in place by Jan/Feb 2022. He noted the networks that are being developed as part of this piece of work. HH reported on a workshop planned for 26 July, where the intention is to: • Re-affirm roles, networks and supporting networks • Agree the senate's membership • Agree a process for mandating roles HH listed those invited to the workshop and asked for amendments/additional names to be emailed to him.
6(vi)	**Quality Assurance** CJ gave a verbal update on the background to this piece of work, explaining that a report on system assurance is due to go to Integrated Delivery Board on 23 June. She said that there

	was now an opportunity to do things differently, noting that statutory functions might not necessarily continue to sit in localities. CJ highlighted the role of the VCFA and Healthwatch in supporting the perspective of the patient experience in this work. She said that conversations on this topic are taking place between partner organisations and that a paper will come to the next meeting of this Board. **Action: System quality assurance paper to come to this Board on 15 July (A/06/04)** GL highlighted the work around children's safeguarding arrangements, where a community of practice approach is being utilised. He said work will be taking place over the next few months to ensure formal accountabilities are in place before the cessation of CCGs. He suggested that the work is fed into this Board. WB said there was work to be done on a range of statutory functions and where these would fit in the new architecture. Summing up, EO'B noted that there is a clear vision and direction of travel in Bury; he thanked everyone for their hard work and commitment in progressing this.
	SYSTEM BOARD
7.	**Bury Local Care Approach: Final Evaluation**
	The Cordis Bright final evaluation report had been previously shared with Board. WB gave the background to this work and its context within the evaluation of GM around the effect of the transformation fund and transformation programmes. WB noted the key theme in the document (in the context of the pandemic) was the quality of partnership working, especially that within neighbourhoods. He said it was important to capture any learning and that the document was here for receipt and acknowledgement. KWJ said that the strategic issues highlighted in the document are being picked up as part of the IDC development programme. She said the report had acted as a validation tool and would be used to inform the next stage of strategic development. TR reported that on the regular system calls with Raj Jain Bury is highlighted in a positive way, specifically for its responsive approach. Via the Chat facility AS noted the work the NCA has done on health inequalities and waiting lists is exemplary. Via the Chat facility LD reported that Cordis have now asked us to share our practices and development in INT's with systems in other parts of the country, referring to the Bury model as "one of the furthest developed in GM".
8.	**Elective Care Work - update**
	IM and CT jointly presented on the Elective Care transformation work, setting this in the context of the impact of Covid, increased waiting lists and increased health inequalities. Areas highlighted were: • Programme objectives • Series of workshops held on scoping, building back better and Let's Do It • Roadmap for June – August • Governance and the establishment of the Bury Advisory Group, acting as a critical friend • Key role of the joint communications group for collective messaging • Last 10 patients review, supported by NHSE/I and the integrated neighbourhood teams

- Focus on the patient experience and what outcomes an individual would want
- Alternatives to a medicalised approach, including pathways to social prescribing
- Working towards a model of co-production which can be scaled up

Responding to KWJ's question around short-term solutions within the acute sector IM confirmed that quick wins around MSK opportunities are being investigated.

Responding to GL's questions IM confirmed that:

1. Data is available for our different communities, including information on waiting lists, wards and ethnicity
2. Conversations are underway with Sajid Hashmi so that a strategic approach to the residents' lived experience is included in this work
3. Alternatives to non-medical admission are being investigated via an MDT approach; PCNs are working on this area

TR asked about the body of evidence on behaviour change and the use of coaches. CT explained that the team were working closely with Public Health colleagues on the prevention agenda. TR said he would share the link to the King's Fund podcast on this topic.

Action: TR to share a King's Fund podcast around behaviour change (A/06/05)

LD said there was a need for joined up conversations around system finances, noting the reliance on neighbourhoods in this proposed model. She noted the challenge around ethnographics and behaviour change and the need to expand this work.

LD suggested that a joint system and financial discussion is required in order to agree priorities as a system. She suggested further detail on this may be available following the scheduled "show and tell" sessions.

WB placed this work as sitting alongside the NCA's work on technical efficiency.

9. High Level Target Operating Model for Health and Care Neighbourhoods

A diagram on the intentions behind the place-based co-ordination of the wider neighbourhood model work had previously been shared with the group. VC joined the meeting to highlight some of the aspects of this work, including:

- Joining of public services in one place
- Consistency of language
- Collective community action including ward members and community champions
- Differing levels of intervention as and where required
- Creation of a person-centred, strengths-based framework
- Multi-agency approach
- Building on community resources
- Cohort analysis

Target Operating Model for Health and Care Neighbourhoods
LD's update paper on this topic had previously been shared with Board. Main points included:

- Components of the TOM
- Expansion of the INTs
- Testing out with wider staff groups
- Development of the neighbourhood task and finish group into a formal committee in July
- Further work being developed on an outcomes framework and KPIs across neighbourhoods
- Testing around the MH PCN roles and Public Health community grants and decision making

	LD confirmed that a more detailed paper would be available at the next meeting. **Action: Paper on the TOM for health and care neighbourhoods to come to the next meeting (A/06/06)** SE noted the opportunities and challenge of roles in the PCNs and wider and the need to attract more people into this area. GL noted the key aspect of case co-ordination, saying that if there are challenges around participation these need to be reported to this Board. LD noted that the use of the Primary Care contract in neighbourhoods will be an important aspect of this work. She confirmed that a benefits realisation proposal is due to be reviewed by the Strategic Finance Group, before being socialised more widely through the system.
10.	**Closing Matters**
	None discussed.

Next Meeting	**Date: 15 July 2021, 10.30-12.30pm, via Teams**
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